Ventilation-Perfusion Inequality in Chronic Obstructive Pulmonary Disease

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ABSTRACT A multiple inert gas elimination method was used to study the mechanism of impaired gas exchange in 23 patients with advanced chronic obstructive pulmonary disease (COPD). Three patterns of ventilation-perfusion (VA/Q) inequality were found: (a) A pattern with considerable regions of high (greater than 3) VA/Q, none of low (less than 0.1) VA/Q, and essentially no shunt. Almost all patients with type A COPD showed this pattern, and it was also seen in some patients with type B. (b) A pattern with large amounts of low but almost none of high VA/Q, and essentially no shunt. This pattern was found in 4 of 12 type B patients and 1 of type A. (c) A pattern with both low and high VA/Q areas was found in the remaining 6 patients. Distributions with high VA/Q areas occurred mostly in patients with greatly increased compliance and may represent loss of blood-flow due to alveolar wall destruction. Similarly, well-defined modes of low VA/Q areas were seen mostly in patients with severe cough and sputum and may be due to reduced ventilation secondary to mechanical airways obstruction or distortion. There was little change in the VA/Q distributions on exercise or on breathing 100% O2. The observed patterns of VA/Q inequality and shunt accounted for all of the hypoxemia at rest and during exercise. There was therefore no evidence for hypoxemia caused by diffusion impairment. Patients with similar arterial blood gases often had dissimilar VA/Q patterns. As a consequence the pattern of VA/Q inequality could not necessarily be inferred from the arterial PO2 and PCO2.

INTRODUCTION

Chronic obstructive pulmonary disease (COPD) is classically associated with abnormalities of pulmonary gas exchange. In the past these abnormalities have most often been characterized by the alveolar-arterial PO2 difference (AaDO2), venous admixture (QVA/QT), and physiologic deadspace (VD/VT). However, characterization by these indices cannot provide a complete picture of the physiological abnormalities that are present.

An unresolved issue is whether diffusion impairment contributes to the hypoxemia in these patients. It has been known for many years that they may have a low diffusing capacity for carbon monoxide but this measurement is notoriously difficult to interpret in patients with large amounts of uneven ventilation (1). More recently King and Briscoe (2) have argued on the basis of two-compartment models that some of the hypoxemia may be caused by failure of PO2 equilibration between alveolar gas and end-capillary blood.

Consequently there are numerous unanswered questions concerning both the nature of ventilation-perfusion (VA/Q) inequality and the mechanism of hypoxemia in COPD: (a) the shape, position, and dispersion of the distribution of VA/Q ratios remain essentially undefined; (b) to what extent shunting and diffusion impairment are responsible for the hypoxemia are unresolved issues; (c) it is also not known to what degree there is impaired gaseous diffusion in the alveoli and airways as a result of the structural changes in the lungs; (d) the effects of breathing 100% oxygen are important but poorly understood because of uncertainty about how completely poorly ventilated areas have their nitrogen washed out; (e) the relationships between the pattern of VA/Q abnormalities, the mechanical properties of the lung, and the clinical picture are not well understood.

1 Abbreviations used in this paper: AaDO2, alveolar-arterial PO2 difference; BTFS, body temperature, pressure, saturated with water; COPD, chronic obstructive pulmonary disease; DLCO, diffusing capacity for carbon monoxide (single breath); FEV1, forced expiratory volume in 1 s; FRC, functional residual capacity; Fio2, fractional concentration, inspired gas; VA/Q, ventilation-perfusion; VC, vital capacity.
would be of value to know whether the clinical extremes of COPD (as described, for example, by Burrows and co-workers [3]) are in general associated with grossly dissimilar patterns of Va/Q inequality, or whether, on the other hand, there is a fundamental similarity in the distribution of Va/Q ratios across the spectrum of COPD. Resolution of this issue may throw light on the pathophysiology of these clinical entities.

It is the purpose of this paper to attempt to answer, at least in part, the foregoing issues. The primary technique employed in this study is our previously described multiple inert gas elimination method for measuring Va/Q ratio distributions (4–7). In a group of 23 patients with advanced but stable COPD of differing clinical types, the inert gas technique was applied under a variety of conditions, and the results have been related to the standard clinical indices of cardiopulmonary structure and function, including the clinical picture, pulmonary function tests, the chest X-ray, arterial and expired respiratory gas concentrations, and hemodynamic indices of the pulmonary circulation. Particular attention has been applied (Appendix) to the description of variability in distributions compatible with a given data set.

METHODS

Selection of subjects. 23 male patients with severe and advanced but stable COPD were studied (Table I). Based on clinical and pulmonary function data, the patients were separated into three categories: (a) 8 patients (patients 1–8 in Table I) had the clinical features of COPD type A as defined by Burrows and co-workers (3). In general they had minimal cough or sputum production, marked over-distension of their lungs, no history of peripheral edema, attenuated vessels on the chest X-ray, reduced elastic lung recoil, relatively mild hypoxemia, and no CO₂ retention. (b) 12 patients (patients 9–20 in Table I) had the clinical features of COPD type B as defined by Burrows and co-workers. In general these patients had a long history of bronchitis with copious sputum production, evidence of chronic cor pulmonale, normal elastic lung recoil, increased airways resistance, severe hypoxemia, and CO₂ retention. (c) 3 patients (21–23) had features common to both the preceding groups.

Preparation of patients. Three catheters were inserted under continuous electrocardiographic monitoring with the patient in the supine position. (a) Using a sterile introducer, a balloon-tipped catheter (Swan-Ganz no. 7 double lumen end hole, Edwards Lab Inc., Santa Ana, Calif.) was inserted percutaneously into an antecubital vein and advanced into the pulmonary artery. Right ventricular, pulmonary artery, and pulmonary artery wedge pressures were recorded at this time; the catheter was then withdrawn slightly for sampling of pulmonary arterial blood away from the wedge position. (b) A Medicut cannula (A. S. Aloe Co., St. Louis, Mo., 20 gauge) was inserted into the radial artery of the non-dominant hand. (c) A similar cannula was inserted into the most convenient peripheral arm vein.

The patient was then placed in a comfortable position, generally semirecumbent at an angle of about 30° to the horizontal. All studies were made in this position.

General outline of experimental protocol. Measurements were obtained under three conditions: breathing air at rest, breathing air during exercise with a pedal ergometer, and breathing 100% O₂ at rest. Not all subjects were able to tolerate exercise, while in others exercise studies could not be made for technical reasons. Thus only 10 of the 23 patients underwent exercise studies (patients 1, 2, 4, 9, 11, 12, 14, 18, 19, and 22; see Table I).

In 17 of the patients the sequence of measurements was (a) breathing air at rest, (b) breathing 100% O₂ at rest, (c) breathing air at rest. In 4 of these patients measurements were made during exercise, breathing air as well. In the remaining 6 patients the sequence of measurements was (a) breathing air at rest, (b) breathing air on exercise, (c) breathing air at rest. In 5 of these patients additional measurements were made during O₂ breathing at rest.

Since the details of the preparation of the six gas solutions, methods of infusion and sampling (4), techniques of gas chromatography (6), and the computer analysis (5, 7) have all been reported previously, these aspects will not be dealt with here.

The measurements made under any one of the physiological conditions were as follows: with the subject in a general steady state with relatively constant (±10% or less) tidal volume and frequency, end tidal Po₂ and PCO₂, and heart rate, the following samples were taken and measurements made. (a) 10–15 ml heparinized samples of both arterial and pulmonary arterial blood were taken slowly at a uniform rate over approximately 30 s. (b) A simultaneous 20-ml sample (in duplicate) of mixed expired gas was collected. Because of the solubility of halothane, ether, and acetone in plastics and water, special arrangements were necessary for the expired gas collection. The details of the heated flow-through system for this have been described previously (4).

(c) Immediately after the above sampling, heparinized arterial and pulmonary arterial samples (3 ml) were taken for measurement of Po₂, PCO₂, and pH with Radiometer blood gas electrodes (Radiometer Co., Copenhagen, Denmark). Simultaneously, another sample of mixed expired gas was collected for measurement of expired Po₂ and PCO₂. (d) Minute ventilation was recorded minute by minute using a calibrated Wright’s respirometer (British Oxygen Co., Essex, England). (e) End tidal CO₂ was measured by dye dilution using indocyanine green and a Gilford densitometer (Gilford Instrument Laboratories, Inc., Oberlin, Oh.). (f) End tidal Po₂ and PCO₂ and mixed expired Po₂ and PCO₂ were recorded continuously by mass spectrometer (Perkin-Elmer Corp., Pomona, Calif.).

A single 10-ml heparinized sample of venous blood was collected once during the study for measurement of the Po₂ of the oxyhemoglobin dissociation curve. This measurement was made by tonomterizing the sample of blood at least three different Po₂ values in the range 20–35 mmHg, and measuring both the Po₂ and saturation of the sample using the Instrumentation Laboratory (Lexington, Mass.) cooximeter and blood gas electrode system.

Calculations. Having obtained the Va/Q ratio distribution by computer analysis of the inert gas data (the value of the smoothing coefficient Z was 40), it was possible to compute respiratory gas exchange compatible with each recovered distribution by means of a computer program (8). Knowing the directly measured value for mixed venous and inspired Po₂ and PCO₂, acid-base status, hemoglobin and hematocrit, Pao₂ and body temperature, this program was used to construct a Va/Q line on the O₂–CO₂ diagram. On the assumption of complete alveolar end-capillary partial pressure equilibrium for oxygen and carbon dioxide, and taking into account the small amount of nitrogen exchange that occurs in
### Table I

**Anthropometric and Pulmonary Function Data**

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TLC, total lung capacity; FRC, functional residual capacity; RV, residual volume; VC, vital capacity; FVC, forced vital capacity; FEV₁, forced expired volume in 1 s; MMEFR, maximal mid-expiratory flow rate; Raw, airways resistance; Cl, compliance of lung and chest wall; P_F, transpulmonary pressure.

Each gas exchange unit, end-capillary and alveolar values for O₂ and CO₂ were calculated for each VA/Q compartment in the distribution. The mixed arterial and mixed expired Pₒ₂ and P_CO₂ values could then be computed by the ventilation and perfusion-weighted sums of the compartmental alveolar and end-capillary values, respectively. These calculated values could then be compared with directly measured mixed expired and arterial Pₒ₂ and P_CO₂.

### RESULTS

**Retention-solubility and excretion-solubility curves and distribution of VA/Q ratios at rest**

Each of the 23 patients was found to have one of three distinct patterns, which are illustrated in Fig. 1. In the example of each pattern, retention (ratio of arterial to mixed venous partial pressure) and excretion (ratio of mixed expired to mixed venous partial pressure) are plotted against inert gas solubility for the six gases used. In addition, the corresponding curves for a homogeneous lung with the measured total ventilation and blood flow are included as solid lines for comparison. From the retention and excretion values in Fig. 1A, it is evident that there are large differences in the raw data among the three patterns. These differences involve both shape and position of the retention and excretion curves. Thus in the upper panel, retention is not very different in shape from that of the homogeneous lung, but is shifted leftward of the homogeneous curve. By contrast the excretion curve falls away from the homogeneous curve mainly for the gases halothane and ether so that the shape differs from that of the homogeneous lung (this is better illustrated in the lower panel). By contrast with the upper panel, the middle panel demonstrates that ethane and cyclopropane retentions differ greatly from the homogeneous lung, and the two retention curves thus have different shapes. The excretion curve has essentially the same shape as the homogeneous lung but is shifted to the right. In the lowest panel, the excretion curve type of the upper panel and retention curve type of the middle panel coexist. Retention and excretion values of all 23 subjects are given in the Appendix.²

² Supplemental material, Figs. 8–10, Tables III–V, and an Appendix, has been deposited with the National Auxiliary Publications Service (NAPS) as NAPS document no. 02929. This information may be ordered from ASIS/NAPS, 515 Microfiche Publications, 305 East 46th Street, New York 10017. Remit with order for each NAPS document number.
Fig. 1B shows that three distinct patterns of $VA/Q$ distribution as derived from the retention-solubility and excretion-solubility curves could be identified. (a) Type H (high) pattern was so named because it is characterized by a mode of high $VA/Q$ units to the right of the main body of the distribution. This mode contains little blood flow so the H pattern has almost all of its blood flow in the region of lower $VA/Q$. This last point is the most satisfactory identifying feature. (b) By contrast type L (low) pattern is characterized by a mode of low $VA/Q$ units and has most of its ventilation in the region of higher $VA/Q$. (c) Type HL (high, low) has additional modes both above and below the main body. Position along the $VA/Q$ scale is not per se considered to be a criterion for classification.
Thus patients 16B and 19B (Figs. 2 and 3) have all of the ventilation and blood flow in the same region, but the patterns are different.

All patients had base-line (resting) distributions measured twice during the study at least 1 h apart, and each time in duplicate. In every case, the pattern (H, L, or HL) remained unchanged throughout these four measurements, indicating its reproducibility.

Comparing the retention-solubility and excretion-solubility curves with the resulting distributions, it is evident therefore that high \( V_{A}/Q \) areas (patterns H and HL) are mainly evidenced by a fall in excretion of the soluble gases halothane and ether, while in a similar manner low \( V_{A}/Q \) areas reflect an increase in retention of the less soluble gases. The necessary relationships between the patterns of \( V_{A}/Q \) inequality and the shapes of the retention-solubility and excretion-solubility curves have been examined in detail elsewhere (9).

It should be noted at this point that the distribution recovered in each case is not the only one compatible with the data within the limits of experimental error. For this reason considerable effort was made to define the possible differences that could exist within the family of compatible distributions in each case. In the Appendix, using retentions from patients 1, 4, and 9, we show that the three patterns shown in Fig. 1 cannot be confused with one another on the basis of nonuniqueness of the method.

The distributions recovered in all 23 patients appear in Figs. 2, 3, and 4. Here, patients were grouped according to the \( V_{A}/Q \) pattern (H, L, or HL), and the similar pattern classes are evident. The fundamental physiologic defect common to the 23 patients is severe irreversible airways obstruction so that the immediate question is whether there is an explanation for the widely differing classes of \( V_{A}/Q \) patterns. Consequently, the pattern in each case was examined in relation to the available clinical and physiological data (Tables I and II).

The relationships between the \( V_{A}/Q \) pattern and the clinical classification (predominantly type A, predominantly type B, or mixed) is shown in Fig. 5. Seven of the eight patients classified as type A had showed a distribution of pattern H; only one had
variety commonly have distinct low and/or high VA/Q areas although there is clearly much more variability within this group. The possible relationships between individual pulmonary function data and the VA/Q pattern are discussed later.

Shunt

Only 2 of the 23 patients had shunts greater than 5% of the cardiac output while breathing air. The mean shunt in these 21 patients was 0.7% of the cardiac output with a range of 0.0–4.4. The remaining two (patients 11 [type B] and 23 [mixed type A and B], respectively, had shunts of 12.4 and 22.2% breathing air. Neither of these patients had clinical evidence of a right to left intracardiac shunt, nor chest X-ray evidence of areas of atelectasis or infiltration so that the site of shunting was not evident. Upon breathing 100% O2 for 30 min, shunts indicated by the inert gas method generally increased but only by small amounts. The mean shunt in the group of 21 breathing 100% O2 was 1.6% of cardiac output with a range of 0.0–7.2. In the remaining two patients, the shunts measured by the method during O2 breathing were 13.9 and 20.4%, respectively. The mean increase in percent shunt for all 23 patients following O2 breathing was 0.8.

pattern L. By contrast, the VA/Q patterns in patients classified as type B were diverse: one-third had low but not high VA/Q areas (pattern L); one-third had high but not low VA/Q areas (pattern H); and one-third had both (pattern HL). Of the three patients who had clear clinical features of mixed types A and B COPD, two had both high and low VA/Q areas (pattern HL), and one had the high VA/Q pattern (H).

Thus it can be seen from Fig. 5 that 10 of the 11 patients who had clinical evidence of type A COPD (with or without associated signs of type B COPD) had VA/Q distributions containing high VA/Q modes. Of the 15 patients who had clinical features of type B COPD (with or without associated signs of type A COPD), 10 showed distributions containing low VA/Q areas (patterns L or HL) but 5 did not. Of the 12 type B patients without clinical evidence of type A COPD, 8 did in fact have areas of high VA/Q, although 3 had abnormally increased static compliance (Table 1, patients 12, 19, and 20) and in 4 others compliance measurements were not made.

These results therefore suggest that patients with advanced COPD of the type A variety are very likely to have high VA/Q areas. Furthermore, these patients are unlikely to have distinct low VA/Q areas unless they have clinical evidence of type B COPD as well. On the other hand, those patients thought to be of the type B

FIGURE 3 L pattern. This was found in 5 of the 23 subjects. Note the areas of low VA/Q but essentially no shunt and no areas of very high VA/Q (cf. Fig. 2). Patient 1 had features of type A COPD while patients 14–20 had features of type B COPD.

FIGURE 4 HL pattern found in 6 of the 23 subjects. Both low and high VA/Q areas are present and in two, sizable shunts are demonstrated as well. Patients 9–18 had features of type B COPD, and patients 21–22 had features of both types A and B COPD.
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Thus, most of the patients had little or no intrapulmonary shunting, and while there was a small increase in shunt after breathing 100% O2, this was of minor proportions, even in those patients having considerable amounts of lung with low VA/Q ratios (i.e., those patterns L or HL) in whom lung units with VA/Q ratios considerably below critical values (10) were present. By contrast, in a group of patients with post-traumatic respiratory failure who also had low VA/Q areas of lung (11), there was a considerably greater increase in shunt given by the inert gas method upon breathing 100% O2. Possible reasons for the lack of development of larger shunts while breathing O2 are discussed later.

**Deadspace**

In the inert gas method, the proportion of ventilation that is contained in the compartment of infinitely high VA/Q (deadspace) comes from several sources: instrumental deadspace, anatomic deadspace, gas exchange units that are unperfused, perfused gas exchange units with VA/Q ratios >100. Instrumental deadspace is accountable, but the remainder cannot be separately identified.

In a study of 12 normal volunteers of ages 21–60 (4), the value of deadspace as defined above and expressed in milliliters was very close to the body weight in pounds (mean of 0.43 ml body temperature, pressure, saturated with water (BTPS)/kg body weight). None of these subjects was either cachectic or grossly obese, or had an abnormal functional residual capacity (FRC).

The 11 patients with type A COPD (including the 3 with mixed type A and B diseases) had a mean weight of 66 kg and height of 1.73 m, while those with type B disease had a mean weight of 81.4 kg and height of 1.75 m. Mean total deadspace after subtracting the instrumental component in the first group was 217 ml BTPS/breath (0.68 ml/kg) while in the second group it was 201 ml BTPS/breath (0.51 ml/kg). Much if not all of this increase can probably be accounted for by the effect of increased FRC (Table I) on airway caliber, and it is not possible to ascertain whether any of the increased deadspace is attributable to ventilation of unperfused peripheral gas exchange units in the lung. Certainly rough extrapolation of the regression equation of Hart et al. (12) to an FRC of 169% of predicted (mean of all patients in the present

**VA/Q Distributions in Emphysema and Chronic Bronchitis**
with L, H, or HL patterns at rest continued to show the same pattern during exercise, with no detectable quantitative alterations. Respiratory and inert gas data during exercise appear in the Appendix (Tables IV, V).

There were also no detectable systematic changes in the inert gas data or the distributions after 30 min of breathing 100% O₂, except for the small increase in the shunt discussed above. In particular, the distribution pattern (L, H, or HL) did not change with O₂ breathing.

**Relationships between inert and respiratory gas exchange**

A technique for predicting gas exchange for oxygen and carbon dioxide from the recovered V̇A/Q distribution was described earlier, the central assumption being that in every gas exchange unit there is complete diffusion equilibration. The purpose of this computation is to test the hypothesis that the observed V̇A/Q inequality (including shunt) accounts for all of the independently observed hypoxemia, and that there is consequently no detectable impairment of diffusion equilibration. Should this be the case, the statistical relationship between measured and predicted arterial PO₂ would be one of identity. On the other hand, if diffusion impairment were a significant factor contributing to hypoxemia, the measured arterial PO₂ would be systematically lower than that predicted from V̇A/Q inequality and shunt alone. These arguments depend on the known order of magnitude difference between the rates of diffusion equilibration for inert gases (13) on the one hand, and O₂ and CO₂ (14, 15, 16) on the other.

**Arterial PO₂**

Fig. 6 shows the relationship between measured arterial PO₂ and that calculated by the above method (predicted). All measurements in all patients are included: breathing air at rest (PO₂ < 100), breathing 100% O₂ at rest (PO₂ > 100), and breathing air during exercise. The values obtained from 18 measurements on 10 patients during exercise are shown by the open circles. Actual retentions and mixed venous respiratory gas data were obtained under all of these conditions and were used to calculate the arterial PO₂.

**Breathing room air at rest.** Over the range from 36 to 75 mm Hg, there was good statistical agreement between calculated and measured arterial PO₂ (r = 0.95 and the relationship not different from identity), suggesting that the observed V̇A/Q inequality (and shunt, when present) accounted for all of the measured hypoxemia. The increasing scatter with increasing PO₂ most likely represents effects of the decreasing slope of the O₂ Hb dissociation curve. As PO₂ rises
this causes a larger error in calculated Po2 for a given error in calculated O2 content. In Fig. 6, at a Po2 of 40, the scatter is ±4 mm Hg (95%) while at Po2 of 60 it is ±9 mm Hg for 95% of values. Because of the shape of the O2 Hb dissociation curve, these both correspond to about ±0.8 ml % scatter in O2 content. It must be remembered that this scatter reflects the cumulative error of inert gas measurements, of measurements of arterial and venous Po2 and PCO2, and of ancillary variables such as Hb and P50.

Breathing room air during exercise. Arterial Po2 fell with exercise in every patient, but over the measured range of from 34 to 62 mm Hg the agreement between measured and calculated arterial Po2 was equally as good as at rest (Fig. 6).

The predictability of arterial Po2, especially during exercise, supports the hypothesis that failure of alveolar end-capillary diffusion equilibrium is not present as a mechanism contributing to hypoxemia in these patients. Even if individual discrepancies between measured and calculated Po2 in Fig. 6 were the result of diffusion impairment (rather than experimental error), this mechanism must play a minor role in terms of the total alveolar-arterial Po2 difference (AaDo2). For example, at a Po2 of 40 (AaDo2 of about 60 mm Hg), the observed maximum difference of 4 mmHg is only 1/15 or about 7% of the total AaDo2.

While this agreement between measured and calculated Po2 excludes a significant contribution to hypoxemia from failure of alveolar end-capillary diffusion equilibrium, it should not be taken to imply that the rate of capillary Po2 equilibration is necessarily normal. Our conclusion is simply that sufficient time is available to permit equilibration by the end of the red cell capillary transit. It has been established from theoretical calculations (14, 16, 17) that the overall capillary exchange process (combined diffusion and chemical equilibration) must be retarded by a factor of about four before detectable alveolar end-capillary differences will occur. Thus, considerable reduction in
diffusing properties of the blood gas barrier could be present and undetectable by this method.

It is concluded on the basis of (a) the agreement between measured and predicted PO₂, and (b) the lack of change in the distributions with exercise that the reason for the fall in arterial PO₂ during exercise was the fall in mixed venous PO₂ which in turn was the result of the relatively greater rise in VO₂ than in cardiac output.

Breathing 100% O₂ at rest. There was good agreement between the measured and calculated arterial PO₂ in the two patients with large shunts as determined by the inert gas method (PO₂ in the range 100–300 mm Hg). On the other hand, in the remaining 21 patients there was usually a large (50–200 mm Hg) difference between the calculated and measured PO₂ values during O₂ breathing. The measured value was virtually always considerably lower than predicted from the inert gas data (Fig. 6). As stated previously in discussing the same finding in normal subjects (4), it is reasonable to ascribe perhaps 50 mm Hg of this discrepancy to the combined effects of bronchial and Thebesian venous admixture (not detected by the inert gas method) and of errors in PO₂ measurement at these high values. This, however, leaves residual differences of up to 150 mm Hg between calculated and measured PO₂.

Since the retention of the inert gases of low solubility was essentially stable for 2 h during these studies (after the initial 30-min equilibration period), and certainly never increased systematically, it is highly unlikely that the discrepancy results from falsely low retention values for the insoluble gases resulting, in turn, from failure of equilibration within the lungs.

A more reasonable hypothesis for the PO₂ discrepancy during O₂ breathing is that after 30 min of O₂ breathing, the alveolar PO₂ in low VA/Q, poorly ventilated gas exchange units remained considerably below the predicted steady-state value for complete denitrogenation. Three factors could combine to produce this effect: (a) existence of poorly ventilated low VA/Q regions of lung; (b) inevitable small leaks in the O₂ delivery system, such that the effective FIO₂ was not precisely 1.0; and (c) continuing elimination of N₂ from the tissues.

**Arterial PCO₂ and Mixed Expired PO₂ and PCO₂**

The comparisons between measured and calculated arterial PCO₂ and mixed expired PO₂ and PCO₂ were made but are considerably less informative than that of arterial PO₂.

For arterial PCO₂, because of the usually small arteriovenous tension difference and the errors of measurement of PCO₂ (±2 mm Hg for 95% limits), the comparison is very insensitive to the nature of the VA/Q distribution. Agreement between measured and predicted PCO₂ was good over an almost 60 mm Hg range of PCO₂ (23–79) with r = 0.98 and 95% of the calculated values lying between ±3 mm Hg of measured PCO₂.

Over a much narrower range (10–27 mm Hg) of mixed expired PCO₂, there was equally good agreement between calculated and measured PCO₂, and similar results were obtained for expired PO₂.

**Relationships between respiratory gas exchange and the pattern of VA/Q distribution**

Those patients with type A COPD generally had well-preserved arterial blood gases since this was one of the criteria for selection. Thus arterial PO₂ was only once (patient 7) below 60 mm Hg, and PCO₂ exceeded 45 mm Hg only once (patient 2). These patients had sufficient minute ventilation (mean of 11.0 liters/min) to prevent CO₂ retention. They were hypoxemic because the main body of the blood flow distribution was shifted slightly toward low VA/Q values. Thus, as Fig. 2 shows, the main body of the distribution in the H pattern is typically centered on a VA/Q of about 0.6, a value which is consistent with a PO₂ in the 60–70 mm Hg range. By contrast, there was essentially no contribution to hypoxemia in this group from shunt or areas of very low VA/Q (<0.1).

It is of interest to compare the blood gases of four patients, of clinical type B (or mixed type) but who had VA/Q patterns of the H type (Fig. 2). In two (patients 17 and 23 with minute ventilation of 9.9 and 10.2 liters/min), the positions of the distributions and the arterial PO₂ and PCO₂ were essentially the same as in the type A patients, but in the remaining two (patients 13 and 16 with minute ventilations of 7.0 and 8.1 liters/min) there was more severe hypoxemia and there was hypercapnia. Fig. 2 can be used to compare these two subgroups of patients with the typical type H distribution in patients 2–10. It can be seen that the main body of the distribution is shifted considerably more toward lower VA/Q values in patients 13 and 16.

In other words, the finding that grossly dissimilar blood gases were found in patients with qualitatively similar VA/Q patterns is compatible with the relatively lower mean VA/Q in the more hypoxemic patients, which in turn is compatible with their reduced minute ventilations, also found by King and Briscoe (2). This finding is reinforced by examining the patients with the L type patterns in whom the range of arterial PO₂ was 47–71 mm Hg. In all examples, prediction of Pao₂ was good (Fig. 6). The conclusions are that it is often not possible to infer even the broad pattern
(H, L, HL) of $\overline{VA}/Q$ inequality from the arterial blood gases. Moreover, dissimilar $\overline{VA}/Q$ patterns may give rise to similar $P_{O_2}$ and $PCO_2$ values.

**DISCUSSION**

Assumptions of steady-state conditions. Studies were not made without evidence of a general cardiopulmonary steady state as indicated by stability of heart rate, tidal volume and frequency, arterial and mixed venous blood gases, end-tidal and mixed expired $P_{O_2}$ and $PCO_2$, and mean pulmonary artery pressure (all to within $\pm 10\%$). Occasionally, tidal volume or frequency changed between duplicate measurements, but when this was observed, 5 min at the new level of ventilation was allowed before sampling, on the basis of previous studies in dogs (18).

Additional evidence that inert gas exchange was in an acceptable steady state was the agreement for all gases in retention (and excretion) between initial and duplicate values obtained under a given circumstance 5 min apart. In the entire study of 23 patients, 118 such duplicate measurements (i.e., 59 pairs) were obtained. The mean difference was not statistically different from zero for any gas supporting the argument that a sufficiently steady state existed. Further support lies in the mean (of initial and duplicate) values breathing air at rest at the beginning of the study and again about 1 h later on in the study (either after breathing 100% $O_2$ or after a period of exercise). In the twenty studies in which two such runs (breathing air at rest) were made, the mean difference ($\Delta$) in retention (and excretion) individually for each gas was not significantly different from zero (overall $\Delta = 0.003, \pm 0.027$ SD). For the gas $SF_6$ (most likely to require the longest time to reach a steady state on theoretical grounds [5]) $\Delta = -0.002 \pm 0.011$ SD (at a mean $SF_6$ retention of 0.045). This supports the contention that even $SF_6$ had reached steady-state levels within 30 min of beginning the infusion.

Assumptions of diffusion equilibrium. The method depends on mass balance and uses the Fick principle, as originally formulated by Farhi (19). Specifically, at the level of the gas exchange unit, this implies complete alveolar end-capillary diffusion equilibrium for the inert gases.

Should this assumption not be justified for the inert gases, there should be a detectable molecular weight-dependent behavior of elimination. This was never found. However, by the time such a severe degree of interference to diffusion across the blood-gas barrier existed, there would be a far greater degree of interference for $O_2$, and the inert gas data would not be consistent with the measured arterial $P_{O_2}$. Fig. 6 confirms the consistency of blood gas and inert gas data.

Assumptions of parallel inhomogeneity. It is possible that some of the inequality in COPD may arise from series inequality—a situation in which some gas exchange units inspire (partly or wholly) from other gas exchange units. For these “parasitic” units, inspired gas levels would not be zero. We recently analyzed inert gas exchange in such a system (20) taking into account simultaneous $O_2$ and $CO_2$ exchange, and the results suggest that under the conditions of this study one can always find a ‘parallel’ lung with identical gas exchange to that in a given ‘series’ lung.

This finding has two implications: (a) the presence of series inequality will not lead to internal inconsistencies in the analysis so that the parallel formulation will yield an answer that fits the data even if these data come from a ‘series’ lung; and (b) by the same token it is not possible to separately identify series inequality with the inert gas method (unless as discussed above the series inequality is produced by impaired diffusive gas mixing and is thus molecular weight-dependent).

A further consideration is the effect of rein spiration of deadspace gas. Ross and Farhi (21) showed that because of the sharing of common tracheobronchial pathways the extremes of alveolar gas composition (inspired for ventilated, unperfused areas, and near mixed venous for perfused, essentially unventilated areas) would be unlikely to occur in real lungs as a result of common deadspace rein spiration. Although discussed principally for $O_2$, their arguments also apply to inert gases. While it is presently impossible to assess the quantitative aspects of this phenomenon, the results of the inert gas analysis generally will be to underestimate areas of both high and low $VA/Q$. Thus the apparent $VA/Q$ of a truly high $VA/Q$ lung unit rein spiring common deadspace will be lower than expected on the assumption of no common deadspace inspiration.

Relationships of patterns of inequality to clinical type and to pulmonary function. It is clear that virtually all patients possessing type A features demonstrated large amounts of ventilation to lung units with high $VA/Q$ ratios, and essentially no shunt or areas of very low $VA/Q(<0.1)$ if they were also devoid of type B features. However, such a good correlation was notably absent for the type B patients. One-third each of the type B patients had $VA/Q$ patterns H, L, and HL (Fig. 1). Moreover, as was pointed out, of the four type B patients with pattern H, two had well preserved blood gases ($P_{O_2} \approx 60$, $P_{CO_2} = 40$ mm Hg), while the two had severe hypoxemia with $CO_2$ retention ($P_{O_2} < 50$, $P_{CO_2} > 60$). The differences in the distributions were consistent with the differences in blood gases but the shapes of the $VA/Q$ patterns were similar. The difference in the distribution was only one of position along the $VA/Q$ axis, presumably related to the lower alveolar ventilation in the two more hypoxic.
patients. Thus, neither purely clinical features nor arterial blood gases were closely related to the VA/Q pattern, although tendencies were observed.

Fig. 7 shows the relationships among FEV₁/VC% (A), DLCO (B), airways resistance (C), and transpulmonary pressure at total lung capacity (D), and both VA/Q pattern and clinical type. Although in general reduced transpulmonary pressure at total lung capacity (increased compliance) was observed in patients with the H pattern, there were instances of pattern H in the presence of normal transpulmonary pressure values and of absence of pattern H in the presence of reduced transpulmonary pressure values. There is a reasonable pathophysiological basis for such a relationship (see below), but it is difficult to explain the exceptions noted above.

The degree of airways obstruction as expressed by FEV₁/VC% (and by other indices) was also unrelated to the pattern of VA/Q inequality. The same lack of relationship held for DLCO (single breath).

**Anatomical interpretation of VA/Q patterns.** The production of areas of high VA/Q as seen in the H pattern of inequality must involve reduction in blood flow to areas of the lung, since in order to achieve such
high VA/Q ratios without loss of perfusion an enormous fraction of ventilation would have to be directed to an extremely small region of lung. (For example, an area normally receiving just 5% of the total blood flow and occupying a similar proportion of lung volume would have to receive on the order of half of the total ventilation to achieve a VA/Q of 10. This is unreasonable.)

Such reduction in local perfusion is compatible with the loss of alveolar tissue (and consequently of elastic recoil) seen in emphysema, and may be the important factor in generation of the high VA/Q areas seen in this study. However, it is clear that such a redistribution of perfusion is insufficient to explain all the gas exchange abnormalities, and other reports of delayed nitrogen washout in particular. Irrespective of the method of analysis, nitrogen washout in advanced COPD is grossly abnormal and must represent inequality of ventilation with respect to lung volume (22). Thus the large amount of high VA/Q ratio lung observed probably reflects ventilation inequality together with reduction in blood flow.

A similar argument can be applied to the VA/Q patterns in which considerable amounts of very low VA/Q are found (pattern L). Here, there must be reduction in ventilation as the predominant cause of low VA/Q ratios rather than an increase in blood flow. (If anything, perfusion is likely to be reduced as a consequence of long-standing hypoxic vasoconstriction in these areas). Such a reduction in ventilation would be consistent with mechanical bronchial obstruction due to mucus, edema, and distortion of airways, and is to be expected in the presence of chronic bronchitis. Such low VA/Q areas were, however, seen in only 10 of the 15 patients classified as type B or as mixed types A and B, leaving 5 patients with clinical evidence of chronic bronchitis and no areas of very low VA/Q ratio.

An additional possible mechanism for these low VA/Q areas is suggested by the failure of a shunt to develop after 100% O2 breathing. Such a shunt frequently develops in patients (and dogs) with abnormal lungs having low VA/Q areas after they are given O2 to breathe. The fact that these patients with COPD do not follow this pattern suggests that a different mechanism is responsible, namely, collateral ventilation behind airways that are completely obstructed. In this instance, the low VA/Q would in effect be caused by series inequality and preliminary calculations show that under these circumstances, collapse during O2 breathing is much less likely. However, direct evidence for or against this remains to be collected.

ACKNOWLEDGMENTS

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