Effects of Alveolar Hypoxia on Lung Fluid and Protein Transport in Unanesthetized Sheep

RICHARD D. BLAND, ROBERT H. DEMLING, SAMUEL L. SELINGER, AND NORMAN C. STAUB

Summary

To determine whether hypoxia directly affects pulmonary microvascular filtration of fluid or permeability to plasma proteins, we measured steady state lung lymph flow and protein transport in eight unanesthetized sheep breathing 10% O2 in N2 for 4 hours. We also studied three sheep breathing the same gas mixture for 48 hours. We surgically prepared the sheep to isolate and collect lung lymph and to measure average pulmonary arterial (Ppa) and left atrial (Pia) pressures. We placed a balloon catheter in the left atrium to elevate Pia. After recovery, the sheep breathed air through a tracheostomy for 2-4 hours, followed by 4 or 8 hours of hypoxia. In 13 4-hour studies, the average arterial Pao fell from 97 to 38 torr; Ppa rose from 20 to 33 cm H2O; and lung lymph flow and lymph protein flow were unchanged. We also found that during 48-hour hypoxia, with a sustained elevation in Pia and a decline in Ppa, lymph flow and protein flow did not increase. In four sheep, we also raised Pia for 4 hours, followed by 4 hours of hypoxia with elevated Pia. Again, despite the added stress of elevated Pia, we found that lymph flow and lymph protein flow remained constant during hypoxia. We conclude that severe alveolar hypoxia, for 4 or 48 hours, alone or with increased pulmonary microvascular pressure, produced no change in lung fluid filtration or protein permeability, a finding supported by normal postmortem histology and extravascular lung water content.

In 1945, Drinker concluded that "oxygen lack is the most potent and elusive cause of abnormal leakage from the lung capillaries," based on the observations that flow from the right lymphatic duct of anesthetized dogs increased when the dogs breathed a 10% oxygen gas mixture. Courtice and Korner reported in 1952 that hypoxia predisposed rabbits to pulmonary edema induced by infusions of Ringer's solution, but the authors attributed the edema to heart failure and not altered vascular permeability to plasma proteins.

Other investigators have been unable to substantiate Drinker's conclusion. Haddy showed in anesthetized dogs that hypoxia alone did not produce pulmonary edema, but only did so in the presence of elevated pulmonary venous pressure. Hemingway exposed guinea pigs to gas mixtures containing as little as 2% oxygen, but found no evidence of pulmonary edema when he killed the guinea pigs and examined their lungs.

Using isolated, perfused dog lungs, Nicoloff et al. were unable to demonstrate an increase in lung weight with extreme hypoxia. Goodale et al. found that even total absence of oxygen in the inspired gas did not alter the permeability of the alveolocapillary membrane to tracer albumin in isolated, perfused dog lungs. Fisher et al. saw no changes in the ultrastructure of the alveolar septum of intact dog lungs ventilated with nitrogen for 3-7 hours, and Teplitz et al. were unable to elicit pulmonary edema in rats with hypobaric hypoxia equivalent to 7% oxygen in the inspired gas for up to 30 hours.

Despite all of this contrary evidence, the current medical literature continues to cite hypoxia as a source of enhanced pulmonary microvascular permeability to protein and fluid. There are students of high altitude pulmonary edema who attribute that condition to transarterial leakage of plasma proteins or to increased permeability of the alveolocapillary membrane resulting from hypoxia. To our knowledge no one since Drinker has studied the effects of hypoxia on the permeability of the pulmonary microvasculature alone (as opposed to the alveolocapillary barrier) to plasma proteins.

We have reassessed the effects of alveolar hypoxia on steady state lung lymph flow and protein transport in unanesthetized sheep, breathing 10% oxygen in nitrogen for 4 hours in eight sheep and for 48 hours in three. This level and duration of alveolar hypoxia had no significant effect on pulmonary microvascular filtration of fluid or permeability to plasma proteins.

Methods

We studied nine female sheep, 45-60 kg, by isolating and collecting lung lymph and measuring vascular pressures after the sheep had recovered from surgery. Our preparative operations are described elsewhere in detail. Briefly, we first ligated and resected the systemic contributions to the caudal mediastinal lymph node, which is a large, sausage-shaped structure located adjacent to the aorta in the posterior mediastinum. In a later operation, we placed a small heparin-impregnated Silastic catheter (no. 602-015, Dow Corning) in the efferent duct of that node for collecting nearly pure lung lymph.

We also placed catheters in the left atrium, pulmonary artery, thoracic aorta, and superior vena cava, inserted an
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Acute Hypoxia Studies

Elevated Pressure and Hypoxia Studies

(Pia), we inflated the balloon in the left atrium to raise Pia, which they breathed air and had normal left atrial pressure.

We changed the inspired gas mixture to 10% oxygen in nitrogen for 4 hours.

SPECIFIC EXPERIMENTS

ACUTE HYPOXIA

RESULTS

ACUTE HYPOXIA

Figure 1 illustrates the results of a typical experiment in which the sheep breathed 10% oxygen for 4 hours following a steady state, baseline period of room air. With hypoxia, there was no change in lymph flow or lymph protein concentration, despite a substantial rise in average pulmonary arterial pressure (Ppa). There was a slight decline in Pia. The posthypoxia response, though not a stand-
LUNG FLUID AND PROTEIN TRANSPORT DURING HYPOXIA/Bland et al.

**TABLE 1**  
Comparison of Vascular Pressures, Cardiac Output, and Indices of Transvascular Fluid and Protein Movement in the Lungs of Awake Sheep

<table>
<thead>
<tr>
<th>Condition</th>
<th>Inspired gas</th>
<th>Arterial P02 (torr)</th>
<th>Pp(a) (cm H2O)</th>
<th>Ppa (cm H2O)</th>
<th>Cardiac output (liters/min)</th>
<th>Lymph flow (ml/hr)</th>
<th>Lymph protein flow (g/hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Eight sheep breathing air for 2 hr followed by 10% O2 for 4 hr</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>Air</td>
<td>97 ± 2 *</td>
<td>20 ± 1</td>
<td>1</td>
<td>6.81 ± 0.49</td>
<td>4.17 ± 0.13</td>
<td>6.18 ± 0.13</td>
</tr>
<tr>
<td>Increased Pp(a)</td>
<td>Air</td>
<td>101 ± 5</td>
<td>30 ± 5</td>
<td>17 ± 2</td>
<td>9.00 ± 1.02</td>
<td>3.11 ± 0.52</td>
<td>6.31 ± 0.52</td>
</tr>
<tr>
<td>Increased Ppa</td>
<td>10% O2</td>
<td>40 ± 3</td>
<td>36 ± 3</td>
<td>17 ± 2</td>
<td>9.00 ± 1.02</td>
<td>3.20 ± 0.52</td>
<td>6.33 ± 0.52</td>
</tr>
</tbody>
</table>

**B. Four sheep breathing air for 2 hr, followed by 4 hr with elevated left atrial pressure, followed by 10% O2 for 4 hr**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Inspired gas</th>
<th>Arterial P02 (torr)</th>
<th>Pp(a) (cm H2O)</th>
<th>Ppa (cm H2O)</th>
<th>Cardiac output (liters/min)</th>
<th>Lymph flow (ml/hr)</th>
<th>Lymph protein flow (g/hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>Air</td>
<td>102 ± 3</td>
<td>18 ± 2</td>
<td>2 ± 2</td>
<td>5.39 ± 0.8</td>
<td>4.46 ± 0.22</td>
<td>6.40 ± 0.22</td>
</tr>
<tr>
<td>Increased Pp(a)</td>
<td>Air</td>
<td>104 ± 4</td>
<td>38 ± 4</td>
<td>-4</td>
<td>7.52 ± 1.3</td>
<td>4.40 ± 0.26</td>
<td>6.94 ± 0.27</td>
</tr>
<tr>
<td>Increased Ppa</td>
<td>10% O2</td>
<td>43 ± 5</td>
<td>33 ± 3</td>
<td>-3</td>
<td>6.68 ± 1.3</td>
<td>4.11 ± 0.34</td>
<td>6.59 ± 0.31</td>
</tr>
</tbody>
</table>

**C. Three sheep breathing air for 4 hr followed by 10% O2 for 48 hr**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Inspired gas</th>
<th>Arterial P02 (torr)</th>
<th>Pp(a) (cm H2O)</th>
<th>Ppa (cm H2O)</th>
<th>Cardiac output (liters/min)</th>
<th>Lymph flow (ml/hr)</th>
<th>Lymph protein flow (g/hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>Air</td>
<td>105 ± 6</td>
<td>17 ± 3</td>
<td>-1</td>
<td>5.39 ± 0.8</td>
<td>4.46 ± 0.22</td>
<td>6.40 ± 0.22</td>
</tr>
<tr>
<td>Increased Pp(a)</td>
<td>10% O2</td>
<td>108 ± 6</td>
<td>37 ± 3</td>
<td>-4</td>
<td>7.52 ± 1.3</td>
<td>4.40 ± 0.26</td>
<td>6.94 ± 0.27</td>
</tr>
</tbody>
</table>

**Footnotes:**
- * Average ± 1 SEM.

ard part of the experimental protocol, is shown for completeness. During the 2-hour recovery period, vascular pressures returned to near baseline levels, but neither lymph flow nor protein concentration varied.

In 13 such experiments on eight sheep, the switch from air to 10% oxygen breathing was associated with a change in the pattern of ventilation. While minute ventilation was unaltered by hypoxia (20.2 ± 1.9 liters/min vs. 19.6 ± 1.8 liters/min), tidal volume increased from 234 ± 10 ml to 276 ± 10 ml, and frequency of breathing decreased from 81 ± 8/min to 65 ± 7/min. Arterial Pco2 decreased from 39 ± 1 torr to 29 ± 1 torr, and arterial pH rose from 7.47 ± 0.01 to 7.53 ± 0.01. All of these changes were significant and represent a normal adaptive response to acute arterial hypoxemia.

The important new data related to net transvascular fluid and protein flow are summarized in Table 1A. Associated with the fall in arterial P02 from 97 ± 2 torr to 38 ± 2 torr, there was a rise in Pp(a) to 65% above the baseline level, while Ppa decreased slightly. Cardiac output rose by 20% during hypoxia, and the calculated pulmonary vascular resistance increased 44%. All of these changes were significant.

Despite the cardiovascular response to hypoxia, steady state lung lymph flow and lymph protein transport remained unchanged. While plasma protein concentration increased with hypoxia, lymph protein concentration did not change. The albumin fraction of the lymph proteins was higher than that of the plasma proteins (0.49 vs. 0.38) during both baseline and hypoxia periods, showing that albumin transversed the vascular endothelium more readily than the larger globulin molecules, irrespective of the inspired gas.

**ELEVATED PRESSURE AND HYPOXIA STUDIES**

Figure 2 shows the time course of one experiment in which, after a 2-hour baseline period, we inflated the balloon catheter in the left atrium for 4 hours, followed by the additional stress of hypoxia with elevated vascular pressures for 4 hours. As expected, with the rise in Pp(a) and the secondary increase in Ppa induced by inflating the balloon, lung lymph flow increased and lymph protein...
concentration fell. Then, with $P_{pa}$ elevated at a constant level, hypoxia produced a further rise in $P_{pa}$, a slight decline in lymph flow, and a comparably small rise in lymph protein concentration. With resumption of air breathing, $P_{pa}$ declined slightly, as lymph flow and protein concentration returned to their prehypoxia levels. All indices returned to baseline when $P_{pa}$ was reduced to normal.

Inflation of the balloon in the left atrium caused no significant change in ventilation. But when the sheep breathed 10% oxygen, with elevated $P_{pa}$, arterial $P_{co_2}$ decreased from 35 ± 1 torr to 27 ± 1 torr and $pH$ increased from 7.48 ± 0.01 to 7.56 ± 0.01, similar to the experiments with hypoxia alone. This respiratory alkalosis was associated with an increase in tidal volume from 291 ± 22 ml to 345 ± 29 ml but no change in minute ventilation (30.0 ± 5.7 liters/min vs. 31.2 ± 3.4 liters/min).

Table 1B summarizes the important data relating to vascular pressures, cardiac output, and transvascular fluid and protein movement in the four experiments in which we combined hypoxia with increased pulmonary microvascular pressure. With inflation of the left atrial balloon, average arterial $P_{o_2}$ did not change, cardiac output fell in three of four sheep, and $P_{pa}$ rose from 18 ± 1 cm H$_2$O to 30 ± 1 cm H$_2$O. Lymph flow and lymph protein flow increased as expected. These changes were associated with a rise in plasma protein concentration and a fall in lymph protein concentration in all four experiments.

When the sheep breathed 10% oxygen for 4 hours, in the presence of a sustained elevation of $P_{pa}$, arterial $P_{o_2}$ fell from 101 ±5 torr to 40 ± 3 torr. $P_{pa}$ rose by an additional 20%, and cardiac output increased by 40%. Yet average lymph flow and lymph protein transport did not change appreciably.

**EXTENDED HYPOXIA STUDIES**

Figure 3 illustrates the effects of alveolar hypoxia on lung lymph flow, protein concentration, and vascular pressures during one 52-hour experiment. The change from air to 10% oxygen breathing at 4 hours was associated with an abrupt rise in $P_{pa}$, which was sustained over the next 48 hours. During this period, there was no appreciable change in lymph flow, though lymph protein concentration increased slightly for the first 24 hours and then fell to just below the baseline level during the second 24-hour period.

In all three 52-hour studies, hypoxia led to a sustained respiratory alkalosis resulting from an increase in tidal volume, again with no change in minute ventilation.

Table 1C summarizes the important data for the three extended-hypoxia studies. As in the 4-hour experiments, $P_{pa}$ increased to almost twice the baseline level, while $P_{pa}$ decreased by a smaller amount. Concurrently, cardiac output rose by 40% at 24 hours and remained 22% above the baseline output at 48 hours. At the end of the period of hypoxia, average pulmonary vascular resistance was 98% higher than the calculated resistance before hypoxia. Yet the average lymph flow and lymph protein flow did not increase.

As in the shorter experiments, plasma protein concentration increased with hypoxia (by an average of 9% at 24 hours) in all three studies. This change was accompanied by a 15% rise in mixed venous hematocrit. Lymph protein concentration, however, did not increase, yielding a fall in the lymph to plasma protein ratio from 0.70 to 0.62.

**POSTMORTEM FINDINGS**

We examined sections of fresh frozen lung taken from all sheep breathing 10% oxygen immediately before they were killed. We found normal lung architecture with no perivascular fluid cuffing or alveolar flooding.

Table 2 shows that there was no significant difference in the lung water content of sheep killed after breathing (1) air for 6 hours through a tracheostomy tube (controls), (2) air for 2 hours followed by 10% oxygen for 4 hours, or (3) air for 4 hours followed by 10% oxygen for 48 hours.

**Discussion**

Measurement of pulmonary lymph flow and protein concentration is a sensitive index of the net transvascular movement of fluid and protein in the lung. Humphreys and associates found that in the sheep approxi-
We found a persistant increase in pulmonary vascular resistance by almost 50% above baseline during 4 hours of hypoxia and by almost 100% after 48 hours. Previous studies by Reeves et al.\textsuperscript{27} and Grover\textsuperscript{28} showed that lambs have an immediate but small increase in vascular resistance during hypoxia, but that this effect is not sustained. Perhaps the fact that they studied young lambs, not adult sheep, bred at an elevation of 3,500 feet, not at sea level, and transported to 12,700 feet (equivalent to 13% inspired $O_2$, rather than 10%) contributed to their attenuated response. It is also possible that the return to normal vascular resistance during hypoxia requires longer than 48 hours (the maximum duration of hypoxia in our studies), since Reeves et al.\textsuperscript{27} restudied the lambs after several weeks at high altitude.

Previous investigators have demonstrated that the change in vascular resistance associated with hypoxia occurs proximal to the lung capillaries.\textsuperscript{26-31} Our finding of no change in lung lymph flow with the persistent elevation of pulmonary vascular resistance is further evidence that the site of vasoconstriction is proximal to the fluid exchange vessels in the lung, since more distal constriction would have caused an increase in lymph flow by a rise in vascular hydraulic pressure, as we always see when $P_{alveolus}$ increases.\textsuperscript{18}

We considered the possibility that a superimposed stress, such as elevating $P_{alveolus}$ with hypoxia, or more prolonged hypoxia, might induce pulmonary edema. In neither case did this occur, nor did we find any evidence of altered vascular permeability to plasma proteins. Moreover, the fortuitous premature labor and delivery of one sheep during hypoxia did not evoke an increase in lymph flow or induce an abnormal accumulation of extravascular lung water, suggesting that pregnancy, and labor in particular, has no appreciable effect on lung water transport. Since exercise sometimes precipitates pulmonary edema at high altitudes, it would have been interesting to observe the effects of hypoxia during exercise. The sedentary nature of the sheep, however, prohibited this type of experiment and forced us to settle for observations during hypoxia with left atrial pressure elevation.

The results of this study show that alveolar hypoxia, with or without increased $P_{alveolus}$, does not alter pulmonary microvascular fluid filtration or permeability to plasma proteins. Moreover, we have demonstrated that hypoxia produces a sustained increase in pulmonary vascular resistance in sheep, as in other species, and that the site of vasoconstriction is proximal to the exchanging vessels in the lung.

### References

1. Drinker CK: Pulmonary Edema and Inflammation. Cambridge, Harvard University Press, 1945, p 72
3. Warren MF, Peterson DK, Drinker CK: The effects of heightened negative pressure in the chest, together with further experiments upon anoxia in increasing the flow of lung lymph. Am J Physiol 137: 641-648, 1942

<table>
<thead>
<tr>
<th>Experimental conditions</th>
<th>No. of sheep</th>
<th>Extravascular lung water/blood-free dry lung wt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing air (6 hr)</td>
<td>6</td>
<td>$4.45 \pm 0.08$</td>
</tr>
<tr>
<td>Breathing 10% $O_2$ (4 hr)</td>
<td>8</td>
<td>$4.27 \pm 0.08$</td>
</tr>
<tr>
<td>Breathing 10% $O_2$ (48 hr)</td>
<td>3</td>
<td>$4.42 \pm 0.12$</td>
</tr>
</tbody>
</table>

Results are expressed as mean $\pm$ SEM.
25. Humphreys PW, Normand ICS, Reynolds EOR, Strang LB: Pulmonary lymph flow and the uptake of liquid from the lungs of the lamb at the start of breathing. J Physiol (Lond) 193: 1-29, 1967
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