

SIXTH EDITION

# Fishman's

## PULMONARY DISEASES AND DISORDERS

**Michael A. Grippi**

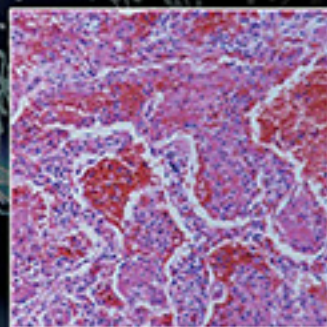
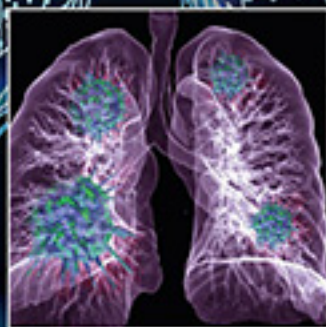
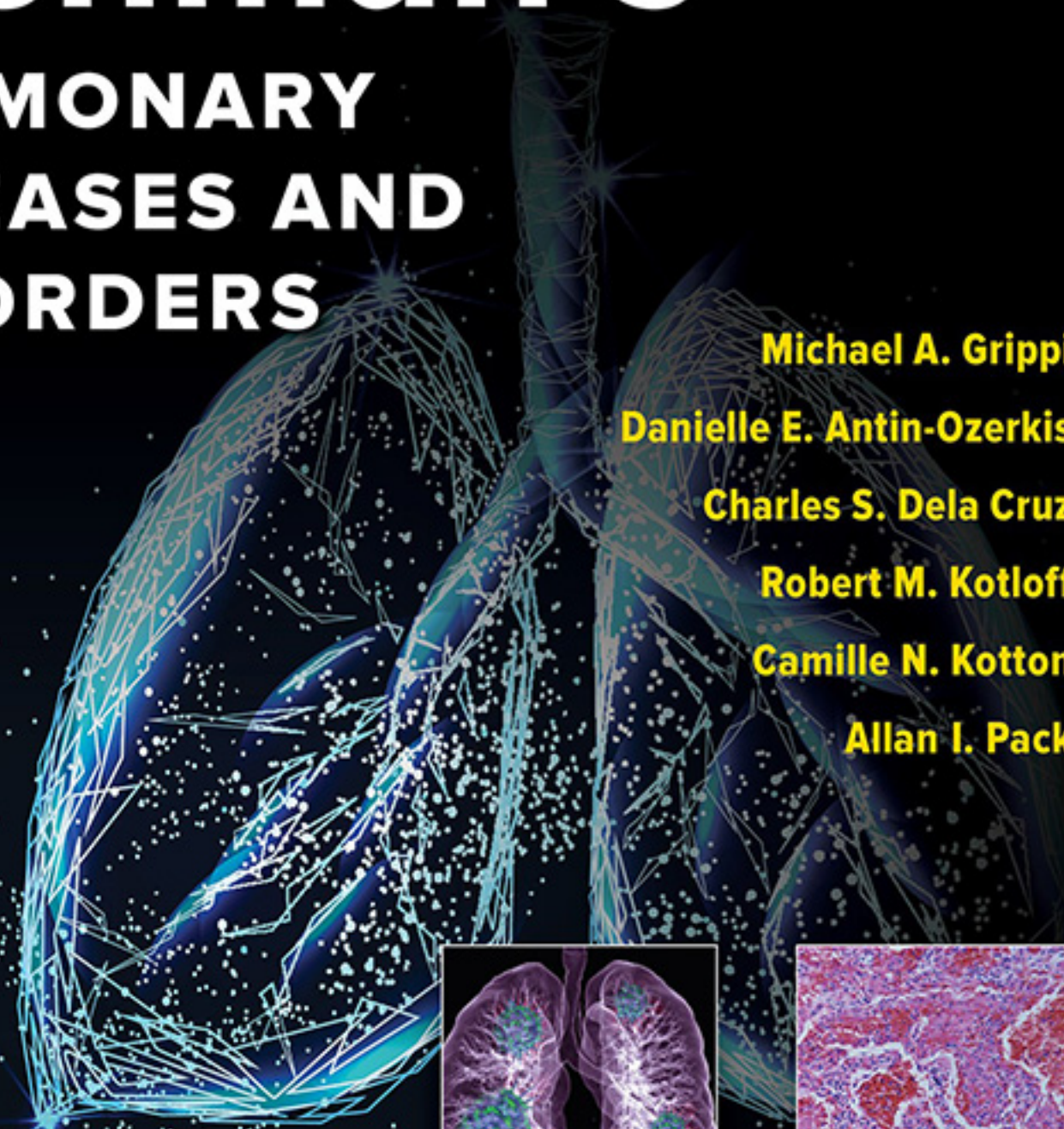
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# Fishman's Pulmonary Diseases and Disorders

Volume 1

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# Fishman's Pulmonary Diseases and Disorders

Sixth Edition

Volume 1

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# DEDICATION

This book is dedicated to the many clinicians worldwide who have devoted themselves to caring for those affected by SARS-CoV-19 and to the scientists who developed vaccines and therapeutic modalities directed against the virus.

MAG: To my wife, Barbara, and to our daughters, Kristen and Amy, for their steadfast support over the years, and to their families—Emily, Ali, Sawyer, Sophie, Levi, and Kieran.

DAO: To my husband, Eric, and our daughters, Orly and Daya. If you are going to spend a pandemic with anyone, you might as well laugh a lot. And to my patients, from whom I learn every day.

CDC: I would like to thank my family, friends, and all the mentors in pulmonary and critical care medicine who helped support me throughout my career. I would also like to thank my patients, from whom I have learned so much and who have been the motivation for my current work.

RMK: To my wife, Debbie, and my sons, Eric, Brian, and Ethan, for their unwavering love and support. And to the memory of my parents, Jean and Leon Kotloff, for instilling in me the principles by which I live my life and practice my profession.

CNK: Thanks to my husband, Darrell Kotton, and to our wonderful sons, David and Benjamin, for their thoughtfulness and support, especially as we navigated our family through the peaks of the COVID-19 pandemic. And thanks to my patients over the years, who have taught me so much about medicine, but also about resilience, optimism, and hope.

AIP: To my very supportive wife, Frances; my long-collaborating Administrative Assistant, Daniel Barrett; my four children, Alison, Angela, Andrew, and Allan Junior; and our 11 grandchildren.

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# PREFACE

This, the 6th edition of *Fishman's Pulmonary Diseases and Disorders*, represents a major update of the prior edition. The book continues to incorporate broad and authoritative discussions of topics relevant to pulmonary physicians and those interested in sleep medicine and associated disorders; it also includes core topics of importance to the practice of critical care medicine. As in previous editions, the 6th relies heavily upon expert presentations of many basic science areas that, in the Editors' opinions, constitute an important substrate for clinically based discussions. The clinical sections of the book have been extensively revamped and expanded.

Notable content additions include important information on the respiratory effects of vaping, more detailed discussion of the idiopathic interstitial pneumonitides, an expanded presentation on the imaging and work-up of lung nodules, consideration of immunotherapy in the treatment of lung cancer, information on COVID-19-related lung disease and its management, and comprehensive discussion of noninvasive ventilation, including its use in ambulatory and ICU settings. In addition, new chapters on cystic lung disease, lung cancer screening, the lung microbiome, developmental lung disorders, nocardiosis and actinomycosis, and application of ECMO have been included. The work is extensively referenced, with more than 22,000 citations.

Remarkably, all the material presented was prepared during an unprecedented global pandemic caused by the coronavirus, SARS-CoV-2. At the time of the 6th edition's publication, more than 6.3 million deaths due to COVID-19 had been reported worldwide. The

impact that the pandemic has had on all aspects of society, including health care, has been extraordinary. The fact that this edition was orchestrated during a time when those most engaged in its preparation were also heavily involved in caring for patients with coronavirus-related respiratory disease is noteworthy. The dedication of the scientists and clinicians globally who contributed to the volume during this time is duly recognized and greatly appreciated. In fact, the 6th edition is the result of contributions from 328 authors from many countries around the world, reflecting expertise that is truly global in nature; 141 are new to the publication.

Illustrations remain a pivotal component of the book, with nearly 2500 included in the book and online on *AccessMedicine.com*.

Preparation of this edition required the work of many. The Editors wish to express their sincere gratitude to the clinicians and scientists who contributed content. They are among the leading authorities on the topics on which they have written. The Editorial group itself includes three new members. Each has stepped up to the challenge and has invested considerable time and energy in helping to prepare the work. On a personal note, I'd like to express my sincere gratitude to all my Editor colleagues who collaborated in the book's development.

Finally, the Editors wish to thank key individuals on the McGraw-Hill staff who played important roles during the project, including Jason Malley, Executive Editor, Medical Publishing; Christie Naglieri, Senior Project Development Editor; and Leah Carton, Associate Editor.

*Michael A. Grippi, M.D.*

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# PART 1

## Perspectives

<b>1</b>	<b>Milestones in the History of Pulmonary Medicine . . . . .</b>	<b>2</b>
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## CHAPTER 1

## Milestones in the History of Pulmonary Medicine\*

Michael A. Grippi

Clinical, scientific, and technologic aspects of medicine have evolved over more than 2000 years, and the study of lung function and pulmonary diseases has been an integral part of its growth and development. About 3 centuries ago, progress toward scientific medicine accelerated markedly, and it has continued to gain speed ever since. In the 17th century, research and experimentation began to tilt clinical medicine toward the exact sciences; by the 18th century, pathology had become an integral part of clinical medicine, and clinical–pathologic correlations succeeded empiricism, dogmatism, and metaphysics. The age of the great clinicians dawned in Europe in the early 19th century, when autopsies became legal and socially acceptable, and when physicians who cared for patients actually *performed* the autopsies.

The road to our current understanding and practice of pulmonary medicine and science has been somewhat convoluted.<sup>1–3</sup> However, it is possible to retrace the scientific trail by examining iconic figures and addressing milestones (Table 1-1). This chapter traces the course of scientific pulmonary medicine over the last two millennia. By necessity, what follows constitutes a limited overview of *selected* aspects of the history of the field, including alveolar–capillary gas exchange, lung volumes, mechanics of breathing, control of breathing, ventilation–perfusion relationships, and scientific advancements impacting clinical medicine, including chest imaging, lung transplantation, bronchoscopic techniques, and advances in critical care. Indeed, much of the content of the book addresses the many advances in respiratory disorders achieved over the last 50 years.

### ALVEOLAR–CAPILLARY GAS EXCHANGE

In reflecting on the history of the science and thinkers largely responsible for our current understanding of the central role of the lungs in gas exchange, the following are considered: the ancient Greeks, William Harvey and the Oxford physiologists, the “phlogiston theory,” theories of blood gas diffusion and “secretion” of oxygen, and the physical chemistry of blood gas transport.

#### ■ Ancient Greek Medicine

The beginnings of scientific medicine can be traced to ancient Greece in the sixth century BC. At that time, natural philosophers speculated that air, or an essential ingredient in air, was inspired to generate a “vital essence” for distribution throughout the body.

Hippocrates, the “father of medicine,” is as much a symbol of the Greek physician of the fifth and fourth centuries BC as the name of a real figure (Fig. 1-1). As an individual, he exemplified the caring physician who kept accurate records, made cautious inferences, and relied more on nature, rest, and diet than on drugs for treatment. His name has been immortalized by affixing it to three major components of Greek medicine, even though none appears to be the work of a single individual.

The first is the *Hippocratic corpus*, a collection of about 70 works that includes case reports, textbooks, lectures, and notebooks. The collection contains a description of Cheyne–Stokes respiration and the use of *Hippocratic succussion* for the diagnosis of fluid and air in the pleural space. The second is a collection of aphorisms—a compilation of brief generalizations related to medicine. The third, which is more likely attributable to Pythagoras (c. 530 BC) than Hippocrates (who lived about a century later), is the *Hippocratic oath*, which not only represents the spirit of the physician of ancient Greece, but which has endured to modern times as a reflection of the physician’s code of ethics.

Another Greek, Aristotle, not only had an enduring influence on the intellect of humankind in his own time, but also for two millennia thereafter. Not until the 17th century were Aristotle’s doctrine of the four elements (earth, air, fire, and water) and that of Hippocrates (blood, phlegm, yellow bile, and black bile) laid to rest, thereby clearing the way for modern scientific medicine.

Soon after Aristotle, in about 300 BC, an extraordinary medical school was founded at Alexandria in Egypt. One of the first teachers at the school, Erasistratus, postulated that the “pneuma,” or spirit essential for life, is generated from interplay between air and blood.

About four centuries after Erasistratus, Galen (Fig. 1-2) drew upon the medical, philosophic, and anatomic knowledge of his day to fashion a remarkable physiologic schema.<sup>3,4</sup> His construct was largely teleologic. Unfortunately, it was so convincing that even though it was ultimately proved to be fanciful, it sufficed to retard scientific progress for a millennium and a half. Galen was a talented individual who was well educated, well read, and well positioned in society to popularize his beliefs. Moreover, his concepts fit well into the tenets of Christianity, which was then in its ascendancy; to controvert his authority was tantamount to blasphemy. Among his long-lasting, albeit erroneous, postulates were the following: invisible pores in the ventricular septum that enabled the bulk of the blood to flow from the right ventricle to the left ventricle, thereby bypassing the lungs; a diminutive pulmonary circulation that served only to nourish the lungs; and two-way traffic in the pulmonary veins that enabled inspired air and “effluent waste vapors” to go their respective ways (Fig. 1-3).

Voices raised in protest to Galen’s theories were without lasting effect. In the 13th century, Ibn al-Nafis, writing in his *Canon of Avicenna*, objected that blood does not traverse the ventricular septum from right to left, as Galen had proposed. However, this insight attracted little attention. Three hundred years later, Vesalius voiced similar misgivings. In the 16th century, Michael Servetus, a polymath trained in theology, geography, and anatomy, pictured the pulmonary circulation as the vehicle by which the “inhaled spirit” could be distributed throughout the body. In his theologic treatise, *Christianismi Restitutio*, he pointed out that blood could not traverse the septum between the right and left ventricles, and that the lumen of the pulmonary artery was too large for a nutrient vessel. He became a hunted heretic, wanted for execution by both the Catholic Church and Calvin. He was warned by Calvin to stay out of Geneva. Both Servetus and Calvin then behaved predictably: Servetus showed up at a church where Calvin was preaching, and Calvin had him captured and burned at the stake. In 1559, Realdus Columbus of Cremona, a pupil of Vesalius, rediscovered the pulmonary circulation, as did Andreas Caesalpinus in 1571. Despite these challenging observations, Galen’s schema was to last for more than another half century—until the physiologic experiments of William Harvey.

#### ■ William Harvey and the Oxford Physiologists

William Harvey’s (Fig. 1-4) discovery of the circulation of the blood<sup>5</sup> was preceded by anatomic observations on the valves in systemic veins made by his mentor, Fabricius ab Aquapendente. Harvey’s

\*This chapter is a revision of the original chapter written by Alfred P. Fishman.

**TABLE 1-1** Landmark Figures in the Evolution of Modern Pulmonary Medicine

Alveolar–Capillary Gas Exchange	Mechanics of Breathing
<p><b>Ancient Greek Medicine</b></p> <p>Hippocrates of Cos (c. 460–359 BC)</p> <p>Aristotle (384–322 BC)</p> <p>Erasistratus of Chios (c. 300–250 BC)</p> <p>Galen of Pergamon (AD 129–99)</p> <p>Ibn al-Nafis (c. 1210–1288)</p> <p>Leonardo da Vinci (1452–1519)</p> <p>Miguel Servetus (1511–1553)</p> <p>Andreas Vesalius of Brussels (1514–1564)</p> <p>Realdus Columbus of Cremona (1516–1559)</p> <p>Andreas Caesalpinus of Pisa (1519–1603)</p>	<p>John Hutchinson (1811–1861)</p> <p>Karl Ludwig (1816–1895)</p> <p>Franciscus Cornelius Donders (1818–1889)</p> <p>Fritz Rohrer (1888–1926)</p> <p>Wallace Osgood Fenn (1893–1971)</p>
<p><b>William Harvey and the Oxford Physiologists</b></p> <p>Galileo Galilei (1564–1642)</p> <p>William Harvey (1578–1657)</p> <p>Giovanni Alfonso Borelli (1608–1679)</p> <p>Marcello Malpighi (1628–1694)</p> <p>Robert Boyle (1627–1691)</p> <p>Richard Lower (1631–1691)</p> <p>Robert Hooke (1635–1703)</p> <p>John Mayow (1640–1679)</p>	<p><b>Control of Breathing</b></p> <p><b>The Central Respiratory Centers</b></p> <p>Thomas Lumsden (1874–1953)</p> <p>Hans Winterstein (1878–1963)</p> <p>Merkel Henry Jacobs (1884–1970)</p> <p><b>The Peripheral Chemoreceptors</b></p> <p>Ewald Hering (1834–1918)</p> <p>Joseph Breuer (1842–1925)</p> <p>Cornelius Heymans (1892–1968)</p>
<p><b>Phlogiston: The Rise and Fall</b></p> <p>Georg Ernst Stahl (1660–1734)</p> <p>John Black (1728–1799)</p> <p>Joseph Priestley (1733–1804)</p> <p>Carl Wilhelm Scheele (1742–1782)</p>	<p><b>Scientific Basis of Clinical Medicine</b></p> <p><b>Pathologic Anatomy</b></p> <p>Gioranni Battista Morgagni (1682–1771)</p> <p>Leopold Auenbrugger (1727–1809)</p> <p>Jean Nicolas Corvisart (1755–1821)</p> <p>René Théophile Hyacinthe Laënnec (1781–1826)</p>
<p><b>Respiration and Metabolism</b></p> <p>Antoine Laurent Lavoisier (1743–1794)</p> <p>John Dalton (1766–1844)</p> <p>Julius Robert von Mayer (1814–1878)</p> <p>Carl von Voit (1831–1908)</p> <p>Nathan Zuntz (1847–1920)</p>	<p><b>Microbiology</b></p> <p>Robert Koch (1843–1910)</p> <p><b>Physiology of the Pulmonary Circulation</b></p> <p>Claude Bernard (1813–1878)</p> <p>Auguste Chauveau (1827–1917)</p> <p>Étienne Jules Marey (1830–1904)</p> <p>Dickinson W. Richards (1895–1973)</p> <p>André Frederic Cournand (1895–1988)</p> <p>Werner Forssmann (1904–1979)</p>
<p><b>The Blood Gases</b></p> <p>Joseph Black (1728–1799)</p> <p>John Dalton (1766–1844)</p> <p>Heinrich Gustav Magnus (1802–1870)</p> <p>Felix Hoppe-Seyler (1825–1895)</p> <p>Paul Bert (1833–1886)</p> <p>Christian Bohr (1855–1911)</p> <p>John Scott Haldane (1860–1936)</p> <p>August Krogh (1874–1949)</p>	<p><b>Thoracic Imaging</b></p> <p>Wilhelm Conrad Roentgen (1845–1923)</p> <p>Godfrey N. Hounsfield (1919–2004)</p> <p><b>Bronchoscopy</b></p> <p>Gustav Killian (1860–1921)</p> <p>Chevalier Jackson (1865–1958)</p> <p>Shigeto Ikeda (1925–2001)</p>
<p><b>Diffusion or Secretion of Oxygen</b></p> <p>Joseph Barcroft (1872–1947)</p> <p>Marie Krogh (1874–1943)</p>	<p><b>Lung Transplantation</b></p> <p>Vladimir P. Demikhov (1916–1998)</p> <p>James D. Hardy (1918–2003)</p> <p>Joel D. Cooper</p>
<p><b>The Physical–Chemical Synthesis</b></p> <p>Lawrence J. Henderson (1878–1942)</p>	

small book, *De Motu Cordis*, published in 1628, not only corrected a self-perpetuating error in Galenical teaching, but also marked the birth of modern physiology. The time, however, was not yet ripe to relate the function of the heart to the physiology of breathing. To his dying day, Harvey clung to the idea that the main function of breathing was to cool the heart. Moreover, since he made no

use of the microscope, he could not picture how the pulmonary arteries made connections with the pulmonary veins. Galileo invented the compound microscope in 1610. In 1661, using the compound microscope, Marcello Malpighi reported that alveoli were covered by capillaries and that blood and air were kept separate by the continuous alveolar–capillary barrier.

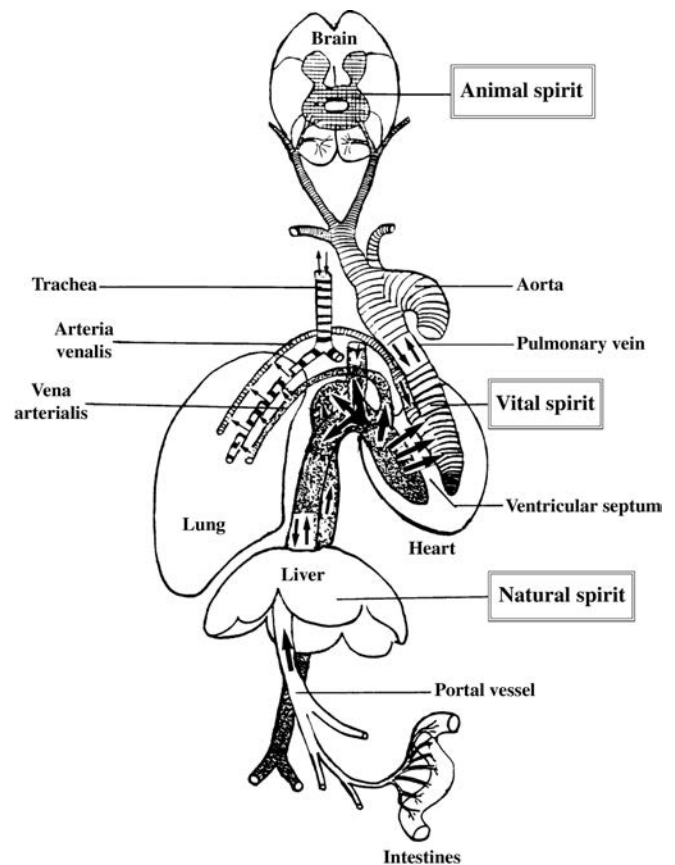




**Figure 1-1** The Hippocrates of Ostia. This damaged bust is believed to represent Hippocrates as perceived in antiquity. It was found in a family tomb in excavations near Ostia. (Reproduced with permission from Dr. Dickinson W. Richards.)



**Figure 1-2** Galen of Pergamon as depicted in medieval times. No authentic reproduction exists of Galen in ancient times. (Reproduced with permission from *Galen's Therapeutica*, published in Venice in 1500.)



**Figure 1-3** Galen's scheme of the circulation. The diagram shows the source and distribution of the three types of spirits. The validity of this scheme depended on invisible pores in the ventricular septum, two-way traffic in the pulmonary vein, and selective permeability of the mitral valve for sooty wastes but not for spirit-containing blood. Vena arterialis, pulmonary vein; arteria venalis, pulmonary artery. (Modified with permission from Singer C. *A Short History of Scientific Ideas to 1900*. London: Oxford University Press; 1959.)



**Figure 1-4** William Harvey (1578–1657). This portrait of William Harvey is part of a family group in which William Harvey and his five brothers are gathered around their father, William Harvey.

Harvey's description in 1628 of the circulation of the blood had three major consequences for pulmonary medicine: (1) it oriented pulmonary medicine toward the basic sciences and away from philosophy and empiricism; (2) it demolished the Galenic concept of the movement of the blood; and (3) it set the stage for an upcoming generation of physiologists at Oxford University to explore breathing in chemical and physical terms.

The physiologists working at Oxford in the 1660s were greatly impressed by Harvey's disciplined approach to scientific inquiry. Many were medical practitioners who conducted research as a sideline. Four, in particular, began the systematic study of air and its constituents, thereby laying the foundations for contemporary respiratory physiology and medicine: Robert Boyle (Fig. 1-5), Robert Hooke, Richard Lower, and John Mayow.

In 1660, Robert Boyle proved by means of his air pump that air is necessary for life. In 1667, Robert Hooke showed that insufflation of the lungs with air while breathing movements were arrested could keep an open-chest animal alive; that is, that movement of the lungs was not essential for life. Richard Lower, the first to practice blood transfusion, took advantage of Hooke's continuously inflated lung preparation in the dog to observe that dark venous blood becomes bright red as it traverses lungs insufflated with air. In 1674, Mayow interpreted the change in the color of blood from venous to arterial as due to the uptake of "nitroaerial particles" (later to be called "oxygen") from the air.

#### ■ Phlogiston: the Rise and Fall

Unfortunately, the discoveries and insights of the Oxford physiologists went largely unnoticed during the century that followed, overshadowed by the "phlogiston theory" of combustion. The theory, advanced by Stahl, postulated that all combustible materials were composed of two ingredients: phlogiston, a principle that transformed into fire when heated, and an ash that was left behind after



**Figure 1-5** Robert Boyle (1627–1691). This engraving, from an original painting by Johann Kerseboom, hangs in the Royal Society, London. Boyle's invention of a pneumatic air pump and his publications concerning "the spring of air and its effect" stimulated considerable research on the physical properties of air and its role in respiration and combustion. He strongly influenced Hooke, Lower, and Mayow at Oxford.

the fiery phlogiston escaped. The phlogiston theory was sufficiently malleable to accommodate almost every new discovery that could have overthrown it, including the rediscovery of carbon dioxide in 1754 by John Black, and the independent discoveries of oxygen by Priestley and Scheele. Although the respiratory gases had been discovered by the end of the 18th century and many of their properties characterized, the discoveries were misapplied to support, rather than destroy, the phlogiston theory. The phlogiston theory was finally undone by the experiments of Lavoisier.

#### ■ Respiration and Metabolism

From the time of Hippocrates until early in the 20th century, debate had continued about the site of heat production in the body. In 1777, Lavoisier suggested that air was composed of one respirable gas (which he later named "oxygen") and another (nitrogen) that remained unchanged in the course of respiration. Between 1782 and 1784, Lavoisier and Laplace concluded, on the basis of calorimetric experiments on guinea pigs, that "respiration is therefore a combustion, admittedly very slow, but otherwise exactly similar to that of charcoal" (Fig. 1-6). The similarity between respiration and combustion had previously been recognized by the Oxford physiologists, especially Mayow.<sup>6</sup> By 1783, Lavoisier was accumulating evidence against the phlogiston theory and began to replace it with an entirely new system of chemistry.





**Figure 1-6** Scene from the laboratory of Antoine Laurent Lavoisier (1743–1794). His wife is acting as his assistant, and Sequin is the subject. Studies such as this led to the conclusion that respiration and combustion are similar processes.

As noted previously, the ancients pictured the heart as the heat generator. Lavoisier favored the lungs. Others held that combustion occurred in the blood. Although Spallanzani had shown in the 18th century that isolated tissues take up oxygen and evolve carbon dioxide, the idea that combustion occurred in the tissues was slow to gain acceptance. However, the hypothesis gained strength through the work of Pflüger in 1878. He measured oxygen consumption and carbon dioxide production in dogs and calculated respiratory quotients. His research substantiated a concept that had been enunciated, but not named, by Lavoisier.<sup>7</sup>

Once the idea that oxidation occurred in the tissues had become generally accepted, investigators delved into the processes involved in utilization of foodstuffs by the tissues, energetics, growth, and repair. Carl von Voit and Max von Pettenkofer, using a respiration chamber, drew upon chemical balances and respiratory quotients in humans to distinguish the nature of the foodstuffs being burned and to show that the amounts of fat, protein, and carbohydrate burned varied with the mechanical work done by the subject. Between 1842 and 1845, Julius Robert von Mayer formulated the law of conservation of energy. Subsequently, Max Rubner showed that the law applied to the living body, and Herman von Helmholtz showed that its relevance to metabolism could be demonstrated experimentally. Application of these principles at the bedside was greatly facilitated by the development of a portable metabolic apparatus by Nathan Zuntz. Pioneering bedside studies of metabolic states were conducted by a succession of distinguished investigators, including Magnus-Levy, Graham Lusk, F. G. Benedict, and Eugene F. DuBois.

### ■ The Blood Gases

The Oxford physiologists set the stage for the discovery of the blood gases. Using his vacuum pump, Robert Boyle extracted “air” from blood. John Mayow came close to discovering oxygen by showing that only a portion of air was necessary for life—the “nitroaerial spirits”—which were removed both by respiration and fire (combustion). One of his famous experiments entailed enclosing a mouse and a lighted lamp in an airtight container; the lamp went out first and then the mouse died. However, Mayow did not realize that the “nitroaerial spirits” could be isolated as a gas.<sup>6</sup>

One hundred years after Mayow, Joseph Priestley (**Fig. 1-7**) exposed a mouse to the gas released from heated mercuric oxide and found that the gas supported life better than air did; he also noticed that a flame burned more vigorously in this gas than in air. Priestley was not alone in his preoccupation with flame. In 1773, about a year

before Priestley had obtained oxygen by heating mercuric oxide, Scheele discovered oxygen independently because of his interest in fire, and he designated oxygen as “fire air.”

In 1662, Van Helmont, a Capuchin friar and talented chemist, as well as a mystic with a drive to quantify, discovered carbon dioxide, coined the word *gas*, and called carbon dioxide “wild gas” (“gas sylvestre”). In 1755, Joseph Black rediscovered carbon dioxide. He showed that calcium carbonate (limestone) and magnesium carbonate (magnesia alba) lost weight on heating, releasing “fixed air” ( $\text{CO}_2$ ) in the process. This fixed air extinguished both flame and life. Lavoisier knew of the observations of Black and of Priestley



**Figure 1-7** Joseph Priestley (1733–1804), the discoverer of oxygen. This figure shows a silver medal struck in his honor in 1783. A Presbyterian minister, he was radical in his religious and political beliefs, inventive in science, and conservative in the interpretation of his findings. (Reproduced with permission from Fishman AP, Richards DW. *Circulation of the Blood: Men and Ideas*. New York, NY: Oxford University Press; 1964.)



**Figure 1-8** Christian Bohr (1855–1911). At work in his laboratory, Bohr (far right) and his associates systematically explored the interplay between the respiratory gases and hemoglobin that led to the discovery of the “Bohr effect.” (Reproduced with permission from Fishman AP, Richards DW. *Circulation of the Blood: Men and Ideas*. New York, NY: Oxford University Press; 1964.)

and Scheele. He decided in 1778 that the gas obtained from heating mercuric oxide was not “fixed air” or “common air,” but “highly respirable air” (oxygen).

The story of hemoglobin, the essential element in the transport of the respiratory gases by the blood, begins with Hoppe-Seyler, who, between 1866 and 1871, crystallized hemoglobin, explored its chemical properties, and assigned it a proper role in the transport of oxygen by the blood. At the turn of the 19th century, Dalton reported his experiments with the respiratory gases, which led to the development of his atomic theory. In 1872, taking advantage of Dalton’s law, Paul Bert published the first oxygen dissociation curve, that is, oxygen content at different barometric pressures;

he pictured the curve as hyperbolic. Christian Bohr (Fig. 1-8) subsequently identified its s-shaped contour, and in 1904, together with Hasselbach and August Krogh, showed that increasing carbon dioxide tension in blood drives out oxygen, that is, the “Bohr effect.” Shortly thereafter, the influence of various factors, for example, temperature and electrolytes, on the affinity of oxygen for hemoglobin (and, consequently, on the position of the oxygen dissociation curve) was explored in detail by Barcroft and associates. In 1914, Christiansen, Douglas, and Haldane reported that an increase in the oxygen tension of the blood drives out carbon dioxide, that is, the “Haldane effect.” In 1967, a new dimension was added to the understanding of the position and configuration of the oxygen dissociation curve by the demonstration that diphosphoglycerate, a chemical constituent of red cells, regulates the release of oxygen from oxyhemoglobin.

#### ■ Diffusion or Secretion of Oxygen

Bohr is a central figure as an investigator and mentor in respiratory physiology.<sup>8</sup> In 1904, he raised a troublesome issue that was not easily resolved, primarily because of limitations in methodology at the time. He postulated that even though diffusion could account for oxygen uptake at rest, it could not suffice during strenuous exercise, particularly at altitude. He held that oxygen *secretion* had to be involved.<sup>9</sup> He clung to this misconception during his lifetime, a conviction supported by two major lines of evidence. The first was indirect: Oxygen secretion by the swim bladder of fish showed by extrapolation that active transport of oxygen in the lungs was possible. The second was based on observations made during Bohr’s expedition to Pike’s Peak in 1912, during which it was erroneously demonstrated that with exercise at altitude, arterial oxygen tension exceeded alveolar oxygen tension.

However, even before the report from high altitude, Bohr’s former assistant, August Krogh, and his wife, Marie Krogh (Fig. 1-9) had marshaled new evidence to show that “the absorption of oxygen and the elimination of carbon dioxide in the lungs takes place by diffusion and diffusion alone.” The final blow to the secretion theory was delivered by Marie Krogh.<sup>10</sup> Based on the single-breath carbon monoxide method for determining diffusing capacity that she and her husband had developed in 1910,<sup>11</sup> she was able to account for oxygen uptake in the lungs by diffusion alone, even during strenuous exercise under conditions of low oxygen tension. Refinements in the carbon monoxide method by Roughton and others extended



**Figure 1-9** August and Marie Krogh in 1922, at the time of their first visit to the United States so that August Krogh could deliver the Silliman Lecture at Yale. They demonstrated that diffusion, without secretion, could account for the transfer of O<sub>2</sub> and CO<sub>2</sub> across the alveolar–capillary membranes of the lungs. (Reproduced with permission of their daughter, Dr. Bodil Schmidt-Nielsen.)





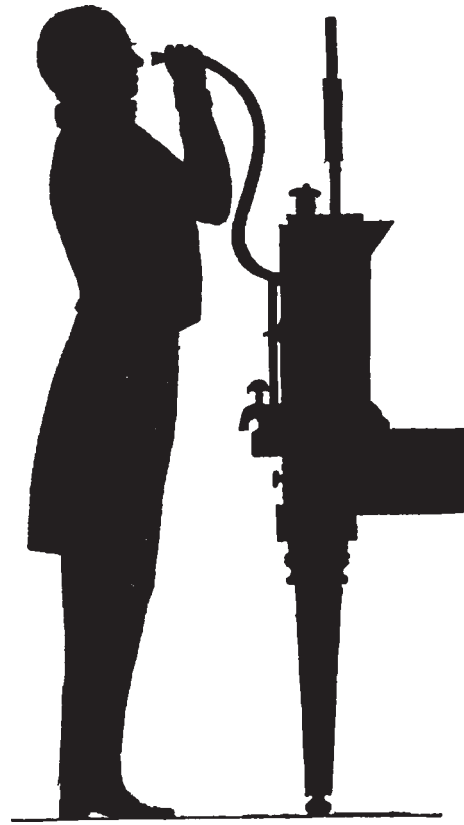
**Figure 1-10** Two founders of contemporary respiratory physiology in 1936. Sir Joseph Barcroft (1872–1947) (*left*) proved, in experiments on himself, that diffusion was the mechanism for gas exchange in the lungs and pioneered current understanding of the respiratory functions of the blood. Lawrence J. Henderson (1878–1942) (*right*) provided a mathematical analysis of blood as a physiochemical system and stimulated research on the complex interplay involved in respiratory gas exchange during exercise. (Reproduced with permission from Fishman AP, Richards DW. *Circulation of the Blood: Men and Ideas*. New York, NY: Oxford University Press; 1964.)

its clinical applicability and provided further evidence against the secretion theory.<sup>12</sup> Despite these observations, Haldane would not let go. Throughout his life, despite mounting evidence to the contrary, he adhered to the idea that oxygen was secreted by the alveolar membrane.

The issue was finally settled by Joseph Barcroft (**Fig. 1-10**). Using a chamber to reproduce the circumstances of hypoxia and strenuous exercise assessed during the Pike's Peak expedition, he found that under all conditions, the oxygen saturation of arterial blood was less than that of arterial blood exposed to a sample of alveolar gas obtained at the same time. He subsequently confirmed these results by experiments done at high altitude at Cerro de Pasco (1921–1922).

### ■ The Physical–Chemical Synthesis

Lawrence J. Henderson undertook the herculean task of depicting the reactions of oxygen and carbon dioxide in blood, not as cause and effect, but as interplay among physiochemical variables and functions (**Fig. 1-10**). His theoretical considerations and practical applications in the Fatigue Laboratory at Harvard University were greatly abetted by close collaboration with Van Slyke, Wu, and McLean at the Rockefeller Institute in New York, who were exploring the exchanges of blood constituents between red cells and plasma. In 1828, Henderson presented his synthesis in the form of a d'Ocagne nomogram that displayed changes in the various elements that entered into the exchange of the respiratory gases between alveolar gas and blood: plasma; the red cell; hemoglobin; and chloride, bicarbonate, and hydrogen ions. He presented nomograms not only for the normal subject at rest and during exercises, but also for individuals with anemia, nephritis, diabetic coma, and other major clinical entities. Henderson dealt with steady-state observations. Roughton and associates enlarged the physiochemical horizons



**Figure 1-11** John Hutchinson's illustration of a subject about to undergo measurements of lung volumes. (Reproduced with permission from Hutchinson J. *On the capacity of the lungs, and on the respiratory functions, with a view of establishing a precise and easy method of detecting disease by the spirometer*. *Med Chir Trans*. 1846;29:137–252.)

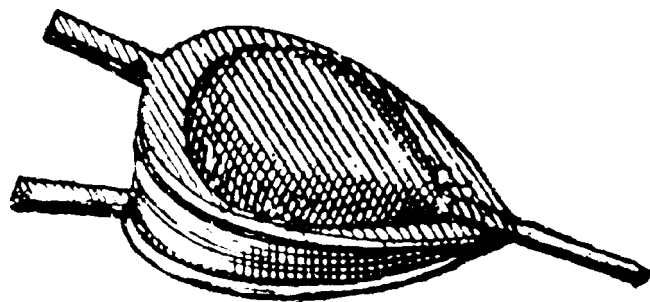
further by discovering carbonic anhydrase in the red cell and addressing transient phenomena related to transport of respiratory gases and carbon monoxide in blood.

### LUNG VOLUMES

Although Humphrey Davy had determined his own lung volume using hydrogen as the test gas in 1800,<sup>13</sup> it was not until the 1840s that John Hutchinson laid the groundwork for modern pulmonary function testing. He devised a spirometer and used it to determine the subdivisions of the lung in a large number of healthy subjects, relating the measurements to height and age (**Fig. 1-11**). The many refinements since then are too numerous for mention in this chapter. A big step forward was the invention of the body plethysmograph many years later, which made possible the determination of the thoracic gas volume and airway resistance.

### MECHANICS OF BREATHING

The ancients wondered how air moved into and out of the lungs; as far back as the time of Erasistratus, the diaphragm was recognized as involved in breathing. Galen was aware that the lungs fill the chest cavity and are moved by the actions of the thorax, and that the large airways enlarge and lengthen during inspiration. He marveled at the long course of the nerves to the diaphragm and the innervation of the intercostal muscles. After Galen, interest in the mechanics of breathing waned except for sporadic observations and experiments by anatomists, notably Leonardo da Vinci and Andreas Vesalius. Interest in respiratory mechanics resumed in the 16th century, largely as a result of progress in physics and mathematics, as exemplified in the works of Borelli and Galileo.



**Figure 1-12** Mayow's model of the chest and lungs. The bellows encloses a bladder, the neck of which opens to the outside. A glass window on the upper side makes it possible to observe the bladder during inflation and deflation. (Reproduced with permission from Mayow J: *Medico-Physical Works*, Crum A, Brown, Dobbin L [trans]. Edinburgh, Alembic Club, Reprints, no 17, 1957. [Translated from *Tractatus quinque medico-physica*, 1674.]

### ■ The Respiratory Muscles

Mayow, one of the Oxford physiologists, drew heavily on the work of colleagues, including Boyle and Hooke, to develop considerable insight into the mechanics of breathing. He also built the first model on record of the chest as a bellows, which contained a bladder within it (Fig. 1-12). He understood that air moved into the lungs as the chest expanded because of the pressure and elasticity of ambient air; he also appreciated that the chest expands because of the action of the intercostal muscles (internal and external), that the diaphragm is the primary muscle of inspiration, and that normal expiration is passive. After Mayow, little research was done on the role of the respiratory muscles in breathing until the mid-19th century, when Donders distinguished between the respective roles played by the inspiratory muscles and elastic forces.

### ■ Elastic Properties of Lungs and Chest Wall

Until the 20th century, observations on the elastic properties of the lungs and chest wall in humans were fragmentary. Access to the pleural space was the major limiting factor. With few exceptions—notably Neergaard and Wirz, who used pleural pressures to determine elastic recoil in normal human subjects, and Christie, who recorded pleural pressures to demonstrate loss of pulmonary elasticity in emphysematous patients—measurements in humans were largely confined either to therapeutic interventions, for example, induction of a pneumothorax or aspiration of pleural fluid, or experiments done at autopsy. The number of observations on the mechanical properties of the lungs increased dramatically when it was shown by Buytendijk, in 1949, and again by Dornhurst and Leathart, in 1952, that esophageal pressures provided an accurate measure of pleural pressures.

The role of alveolar surface tension in determining the elastic forces in the lungs began to be widely appreciated in the late 1950s, although the stage had been set long before. In 1812, Laplace had published the law of surface tension. The implication of this law for the lungs was appreciated initially in 1929 when Neergaard compared pressure–volume curves of lungs filled with air with those filled with fluid. He concluded that unopposed surface tensions would favor alveolar collapse. Then, between 1954 and 1960, a remarkable outpouring of papers from different laboratories showed that a unique surfactant lined the alveoli, and that this material was absent in premature infants with hyaline membrane disease (and alveolar collapse); these papers prompted extensive research on the chemical and physical properties of surfactant and on its sites of formation and removal.

### ■ Airway Resistance

A giant step forward occurred in 1916 when Rohrer, as part of his doctoral dissertation, presented a conceptual framework for determining flow and resistance in airways. His equations were based on precise anatomic measurements of airway dimensions in a human cadaver, coupled with aerodynamic principles. During the following decade, he and his coworkers, Neergaard and Wirz, applied Poiseuille's law for laminar flow and his equations to the determination of airway resistance. Use of Fleisch's pneumotachograph, coupled with periodic interruptions of airflow, permitted measurement of alveolar pressure. Clinically useful measurements of alveolar pressure became available in 1956 with the introduction by DuBois and associates of the whole-body plethysmograph, which they coupled with the application of Boyle's law.

### ■ Synthesis of Mechanics

During the decade between 1915 and 1926, Rohrer and his colleagues provided a remarkably comprehensive synthesis of respiratory mechanics that included a description of the static pressure–volume characteristics of the respiratory system and the work of breathing; they also developed the principle of optimal frequencies of breathing to minimize respiratory work. Together with von Neergaard and Wirz, Rohrer developed and tested, experimentally, concepts involving pressures, flows, and volumes. The full significance of Rohrer's work was not appreciated until the publications by Fenn and his group at the University of Rochester, starting in the 1940s. The contributions of W. O. Fenn, H. Rahn, and A. B. Otis to our present understanding of the mechanics of breathing are significant, and there is little doubt that this group shaped much of the contemporary thinking of respiratory physiologists and pulmonary physicians.<sup>14–17</sup>

## CONTROL OF BREATHING

The control of breathing is a complex process that depends on the integrity of the entire respiratory system—lungs, airways, circulation, and control systems.<sup>18</sup> Two dominant control systems exist. One is in the central nervous system; the other is outside the brain. Control mechanisms in the central nervous system are influenced by the state of wakefulness or alertness and are subject to voluntary control. These mechanisms are also influenced reflexively by a variety of peripheral receptors.

### ■ Localization of the Central Respiratory Centers

In 1812, Legallois, apparently intrigued by the gasping movements of the head after decapitation, identified an area in the medulla that was essential for life. In 1923, Lumsden systematically explored the effects of serial sectioning of the brain stem on respiration, marking the beginning of the era of contemporary research on rhythmic breathing. He designated an area in the caudal pons responsible for a sustained inspiratory drive as the “apneustic center,” and an area in the rostral and lateral portions of the pons that presumably inhibited the apneustic drive as the “pneumotaxic center”; sectioning of the vagi exaggerated the inhibition of the apneustic drive by the pneumotaxic center. Sixteen years later, Pitts et al.,<sup>19</sup> using stereotactic stimulation of the cat medulla, identified inspiratory and expiratory centers and proposed a theory that could account for both rhythmic breathing and apneusis.

### ■ Chemical Stimulation of the Respiratory Centers

The chemical stimuli to breathing have been known for more than a century. In 1885, Miescher-Ruesch showed in humans that ventilation at rest is primarily regulated by carbon dioxide. Between 1887 and 1901, cross-perfusion experiments by Leon Fredericq underscored the role of carbon dioxide. However, it was not until 1905