Ventilation–Perfusion and Gas Exchange Effects of Sodium Nitroprusside in Dogs with Normal and Edematous Lungs

Peter S. Colley, M.D.,* Frederick W. Cheney, Jr., M.D.,† Michael P. Hlastala, Ph.D.‡

This study was designed to investigate the mechanism by which sodium nitroprusside (SNP) decreases oxygenation by determining its effects on venous admixture (Qv/Qp) and ventilation–perfusion distribution (Vv/Qp) in animals with normal and abnormal lungs. SNP was infused into seven dogs anesthetized with pentobarbital. Mean blood pressure was decreased by 40 per cent during normal lung function and again after the production of diffuse pulmonary edema by intravenous administration of oleic acid. Measurements of blood-gas values, Qv/Qp, and Vv/Qp by the inert-gas-elimination method were taken before, during, and after SNP infusion during ventilation with air and then during ventilation with 100 per cent oxygen in each pulmonary condition. SNP caused no change in cardiac output (Qp) during normal lung function or after the production of pulmonary edema. SNP had no effect on pulmonary gas exchange during normal lung function. During pulmonary edema and ventilation with air, SNP decreased Pao₂ from 71 ± 7 torr (mean ± 1 SD) to 61 ± 11 torr (P < .01), and increased Qv/Qp (oxygen method) from 22 ± 8 to 38 ± 18 per cent (P < .01). The increase in Qv/Qp correlated well with a 28 per cent decrease in pulmonary vascular resistance (PVR) (r = −.863). During pulmonary edema with air and ventilation SNP increased Vv/Qp maldistribution, but during ventilation with oxygen, SNP caused no significant change in Qv/Qp, PVR, or Vv/Qp. The increase in Qv/Qp and increases in perfusion to low Vv/Q regions seen only in animals with pulmonary edema during ventilation with air are compatible with the hypothesis that nitroprusside impairs pulmonary gas exchange by inhibiting hypoxic vasoconstriction, thus increasing Vv/Qp maldistribution. (Key words: Anesthetic techniques, hypotension, induced, nitroprusside. Lung: blood flow; edema; shunting; hypoxic vasoconstriction; perfusion.)

The safety of controlled hypotension depends upon the maintenance of adequate oxygen delivery to various organs. Oxygen delivery in turn depend on both the maintenance of blood flow and the adequacy of arterial oxygenation. Sodium nitroprusside (SNP), a potent vasodilator, is frequently used to produce controlled hypotension. Some investigators1–3 have found that it has no effect on pulmonary gas exchange, while others have shown that SNP may decrease arterial oxygenation4,5 and increase venous admixture.6,7

The purpose of this study was to elucidate the mechanism by which SNP impairs pulmonary gas exchange. We have previously shown that SNP decreases arterial oxygenation and increases intrapulmonary shunting (Qs/Qp) in the presence of regional atelectasis.6 We suggested that it acted directly to increase Qs/Qp by inhibiting hypoxic pulmonary vasoconstriction. Regional atelectasis, however, not only causes hypoxic vasoconstriction, but also produces hydrostatic gradients which, in the presence of pulmonary-artery hypotension, result in a disproportionate increase in vascular resistance of the ventilated lung.4 In the present study we used a model of diffuse pulmonary injury produced by oleic acid8 to investigate the effects of SNP on pulmonary gas exchange and Vv/Qp. Oleic acid induces diffuse pulmonary edema and hypoxia but avoids the hydrostatic effects produced when hypoxia and hypoxic vasoconstriction are the result of regional atelectasis. If nitroprusside exerts its effects on oxygenation by inhibition of hypoxic vasoconstriction, then changes in gas exchange caused by SNP should depend on the presence of pre-existing pulmonary injury and the inspired oxygen concentration.

Materials and Methods

The effects of nitroprusside on gas exchange and Vv/Qp were studied during four situations: normal lung function at inspired oxygen fractions (Fio₂) of .21 and 1.0, and impaired lung function at Fio₂ = .21 and 1.0. Seven mongrel dogs (weights 20–40 kg) without evidence of pulmonary abnormalities, i.e., fever, cough, or abnormal lung sounds, were studied. Each was anesthetized with pentobarbital, 30 mg/kg, iv. The trachea was intubated with a cuffed endotracheal tube and the dog placed in the prone position. The animal was then paralyzed with succinylcholine, 5 mg/kg, and the lungs ventilated with room air (Fio₂ = .21) at a tidal volume of 12–15 ml/kg with a frequency sufficient to maintain Pao₂ approximately 35 torr. Once established, ventilation was not adjusted again during the experiment. Using sterile surgical technique, pulmonary-artery (thermodilution)
Table 1. Systemic Hemodynamic Values in Dogs before, during, and after Sodium Nitroprusside (SNP) Administration

<table>
<thead>
<tr>
<th></th>
<th>Normal Lungs</th>
<th></th>
<th>Pulmonary Edema</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-SNP</td>
<td>SNP</td>
<td>Post-SNP</td>
<td>Pre-SNP</td>
</tr>
<tr>
<td><strong>Heart rate (beats/min)</strong></td>
<td>139 ± 14</td>
<td>157 ± 18</td>
<td>139</td>
<td>140 ± 58</td>
</tr>
<tr>
<td><strong>Q̇ (l/min)</strong></td>
<td>5.27 ± 1.22</td>
<td>5.18 ± 1.08</td>
<td>6.09</td>
<td>6.29 ± 1.71</td>
</tr>
<tr>
<td><strong>MAP (torr)</strong></td>
<td>138† ± 13</td>
<td>65† ± 8</td>
<td>124</td>
<td>127† ± 8</td>
</tr>
<tr>
<td><strong>SVR (dyne.sec.cm⁻¹)</strong></td>
<td>2.198 ± 584</td>
<td>1.016* ± 252</td>
<td>1.746</td>
<td>1.731* ± 523</td>
</tr>
<tr>
<td><strong>Dose of SNP (µg/kg/min)</strong></td>
<td>43 ± 18</td>
<td>64</td>
<td>47</td>
<td>26 ± 16</td>
</tr>
</tbody>
</table>

Mean values ± 1 SD; n = 7. Q̇ = cardiac output; MAP = mean arterial pressure; SVR = systemic vascular resistance.

and systemic arterial catheters were placed via an external jugular vein and forepaw arterial vessels, respectively.

Initial studies were done at FiO₂ .21. After control measurements of vascular pressures and gas exchange, SNP,.1 per cent, was infused with a Harvard infusion pump until mean arterial pressure (MAP) had decreased to approximately 60 torr. After 15 min at the decreased pressure, measurements were repeated. Nitroprusside infusion was then stopped and measurements were again repeated 20 min after the blood pressure returned to control levels.

Following measurements in dogs with normal lungs, the intravascular catheters were filled with heparin and covered with plastic protective dressings. The animals were allowed to recover from the effects of anesthesia for 24 hours. On the following day, diffuse pulmonary injury was produced by injecting oleic acid,.06–.07 ml/kg, into the right atrium. This dose of oleic acid produces a fairly predictable and stable noncardiogenic pulmonary edema, with the peak extent of injury occurring 24 hours after injection.§ Therefore, 24 hours after oleic acid injection the animals were reanesthetized and the effects of nitroprusside again assessed, first at FiO₂ .21 and then at FiO₂ 1.0 as previously described. Following studies of both normal lungs and those with pulmonary edema, the ability of the lung to respond to alveolar hypoxia was tested by ventilating the lungs with oxygen, 10 per cent, and observing the change in pulmonary vascular resistance (PVR).

Vascular pressures and thermodilution cardiac output (Q̇) values were measured during each control and SNP treatment period. Systemic arterial, pulmonary arterial (PAP), and airway (Pₐₕₐᵢᵢₚₕ) pressures were monitored continuously and pulmonary wedge pressures (PAW) were monitored intermittently. Systemic vascular resistance (SVR) in dyne.sec.cm⁻¹ was calculated using the formula SVR = MAP × 80/Q̇. Pulmonary vascular resistance (PVR) was calculated as PVR = (PAP - PAW) × 80/Q̇. Systemic arterial and pulmonary arterial blood samples were drawn, placed in ice, and analyzed for PO₂, P CO₂, and pH on a blood-gas analyzer (Radiometer, Model BMS3 MK2). Arterial blood samples were measured within 2–3 min after collection to minimize errors in PO₂ measurement. The analyzer was calibrated with 100 per cent oxygen prior to measuring arterial blood samples with expected PO₂ values greater than 300 torr and calibrated with room air prior to determining blood-gas values of the remaining arterial and mixed venous blood samples. PO₂ values were multiplied by a factor of 1.04 to correct for the difference between blood and gas calibration. Hemoglobin (Hb) was measured using a Co-oximeter (Instrumentation Laboratories, Model IL182) calibrated for dog hemoglobin. Hb saturation was determined from the blood-gas values using a program developed by Ruiz et al.¹⁰ and modified for use in dogs.¹ Arterial and mixed venous blood oxygen content values were determined from blood-gas, saturation, and Hb values where content = per cent saturation × Hb × 1.34 + 0.0031 P O₂. Q VT/Q̇ during air


¹ Ruiz BC, Department of Anesthesiology, University of Florida College of Medicine, Gainesville, Florida: Personal communication.
ventilation and $\dot{Q}_A/\dot{Q}_T$ during ventilation with oxygen were calculated using the standard oxygen method. The dead space-to-tidal volume ratio ($V_D/V_T$) was calculated using the Enghoff modification of the Bohr equation.

The multiple-inert-gas-infusion technique of Wagner et al. was used to measure the effect of nitroprusside on $\dot{V}_A/\dot{Q}$. A mixture of six gases (sulfur hexafluoride, ethane, cyclopropane, halothane, diethyl ether, and acetone) with different blood-gas solubilities dissolved in saline solution was infused into a leg vein continuously at a rate of approximately 3 ml/min, beginning at least 30 min before the first measurements. Samples of arterial blood, mixed venous blood, and mixed expired gas were collected at the same time as the other measurements and blood sampling were done. Blood and expired gas samples were analyzed for their relative gas concentrations using a gas chromatograph (Beckman, Model GC 72-5) with a flame ionization detector and electron-capture detector (Analog Technology). The retention (Pa/Pv) vs. solubility and the excretion (Pa/Pv) vs. solubility curves were then plotted, using methods described previously. These curves reflect the particular distribution of ventilation-perfusion ratios that produce them. Retention and excretion plots were also converted by computer analysis to distributions reflecting the relationship between perfusion and ventilation as a function of $\dot{V}_A/\dot{Q}$ ranging from 0.005 to 100, as well as shunt ($\dot{V}_A/\dot{Q}$ less than .005) and dead space ($\dot{V}_A/\dot{Q}$ greater than 100.0). Derived $\dot{V}_A/\dot{Q}$ distributions were used to calculate predicted arterial blood-gas values. The inert gas venous admixture was calculated using the standard oxygen method from the predicted blood-gas values.

The data were analyzed by two-way analysis of variance, followed by multiple-comparison procedures comparing all pairs of means by the Newman-Keuls test. Changes in PaO2 values, however, were compared using Student's t test for paired data rather than analysis of variance because of the nonlinear relationship between PaO2 and oxygen content. The inert gas elimination data were analyzed by Student's t test for paired data. Because of technical problems, inert gas values were measured during pulmonary edema and air ventilation in seven dogs, but in only six dogs in each of the other three situations. Unless otherwise noted, only the significant effects of SNP in comparison with control values are reported.

### Results

Nitroprusside produced similar effects on systemic hemodynamics in normal and oleic acid-injured lungs at both FIO2 .21 and FIO2 1.0 (table 1). There was no significant effect on heart rate (HR) or $\dot{Q}_A$. There were, however, significant decreases in mean arterial pressure (MAP) of approximately 50 per cent and of SVR of approximately 45 per cent in each situation. After oleic acid had been administered, the dose of SNP necessary to decrease MAP to the same values as in normal lungs decreased by about 50 per cent.

Nitroprusside had no effect on PAP in normal animals, but decreased PAP significantly during pulmonary edema at both levels of FIO2 (table 2). There was no significant effect on PAW. PVR was decreased significantly only during pulmonary edema and venti-

### Table 2. Pulmonary Dynamic Values in Dogs before, during, and after Sodium Nitroprusside (SNP) Administration

<table>
<thead>
<tr>
<th>Luft</th>
<th>Normal Lungs</th>
<th>Pulmonary Edema</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Air Ventilation</td>
<td>Oxygen Ventilation</td>
</tr>
<tr>
<td></td>
<td>Pre-SNP</td>
<td>SNP</td>
</tr>
<tr>
<td>PAP (cm H2O)</td>
<td>17 ± 3</td>
<td>14 ± 4</td>
</tr>
<tr>
<td>PAW (cm H2O)</td>
<td>5 ± 2</td>
<td>4 ± 2</td>
</tr>
<tr>
<td>PVR (dyncm sec cm⁻⁵)</td>
<td>179 ± 38</td>
<td>156 ± 31</td>
</tr>
<tr>
<td>P_airway (cm H2O)</td>
<td>8 ± 1</td>
<td>9 ± 1</td>
</tr>
<tr>
<td>$V_D/V_T$</td>
<td>.56 ± .08</td>
<td>.61 ± .07</td>
</tr>
</tbody>
</table>

Mean values ± 1 SD; $n = 7$. PAP = mean pulmonary arterial pressure; PAW = pulmonary-artery wedge pressure; PVR = pulmonary vascular resistance; P_airway = peak airway pressure; $V_D/V_T$ = dead space-to-tidal volume ratio.

* .01 < P < .05 between successive values.

† P < .01 between successive values.
lotion with air. When the animals were ventilated with oxygen, 10 per cent, at the end of the experiment, 
PVR increased significantly by 52 per cent (170 ± 15 to 259 ± 45 dyne.sec.cm⁻²) during pulmonary edema. 
In none of the situations was there a significant change in airway pressure or ventricular pressure.

During normal lung function, nitroprusside caused no change in either $Q_{VA}/Q_t$ or $Q/Q_t$ at the different 
inspired oxygen levels (fig. 1, tables 3 and 4). When $F_1 O_2$ was increased from .21 to 1.0 during normal lung 
function, $Q/Q_t$ was increased and markedly higher 

than the inert gas shunt. The increased $Q/Q_t$ value may have been due to difficulty in accurately measuring 
high $P_{O_2}$ values. Once the animals had pulmonary 
edema and were breathing room air, nitroprusside 
cause significant increases in $Q_{VA}/Q_t$. The oxygen 
method value went from 20 to 38 per cent and the 
inert-gas venous-admixture method value from 21 
to 34 per cent. There was also a significant increase 
in the inert gas shunt component, which went from 
8 to 15 per cent. There was a highly significant negative 
correlation between $Q_{VA}/Q_t$ (oxygen method) and

Table 3. Pulmonary Gas Exchange Effects in Dogs before, during, and after Sodium Nitroprusside (SNP) Administration

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Air Ventilation</td>
<td>Oxygen Ventilation</td>
</tr>
<tr>
<td></td>
<td>Pre-SNP</td>
<td>SNP</td>
</tr>
<tr>
<td>$Q/Q_t$ (per cent)</td>
<td>6 ± 4</td>
<td>7 ± 3</td>
</tr>
<tr>
<td>$Q_{VA}/Q_t$ (per cent)</td>
<td>±3.0 ± 4.0</td>
<td>±3.0 ± 4.0</td>
</tr>
<tr>
<td>$P_{O_2}$ (torr)</td>
<td>94 ± 8</td>
<td>95 ± 7</td>
</tr>
<tr>
<td>$P_{CO_2}$ (torr)</td>
<td>33 ± 8</td>
<td>33 ± 7</td>
</tr>
<tr>
<td>$pH_a$</td>
<td>7.39 ± 0.06</td>
<td>7.36 ± 0.07</td>
</tr>
<tr>
<td>$P_{O_2}$ (torr)</td>
<td>46 ± 8</td>
<td>46 ± 7</td>
</tr>
<tr>
<td>$P_{CO_2}$ (torr)</td>
<td>37 ± 8</td>
<td>37 ± 7</td>
</tr>
<tr>
<td>$pH_a$</td>
<td>7.37 ± 0.05</td>
<td>7.34 ± 0.06</td>
</tr>
</tbody>
</table>

Mean values ± 1 SD; n = 7; a = arterial; v = mixed venous. 
*.01 < P < .05 between successive values. 
† P < .01 between successive values.
PVR caused by nitroprusside in the animals with pulmonary edema during ventilation with air (fig. 2). During this situation only, nitroprusside increased the ventilation–perfusion maldistribution (figs. 3 and 4). The log standard deviation (log SD) of the perfusion distribution (an index of perfusion dispersion) increased, and there was an increase in the arterial–alveolar difference for each inert gas, indicating increased maldistribution of $V_A/Q$ (table 4).

When the lungs with pulmonary edema were ventilated with oxygen, the initial control inert gas shunt value was $15 \pm 7$ per cent. While this value was not significantly different from the post-nitroprusside control value during ventilation with air, it was significantly higher than the prenitroprusside control value of $8 \pm 7$ per cent during ventilation with air. When nitroprusside was infused during pulmonary edema and ventilation with oxygen, there was no significant change in either oxygen or inert gas shunt values.

Nitroprusside produced no significant change in arterial or mixed venous blood-gas values during normal lung function at either $F_{O_2}$ (table 3). During pulmonary edema and ventilation with air, $P_{A_O_2}$ decreased significantly. During pulmonary edema and ventilation with oxygen, $P_{A_O_2}$ decreased significantly also, although there was no significant change in $Q_{VA}/Q_i$ or $Q_I$.

**Discussion**

Nitroprusside in our study caused no change in $P_{A_O_2}$, $Q_{VA}/Q_i$, or $Q_I$ in the normal lungs at either $F_{O_2}$. There was also no change in PVR when ventilation was changed from air to oxygen, suggesting the absence of significant amounts of hypoxic vasoconstriction. These observations are consistent with the findings that nitroprusside causes no change in gas exchange in anesthetized patients or dogs.

In contrast to the lack of effect during normal lung function, SNP markedly impaired pulmonary gas exchange once pulmonary edema had been induced when the animals' lungs were ventilated with air. SNP caused significant decreases in $P_{A_O_2}$, marked increases in $Q_{VA}/Q_i$, and increases in perfusion to lung areas with low $V_A/Q$ ratios. The log SD of the perfusion mode and the area under the arterial–alveolar difference–solubility curve were also increased. We have previously shown the latter index to be a useful quantifier of $V_A/Q$ maldistribution.

**Table 4. Ventilation–Perfusion Effects of Sodium Nitroprusside (SNP) Determined by the Inert-gas-elimination Method**

<table>
<thead>
<tr>
<th></th>
<th>Normal Lung</th>
<th>Pulmonary Edema</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-SNP</td>
<td>SNP</td>
</tr>
<tr>
<td>Log SD perfusion</td>
<td>.470 ± .125</td>
<td>.611* .082</td>
</tr>
<tr>
<td>$Q_{VA}/Q_i$ (%)</td>
<td>7 ± 7</td>
<td>11 ± 9</td>
</tr>
<tr>
<td>Shunt (per cent)</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Mean values ± 1 SD; log SD = log standard distribution of perfusion mode; a-A area = area under the arterial–alveolar difference–solubility curve.

* .01 < P < .05 between successive values.
† P < .01 between successive values.
The inverse relationship between PVR and $Q_{VA}/Q_{l}$ in the animals with pulmonary edema during ventilation with air indicates that SNP has a disproportionate vasodilating effect on vessels perfusing hypoxic areas of the lung. These vessels are likely to have increased vascular tone due to hypoxic vasoconstriction. Previous studies have shown that the relaxant effect of nitroprusside on vascular smooth muscle is greatest on vessels undergoing active contraction. Arkin et al.** found that nitroprusside restored flow to lung in which hypoxic vasoconstriction was induced by nitrogen ventilation. As in our study, Knapp et al.17 found that nitroprusside produced a greater decrease in PVR in patients with the highest values of PVR. Nitroprusside exerts a marked, dose-dependent relaxant effect on isolated bovine veins contracted by epinephrine, but little effect on relaxed bovine veins.18

When the animals with pulmonary edema were ventilated with oxygen, there was a small increase in the initial inert gas shunt value. This value was significantly higher than the pre-SNP control value during ventilation with air. A likely explanation is that oxygen caused some absorption atelectasis or release of hypoxic vasoconstriction, as found by Wagner et al.19

in older human subjects breathing 100 per cent oxygen.

During pulmonary edema, when ventilation was with oxygen, SNP caused a significant decrease in PaO₂ even though there was no significant change in Q̇ or Q̇/Q̇. This is because small changes in arterial blood oxygen content cause large changes in PaO₂. The small decrease in arterial blood oxygen content was due to a combination of an insignificant decrease in Q̇ and an insignificant increase in Q̇/Q̇. The lack of effect of SNP on Q̇/Q̇ probably occurred because inhalation of oxygen increased alveolar Pₐ₉ to above the threshold for hypoxic vasoconstriction in poorly ventilated alveoli by diffusion. Another possibility is that the increase in mixed venous blood oxygen tension (PvO₂) reversed hypoxic vasoconstriction in unventilated areas. Both Barer et al.⁴⁰ and Bergofsky⁴¹ have shown that changes in PvO₂ in this range affect pulmonary vascular tone.

Selzer et al.⁵ concluded that nitroprusside decreased arterial blood PaO₂ by “opening of intrapulmonary shunts.” In our study, however, no change in shunt flow occurred during normal lung function. Our results indicate that nitroprusside does not open anatomic intrapulmonary shunts, as the presence of such shunts should be unaffected by the extent of abnormality of the lung. Mookherjee et al.⁷ found that nitroprusside increased venous admixture in patients with congestive heart failure, and attributed the mechanism to the concurrent increase in cardiac output. In the present study nitroprusside increased venous admixture in the absence of a change in cardiac output. It is likely, then, that variation in cardiac output is not the primary mechanism by which nitroprusside changes venous admixture. The results of our study indicate that nitroprusside increases venous admixture by inhibiting hypoxic vasoconstriction, and that this effect can be minimized by increasing FIO₂. The extent to which nitroprusside impairs pulmonary gas exchange is dependent on the extent to which conditions favorable to the production of hypoxic vasoconstriction are present—namely, the relative magnitude of pre-existing pulmonary disease and FIO₂.

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References


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