Relationship of Preoperative Closing Volume to Functional Residual Capacity and Alveolar–Arterial Oxygen Difference during Anesthesia with Controlled Ventilation

C. S. Weenig, M.D.,* S. Pietak, F.R.C.P.,* R. F. Hickey, M.D.,† H. B. Fairley, M.B.‡

Patients undergoing peripheral surgical procedures were studied before and after induction of halothane anesthesia to determine the interrelationship of functional residual capacity (FRC), closing volume (CV) and alveolar–arterial oxygen difference (A-aD\(_{\text{O}_2}\)). Measurements of FRC, CV, and A-aD\(_{\text{O}_2}\) (F\(_{\text{I}_\text{O}_2}\) = 1.0) were made preoperatively. During anesthesia all patients were ventilated at normal P\(_{\text{a}}\text{CO}_2\) with tidal volumes (V\(_T\)) of 5 and 10 ml/kg, the order determined randomly. FRC and A-aD\(_{\text{O}_2}\) were measured 30 and 60 minutes after institution of each tidal volume. FRC during anesthesia was unchanged from preoperative values at either tidal volume. Examining the relationship between preoperative CV and inspiratory lung volume (FRC + V\(_T\)) at the two tidal volumes administered revealed that when FRC exceeded CV, A-aD\(_{\text{O}_2}\) did not change with anesthesia and was not affected by tidal volume. When CV exceeded inspiratory lung volume, A-aD\(_{\text{O}_2}\) increased significantly with anesthesia. During anesthesia, changing from a small to a large tidal volume decreased A-aD\(_{\text{O}_2}\) when this increased inspiratory lung volume from below to above CV. (Key words: Lung, functional residual capacity; Lung, closing volume; Ventilation, mechanical; Anesthetics, volatiles: halothane.)

AN INCREASE in pulmonary venous admixture relative to preoperative values has been demonstrated in anesthetized man.\(^1\)\(^2\) A proposed mechanism for this increased pulmonary shunting is that anesthesia is associated with a reduction in functional residual capacity which in certain patients results in closure of dependent airways. This results in either equilibration of alveolar gas with venous blood or absorption of gas behind these closed airways, atelectasis, and consequently an increased pulmonary venous admixture. In support of this proposed mechanism, Don et al.\(^3\) have demonstrated that anesthesia with spontaneous ventilation increases the volume of trapped gas in patients in whom intraoperative functional residual capacity (FRC) is reduced to a volume less than the lung closing volume measured preoperatively. This interrelationship has not been examined previously during controlled ventilation.

The objectives of this study were to examine in anesthetized man during controlled ventilation: 1) The relationship of preoperative closing volume (CV), FRC, and alveolar–arterial oxygen tension difference (A-aD\(_{\text{O}_2}\)) to intraoperative FRC and A-aD\(_{\text{O}_2}\). 2) The effect of ventilation with small (5 ml/kg) and large (10 ml/kg) tidal volumes (V\(_T\)) on these relationships. 3) The relationship of body stature to FRC and the relationship of age to A-aD\(_{\text{O}_2}\).

Methods

Thirty-three patients scheduled for peripheral or lower abdominal surgical procedures were studied before and during surgery in the supine position. The day before operation, FRC, A-aD\(_{\text{O}_2}\), and CV (24 of the patients) were measured. Patients were premedicated with atropine (0.4–0.6 mg) and morphine sulfate (5–10 mg). Anesthesia was induced with thiopental (2–3 mg/kg), suc-
TABLE I. Ages and Body Statures in Groups I–III (Means ± SE)

<table>
<thead>
<tr>
<th></th>
<th>Age (Years)</th>
<th>Body Stature Height/Weight (cm/kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group I (n = 8)</td>
<td>36.8 ± 6.6</td>
<td>2.49 ± 0.12</td>
</tr>
<tr>
<td>Group II (n = 8)</td>
<td>47.9 ± 5.2</td>
<td>2.41 ± 0.15</td>
</tr>
<tr>
<td>Group III (n = 8)</td>
<td>56.8 ± 1.8</td>
<td>2.37 ± 0.13</td>
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* Significantly different from Group I, \( P < 0.05 \).

cyninecholine was administered (60–100 mg) and endotracheal intubation was accomplished. Following intubation, the lungs were inflated manually for two consecutive breaths, and an end-inspiratory airway pressure of 30–40 cm H2O was maintained for 30 seconds. Ventilation was then controlled and patients were not allowed to breathe spontaneously. Anesthesia was maintained with oxygen (flow rate 5 l/min) and halothane (.75–1.0 vol per cent) administered by a standard circle system. d-Tubocurarine was administered in a dosage sufficient to abolish spontaneous ventilatory effort.

By random selection, half of the patients were first ventilated at a tidal volume of 5 ml/kg for one hour and then at 10 ml/kg for one hour. This sequence was reversed for the other patients. Respiratory rate was adjusted to maintain \( P_{aco2} \), at 40 torr (mean \( P_{aco2} = 40 ± 1 \) SD). FRC and \( A-aD_{O2} \) were measured in duplicate 30 and 60 minutes after institution of the two tidal volumes. FRC was measured using a closed-system helium-dilution method employing a cathetometer and spirometer. Preoperative duplicate measurements were made with the patients breathing room air with oxygen added to the closed system to keep the volume constant. The mean difference between the high and low duplicate values of FRC was 161 ml ± 19 (SE). Intraoperatively the same system was used, filled with oxygen–helium and connected by a three-way valve so that the patient’s airway could be connected either to the anesthetic circle system or to the spirometer. The spirometer was modified for measurement intraoperatively by the insertion of a self-inflating reservoir bag and unidirectional valving system. During the period of helium dilution, tidal volume and respiratory frequency were kept identical to those of the ventilation pattern being studied. Halothane concentrations were measured by an infrared analyzer, and a correction factor was applied for the effect of halothane on the cathetometer. The mean difference between the high and low duplicate values intraoperatively was 22.4 ml ± 28 (SE).

Closing volume was measured using the single-breath nitrogen washout curve described by Anthonisen et al. Each patient had at least two measurements of closing volume. The mean difference between the high and low duplicate values was 75 ml ± 21 (SE).

All volumes measured were corrected to body temperature and pressure, saturated.

Preoperatively, arterial blood was drawn after the patient had breathed pure oxygen through a mouthpiece connected to a one-way valve until end-expired nitrogen was less than 1 per cent. Intraoperatively, arterial blood samples were collected immediately before each FRC measurement. Samples were drawn in heparinized glass syringes, placed in ice, and analyzed for \( P_{O2} \), \( P_{CO2} \), and \( pH \) within three hours of sampling. Samples were corrected for changes produced by time and temperature. A blood-gas factor for the oxygen electrode was obtained daily, using a tonometer and a 30 per cent mixture of glycerol in water. \( P_{aco2} \) was calculated from the following relationship: \( P_{aco2} = P_{tot} - P_{aco2} - P_{haemoglobin} \). Statistical analysis of the data was done by analysis of variance and linear regression.

Results

Patients were divided into groups according to the relationship of preoperative CV to intraoperative FRC plus \( V_T \). FRC + \( V_T \) is equal to inspiratory lung volume (ILV). Three groups with eight patients in each were apparent: Group I, CV < ILV at either \( V_T \); Group II, CV > ILV at \( V_T \) but <ILV at \( V_{T0} \); Group III, CV > ILV at \( V_{T0} \) or \( V_T \). Table 1 lists mean ages and body statures of the patients in the three groups. \( A-aD_{O2} \) was smallest preoperatively and did not significantly increase with anesthesia at either tidal volume in Group I. \( A-aD_{O2} \) in Group II increased significantly \(( P < .001) \) with anesthesia. In Group II, when the larger \( V_T \) was administered (CV < FRC + \( V_{T0} \)), \( A-aD_{O2} \) was significantly less \(( P < .05) \) than
A-aDo₂ at the smaller V₆ (CV > FRC + V₆). In Group III, CV exceeded FRC + V₆ at either tidal volume. A-aDo₂ was largest in this group preoperatively, increased with anesthesia, but was not significantly different at either tidal volume. Table 2 shows the data obtained for each group and also presents the difference between ILV (FRC + V₆) and CV to illustrate the correlation of these variables with A-aDo₂.

Comparison of FRC's measured preoperatively and during anesthesia showed no significant difference at either tidal volume. In the 33 patients studied awake, FRC was 2,599 ml ± 139 (SE). FRC's measured preoperatively were 2,566 ml ± 165 (SE) at V₆, 5 ml/kg and 2,536 ml ± 159(SE) at V₆, 10 ml/kg.

FRC's measured in awake patients and standardized to body weight correlated inversely with an index of obesity (lt/wt), r = 0.49; P < 0.005. The regression equation for this correlation is y = 6.92x - 1.81, where y = FRC(ml)/height(cm) and x = height (cm)/weight (kg). Age did not correlate with A-aDo₂ measured preoperatively (F₀ = 1.0). Intraoperatively, A-aDo₂ correlated directly with age when patients were ventilated at tidal volumes of both 5 and 10 ml/kg. Correlation coefficients are V₆, 5 ml/kg, r = 0.42; P < 0.025; V₆, 10 ml/kg, r = 0.48; P < 0.005.

Discussion

In a previous report of the effect of tidal volume on A-aDo₂ during controlled ventilation, large tidal volumes were shown to provide the optimum pulmonary gas exchange. In this study we found that the magnitude of A-aDo₂ can be related to the relationship between preoperative CV and inspiratory lung volume (FRC + V₆). In patients in whom inspiratory volumes always exceeded CV, A-aDo₂ remained unchanged when measured before and for two hours following induction of anesthesia (table 2, Group I). Of greater interest were the findings in patients classified in Group II (table 2). These were patients whose inspiratory lung volumes exceeded CV at tidal volumes of 10 ml/kg but not at 5 ml/kg. In these patients the higher tidal volume decreased A-aDo₂. Thus, this study supports the postulate of Don et al. that the FRC-CV difference is an important determinant of pulmonary oxygen exchange during anesthesia. By studying anesthetized patients breathing spontaneously, these authors supported their postulate by measuring volume of trapped gas (VTG) and relating VTG to the relative magnitude of FRC and CV. This present study supports this thesis by measurement of a more direct index of pulmonary oxygen exchange, A-aDo₂. However, if the relationship of CV to FRC is a major factor in oxygen exchange, why should anesthesia and controlled ventilation cause an increase in A-aDo₂ unless there is a change in FRC or closing volume? (Group III, Table 2.) One explanation is that a reduction in mixed venous oxygen concentration initiated by anesthesia and controlled ventilation would cause an increase in A-aDo₂ even though the pulmonary shunt fraction remained constant.
A decrease in mixed venous oxygen content could explain the increase in A-aDo₂ in this study, but fails to explain the decrease in A-aDo₂ found in Group II (table 2) when V₁ was increased so that inspiratory lung volume exceeded the closing volume measured preoperatively.

A second explanation for these results is provided by West et al.¹¹ These investigators have described different zones of perfusion of the lung which are dependent upon the relationship between pulmonary arterial, pulmonary venous, and alveolar pressure. When alveolar pressure is greater than pulmonary arterial pressure, pulmonary blood flow ceases. This relationship exists in the uppermost region of the lung. Patients in Group III (CV > FRC prior to anesthesia) had increased A-aDo₂'s. Anesthesia with positive-pressure ventilation would raise alveolar pressure, thus increasing the relative size of West's Zone 1, and would direct a greater proportion of pulmonary blood flow to nonventilated alveoli in the dependent lung.

We have made comparisons between intraoperative FRC's and preoperative CV's. Present methods used for the measurement of closing volume preclude its estimation during anesthesia. The assumption that CV does not change with anesthesia and muscle paralysis may be in error, and investigation of the effect of anesthesia and muscle paralysis on CV is indicated.

It is not clear why FRC should change during anesthesia with paralysis and controlled ventilation. Controlled ventilation would be expected to reduce pulmonary blood volume, and paralysis would reduce inspiratory muscle tone if such tone is present at FRC. These effects, if they occur, would oppose each other. However, the relative magnitude and the occurrence of these effects have not been documented. FRC did not decrease in our study. Other studies of patients who were anesthetized and paralyzed, with ventilation controlled, have shown that FRC decreases (table 3). A difference in techniques of anesthesia or in the patient population may explain these findings. Laws et al. found a 12 per cent reduction in FRC after administration of thiopental, succinylcholine, and intubation.⁴ For this reason the design of our study included two large lung inflations (40 cm H₂O for 30–40 seconds) following intubation. Because of the well-documented reduction in FRC with anesthesia and spontaneous ventilation,⁴ patients were not allowed to breathe spontaneously following induction. Other investigators listed in table 3 did not administer large inflations and did allow spontaneous breathing before beginning controlled ventilation. If atelectasis resulted, subsequent end-inspiratory pressures may not have exceeded opening pressure. As pointed out by Wyche et al.,¹⁶ upper abdominal operations, with attendant retractors and packs, may significantly reduce FRC.

### Table 3. Effects of Anesthesia with Controlled Ventilation on FRC

<table>
<thead>
<tr>
<th>Author</th>
<th>Number of Subjects</th>
<th>Anesthesia</th>
<th>Surgical Procedure</th>
<th>When Measured</th>
<th>Effect on FRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laws</td>
<td>12</td>
<td>Thiopental Succinylcholine</td>
<td>None</td>
<td>Immediately following intubation</td>
<td>10 per cent decrease from preoperative</td>
</tr>
<tr>
<td>Rehder et al.</td>
<td>12</td>
<td>Thiopental Succinylcholine</td>
<td>Thiopental Succinylcholine Meperidine</td>
<td>One hour post-induction</td>
<td>14 per cent decrease from preoperative</td>
</tr>
<tr>
<td>Westbrook et al.</td>
<td>5</td>
<td>Thiopental Succinylcholine</td>
<td>Thiopental Meperidine Hydrochloride</td>
<td>Throughout study</td>
<td>22 per cent decrease from preoperative</td>
</tr>
<tr>
<td>Wyche et al.</td>
<td>24</td>
<td>Thiopental Succinylcholine</td>
<td>N₂O/O₂ Narcotic d-tubocurarine</td>
<td>Lower and upper abdominal Within one hour of opening of abdomen</td>
<td>34 per cent decrease from preoperative</td>
</tr>
<tr>
<td>Weenig</td>
<td>33</td>
<td>Thiopental Succinylcholine</td>
<td>Halothane/O₂ d-tubocurarine</td>
<td>Peripheral 30–60–90 and 120 minutes following induction</td>
<td>No change from preoperative</td>
</tr>
</tbody>
</table>
Of further interest in this study was the effect on FRC when a patient coughed or strained during anesthesia. This occurred in four patients. Anesthesia depth was increased and relaxants were administered to abolish expiratory straining.

No attempt was made to re-expand the lungs. Subsequent measurement of FRC revealed a mean reduction to 69.5 per cent of the preoperative value (range 63–76 per cent). Data from these patients were not included in our study.

Previous work indicates that during anesthesia with spontaneous ventilation, the reduction in FRC can be correlated with an index of body stature and is greater in relatively obese patients. In this report an index of body stature (ht/wt) did correlate directly with FRC measured in supine, awake patients. This significant but relatively poor correlation (r = 0.49) compares favorably with other larger series which report that normal values for FRC have correlated best with body height. Correlation coefficients have ranged from 0.32 to 0.49 in these reports.

Finally, although FRC was not reduced with anesthesia and controlled ventilation in this study, our work examined only a short duration of time under carefully controlled conditions. FRC might be reduced in other patients by many events that occur with anesthesia and surgery, such as apnea, endotracheal intubation, hypoventilation, rapid absorption of soluble anesthetic gases, expiratory straining, abdominal retractors, and in the postoperative patient, abdominal pain and use of opiates to relieve this pain. If this is the case, then placing the patient in a more upright posture, as Don et al. have suggested, might improve pulmonary gas exchange. If so, the change in FRC that results from moving from the supine to the upright posture, and the effects of body stature and surgical incision on this change, are important considerations.

References