M1 - Cardiovascular / Respiratory, Fall 2007

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Ventilation/Perfusion Matching

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Objectives

• To recognize the importance of matching ventilation and perfusion
  – To explain the consequences of mismatched ventilation and perfusion
  – To define shunt and dead space physiology
  – To be able to determine the alveolar pO$_2$
  – To be able to determine the A-a O$_2$ gradient and understand the implications of an increased gradient
  – To explain and understand the consequences of regional differences in ventilation and perfusion due to effects of gravity
Ventilation and Perfusion at the Level of the Whole Lung

- Tidal Volume: 500 mL
- Anatomic Dead Space: 150 mL
- Alveolar Gas Volume: 3000 mL
- Volume of Blood in Pulmonary Capillaries: 70 mL
- Respiratory Rate: 15/min
- Total Ventilation: 7500 mL/min
- Alveolar Ventilation: 5250 mL/min
- Ventilation to Perfusion Ratio: \( \frac{\dot{V}}{\dot{Q}} = 1 \)
- Pulmonary Blood Flow: 5000 mL/min
Gas Composition in the Alveolar Space

Trachea: partial pressure of CO2 is approximately 0

\[ \text{PiO}_2 = (\text{barometric pressure} - \text{H}_2\text{O vapor pressure}) \times \text{FiO}_2 \]

\[ = (760 - 47) \times 0.21 = 150 \text{ mmHg} \]

In the alveolar space, oxygen diffuses into the blood and CO2 diffuses into the alveolus from the blood.
Alveolar Gas Equation

\[ PAO_2 = (PiO_2) - (PaCO_2/R). \]

PaCO\(_2\) approximates PACO\(_2\) due to the rapid diffusion of CO\(_2\)

\[ R = \text{Respiratory Quotient} (VCO2/V02) = 0.8 \]

In a normal individual breathing room air:

\[ PAO_2 = 150 - 40/0.8 = 100 \text{ mmHg} \]
Gas Composition in the Normal Alveolar Space

Trachea: partial pressure of CO2 is approximately 0

\[ \text{PiO}_2 = (\text{barometric pressure} - \text{H}_2\text{O vapor pressure}) \times \text{FiO}_2 \]

\[ = (760 - 47) \times 0.21 = 150 \text{ mmHg} \]

In the alveolar space, oxygen diffuses into the blood and CO2 diffuses into the alveolus from the blood.
Consequences of Inadequate Ventilation

- **Apnea:**
  - PACO2 rises
  - PAO2 falls until there is no gradient for diffusion into the blood

- **Hypoventilation:**
  - Inadequate ventilation for perfusion
  - PACO2 rises
  - PAO2 falls, but diffusion continues
How Can We Tell if Alveolar Ventilation is Adequate?
PaCO2 and Alveolar Ventilation

• PaCO2 is:
  – directly related to CO2 production (tissue metabolism).
  – Inversely related to alveolar ventilation.

• Increased PaCO2 (hypercarbia) is always a reflection of inadequate alveolar ventilation (VA).

\[ PaCO2 \approx \frac{VCO2}{VA} \]
Suppose a patient hypoventilates, so that the PCO2 rises to 80 mmHg. We can estimate the PAO2 based on the alveolar gas equation.

\[ \text{PAO2} = 150 - \frac{80}{0.8} = 50 \text{ mmHg} \]

Thus even with perfectly efficient lungs, the PaO2 would be 50, and the patient would be severely hypoxemic. Therefore, hypoventilation results in hypoxemia.
V/Q Matching

• 300 million alveoli.

• Different alveoli may have widely differing amounts of ventilation and of perfusion.

• Key for normal gas exchange is to have matching of ventilation and perfusion for each alveolar unit
  – Alveoli with increased perfusion also have increased ventilation
  – Alveoli with decreased perfusion also have decreased ventilation
  – V/Q ratio = 1.0
Two Lungs, Not One

- Suppose the left lung is ventilated but not perfused (dead space).
- Suppose the right lung is perfused but not ventilated (shunt).
- Total V/Q = 1, but there is no gas exchange (V/Q must be matched at level of alveolar unit).
Low V/Q Effect on Oxygenation

One lung unit has normal ventilation and perfusion, while the other has inadequate ventilation.

- Normal
- Low V/Q

PO2 114
PO2 50
PO2 ?

↑ PCO2
↓ PO2
Mixing Blood

- What is the PO2 of a mixture of two volumes of blood with different initial PO2?
- Determined by interaction of oxygen with hemoglobin.
  - the partition of oxygen between plasma (and thus the pO2) and bound to hemoglobin is determined by the oxyhemoglobin dissociation curve.
Oxyhemoglobin Dissociation Curve

% Hemoglobin Saturation

Oxygen Combined With Hemoglobin

Dissolved Oxygen

CO2 = (1.3 x HGB x Sat) + (.003 x PO2)

Oxygen Content (ml/100 ml)

PO2 (mmHg)
Low V/Q Effect on Oxygenation

One lung unit has normal ventilation and perfusion, while the other has inadequate ventilation.
Low V/Q Effect on Oxygenation

One lung unit has normal ventilation and perfusion, while the other has inadequate ventilation.

Normal

PO2 114 mmHg
O2sat 100%
O2 content 20ml/dl

Low V/Q

PO2 50 mmHg
O2sat 80%
O2 content 16ml/dl

PO2 114

PO2 50
Low V/Q Effect on Oxygenation

One lung unit has normal ventilation and perfusion, while the other has inadequate ventilation.

- **Normal**: PO2 114 mmHg, O2sat 100%, O2 content 20 ml/dl
- **Low V/Q**: PO2 50 mmHg, O2sat 80%, O2 content 16 ml/dl
- **Normal**: PO2 60 mmHg
- **Low V/Q**: PO2 50 mmHg
PCO2 in V/Q Mismatch

- Increased ventilation can compensate for low V/Q units.
  - Shape of CO2 curve
- Total ventilation (VE) must increase for this compensation.
Extremes of V/Q Inequality

- **Shunt**
  - Perfusion of lung units without ventilation
    - Unoxygenated blood enters the systemic circulation
    - $V/Q = 0$

- **Dead space**
  - Ventilation of lung units without perfusion
    - Gas enters and leaves lung units without contacting blood
    - Wasted ventilation
    - $V/Q$ is infinite
Effect of Changing V/Q Ratio on Alveolar PO2 and PCO2

- \( P_{O_2} = 150\, \text{mmHg} \)
  - \( P_{CO_2} = 0\, \text{mmHg} \)

- \( P_{O_2} = 100\, \text{mmHg} \)
  - \( P_{CO_2} = 40\, \text{mmHg} \)

- \( P_{O_2} = 40\, \text{mmHg} \)
  - \( P_{CO_2} = 45\, \text{mmHg} \)

Gas Composition:
- Mixed Venous Blood
- Normal
- Inspired Air

V/Q:
- 0
- 1
- \( \infty \)

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Effects of V/Q Relationships on Alveolar PO2 and PCO2

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One lung unit has normal ventilation and perfusion, while the other has no ventilation.
**Response to Breathing 100% Oxygen**

- Alveolar hypoventilation or V/Q mismatch responds to 100% oxygen breathing.

- Nitrogen will be washed out of low ventilation lung units over time.

- $\text{PaO}_2$ will rise to $> 550 \text{ mmHg}$.

- Limited response to oxygen in shunt.

- Use this characteristic to diagnose shunt.
Shunt Calculation

- \( Qt \times CaO2 \) = total volume of oxygen per time entering systemic arteries
  - \( Qt \) = total perfusion
  - \( Qs \) = shunt perfusion
  - \( CaO2, Cc'O2, CvO2 \) are oxygen contents of arterial, capillary and venous blood
- \((Qt-Qs) \times Cc'O2 \) = oxygen coming from normally functioning lung units
- \( Qs \times CvO2 \) = oxygen coming from shunt blood flow
Shunt

\[ \dot{Q}_t, \bar{C}_{\bar{v}O_2}, \dot{Q}_s, \frac{C_{c'O_2}}{C_{aO_2}}, \dot{Q}_t \]
Shunt Equation

\[ Qt \times CaO2 = [(Qt - Qs) \times CcO2] + [Qs \times CvO2] \]

\[
\frac{Qs}{Qt} = \frac{Cc'O2 - CaO2}{Cc'O2 - CvO2}
\]
Causes of Shunt

• Physiologic shunts:
  – Bronchial veins, pleural veins

• Pathologic shunts:
  – Intracardiac
  – Intrapulmonary
    • Vascular malformations
    • Unventilated or collapsed alveoli
Detecting V/Q Mismatching and Shunt

• Radiotracer assessments of regional ventilation and perfusion.

• Multiple inert gas elimination.
  – Takes advantage of the fact that rate of elimination of a gas at any given V/Q ratio varies with its solubility.

• A-aO2 Gradient.
V/Q Relationships

Multiple Inert Gas Elimination

A-a O2 gradient

• In a totally efficient lung unit with matched V/Q, alveolar and capillary PO2 would be equal.

• Admixture of venous blood (or of blood from low V/Q lung units) will decrease the arterial PaO2, without effecting alveolar O2 (PAO2).

• Calculate the PAO2 using the alveolar gas equation, then subtract the arterial PaO2: \[ (PiO_2) - (PaCO_2/R)] - PaO2.

• The A-a O2 gradient (or difference) is < 10-15 mmHg in normal subjects
  – Why is it not 0?
Apical and Basilar Alveoli in the Upright Posture

• Elastic recoil of the individual alveoli is similar throughout the normal lung.

• At end expiration (FRC) apical alveoli see more negative pressure and are larger than basilar alveoli.

• During inspiration, basilar alveoli undergo larger volume increase than apical alveoli.

• Thus at rest there is more ventilation at the base than the apex.

• Also More Perfusion to Lung Bases Due to Gravity.
Effects of Gravity on Ventilation and Perfusion

Effects of Gravity on Ventilation and Perfusion Matching

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Causes of Abnormal Oxygenation

- Hypoventilation
- V/Q mismatch
- Shunt
- Diffusion block
Key Concepts:

- Ventilation and Perfusion must be matched at the alveolar capillary level.

- V/Q ratios close to 1.0 result in alveolar PO2 close to 100 mmHg and PCO2 close to 40 mmHg.

- V/Q greater than 1.0 increase PO2 and Decrease PCO2. V/Q less than 1.0 decrease PO2 and Increase PCO2.

- Shunt and Dead Space are Extremes of V/Q mismatching.

- A-a Gradient of 10-15 Results from gravitational effects on V/Q and Physiologic Shunt.