**Altitude, the Ratio of PaO₂ to Fraction of Inspired Oxygen, and Shunt: Impact on the Assessment of Acute Lung Injury**

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The ratio of PaO₂ to the fraction of inspired oxygen (PaO₂/FIO₂) is commonly used to determine the severity of acute lung injury and acute respiratory distress syndrome (ARDS). The research presented here used computational models of the lung to analyze the effect of altitude on the PaO₂/FIO₂ ratio and pulmonary shunt.

At a given shunt, the PaO₂/FIO₂ ratio is lower at higher altitudes. Therefore, when evaluating for ARDS based on a PaO₂/FIO₂ ratio of <200 mm Hg, patients residing at high altitudes will have less shunt and, presumably, less severe lung injury than patients at sea level.

This should be taken into consideration when comparing patients from different altitudes. Shunt should more often be measured directly or be estimated assuming a constant arteriovenous oxygen content difference.

Key words: Shunt. Oxygenation index. Ratio PaO₂ to fraction of inspired oxygen (FIO₂). PaO₂/FIO₂. Acute respiratory distress syndrome (ARDS). Altitude.

La altitud modifica la relación entre la PaO₂/FiO₂ y el cortocircuito: impacto en la valoración de la lesión pulmonar aguda

El cociente presión arterial de oxígeno/fracción inspiratoria de oxígeno (PaO₂/FiO₂) se utiliza comúnmente para definir el grado de lesión pulmonar y el síndrome de insuficiencia respiratoria progresiva del adulto. En el presente trabajo se analizan las modificaciones que experimenta el índice con la altura sobre el nivel del mar y con los cortocircuitos en modelos computacionales de pulmón.

El cociente PaO₂/FiO₂ disminuye con la altura sobre el nivel del mar al mismo cortocircuito. Por lo tanto, los pacientes que residen a alturas considerables sobre el nivel del mar tienen un cortocircuito menor y presumiblemente un grado de daño pulmonar menor que los residentes al nivel del mar en el momento de cumplir el criterio de síndrome de insuficiencia respiratoria progresiva del adulto con un cociente PaO₂/FiO₂ de 200 Torr.

Esta variación debe tomarse en cuenta para la comparación de pacientes cuando provienen de alturas diferentes e indica que se ha de utilizar más frecuentemente la medición directa del cortocircuito o bien el cortocircuito calculado, asumiendo una diferencia arteriovenosa del contenido de oxígeno constante.


**Introduction**

In patients with acute respiratory distress syndrome (ARDS), the primary physiological mechanism of hypoxemia is shunt. Shunt is precisely measured using the Berggren equation based on simultaneous arterial blood and mixed venous blood samples drawn with a pulmonary artery catheter while the patient is ventilated with pure oxygen. However, this measurement is rarely performed and is not generally available. Shunt is more commonly assessed based on a series of oxygenation indices that do not require a pulmonary artery blood sample: the ratio of PaO₂ to the fraction of inspired oxygen (PaO₂/FIO₂), the ratio of PaO₂ to alveolar oxygen pressure (PaO₂/PAO₂), the arterial-alveolar oxygen tension gradient of the PaO₂ (P[A-a]O₂), and the ratio of P[A-a]O₂ to PaO₂.¹⁻¹⁰

In 1994, the American-European Consensus Conference on ARDS issued definitions that have been accepted by many clinicians and researchers.¹¹,¹² The recommendations cover radiographic, gasometric, and clinical categories, including use of the PaO₂/FIO₂ ratio.¹¹,¹² An acute lung injury is defined by a PaO₂/FIO₂ ratio of equal to or less than 300 mm Hg and ARDS is defined by a ratio of less than or equal to 200 mm Hg.¹¹,¹² However, in addition to known PaO₂/FIO₂ ratio...
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In the present study, the PaO₂/FIO₂ indices were estimated at different values of shunt and altitude based on data provided by 2 mathematical models of pulmonary gas exchange: the West model and the oxygen status algorithm (OSA) designed by Siggaard-Andersen and Siggaard-Andersen. The West model requires knowing oxygen consumption, carbon dioxide production, hemoglobin level, hematocrit, barometric pressure, FIO₂, base excess, pressure at 50% saturation, fraction of inspired carbon dioxide, cardiac output, alveolar ventilation, shunt, and degree of change in the pulmonary ventilation-perfusion relationship. With this data, the West model calculates the gasometric concentrations of arterial and venous blood through successive iterations. The OSA was designed mainly to calculate gas exchange variables, after inputting values for arterial blood gases, including oxygen content difference (C(a-v)O₂) of 5.15 mL/dL. Nor does it use changes in the ventilation-perfusion relationship or calculate the venous admixture. Percentages of carboxyhemoglobin, methemoglobin, and fetal hemoglobin in blood are also required, as is 2,3-diphosphoglycerate (2,3-DPG) content. Both models use a FIO₂ of 1.0, which allows precise shunt assessment with arterial and mixed venous blood samples. When the patient has a lower FIO₂, the shunt is overestimated by alterations in the ventilation-perfusion relationship and diffusion limitations when present. In addition, the PaO₂/FIO₂ ratio and other simplified oxygenation indices previously mentioned vary with FIO₂ and, therefore, variations resulting from changes in altitude are difficult to distinguish—the problem that has led to the present study. The barometric pressure was estimated based on the altitude; PaCO₂ was also estimated based on altitude, to reflect values for acclimated subjects. All calculations assumed a hemoglobin concentration of 15 g/dL, a hematocrit of 45, a pH of 7.4 (an appropriate alkaline excess for hemoglobin), PaCO₂, and a 50% saturation of 26.9 mm Hg. In addition, the West model assumes an oxygen consumption of 300 mL/min and a carbon dioxide production of 240 mL/min (respiratory exchange ratio of 0.8). The OSA used a 2,3-DPG concentration of 5.3 mmol/L and concentrations of carboxyhemoglobin, fetal hemoglobin, and methemoglobin of 0.5% each. The total cardiac output values (6 L/min), hemoglobin, and 50% saturation level remained constant at varying altitudes and shunt sizes. The cardiac output of acclimated subjects tended to remain constant with changes in altitude.

The computational models of the programs differ, but both use iteration to adjust the values. If a slightly unbalanced ventilation-perfusion ratio is input into the West program and a C(a-v)O₂ similar to that assumed by the OSA model is generated (5.15 mL/dL) the estimated arterial blood concentrations would be very similar to those that would be estimated by the OSA program if normal concentrations of 2,3-DPG and abnormal hemoglobin levels were input. In addition, the relationship between the oxygenation indices and altitude can be clearly defined in both models.

The arterial blood composition and the PaO₂/FIO₂ ratio were estimated with increasing shunts from 1% to 50% of cardiac output and varying altitudes from sea level to 3000 m. Estimated shunt behavior in relation to altitude was determined by using a C(a-v)O₂ of 3.5 mL/dL recommended for critically ill patients.

The shunt formula was as follows:

\[
\text{Estimated shunt} = \frac{(C\text{CO}_2 - C\text{aCO}_2)}{(C\text{CaO}_2 - 2C\text{aCO}_2) + 3.5}
\]

where CCO₂ is the end-capillary oxygen concentration and Cao₂ is the arterial oxygen concentration.

The estimated arterial oxygen concentrations and PaO₂/FIO₂ ratios produced by the West and OSA models were equivalent. Shunt size increased as PaO₂/FIO₂ decreased, but the values estimated for altitudes between 0 and 3000 m differed (Figure 1). For a given shunt, the PaO₂/FIO₂ ratio decreased as altitude increased, although the curves converged as large shunt values were reached. The complex curvilinear relationship between shunt and the PaO₂/FIO₂ ratio is also evident. Figure 2 shows that the PaO₂/FIO₂ ratio decreases in relation to altitude with no change in shunt or FIO₂, and that the impact of altitude decreases as shunt increases. Oxygenation indices dependent on PaO₂ (PaO₂/PaCO₂, PaO₂/PIP₂, P(A-a)O₂, and P(A-a)O₂/PaO₂) also have curvilinear relationships with shunt and altitude.

![Figure 1. Relation between the ratio of PaO₂ to fraction of inspired oxygen (PaO₂/FIO₂) in mm Hg and arteriovenous shunt (vertical axis), in function of altitude. The highest curve corresponds to sea level and the lowest one corresponds to an altitude of 3000 m. The curves between them show the relations at altitude increments of 500 m. At the highest altitude, the PaO₂/FIO₂ ratio is less than the shunt. The PaO₂/FIO₂ ratios of 300 and 200 (horizontal lines) correspond to the gas exchange levels associated with lung injury and acute respiratory distress syndrome, respectively. Shunt sizes vary with altitude.](image-url)
changing in varying degrees with large and small shunts. In contrast, Figure 3 shows that estimated shunt does not change significantly with altitude, although a systematic error is produced resulting from error in estimating the true C(a-v)O₂.

The estimated shunts for different PaO₂/FIO₂ values and altitudes are presented in the Table. For example, when the PaO₂/FIO₂ ratio is 300—the cutoff indicative of acute lung injury at 100% oxygen—a shunt that is 19% at sea level would be 11.5% in Mexico City and 9.5% at 3000 m. This indicates that the PaO₂/FIO₂ ratio will identify patients with less severe lung injuries at higher altitudes than at sea level. It should be noted that the calculations in the Table were based on a FIO₂ of 1.0 and the results will change considerably with modifications to the FIO₂. For example, if a measurement were made at sea level with a FIO₂ of 0.5 and a PaO₂/FIO₂ of 300, the shunt would be 12.5%, whereas it would be 19% with a FIO₂ of 1.0. However, even with varying FIO₂ values, the PaO₂/FIO₂ changed with the altitude.

The correction factor used to estimate the PaO₂/FIO₂ ratio at sea level based on measurements at a higher altitude was difficult to establish (Figure 4). For shunts of 20%, the PaO₂/FIO₂ ratio would be nearly double at the altitude of Mexico City in comparison with the ratio at sea level.
Discussion

The advantage of the PaO₂/FiO₂ ratio is clearly that it is easy to use, but its disadvantage is that it behaves differently at varying altitudes and values of FiO₂. In particular, changes occurring with altitude mean that it is unreliable for comparing patients diagnosed with ARDS or acute lung injury using international criteria. In order to determine the effects of altitude on shunt size, it will undoubtedly be important to verify empirically the results we have found using computational lung models in which the gas exchange parameters that change in severely ill patients have been held constant in order to bring altitude-related variation to the forefront. It is important to mention that other simplified oxygenation indices such as PaO₂/PaCO₂, PaO₂/PAO₂, and P(A-a)O₂ are similarly influenced by changes in the FiO₂. Although the data is not presented here, they are effected by altitude and their use does not resolve the problem of the unreliability of the PaO₂/FiO₂ ratio. The estimated shunt, on the other hand, is resistant to change of altitude. However, the estimation of shunt is a less reliable strategy to use for patients with respiratory insufficiency given that cardiac output and metabolic rate are often affected by disease, therapeutic management, and vasoactive drugs. Previous studies have looked at simplified oxygenation indices in detail have led to the conclusion that they are of questionable reliability, although estimated shunt is the one that best correlates with measured shunt. The evaluation of lung injury and ARDS using the international definitions based on the PaO₂/FiO₂ ratio results in fewer diagnoses of shunt (and lung injuries) in residents at high altitudes than residents at sea level. This problem implies that direct shunt measurement should be used more frequently with patients suffering hypoxemia and would be required when comparing subjects that reside at different altitudes. It is important to note that even in patients with a pulmonary catheter in place, the practice of measuring shunt while the patient is ventilated with pure oxygen has decreased because of the time it requires and because poorly ventilated alveolar units may collapse under high oxygen concentrations, and, therefore, worsen the shunt. This problem is not present with multiple inert gas measurements, but are not applicable in daily clinical practice. The Bergren method, which admits use of a FiO₂ that is less than 1.0 in ventilated patients, overestimates the actual shunt in patients with poorly ventilated pulmonary areas as a result of venous admixture. As the FiO₂ increases, the degree of overestimation decreases—producing yet an additional source of measurement variation. Despite this, traditional shunt measurement using the Bergren method is considered the standard technique because it is widely available, representative, and sufficiently stable.

In patients who have not undergone direct shunt measurement, the effects of altitude can be adjusted for by calculating shunt assuming a constant arteriovenous oxygen difference. However, this measurement will not be accurate if the arteriovenous difference is erroneous.

REFERENCES