

Pulmonary Ventilation



The goals of respiration are to provide oxygen to the tissues and to remove carbon dioxide. To achieve these goals, respiration can be divided into four major functions: (1) *pulmonary ventilation*, which means the inflow and outflow of air between the atmosphere and the lung alveoli; (2) *diffusion of oxygen and carbon dioxide between the alveoli and the blood*; (3) *transport of oxygen and carbon dioxide in the blood and body fluids* to and from the body's tissue cells; and (4) *regulation of ventilation* and other facets of respiration. This chapter is a discussion of pulmonary ventilation, and the subsequent five chapters cover other respiratory functions plus the physiology of special respiratory abnormalities.

Mechanics of Pulmonary Ventilation

Muscles That Cause Lung Expansion and Contraction

The lungs can be expanded and contracted in two ways: (1) by downward and upward movement of the diaphragm to lengthen or shorten the chest cavity, and (2) by elevation and depression of the ribs to increase and decrease the anteroposterior diameter of the chest cavity. Figure 37–1 shows these two methods.

Normal quiet breathing is accomplished almost entirely by the first method, that is, by movement of the diaphragm. During inspiration, contraction of the diaphragm pulls the lower surfaces of the lungs downward. Then, during expiration, the diaphragm simply relaxes, and the *elastic recoil* of the lungs, chest wall, and abdominal structures compresses the lungs and expels the air. During heavy breathing, however, the elastic forces are not powerful enough to cause the necessary rapid expiration, so that extra force is achieved mainly by contraction of the *abdominal muscles*, which pushes the abdominal contents upward against the bottom of the diaphragm, thereby compressing the lungs.

The second method for expanding the lungs is to raise the rib cage. This expands the lungs because, in the natural resting position, the ribs slant downward, as shown on the left side of Figure 37–1, thus allowing the sternum to fall backward toward the vertebral column. But when the rib cage is elevated, the ribs project almost directly forward, so that the sternum also moves forward, away from the spine, making the anteroposterior thickness of the chest about 20 per cent greater during maximum inspiration than during expiration. Therefore, all the muscles that elevate the chest cage are classified as muscles of inspiration, and those muscles that depress the chest cage are classified as muscles of expiration. The most important muscles that raise the rib cage are the *external intercostals*, but others that help are the (1) *sternocleidomastoid* muscles, which lift upward on the sternum; (2) *anterior serrati*, which lift many of the ribs; and (3) *scaleni*, which lift the first two ribs.

The muscles that pull the rib cage downward during expiration are mainly the (1) *abdominal recti*, which have the powerful effect of pulling downward on the lower ribs at the same time that they and other abdominal muscles also compress the abdominal contents upward against the diaphragm, and (2) *internal intercostals*.

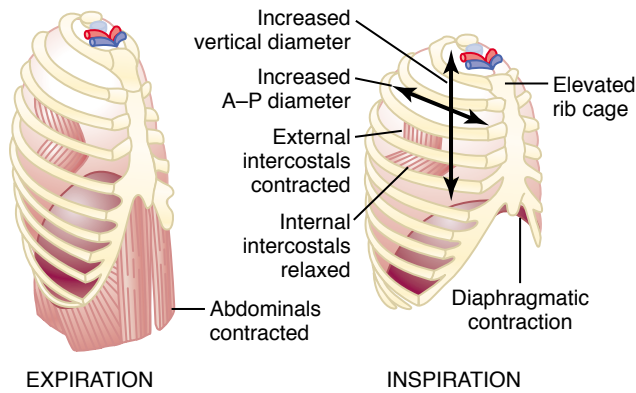


Figure 37-1

Contraction and expansion of the thoracic cage during expiration and inspiration, demonstrating diaphragmatic contraction, function of the intercostal muscles, and elevation and depression of the rib cage.

Figure 37-1 also shows the mechanism by which the external and internal intercostals act to cause inspiration and expiration. To the left, the ribs during expiration are angled downward, and the external intercostals are elongated forward and downward. As they contract, they pull the upper ribs forward in relation to the lower ribs, and this causes leverage on the ribs to raise them upward, thereby causing inspiration. The internal intercostals function exactly in the opposite manner, functioning as expiratory muscles because they angle between the ribs in the opposite direction and cause opposite leverage.

Movement of Air In and Out of the Lungs and the Pressures That Cause the Movement

The lung is an elastic structure that collapses like a balloon and expels all its air through the trachea whenever there is no force to keep it inflated. Also, there are no attachments between the lung and the walls of the chest cage, except where it is suspended at its hilum from the mediastinum. Instead, the lung “floats” in the thoracic cavity, surrounded by a thin layer of *pleural fluid* that lubricates movement of the lungs within the cavity. Further, continual suction of excess fluid into lymphatic channels maintains a slight suction between the visceral surface of the lung pleura and the parietal pleural surface of the thoracic cavity. Therefore, the lungs are held to the thoracic wall as if glued there, except that they are well lubricated and can slide freely as the chest expands and contracts.

Pleural Pressure and Its Changes During Respiration

Pleural pressure is the pressure of the fluid in the thin space between the lung pleura and the chest wall pleura. As noted earlier, this is normally a slight suction, which means a slightly *negative* pressure. The normal pleural pressure at the beginning of inspiration

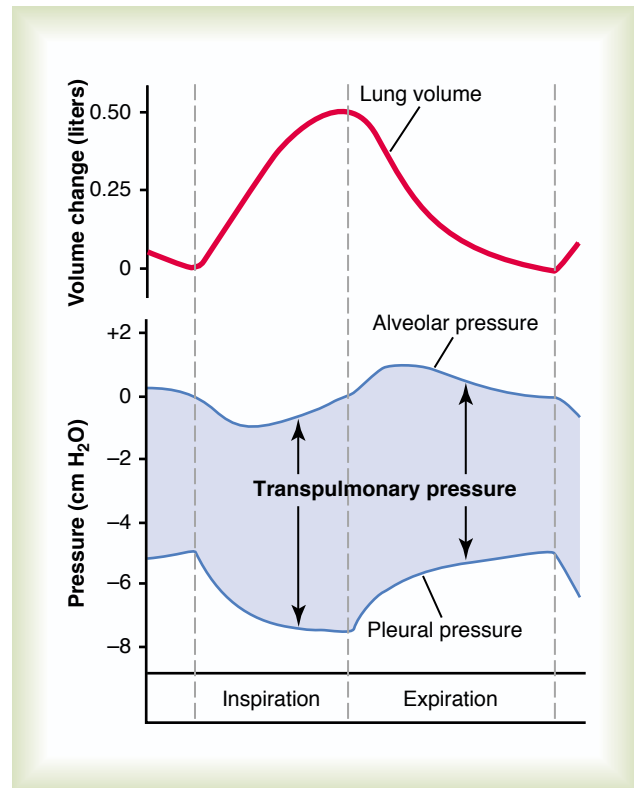


Figure 37-2

Changes in lung volume, alveolar pressure, pleural pressure, and transpulmonary pressure during normal breathing.

is about -5 centimeters of water, which is the amount of suction required to hold the lungs open to their resting level. Then, during normal inspiration, expansion of the chest cage pulls outward on the lungs with greater force and creates more negative pressure, to an average of about -7.5 centimeters of water.

These relationships between pleural pressure and changing lung volume are demonstrated in Figure 37-2, showing in the lower panel the increasing negativity of the pleural pressure from -5 to -7.5 during inspiration and in the upper panel an increase in lung volume of 0.5 liter. Then, during expiration, the events are essentially reversed.

Alveolar Pressure

Alveolar pressure is the pressure of the air inside the lung alveoli. When the glottis is open and no air is flowing into or out of the lungs, the pressures in all parts of the respiratory tree, all the way to the alveoli, are equal to atmospheric pressure, which is considered to be zero reference pressure in the airways—that is, 0 centimeters water pressure. To cause inward flow of air into the alveoli during inspiration, the pressure in the alveoli must fall to a value slightly below atmospheric pressure (below 0). The second curve (labeled “alveolar pressure”) of Figure 37-2 demonstrates that during normal inspiration, alveolar pressure decreases to about -1 centimeter of water. This slight negative

pressure is enough to pull 0.5 liter of air into the lungs in the 2 seconds required for normal quiet inspiration.

During expiration, opposite pressures occur: The alveolar pressure rises to about +1 centimeter of water, and this forces the 0.5 liter of inspired air out of the lungs during the 2 to 3 seconds of expiration.

Transpulmonary Pressure. Finally, note in Figure 37–2 the difference between the alveolar pressure and the pleural pressure. This is called the *transpulmonary pressure*. It is the pressure difference between that in the alveoli and that on the outer surfaces of the lungs, and it is a measure of the elastic forces in the lungs that tend to collapse the lungs at each instant of respiration, called the *recoil pressure*.

Compliance of the Lungs

The extent to which the lungs will expand for each unit increase in transpulmonary pressure (if enough time is allowed to reach equilibrium) is called the *lung compliance*. The total compliance of both lungs together in the normal adult human being averages about 200 milliliters of air per centimeter of water transpulmonary pressure. That is, every time the transpulmonary pressure increases 1 centimeter of water, the lung volume, after 10 to 20 seconds, will expand 200 milliliters.

Compliance Diagram of the Lungs. Figure 37–3 is a diagram relating lung volume changes to changes in transpulmonary pressure. Note that the relation is different for inspiration and expiration. Each curve is recorded by changing the transpulmonary pressure in small steps and allowing the lung volume to come to a steady level

between successive steps. The two curves are called, respectively, the *inspiratory compliance curve* and the *expiratory compliance curve*, and the entire diagram is called the *compliance diagram of the lungs*.

The characteristics of the compliance diagram are determined by the elastic forces of the lungs. These can be divided into two parts: (1) *elastic forces of the lung tissue itself* and (2) *elastic forces caused by surface tension of the fluid that lines the inside walls of the alveoli* and other lung air spaces.

The elastic forces of the lung tissue are determined mainly by *elastin* and *collagen* fibers interwoven among the lung parenchyma. In deflated lungs, these fibers are in an elastically contracted and kinked state; then, when the lungs expand, the fibers become stretched and unkinked, thereby elongating and exerting even more elastic force.

The elastic forces caused by surface tension are much more complex. The significance of surface tension is shown in Figure 37–4, which compares the compliance diagram of the lungs when filled with saline solution and when filled with air. When the lungs are filled with air, there is an interface between the alveolar fluid and the air in the alveoli. In the case of the saline solution–filled lungs, there is no air–fluid interface; therefore, the surface tension effect is not present—only tissue elastic forces are operative in the saline solution–filled lung.

Note that transpleural pressures required to expand air-filled lungs are about three times as great as those required to expand saline solution–filled lungs. Thus, one can conclude that *the tissue elastic forces tending to cause collapse of the air-filled lung represent only about one third of the total lung elasticity, whereas the*

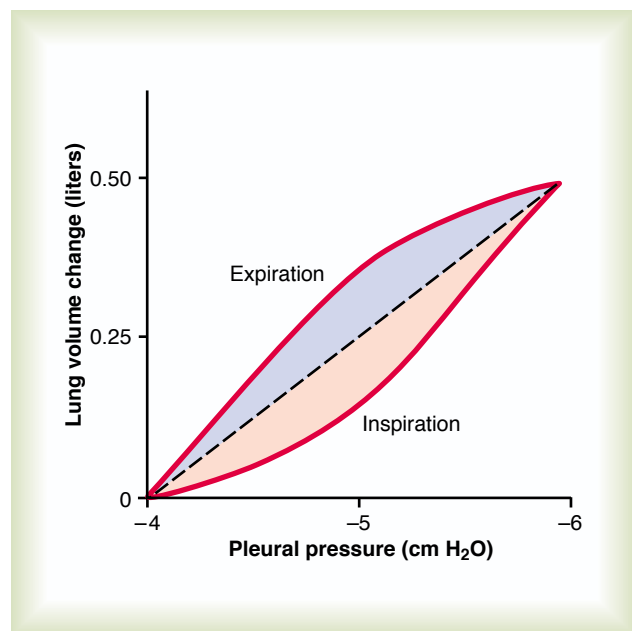


Figure 37–3

Compliance diagram in a healthy person. This diagram shows compliance of the lungs alone.

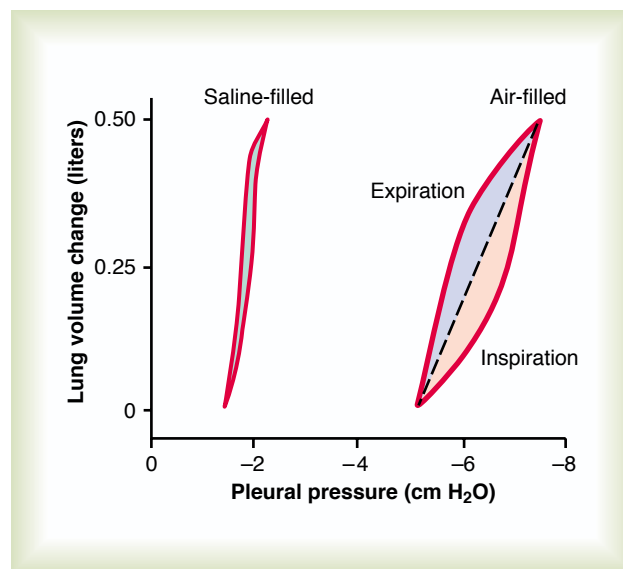


Figure 37–4

Comparison of the compliance diagrams of saline-filled and air-filled lungs when the alveolar pressure is maintained at atmospheric pressure (0 cm H₂O) and pleural pressure is changed.

fluid-air surface tension forces in the alveoli represent about two thirds.

The fluid-air surface tension elastic forces of the lungs also increase tremendously when the substance called *surfactant* is *not* present in the alveolar fluid. Let us now discuss surfactant and its relation to the surface tension forces.

Surfactant, Surface Tension, and Collapse of the Alveoli

Principle of Surface Tension. When water forms a surface with air, the water molecules on the surface of the water have an especially strong attraction for one another. As a result, the water surface is always attempting to contract. This is what holds raindrops together; that is, there is a tight contractile membrane of water molecules around the entire surface of the raindrop. Now let us reverse these principles and see what happens on the inner surfaces of the alveoli. Here, the water surface is also attempting to contract. This results in an attempt to force the air out of the alveoli through the bronchi and, in doing so, causes the alveoli to try to collapse. The net effect is to cause an elastic contractile force of the entire lungs, which is called the *surface tension elastic force*.

Surfactant and Its Effect on Surface Tension. Surfactant is a *surface active agent in water*, which means that it greatly reduces the surface tension of water. It is secreted by special surfactant-secreting epithelial cells called *type II alveolar epithelial cells*, which constitute about 10 per cent of the surface area of the alveoli. These cells are granular, containing lipid inclusions that are secreted in the surfactant into the alveoli.

Surfactant is a complex mixture of several phospholipids, proteins, and ions. The most important components are the phospholipid *dipalmitoylphosphatidylcholine*, *surfactant apoproteins*, and *calcium ions*. The dipalmitoylphosphatidylcholine, along with several less important phospholipids, is responsible for reducing the surface tension. It does this by not dissolving uniformly in the fluid lining the alveolar surface. Instead, part of the molecule dissolves, while the remainder spreads over the surface of the water in the alveoli. This surface has from one twelfth to one half the surface tension of a pure water surface.

In quantitative terms, the surface tension of different water fluids is approximately the following: pure water, 72 dynes/cm; normal fluids lining the alveoli but without surfactant, 50 dynes/cm; normal fluids lining the alveoli and *with* normal amounts of surfactant included, between 5 and 30 dynes/cm.

Pressure in Occluded Alveoli Caused by Surface Tension. If the air passages leading from the alveoli of the lungs are blocked, the surface tension in the alveoli tends to collapse the alveoli. This creates positive pressure in the alveoli, attempting to push the air out. The amount of pressure generated in this way in an alveolus can be calculated from the following formula:

$$\text{Pressure} = \frac{2 \times \text{Surface tension}}{\text{Radius of alveolus}}$$

For the average-sized alveolus with a radius of about 100 micrometers and lined with *normal surfactant*, this calculates to be about 4 centimeters of water pressure (3 mm Hg). If the alveoli were lined with pure water without any surfactant, the pressure would calculate to be about 18 centimeters of water pressure, 4.5 times as great. Thus, one sees how important surfactant is in reducing alveolar surface tension and therefore also reducing the effort required by the respiratory muscles to expand the lungs.

Effect of Alveolar Radius on the Pressure Caused by Surface Tension. Note from the preceding formula that the pressure generated as a result of surface tension in the alveoli is *inversely* affected by the radius of the alveolus, which means that the smaller the alveolus, the greater the alveolar pressure caused by the surface tension. Thus, when the alveoli have half the normal radius (50 instead of 100 micrometers), the pressures noted earlier are doubled. This is especially significant in small premature babies, many of whom have alveoli with radii less than one quarter that of an adult person. Further, surfactant does not normally begin to be secreted into the alveoli until between the sixth and seventh months of gestation, and in some cases, even later than that. Therefore, many premature babies have little or no surfactant in the alveoli when they are born, and their lungs have an extreme tendency to collapse, sometimes as great as six to eight times that in a normal adult person. This causes the condition called *respiratory distress syndrome of the newborn*. It is fatal if not treated with strong measures, especially properly applied continuous positive pressure breathing.

Effect of the Thoracic Cage on Lung Expansibility

Thus far, we have discussed the expansibility of the lungs alone, without considering the thoracic cage. The thoracic cage has its own elastic and viscous characteristics, similar to those of the lungs; even if the lungs were not present in the thorax, muscular effort would still be required to expand the thoracic cage.

Compliance of the Thorax and the Lungs Together

The compliance of the entire pulmonary system (the lungs and thoracic cage together) is measured while expanding the lungs of a totally relaxed or paralyzed person. To do this, air is forced into the lungs a little at a time while recording lung pressures and volumes. To inflate this total pulmonary system, almost twice as much pressure is needed as to inflate the same lungs after removal from the chest cage. Therefore, the compliance of the combined lung-thorax system is almost exactly one half that of the lungs alone—110 milliliters of volume per centimeter of water pressure for the combined system, compared with 200 ml/cm for the lungs alone. Furthermore, when the lungs are expanded to high volumes or compressed to low volumes, the limitations of the chest become extreme;

when near these limits, the compliance of the combined lung-thorax system can be less than one fifth that of the lungs alone.

“Work” of Breathing

We have already pointed out that during normal quiet breathing, all respiratory muscle contraction occurs during inspiration; expiration is almost entirely a passive process caused by elastic recoil of the lungs and chest cage. Thus, under resting conditions, the respiratory muscles normally perform “work” to cause inspiration but not to cause expiration.

The work of inspiration can be divided into three fractions: (1) that required to expand the lungs against the lung and chest elastic forces, called *compliance work* or *elastic work*; (2) that required to overcome the viscosity of the lung and chest wall structures, called *tissue resistance work*; and (3) that required to overcome airway resistance to movement of air into the lungs, called *airway resistance work*.

Energy Required for Respiration. During normal quiet respiration, only 3 to 5 per cent of the total energy expended by the body is required for pulmonary ventilation. But during heavy exercise, the amount of energy required can increase as much as 50-fold, especially if the person has any degree of increased airway resistance or decreased pulmonary compliance. Therefore, one of the major limitations on the intensity of exercise that can be performed is the person’s ability to provide enough muscle energy for the respiratory process alone.

Pulmonary Volumes and Capacities

Recording Changes in Pulmonary Volume—Spirometry

A simple method for studying pulmonary ventilation is to record the volume movement of air into and out of the lungs, a process called *spirometry*. A typical basic spirometer is shown in Figure 37–5. It consists of a drum inverted over a chamber of water, with the drum counterbalanced by a weight. In the drum is a breathing gas, usually air or oxygen; a tube connects the mouth with the gas chamber. When one breathes into and out of the chamber, the drum rises and falls, and an appropriate recording is made on a moving sheet of paper.

Figure 37–6 shows a spirogram indicating changes in lung volume under different conditions of breathing. For ease in describing the events of pulmonary ventilation, the air in the lungs has been subdivided in this diagram into four *volumes* and four *capacities*, which are the average for a *young adult man*.

Pulmonary Volumes

To the left in Figure 37–6 are listed four pulmonary lung volumes that, when added together, equal the maximum volume to which the lungs can be expanded. The significance of each of these volumes is the following:

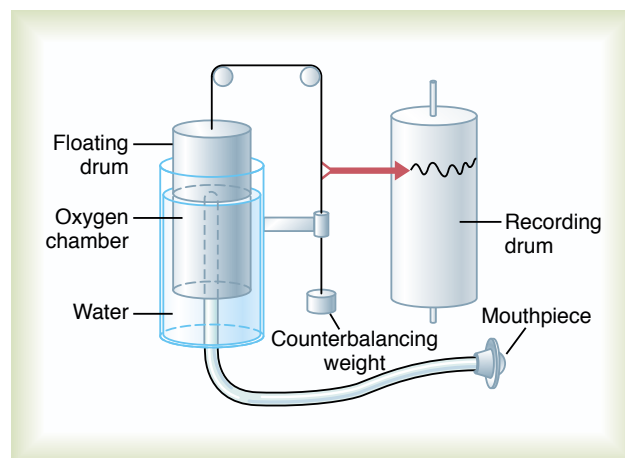


Figure 37–5

Spirometer.

1. The *tidal volume* is the volume of air inspired or expired with each normal breath; it amounts to about 500 milliliters in the adult male.
2. The *inspiratory reserve volume* is the extra volume of air that can be inspired over and above the normal tidal volume when the person inspires with full force; it is usually equal to about 3000 milliliters.
3. The *expiratory reserve volume* is the maximum extra volume of air that can be expired by forceful expiration after the end of a normal tidal expiration; this normally amounts to about 1100 milliliters.
4. The *residual volume* is the volume of air remaining in the lungs after the most forceful expiration; this volume averages about 1200 milliliters.

Pulmonary Capacities

In describing events in the pulmonary cycle, it is sometimes desirable to consider two or more of the volumes together. Such combinations are called *pulmonary capacities*. To the right in Figure 37–6 are listed the important pulmonary capacities, which can be described as follows:

1. The *inspiratory capacity* equals the *tidal volume* plus the *inspiratory reserve volume*. This is the amount of air (about 3500 milliliters) a person can breathe in, beginning at the normal expiratory level and distending the lungs to the maximum amount.
2. The *functional residual capacity* equals the *expiratory reserve volume* plus the *residual volume*. This is the amount of air that remains in the lungs at the end of normal expiration (about 2300 milliliters).
3. The *vital capacity* equals the *inspiratory reserve volume* plus the *tidal volume* plus the *expiratory reserve volume*. This is the maximum amount of air a person can expel from the lungs after first filling the lungs to their maximum extent and then

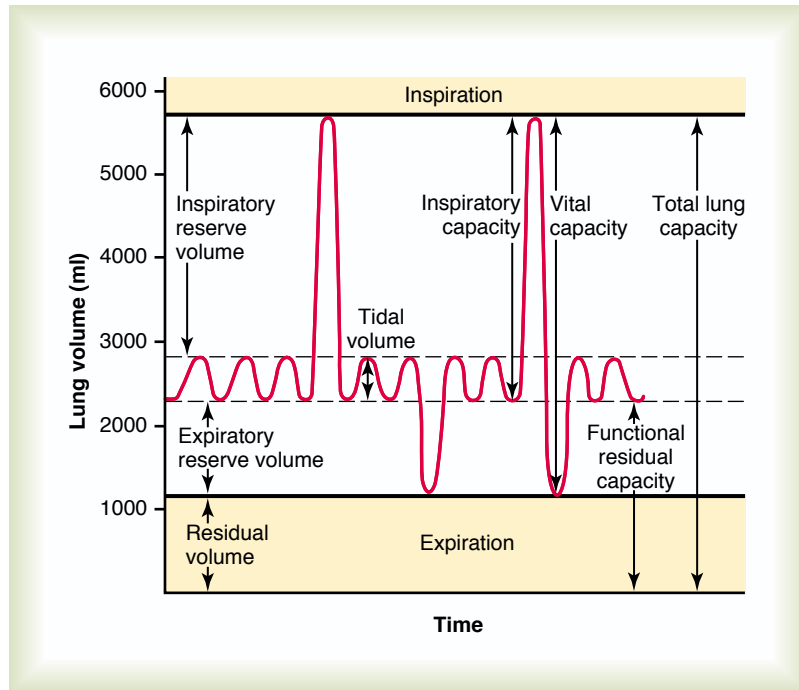


Figure 37-6

Diagram showing respiratory excursions during normal breathing and during maximal inspiration and maximal expiration.

expiring to the maximum extent (about 4600 milliliters).

4. The *total lung capacity* is the maximum volume to which the lungs can be expanded with the greatest possible effort (about 5800 milliliters); it is equal to the *vital capacity* plus the *residual volume*.

All pulmonary volumes and capacities are about 20 to 25 per cent less in women than in men, and they are greater in large and athletic people than in small and asthenic people.

Abbreviations and Symbols Used in Pulmonary Function Studies

Spirometry is only one of many measurement procedures that the pulmonary physician uses daily. Many of these measurement procedures depend heavily on mathematical computations. To simplify these calculations as well as the presentation of pulmonary function data, a number of abbreviations and symbols have become standardized. The more important of these are given in Table 37-1. Using these symbols, we present here a few simple algebraic exercises showing some of the interrelations among the pulmonary volumes and capacities; the student should think through and verify these interrelations.

$$\begin{aligned} VC &= IRV + V_T + ERV \\ VC &= IC + ERV \\ TLC &= VC + RV \\ TLC &= IC + FRC \\ FRC &= ERV + RV \end{aligned}$$

Determination of Functional Residual Capacity, Residual Volume, and Total Lung Capacity—Helium Dilution Method

The functional residual capacity (FRC), which is the volume of air that remains in the lungs at the end of each normal expiration, is important to lung function. Because its value changes markedly in some types of pulmonary disease, it is often desirable to measure this capacity. The spirometer cannot be used in a direct way to measure the functional residual capacity, because the air in the residual volume of the lungs cannot be expired into the spirometer, and this volume constitutes about one half of the functional residual capacity. To measure functional residual capacity, the spirometer must be used in an indirect manner, usually by means of a helium dilution method, as follows.

A spirometer of known volume is filled with air mixed with helium at a known concentration. Before breathing from the spirometer, the person expires normally. At the end of this expiration, the remaining volume in the lungs is equal to the functional residual capacity. At this point, the subject immediately begins to breathe from the spirometer, and the gases of the spirometer mix with the gases of the lungs. As a result, the helium becomes diluted by the functional residual capacity gases, and the volume of the functional residual capacity can be calculated from the degree of dilution of the helium, using the following formula:

$$FRC = \left(\frac{C_{iHe}}{C_{fHe}} - 1 \right) V_{iSpir}$$

Table 37-1

Abbreviations and Symbols for Pulmonary Function

V_T	tidal volume	P_B	atmospheric pressure
FRC	functional residual capacity	P_{alv}	alveolar pressure
ERV	expiratory reserve volume	P_{pl}	pleural pressure
RV	residual volume	PO_2	partial pressure of oxygen
IC	inspiratory capacity	PCO_2	partial pressure of carbon dioxide
IRV	inspiratory reserve volume	PN_2	partial pressure of nitrogen
TLC	total lung capacity	PaO_2	partial pressure of oxygen in arterial blood
VC	vital capacity	$PaCO_2$	partial pressure of carbon dioxide in arterial blood
Raw	resistance of the airways to flow of air into the lung	PAO_2	partial pressure of oxygen in alveolar gas
C	compliance	$PACO_2$	partial pressure of carbon dioxide in alveolar gas
V_D	volume of dead space gas	PAH_2O	partial pressure of water in alveolar gas
V_A	volume of alveolar gas	R	respiratory exchange ratio
\dot{V}_I	inspired volume of ventilation per minute	Q	cardiac output
\dot{V}_E	expired volume of ventilation per minute		
\dot{V}_s	shunt flow		
\dot{V}_A	alveolar ventilation per minute	CaO_2	concentration of oxygen in arterial blood
\dot{V}_{O_2}	rate of oxygen uptake per minute	$C\bar{v}O_2$	concentration of oxygen in mixed venous blood
\dot{V}_{CO_2}	amount of carbon dioxide eliminated per minute	SO_2	percentage saturation of hemoglobin with oxygen
\dot{V}_{CO}	rate of carbon monoxide uptake per minute	SaO_2	percentage saturation of hemoglobin with oxygen in arterial blood
D_{LO_2}	diffusing capacity of the lungs for oxygen		
D_{LCO}	diffusing capacity of the lungs for carbon monoxide		

where FRC is functional residual capacity, C_{iHe} is initial concentration of helium in the spirometer, C_{fHe} is final concentration of helium in the spirometer, and V_{iSpir} is initial volume of the spirometer.

Once the FRC has been determined, the residual volume (RV) can be determined by subtracting expiratory reserve volume (ERV), as measured by normal spirometry, from the FRC. Also, the total lung capacity (TLC) can be determined by adding the inspiratory capacity (IC) to the FRC. That is,

$$RV = FRC - ERV$$

and

$$TLC = FRC + IC$$

Minute Respiratory Volume Equals Respiratory Rate Times Tidal Volume

The *minute respiratory volume* is the total amount of new air moved into the respiratory passages each minute; this is equal to the *tidal volume* times the *respiratory rate per minute*. The normal tidal volume is about 500 milliliters, and the normal respiratory rate is about 12 breaths per minute. Therefore, the *minute respiratory volume averages about 6 L/min*. A person can live for a short period with a minute respiratory volume as low as 1.5 L/min and a respiratory rate of only 2 to 4 breaths per minute.

The respiratory rate occasionally rises to 40 to 50 per minute, and the tidal volume can become as great as the vital capacity, about 4600 milliliters in a young adult man. This can give a minute respiratory volume

greater than 200 L/min, or more than 30 times normal. Most people cannot sustain more than one half to two thirds these values for longer than 1 minute.

Alveolar Ventilation

The ultimate importance of pulmonary ventilation is to continually renew the air in the gas exchange areas of the lungs, where air is in proximity to the pulmonary blood. These areas include the alveoli, alveolar sacs, alveolar ducts, and respiratory bronchioles. The rate at which new air reaches these areas is called *alveolar ventilation*.

“Dead Space” and Its Effect on Alveolar Ventilation

Some of the air a person breathes never reaches the gas exchange areas but simply fills respiratory passages where gas exchange does not occur, such as the nose, pharynx, and trachea. This air is called *dead space air* because it is not useful for gas exchange.

On expiration, the air in the dead space is expired first, before any of the air from the alveoli reaches the atmosphere. Therefore, the dead space is very disadvantageous for removing the expiratory gases from the lungs.

Measurement of the Dead Space Volume. A simple method for measuring dead space volume is demonstrated by the graph in Figure 37-7. In making this measurement, the subject suddenly takes a deep breath of oxygen. This

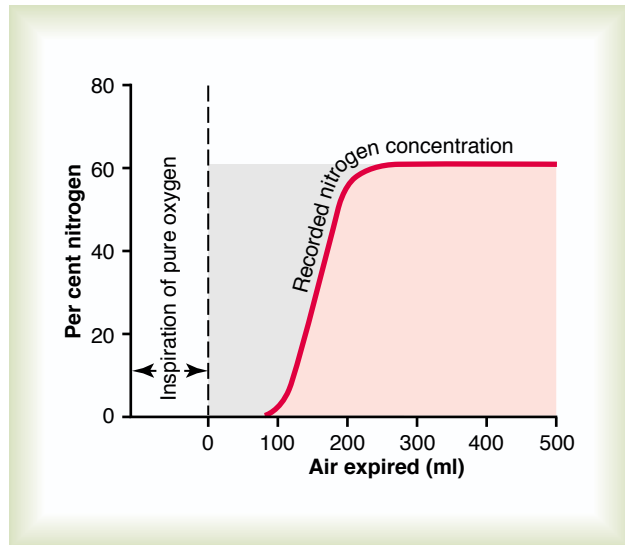


Figure 37-7

Record of the changes in nitrogen concentration in the expired air after a single previous inspiration of pure oxygen. This record can be used to calculate dead space, as discussed in the text.

fills the entire dead space with pure oxygen. Some oxygen also mixes with the alveolar air but does not completely replace this air. Then the person expires through a rapidly recording nitrogen meter, which makes the record shown in the figure. The first portion of the expired air comes from the dead space regions of the respiratory passageways, where the air has been completely replaced by oxygen. Therefore, in the early part of the record, only oxygen appears, and the nitrogen concentration is zero. Then, when alveolar air begins to reach the nitrogen meter, the nitrogen concentration rises rapidly, because alveolar air containing large amounts of nitrogen begins to mix with the dead space air. After still more air has been expired, all the dead space air has been washed from the passages, and only alveolar air remains. Therefore, the recorded nitrogen concentration reaches a plateau level equal to its concentration in the alveoli, as shown to the right in the figure. With a little thought, the student can see that the gray area represents the air that has no nitrogen in it; this area is a measure of the volume of dead space air. For exact quantification, the following equation is used:

$$V_D = \frac{\text{Gray area} \times V_E}{\text{Pink area} + \text{Gray area}}$$

where V_D is dead space air and V_E is the total volume of expired air.

Let us assume, for instance, that the gray area on the graph is 30 square centimeters, the pink area is 70 square centimeters, and the total volume expired is 500 milliliters. The dead space would be

$$\frac{30}{30 + 70} \times 500, \text{ or } 150 \text{ ml}$$

Normal Dead Space Volume. The normal dead space air in a young adult man is about 150 milliliters. This increases slightly with age.

Anatomic Versus Physiologic Dead Space. The method just described for measuring the dead space measures the volume of all the space of the respiratory system other than the alveoli and their other closely related gas exchange areas; this space is called the *anatomic dead space*. On occasion, some of the alveoli themselves are nonfunctional or only partially functional because of absent or poor blood flow through the adjacent pulmonary capillaries. Therefore, from a functional point of view, these alveoli must also be considered dead space. When the alveolar dead space is included in the total measurement of dead space, this is called the *physiologic dead space*, in contradistinction to the anatomic dead space. In a normal person, the anatomic and physiologic dead spaces are nearly equal because all alveoli are functional in the normal lung, but in a person with partially functional or nonfunctional alveoli in some parts of the lungs, the physiologic dead space may be as much as 10 times the volume of the anatomic dead space, or 1 to 2 liters. These problems are discussed further in Chapter 39 in relation to pulmonary gaseous exchange and in Chapter 42 in relation to certain pulmonary diseases.

Rate of Alveolar Ventilation

Alveolar ventilation per minute is the total volume of new air entering the alveoli and adjacent gas exchange areas each minute. It is equal to the respiratory rate times the amount of new air that enters these areas with each breath.

$$\dot{V}_A = \text{Freq} \cdot (V_T - V_D)$$

where \dot{V}_A is the volume of alveolar ventilation per minute, Freq is the frequency of respiration per minute, V_T is the tidal volume, and V_D is the physiologic dead space volume.

Thus, with a normal tidal volume of 500 milliliters, a normal dead space of 150 milliliters, and a respiratory rate of 12 breaths per minute, alveolar ventilation equals $12 \times (500 - 150)$, or 4200 ml/min.

Alveolar ventilation is one of the major factors determining the concentrations of oxygen and carbon dioxide in the alveoli. Therefore, almost all discussions of gaseous exchange in the following chapters on the respiratory system emphasize alveolar ventilation.

Functions of the Respiratory Passageways

Trachea, Bronchi, and Bronchioles

Figure 37-8 shows the respiratory system, demonstrating especially the respiratory passageways. The air is distributed to the lungs by way of the trachea, bronchi, and bronchioles.

One of the most important problems in all the respiratory passageways is to keep them open and allow easy passage of air to and from the alveoli. To keep the trachea from collapsing, multiple cartilage rings extend about five sixths of the way around the trachea. In the walls of the bronchi, less extensive curved cartilage plates also maintain a reasonable amount of rigidity yet allow sufficient motion for the lungs to expand and

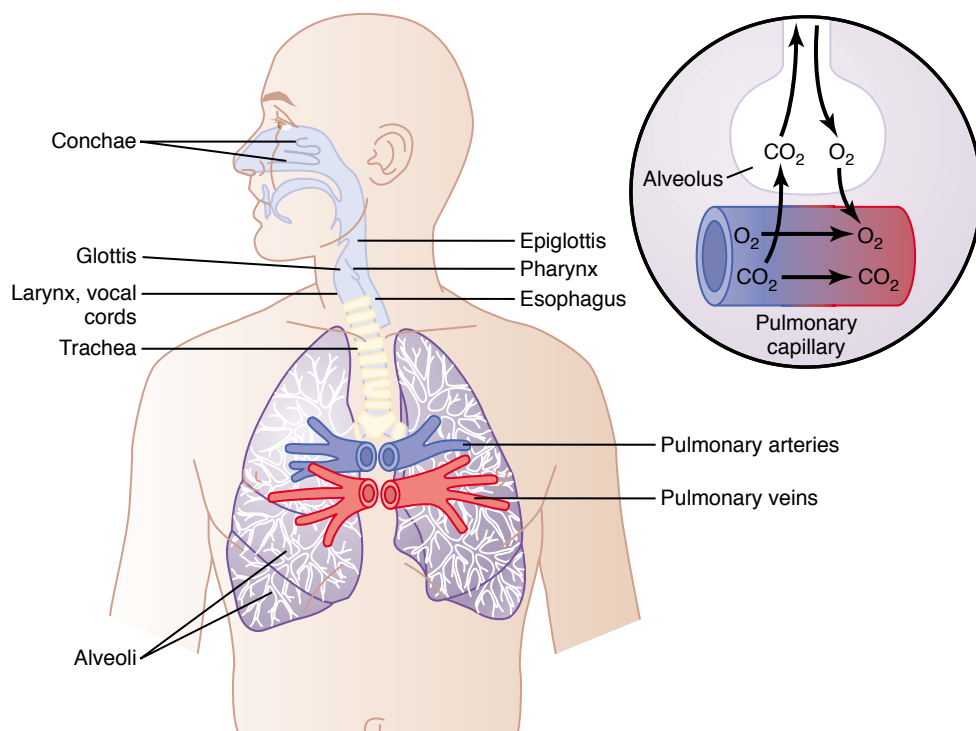


Figure 37-8

Respiratory passages.

contract. These plates become progressively less extensive in the later generations of bronchi and are gone in the bronchioles, which usually have diameters less than 1.5 millimeters. The bronchioles are not prevented from collapsing by the rigidity of their walls. Instead, they are kept expanded mainly by the same transpulmonary pressures that expand the alveoli. That is, as the alveoli enlarge, the bronchioles also enlarge, but not as much.

Muscular Wall of the Bronchi and Bronchioles and Its Control. In all areas of the *trachea* and *bronchi* not occupied by cartilage plates, the walls are composed mainly of smooth muscle. Also, the walls of the *bronchioles* are almost entirely smooth muscle, with the exception of the most terminal bronchiole, called the *respiratory bronchiole*, which is mainly pulmonary epithelium and underlying fibrous tissue plus a few smooth muscle fibers. Many obstructive diseases of the lung result from narrowing of the smaller bronchi and larger bronchioles, often because of excessive contraction of the smooth muscle itself.

Resistance to Airflow in the Bronchial Tree. Under *normal respiratory conditions*, air flows through the respiratory passageways so easily that less than 1 centimeter of water pressure gradient from the alveoli to the atmosphere is sufficient to cause enough airflow for quiet breathing. The greatest amount of resistance to airflow occurs not in the minute air passages of the terminal bronchioles but in some of the larger bronchioles and bronchi near the trachea. The reason for this high resistance is that there are relatively few of these larger bronchi in comparison with the approximately 65,000 parallel terminal bronchioles, through each of which only a minute amount of air must pass.

Yet in disease conditions, the smaller bronchioles often play a far greater role in determining airflow resistance because of their small size and because they

are easily occluded by (1) muscle contraction in their walls, (2) edema occurring in the walls, or (3) mucus collecting in the lumens of the bronchioles.

Nervous and Local Control of the Bronchiolar Musculature—“Sympathetic” Dilation of the Bronchioles. Direct control of the bronchioles by sympathetic nerve fibers is relatively weak because few of these fibers penetrate to the central portions of the lung. However, the bronchial tree is very much exposed to *norepinephrine* and *epinephrine* released into the blood by sympathetic stimulation of the adrenal gland medullae. Both these hormones—especially epinephrine, because of its greater stimulation of *beta-adrenergic receptors*—cause dilation of the bronchial tree.

Parasympathetic Constriction of the Bronchioles. A few parasympathetic nerve fibers derived from the vagus nerves penetrate the lung parenchyma. These nerves secrete *acetylcholine* and, when activated, cause mild to moderate constriction of the bronchioles. When a disease process such as asthma has already caused some bronchiolar constriction, superimposed parasympathetic nervous stimulation often worsens the condition. When this occurs, administration of drugs that block the effects of acetylcholine, such as *atropine*, can sometimes relax the respiratory passages enough to relieve the obstruction.

Sometimes the parasympathetic nerves are also activated by reflexes that originate in the lungs. Most of these begin with irritation of the epithelial membrane of the respiratory passageways themselves, initiated by noxious gases, dust, cigarette smoke, or bronchial infection. Also, a bronchiolar constrictor reflex often occurs when microemboli occlude small pulmonary arteries.

Local Secretory Factors Often Cause Bronchiolar Constriction. Several substances formed in the lungs themselves are

often quite active in causing bronchiolar constriction. Two of the most important of these are *histamine* and *slow reactive substance of anaphylaxis*. Both of these are released in the lung tissues by *mast cells* during allergic reactions, especially those caused by pollen in the air. Therefore, they play key roles in causing the airway obstruction that occurs in allergic asthma; this is especially true of the slow reactive substance of anaphylaxis.

The same irritants that cause parasympathetic constrictor reflexes of the airways—smoke, dust, sulfur dioxide, and some of the acidic elements in smog—often act directly on the lung tissues to initiate local, non-nervous reactions that cause obstructive constriction of the airways.

Mucus Lining the Respiratory Passageways, and Action of Cilia to Clear the Passageways

All the respiratory passages, from the nose to the terminal bronchioles, are kept moist by a layer of mucus that coats the entire surface. The mucus is secreted partly by individual mucous goblet cells in the epithelial lining of the passages and partly by small submucosal glands. In addition to keeping the surfaces moist, the mucus traps small particles out of the inspired air and keeps most of these from ever reaching the alveoli. The mucus itself is removed from the passages in the following manner.

The entire surface of the respiratory passages, both in the nose and in the lower passages down as far as the terminal bronchioles, is lined with ciliated epithelium, with about 200 cilia on each epithelial cell. These cilia beat continually at a rate of 10 to 20 times per second by the mechanism explained in Chapter 2, and the direction of their “power stroke” is always toward the pharynx. That is, the cilia in the lungs beat upward, whereas those in the nose beat downward. This continual beating causes the coat of mucus to flow slowly, at a velocity of a few millimeters per minute, toward the pharynx. Then the mucus and its entrapped particles are either swallowed or coughed to the exterior.

Cough Reflex

The bronchi and trachea are so sensitive to light touch that very slight amounts of foreign matter or other causes of irritation initiate the cough reflex. The larynx and carina (the point where the trachea divides into the bronchi) are especially sensitive, and the terminal bronchioles and even the alveoli are sensitive to corrosive chemical stimuli such as sulfur dioxide gas or chlorine gas. Afferent nerve impulses pass from the respiratory passages mainly through the vagus nerves to the medulla of the brain. There, an automatic sequence of events is triggered by the neuronal circuits of the medulla, causing the following effect.

First, up to 2.5 liters of air are rapidly inspired. Second, the epiglottis closes, and the vocal cords shut tightly to entrap the air within the lungs. Third, the abdominal muscles contract forcefully, pushing against the diaphragm while other expiratory muscles, such as the internal intercostals, also contract forcefully. Consequently, the pressure in the lungs rises rapidly to as much as 100 mm Hg or more. Fourth, the vocal cords and the epiglottis suddenly open widely, so that air under this high pressure in the lungs *explodes* outward. Indeed, sometimes this air is expelled at velocities ranging from 75 to 100 miles per hour. Importantly, the strong compression of the lungs collapses the bronchi and trachea by causing their noncartilaginous parts to

invaginate inward, so that the exploding air actually passes through *bronchial* and *tracheal slits*. The rapidly moving air usually carries with it any foreign matter that is present in the bronchi or trachea.

Sneeze Reflex

The sneeze reflex is very much like the cough reflex, except that it applies to the nasal passageways instead of the lower respiratory passages. The initiating stimulus of the sneeze reflex is irritation in the nasal passageways; the afferent impulses pass in the fifth cranial nerve to the medulla, where the reflex is triggered. A series of reactions similar to those for the cough reflex takes place; however, the uvula is depressed, so that large amounts of air pass rapidly through the nose, thus helping to clear the nasal passages of foreign matter.

Normal Respiratory Functions of the Nose

As air passes through the nose, three distinct normal respiratory functions are performed by the nasal cavities: (1) the air is *warmed* by the extensive surfaces of the conchae and septum, a total area of about 160 square centimeters (see Figure 37–8); (2) the air is *almost completely humidified* even before it passes beyond the nose; and (3) the air is *partially filtered*. These functions together are called the *air conditioning function* of the upper respiratory passageways. Ordinarily, the temperature of the inspired air rises to within 1°F of body temperature and to within 2 to 3 per cent of full saturation with water vapor before it reaches the trachea. When a person breathes air through a tube directly into the trachea (as through a tracheostomy), the cooling and especially the drying effect in the lower lung can lead to serious lung crusting and infection.

Filtration Function of the Nose. The hairs at the entrance to the nostrils are important for filtering out large particles. Much more important, though, is the removal of particles by *turbulent precipitation*. That is, the air passing through the nasal passageways hits many obstructing vanes: the *conchae* (also called *turbinates*, because they cause turbulence of the air), the septum, and the pharyngeal wall. Each time air hits one of these obstructions, it must change its direction of movement. The particles suspended in the air, having far more mass and momentum than air, cannot change their direction of travel as rapidly as the air can. Therefore, they continue forward, striking the surfaces of the obstructions, and are entrapped in the mucous coating and transported by the cilia to the pharynx to be swallowed.

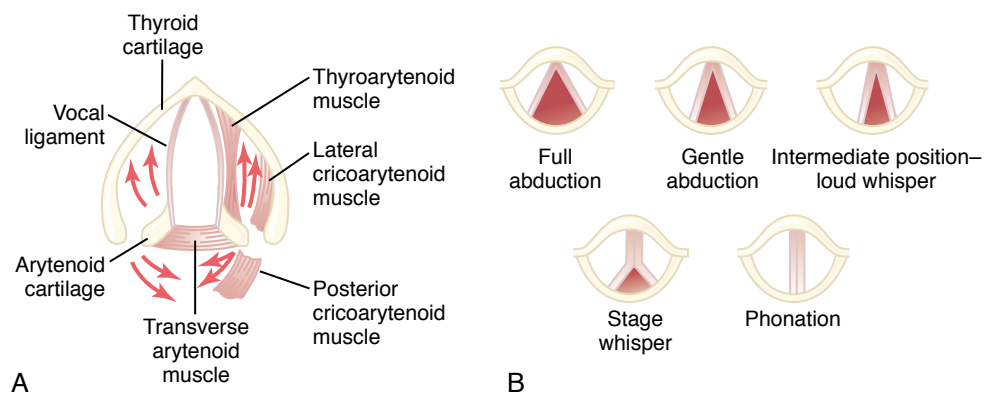
Size of Particles Entrapped in the Respiratory Passages.

The nasal turbulence mechanism for removing particles from air is so effective that almost no particles larger than 6 micrometers in diameter enter the lungs through the nose. This size is smaller than the size of red blood cells.

Of the remaining particles, many that are between 1 and 5 micrometers *settle* in the smaller bronchioles as a result of *gravitational precipitation*. For instance, terminal bronchiolar disease is common in coal miners because of settled dust particles. Some of the still smaller particles (smaller than 1 micrometer in diameter) *diffuse* against the walls of the alveoli and adhere to the alveolar fluid. But many particles smaller than 0.5

Figure 37–9

A, Anatomy of the larynx. B, Laryngeal function in phonation, showing the positions of the vocal cords during different types of phonation. (Modified from Greene MC: *The Voice and Its Disorders*, 4th ed. Philadelphia: JB Lippincott, 1980.)



micrometer in diameter remain suspended in the alveolar air and are expelled by expiration. For instance, the particles of cigarette smoke are about 0.3 micrometer. Almost none of these particles are precipitated in the respiratory passageways before they reach the alveoli. Unfortunately, up to one third of them do precipitate in the alveoli by the diffusion process, with the balance remaining suspended and expelled in the expired air.

Many of the particles that become entrapped in the alveoli are removed by *alveolar macrophages*, as explained in Chapter 33, and others are carried away by the lung lymphatics. An excess of particles can cause growth of fibrous tissue in the alveolar septa, leading to permanent debility.

Vocalization

Speech involves not only the respiratory system but also (1) specific speech nervous control centers in the cerebral cortex, which are discussed in Chapter 57; (2) respiratory control centers of the brain; and (3) the articulation and resonance structures of the mouth and nasal cavities. Speech is composed of two mechanical functions: (1) *phonation*, which is achieved by the larynx, and (2) *articulation*, which is achieved by the structures of the mouth.

Phonation. The larynx, shown in Figure 37–9A, is especially adapted to act as a vibrator. The vibrating element is the *vocal folds*, commonly called the *vocal cords*. The vocal cords protrude from the lateral walls of the larynx toward the center of the glottis; they are stretched and positioned by several specific muscles of the larynx itself.

Figure 37–9B shows the vocal cords as they are seen when looking into the glottis with a laryngoscope. During normal breathing, the cords are wide open to allow easy passage of air. During phonation, the cords move together so that passage of air between them will cause vibration. The pitch of the vibration is determined mainly by the degree of stretch of the cords, but also by how tightly the cords are approximated to one another and by the mass of their edges.

Figure 37–9A shows a dissected view of the vocal folds after removal of the mucous epithelial lining. Immediately inside each cord is a strong elastic ligament called the *vocal ligament*. This is attached anteriorly to the large *thyroid cartilage*, which is the cartilage that projects forward from the anterior surface of the neck and is called the “Adam’s apple.” Posteriorly, the vocal

ligament is attached to the *vocal processes* of two *arytenoid cartilages*. The thyroid cartilage and the arytenoid cartilages articulate from below with another cartilage not shown in Figure 37–9, the *cricoid cartilage*.

The vocal cords can be stretched by either forward rotation of the thyroid cartilage or posterior rotation of the arytenoid cartilages, activated by muscles stretching from the thyroid cartilage and arytenoid cartilages to the cricoid cartilage. Muscles located within the vocal cords lateral to the vocal ligaments, the *thyroarytenoid muscles*, can pull the arytenoid cartilages toward the thyroid cartilage and, therefore, loosen the vocal cords. Also, slips of these muscles *within* the vocal cords can change the *shapes and masses of the vocal cord edges*, sharpening them to emit high-pitched sounds and blunting them for the more bass sounds.

Finally, several other sets of small laryngeal muscles lie between the arytenoid cartilages and the cricoid cartilage and can rotate these cartilages inward or outward or pull their bases together or apart to give the various configurations of the vocal cords shown in Figure 37–9B.

Articulation and Resonance. The three major organs of articulation are the *lips*, *tongue*, and *soft palate*. They need not be discussed in detail because we are all familiar with their movements during speech and other vocalizations.

The resonators include the *mouth*, the *nose* and *associated nasal sinuses*, the *pharynx*, and even the *chest cavity*. Again, we are all familiar with the resonating qualities of these structures. For instance, the function of the nasal resonators is demonstrated by the change in voice quality when a person has a severe cold that blocks the air passages to these resonators.

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