

## High-frequency Alternating Lung Ventilation

Stuart R. Hameroff, M.D.,\* Jerry M. Calkins, M.D., Ph.D.,† Charles K. Waterson, B.S.E.,‡  
Jeffrey S. Kanel, B.A.§

A new mode, high-frequency alternating lung ventilation (HFALV) is described and demonstrated in which the lungs are alternately pulsed. A fluidic oscillator may be used to deliver two pulsed gas streams, 180 degrees out of phase, to bronchial catheters placed via a double lumen endobronchial tube. Inspiratory phase of one lung thus coincides with expiratory phase in the other, and characteristic lateral rocking chest movement is observed.

In six dogs, HFALV was compared to simultaneous pulsing of both lungs with comparable flow (18.5 l/min), frequency (144 min<sup>-1</sup>), and pulse wave shape. Arterial P<sub>CO<sub>2</sub></sub> was significantly lower ( $P < 0.001$ ) with HFALV. Arterial P<sub>CO<sub>2</sub></sub> was also found to increase linearly ( $r = -0.862$ ,  $P < 0.001$ ) with distance of the catheters' distal tips from the dogs' carinae. Theoretical mechanisms and possible applications of HFALV are discussed. (Key words: Equipment: ventilators. Ventilation: alternating lung; high-frequency.)

VENTILATION at high rates has been described in varying modes and frequency ranges.<sup>1-4</sup> One type of high-frequency ventilation is high-frequency jet ventilation (HFJV) which delivers pulsed gas streams via small bore plastic catheters.<sup>5</sup> A bistable fluidic amplifier<sup>6</sup> can be adjusted to oscillate and produce two pulsed streams which are 180 degrees out of phase (fig. 1). If such streams are connected to two bronchial catheters placed via a double lumen endobronchial tube, the lungs may be ventilated alternately (180 degrees out of phase) at frequencies from 60-300 min<sup>-1</sup>. Inspiratory phase of one lung thus coincides with the expiratory phase of the other. To investigate HFALV, we performed the following studies.

### Methods

Six mongrel dogs (10-15 kg) were anesthetized in the dorsal recumbent position with pentobarbital (35 mg/kg), paralyzed with pancuronium (0.1 mg/kg), and their tracheas intubated with right-sided double

lumen endobronchial tubes. Polyethylene catheters (3 mm internal diameter) were passed into both endobronchial lumens and placed so the distal tips were at the orifices (average 1 cm past the carina). Proper endobronchial placement was verified by auscultation and by observing absences of air bubbles from the proximal catheter ends when only the opposite lung was ventilated. The proximal catheter ends were then connected to the outputs of the fluidic oscillator driven by 100 per cent oxygen (20 lbs/in<sup>2</sup>). Lateral rocking chest movements further verified proper endobronchial tube placement. Electrocardiogram and temperature were monitored and a femoral vein and artery cannulated for administration of maintenance crystalloid (5 ml/kg/hr), continuous blood pressure monitoring, and determination of arterial blood gases (ABG). Preliminary studies showed that at total flow of 18.5 l/min (measured by a rotameter proximal to the oscillator), pressures within the system ranged from 3-5 cm H<sub>2</sub>O, and adequate ventilation (Pa<sub>CO<sub>2</sub></sub> < 45 torr, Pa<sub>O<sub>2</sub></sub> > 300 torr) could be obtained regardless of frequency (60-300 min<sup>-1</sup>), inflation of the endobronchial tube cuffs, or PEEP (0-20 cm H<sub>2</sub>O) delivered via a circle system connected to the endobronchial tube.

To determine if HFALV significantly differs from HFJV, each dog was ventilated in random alternating 45-min sequences in the two modes and ABG measured at 15-min intervals. HFJV was made comparable to HFALV by using one output from the fluidic oscillator through a "Y" connector to both bronchial catheters and adjusting flow rate (18.5 l/min to each lung during inspiration), frequency (144 min<sup>-1</sup>), and pressure wave shape (oscilloscopically). Thus each lung received the same apparent flow, rate, and pressure pulse characteristics (I:E = 1:1) during the two modes. With HFJV, the lungs were pulsed simultaneously while with HFALV, the two lungs were pulsed alternately.

Effects of catheter tip placement (at 144 min<sup>-1</sup>) were studied by randomly changing position of both catheters in tandem and measuring ABG at 15-min intervals.

\* Assistant Professor.

† Assistant Professor.

‡ Research Assistant.

§ Research Assistant.

Received from the Department of Anesthesiology, University of Arizona Health Sciences Center, Tucson, Arizona 85724. Accepted for publication September 26, 1980.

Address reprint requests to Dr. Stuart R. Hameroff.

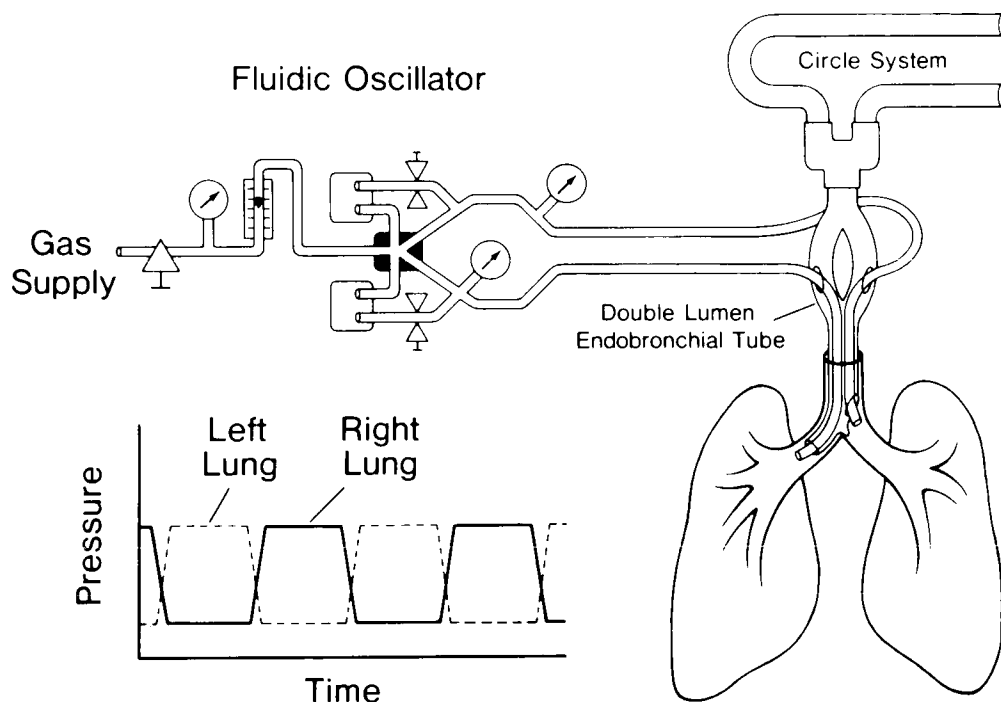


FIG. 1. Schematic representation of high-frequency alternating lung ventilation (HFALV). A bistable fluidic oscillator, driven by a 20 psi gas source, produces two pulsed gas streams which are 180 degrees out of phase (insert). These pulsed streams are delivered to the bronchi by polyethylene catheters (3 mm diameter) via a double lumen endobronchial tube.

## Discussion

Decreased  $P_{CO_2}$  with HFALV compared to HFJV may result from less dependence on chest wall expansion and compliance when only one lung is ventilated, assuming that lung expansion may be transmitted across the mediastinum. In one dog, a thoracotomy was performed during HFALV and the lungs and mediastinum were observed to "rock" back and forth with each gas pulse. Thus, the two lungs need not compete for volume within the chest and the expanding pulsed lung may deflate the opposite lung, augmenting exhalation and  $CO_2$  removal. An alternative explanation for lower  $P_{CO_2}$  with HFALV may be increased cardiac output, not measured in this study. Correlation of  $P_{CO_2}$  with HFALV catheter tip placement may be due to pulse dampening, increased dead space<sup>2</sup> and/or obstruction of expired gas flow by the ventilating pulse streams.

We have demonstrated a new high-frequency mode of ventilation, HFALV, in dogs. Disadvantages include the need for a double lumen endobronchial tube and therefore lack of pediatric application, uncertainty over mediastinal compliance in human adults, and the potential for barotrauma if the catheter tips extend too far into smaller airways. Several potential HFALV advantages may warrant further study. These include lower mean lung volumes (above functional residual capacity) which might reduce pulmonary vascular resistance and dead space in some lung areas.<sup>2</sup> Mediastinal displacement by unilateral lung expansion could reduce ventilation dependence

Data were analyzed using Student's *t* test for grouped data and linear regression analysis. Significance was defined as  $P < 0.05$  and linearity as  $r > |0.8|$ .

## Results

Compared to HFJV, HFALV resulted in lower arterial  $P_{CO_2}$  ( $P < 0.001$ , table 1). HFALV arterial  $P_{O_2}$  was significantly higher than HFJV  $P_{O_2}$  ( $P < 0.05$ ), however, calculated alveolar arterial oxygen differences ( $A-aD_{O_2}$ , respiratory quotient = 1) did not differ significantly between the two groups. We observed no differences in blood pressure, heart rate, or rhythm.

In the HFALV mode, arterial  $P_{CO_2}$  correlated linearly ( $r = -0.862$ ,  $P < 0.001$ , fig. 2) with catheter tip distance from the carina. In one dog, pushing the catheters 5 cm past the carina resulted in fatal barotrauma. Arterial  $P_{O_2}$  was not significantly altered by the catheters' tip position.

TABLE 1. Arterial Blood Gases (torr) with High-frequency Alternating Lung Ventilation (HFALV) Compared to High-frequency Jet Ventilation (HFJV)

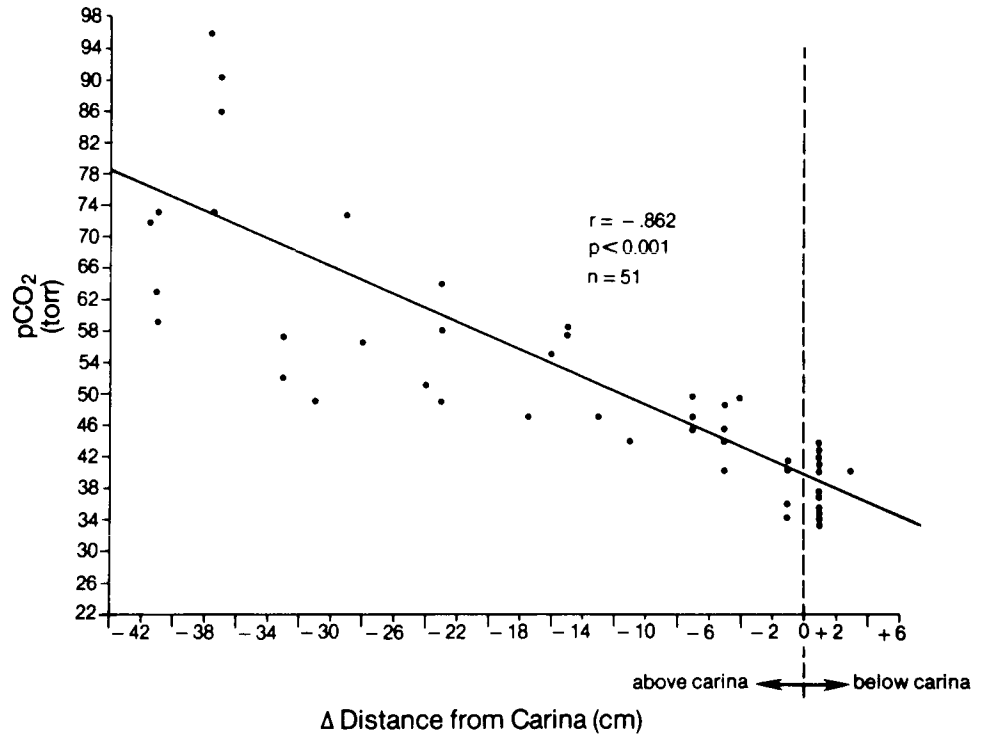
	HFALV	HFJV
$P_{CO_2}$	$36.8 \pm 1.5^*$	$49.2 \pm 2.5$
$P_{O_2}$	$446.1 \pm 6.2^{\dagger}$	$417.6 \pm 10.8$
$A-aD_{O_2}$	$169.8 \pm 7.1$	$186.1 \pm 12.4$

Values are group means  $\pm$  standard error of the mean.

Significantly different from HFJV by Student's *t* test for grouped data at  $*P < 0.001$ ,  $^{\dagger}P < 0.05$ .

Alveolar arterial oxygen differences ( $A-aD_{O_2}$ ) were calculated assuming respiratory quotient = 1. Both HFALV and HFJV at 18.5 l/min, 144  $\text{min}^{-1}$ , with similar pulse wave shapes to each lung.

FIG. 2. Arterial  $P_{CO_2}$  as a function of distance of distal catheter tips from the carina during HFALV. The catheters were moved randomly, in tandem, and  $P_{CO_2}$  rose as the distance above the carina increased. By linear regression analysis,  $r = -0.862$ ,  $P < 0.001$ .



on chest wall and diaphragm movement, thus improving overall compliance. Cardiovascular effects of pulsed mediastinal displacement may depend on relative timing of the pulse to the cardiac cycle. High-frequency ventilation electronically coupled to the EKG reportedly can augment cardiac output.<sup>7</sup> A final potential HFALV advantage is that at a given frequency, the inspiratory time, flow rate, tidal volume, PEEP, and pulse wave shape may be customized for differing lung pathologies<sup>8,9</sup> including "one lung" anesthesia for lateral thoracotomy.

### References

1. Heijman K, Heijman L, Jonzon A., et al: High frequency positive-pressure ventilation during anaesthesia and routine surgery in man. *Acta Anaesthesiol Scand* 16:176-187, 1972
2. Sjöstrand U: Review of the physiological rationale and de-

- velopment of high-frequency positive-pressure ventilation-HFPPV. *Acta Anaesthesiol Scand (Suppl)* 64:7-27, 1977
3. Eriksson J, Jonzon A, Sedin G, et al: The influence of the ventilation pattern on ventilation, circulation and oxygen transport during continuous positive pressure ventilation. *Acta Anaesthesiol Scand (Suppl)* 64:149-163, 1977
4. Kirby RR: High-frequency positive-pressure ventilation (HFPPV): what role in ventilatory insufficiency? *ANESTHESIOLOGY* 52:109-110, 1980
5. Klain M, Smith RB: High frequency percutaneous trans-tracheal jet ventilation. *Crit Care Med* 5:280-287, 1977
6. Klain M, Smith RB: Fluidic technology. *Anaesthesia* 31: 750-757, 1976
7. Klain M, Keszler H: Circulatory assist by high frequency ventilation. *Crit Care Med* 8:232, 1980
8. Carlon GC, Ray C, Klein R, et al: Criteria for selective positive end-expiratory pressure and independent synchronized ventilation of each lung. *Chest* 74:501-507, 1978
9. Glass DD, Tonnesen AS, Gabel JC, et al: Therapy of unilateral pulmonary insufficiency with a double lumen endotracheal tube. *Crit Care Med* 4:323-326, 1976