Effect of Propofol on Carotid Body Chemosensitivity and Cholinergic Chemotransduction

Malin M. Jonsson, M.D.,* Sten G. E. Lindahl, M.D., Ph.D.,† Lars I. Eriksson, M.D., Ph.D.†

Background: Propofol decreases the acute hypoxic ventilatory response in humans and depresses in vivo carotid body chemosensitivity. The mechanisms behind this impaired oxygen sensing and signaling are not understood. Cholinergic transmission is involved in oxygen signaling, and because general anesthetics such as propofol have affinity to neuronal nicotinic acetylcholine receptors, the authors hypothesized that propofol depresses carotid body chemosensitivity and cholinergic signaling.

Methods: An isolated rabbit carotid body preparation was used. Chemoreceptor activity was recorded from the whole carotid sinus nerve. The effect of propofol on carotid body chemosensitivity was tested at three different degrees of PO2 reduction. Nicotine-induced chemoreceptor response was evaluated using bolus doses of nicotine given before and after propofol 10–500 μM. The contribution of the γ-aminobutyric acid A receptor complex was tested by addition of γ-aminobutyric acid A receptor antagonists.

Results: Propofol reduced carotid body chemosensitivity; the magnitude of depression was dependent on the reduction in PO2. Furthermore, propofol caused a concentration-dependent (10–500 μM) depression of nicotine-induced chemoreceptor response, with a 50% inhibitory concentration (propofol) of 40 μM. Bicuculline in combination with propofol did not have any additional effect, whereas addition of picrotoxin gave a slightly more pronounced inhibition.

Conclusions: It is concluded that propofol impairs carotid body chemosensitivity, the magnitude of depression being dependent on the severity of PO2 reduction, and that propofol causes a concentration-dependent block of cholinergic chemotransduction via the carotid sinus nerve, whereas it seems unlikely that an activation of the γ-aminobutyric acid A receptor complex is involved in this interaction.

THE intravenous anesthetic agent propofol (2,6-diisopropylphenol) is extensively used for anesthesia and conscious sedation. Despite relatively few side effects, propofol may cause respiratory depression and hypventilation,1,2 and it is well established that propofol depresses acute hypoxic ventilatory response in humans.3–5 Notably, it is not clear to what extent propofol interferes with central or peripheral regulation (or both) of respiration. In a recent study of the effect of propofol on ventilation using the dynamic ventilatory response to carbon dioxide, the results indicate a depression of central chemoreceptors as opposed to peripheral chemoreceptor signaling.6 Two decades ago, Ponte et al. showed that propofol markedly depresses carotid body chemoreceptor response to hypoxia in an in vivo single-fiber preparation in rabbits.7 Hence, propofol also seems to be a potent depressant of oxygen sensing in the carotid bodies, whereas the nature of this inhibition is still unknown. We therefore believe it is of interest to more directly study the pharmacological properties of propofol on the carotid body.

There is evidence that propofol acts by a positive modulation of the inhibitory action of γ-aminobutyric acid (GABA) through GABA A receptors.8,9 The GABA A receptor channel belongs to the structurally and genetically related superfamily of fast neurotransmitter-gated ion channels that have the muscle type acetylcholine receptor as a prototype but also includes neuronal acetylcholine, glycine and serotonin type 3 receptor channels. Propofol acts as a competitive antagonist on the major brain neuronal nicotinic acetylcholine receptor (nAChR), α4β210,11 but not on the α7 subunit.10 It has also been found that propofol dose-dependently and reversibly inhibits neuronal nAChR-mediated currents in cultured PC12 cells.12 The carotid bodies contain the majority of peripheral chemoreceptors and there is strong evidence that acetylcholine and neuronal nAChRs play a key role for oxygen sensing and signaling.13 Nondepolarizing neuromuscular blocking agents inhibit nicotinic carotid body chemoreceptor responses in an isolated carotid body preparation.14–16 Because propofol depresses hypoxic ventilatory response and has an affinity to neuronal nAChR subtypes we now hypothesize that propofol may act as an antagonist on neuronal nAChRs in the carotid body. We therefore propose that propofol impairs carotid body chemosensitivity by interference with either neuronal nAChRs or the GABA A receptor complex in the carotid body.

The aim of this study was to investigate the effect of propofol on carotid body chemosensitivity and responses to nicotine and furthermore to evaluate to what extent this response is mediated through the nAChR or the GABA A receptor complex.

Materials and Methods

Animals and Anesthesia

The study was approved by the Local Animal Care and Use Committee of the Karolinska Institute, Stockholm,
Preparation of Carotid Bodies

Trachea and esophagus were divided and retracted cranially to expose the carotid bifurcation on both sides. Under the microscope, the carotid sinus nerve (CSN) and glossopharyngeal nerve were identified, carefully dissected, and cut proximally to their confluence. The carotid artery was then identified and the animal was heparinized using 1500 U heparin intravenously (Heparin Leo®, Leo Pharma, Helsingborg, Sweden). The carotid arteries were ligated and cut above the carotid bifurcation. The carotid body with its arterial supply and the CSN were then removed en bloc. The common carotid artery was flushed with a few milliliters of modified Tyrode’s buffer solution before it was put into the perfusion chamber. All preparations were immediately used in the experiment. In the perfusion chamber, the common carotid artery was attached to a small plastic tube and continuously perfused by gravity at a constant pressure (45 cm H2O) with modified Tyrode’s buffer solution equilibrated with 5% carbon dioxide + 95% oxygen. The carotid body was also superfused via the chamber bath which received the same buffer as above via a separate plastic tubing. The perfusate volume in the chamber was approximately 2.5 ml; the exact volume was dependent on the size of the preparation placed in the chamber. The flow through the chamber was constant during each experiment ranging from 4 to 6 ml/min.

The composition of the modified Tyrode’s buffer solution was as follows (in mM): 120.0 NaCl, 4.0 KCl, 2.0 CaCl2, 1.0 MgCl2, 21.4 NaHCO3, 1.9 NaH2PO4, and 10.0 D-glucose. The temperature of the perfusate was maintained at 37.0°C ± 0.5°C by means of a regulated heating system (Heating Immersion Circulator; MP, Jularbo, Germany). The buffer solution was equilibrated with 95% oxygen and 5% carbon dioxide. Repeated samples were taken from the chamber and analyzed (ABL 505; Radiometer, Copenhagen, Denmark) for pH, PO2, PCO2, and electrolyte content to ensure stable experimental conditions.

Sinus Nerve Recording

In the perfusion chamber the CSN was cut from the glossopharyngeal nerve and desheathed. The sinus nerve was placed onto a platinum electrode and covered by mineral oil to prevent drying. A reference electrode was placed in the tissue near the carotid body. Chemosensory discharges were recorded extracellularly from the entire CSN. The activity was amplified and filtered (100–10kHz, notch filter 60 Hz) (A-M systems, differential AC amplifier model 1700; Carlsborg, WA). The signal was then digitized and transferred onto a computer for continuous sampling and online analysis using a Digidata 1320A and pClamp 8 system (Axon Instruments, Foster City, CA). As previously described,17,18 we used an electronic amplifier discriminator that allows selection of action potentials of a given amplitude above the baseline noise. The selected chemosensory impulses were counted with a frequency meter to measure \( f_x \) expressed in Hz. The response was defined as the peak chemoreceptor discharge frequency compared with a baseline recording immediately before hypoxia or nicotine injection (\( \Delta f_x = f_x - f_0 \)).

Protocol

Propofol and Chemosensitivity. Carotid body chemosensory was tested at three degrees of step reduction in PO2 that typically resulted in a change in PO2 (\( \Delta P_{O2} \), control measurements) of respectively 134 ± 27 (mild reduction), 223 ± 65 (moderate reduction), and 343 ± 62 mmHg (severe reduction). Corresponding gas mixtures and matching PO2 are for all test situations are presented in table 1. All experiments started with a step decrease in PO2 using one of the three degrees, and the subsequent order in which the three degrees were tested was alternated in a balanced fashion. Chemosensitivity was tested before and during perfusion with 100 μM propofol and after 30-min washout (fig. 1A).

Before and at chemoreceptor peak response a sample from the perfusion chamber was taken for analysis of PO2, PCO2, pH, sodium, and potassium. The resultant spike frequency was used, comparing baseline recordings with peak response.

Propofol and Nicotine-induced Chemoreceptor Responses. Nicotine-induced responses were recorded after injection of a 500 μg nicotine (nicotine hydrogen tartrate salt; Sigma Chemical, St. Louis, MO) bolus (corresponding to a peak concentration of 360 μM). This dose was chosen because it produced an increase in CSN activity similar to the most severe reduction in PO2. Nicotine was dissolved in 0.5 ml of modified Tyrode’s buffer and injected over 5 s into the perfusate as previously described.15,16 Injection of 0.5 ml of modified Tyrode’s buffer solution did not result in any change of the chemoreceptor activity. The carotid body preparation was perfused with propofol 10, 30, 100, and 500 μM (2,6-diisopropylphe-
Table 1. The Effect of Propofol (100 μM) on Carotid Body Chemosensitivity

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Propofol (100 μM)</th>
<th>After wash-out</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ΔCSNA (Hz)</td>
<td>PO2 Baseline (mmHg)</td>
<td>ΔPO2 (mmHg)</td>
</tr>
<tr>
<td>Severe</td>
<td>630 ± 143</td>
<td>547 ± 41</td>
<td>343 ± 62</td>
</tr>
<tr>
<td>95% N2, 5% CO2 (n = 10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>559 ± 206</td>
<td>519 ± 48</td>
<td>223 ± 65</td>
</tr>
<tr>
<td>25% O2, 70% N2, 5% CO2 (n = 8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>460 ± 186</td>
<td>541 ± 14</td>
<td>134 ± 27</td>
</tr>
<tr>
<td>60% O2, 35% N2, 5% CO2 (n = 6)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ΔCSNA = increase in carotid sinus nerve activity; ΔPO2 = change in oxygen tension.

Data are presented as mean ± SD.

* P < 0.05, propofol vs control.

Fig. 1. (A) A schematic presentation of the experimental protocol testing propofol and carotid body chemosensitivity using three degrees of step reduction in PO2: mild, moderate, and severe. The three degrees of PO2 reduction were tested in different sequence between different animals. Black line represents perfusion with modified Tyrode’s buffer. Black arrows indicate reduction in PO2. Shaded bars show 30-min perfusion with 100 μM propofol. (B) A schematic presentation of the experimental protocol testing nicotine-induced carotid body chemoreceptor responses to 500 μg nicotine. Black line represents perfusion with modified Tyrode’s buffer. Black arrows indicate administration of 500 μg of nicotine. Shaded bars show perfusion with 100 μM nicotine. Shaded bars show perfusion with 100 μM propofol in one of the concentrations 10, 30, or 100 μM, 2) propofol 100 μM (Prop), propofol 100 μM + bicuculline 100 μM (Prop+Bic), propofol 100 μM + picrotoxin 100 μM (Prop+Pic). The order of the concentrations/drugs was rotated between different preparations.

Anesthesiology, V 102, No 1, Jan 2005

Copyright © by the American Society of Anesthesiologists. Unauthorized reproduction of this article is prohibited.
ratio between the response after perfusion with propofol compared with the control response immediately before. Concentration-response curves were adjusted using non-linear regression and one-site competition; \( \frac{Y}{Y_{IC50}} = \frac{1}{1 + 10^{(\log Y_{IC50})}} \), where \( Y \) is the chemoreceptor response expressed as a ratio. The IC50 (50% inhibitory concentration) was calculated using GraphPad Prism version 4.0 for Windows (GraphPad Software, San Diego, CA). Comparison between two groups was made using Wilcoxon signed rank test. Results are expressed as mean ± SD. A P value of less than 0.05 was considered statistically significant.

**Results**

*Effect of Propofol on Chemosensitivity*

Propofol (100 \( \mu M \)) reduced carotid body chemosensitivity at each of the three-step reductions in PO2 (table 1); we observed a decrease in CSN activity from 630 ± 143 to 563 ± 143 (−11.5%; \( P < 0.01 \)), from 559 ± 206 to 471 ± 178 (−15%; \( P < 0.05 \)), and from 440 ± 178 to 354 ± 108 (−17.5%; \( P < 0.05 \)), in mild, moderate, and severe reduction, respectively (fig. 2). An original registration is presented in figure 3. In all groups the depressed chemoreceptor responses were reversed after the 30-min washout period with modified Tyrode's buffer solution (table 1).

*Effect of Propofol and GABA\(_A\) Receptor Antagonists*

During perfusion with 100 \( \mu M \) propofol the chemoreceptor response to nicotine decreased from 571 ± 276 to 343 ± 266 Hz (\( P < 0.05 \)), whereas propofol (100 \( \mu M \)) in combination with bicuculline (100 \( \mu M \)) perfusion gave a similar reduction in chemoreceptor response from 248 ± 107 to 40 ± 69 (\( n = 3 \), no statistics done). There was a concentration-dependent reduction in CSN activity to 500 \( \mu g \) nicotine after perfusion with propofol (10–500 \( \mu M \)); the IC50 was 40.00 \( \mu M \) (95% confidence interval, 8–198 \( \mu M \)) (fig. 6).

Control responses were the same during the whole experimental period (not significant), and there was no effect of the order of which the concentrations were given.

During perfusion with the vehicle (1:560) the response to 500 \( \mu g \) nicotine was unchanged (634 ± 241 versus 602 ± 256 Hz, not significant) (fig. 4).
However, propofol (100 μM) and picrotoxin (100 μM) reduced the response to nicotine from 618 ± 308 to 232 ± 207 Hz (P < 0.05). A comparison of the reduction in chemoreceptor responses to nicotine after perfusion with propofol and in combination with one of the two GABA_A antagonists was done. This comparison was made by construction of a ratio between the control value before and after drug perfusion. The nicotine-induced chemoreceptor response was reduced to 56 ± 29% after 100 μM propofol; addition of 100 μM bicuculline or 100 μM picrotoxin gave a reduction of 46 ± 30% or 33 ± 22%, respectively (fig. 7). Hence, addition of picrotoxin to propofol reduced the chemoreceptor response further (P < 0.05), whereas there was no difference after addition of bicuculline (not significant). This indicates a slight chemodepressant effect of picrotoxin.

The hypoxic tests before and at the end of nicotine test protocols were unchanged; in the propofol group the values were 524 ± 299 and 590 ± 156 Hz, respectively, in the vehicle group the values were 756 ± 102 and 742 ± 144 Hz, respectively, and in the propofol/GABA_A antagonist group the values were 635 ± 300 and 625 ± 352 Hz, respectively, before and after experiments.

**Discussion**

We conclude that propofol depresses carotid body chemosensitivity, the magnitude of depression is dependent on the reduction in PO_2, and propofol causes a concentration-dependent block of nicotine-induced carotid body chemoreceptor response. It seems unlikely that an activation of the GABA_A receptor complex is involved in the depression of nicotine-induced chemoreceptor responses.

Our data confirm previous in vivo results showing that propofol depresses carotid body chemosensitivity.7 During the last decade studies have been done showing that propofol depresses the acute hypoxic ventilatory response in male volunteers.3,5 To further clarify the site of action of this depression, Nieuwenhuijs et al. varied end-tidal carbon dioxide using a multifrequency binary sequence to quantify the effect of propofol on ventilatory control in humans. From this system it was concluded that during sedative concentrations of propofol the depression of ventilation was localized to the central chemoreflex loop at central chemoreceptors.6 To elucidate the mechanisms behind these reports it is appropriate to investigate the effect of propofol directly on the peripheral chemoreceptors (i.e., the carotid bodies). The isolated carotid body preparation has been extensively used for physiologic and pharmacological investigations of the carotid body function.14–17,19 The benefits of using an isolated preparation are that local effects of various agents can be studied on the carotid body chemosensing and signaling without interfering with systemic effects.
The current experiments were performed directly after removal of the carotid body, which is crucial for the reliability of results. To furthermore assure and document a stable preparation throughout the experiment, pH, PCO₂, PO₂, sodium, and potassium were measured in the perfusate at regular 30-min intervals during the entire experimental period while perfusate temperature and flow pressure were strictly controlled. With the application of a constant perfusion flow governed by gravity via the carotid body arterial supply, it is possible to subtract coexisting baroreceptor activity, making it easier to interpret the variation in CSN impulse activity as a reflection of chemosensitivity. Recording from the entire CSN shows the sum effect where the quality of recording may vary over time as a result of recruitment or loss of additional fibers. Therefore, we compared each test situation with the preceding control and furthermore performed another control after each test situation.

The carotid body is the major oxygen sensor in the body, and several recently published reports in this field clarify, to some extent, the mechanisms for oxygen sensing and signaling.20–22 Key events include inhibition of oxygen-sensitive potassium currents (e.g., TASK-1 and Kv11.1), leading to membrane depolarization and voltage-gated calcium influx,23–25 causing release of neurotransmitters and depolarisation of the CSN. The most important neurotransmitters seems to be acetylcholine, dopamine, substance P, and nitric oxide,13,20 and interaction with any of these transmitters alters oxygen signaling by a change in CSN activity. The carotid body originates embryologically from the neural crest, consequently, carotid body nAChRs are predominantly of the neuronal type and presence of the neuronal nAChR subunit α4 has been demonstrated in the carotid body and in the adjacent petrosal ganglion in cat26 whereas the α7 subunits have been found in the carotid body efferent system.26,27 Recently, the α3, α4, and β2 subunit-containing nAChRs were present and functional in cultured glomus cells.28 In addition, the mRNA from six different nAChR subunits (α3, α4, α5, α7, β2, and β4) have been detected in carotid body total RNA.28 Hence, our findings add to the current body of information regarding cholinergic signaling of the carotid body.

The anesthetic effect of propofol is most likely attributable to a positive modulation of GABA on GABA<sub>A</sub> receptor channels.8,9 GABA is a well-characterized inhibitory neurotransmitter of the central nervous system, which acts at ionotropic (GABA<sub>A</sub> and GABA<sub>C</sub>) and metabotropic (GABA<sub>B</sub>) receptors. GABA has been found in glomus cells of mouse<sup>30</sup> and rat.51 Fearon et al. also found a presence of GABA<sub>β1</sub> receptor subunits in glomus cells,51 but there is no report of the GABA<sub>A</sub> receptor in the carotid body. Because of the presence of GABA in the carotid body we speculated that propofol’s inhibitory effect on nicotine-induced chemoreceptor responses might be attributable to an interaction with the GABA<sub>A</sub> receptor complex. Therefore, we also applied two different GABA<sub>A</sub> receptor antagonists, the competitive antagonist bicuculline and the noncompetitive antagonist picrotoxin, to propofol. The rationale for this was to block the GABA<sub>A</sub> receptor in two different ways; however, this did not abolish the reduction of chemoreceptor response to nicotine after propofol and, notably, after picrotoxin the reduction was augmented. Hence, we believe that propofol’s depressant effect of nicotine-induced chemoreceptor activity is attributable to a blockade of neuronal nAChRs in the carotid body or the afferent CSN. Because of the homology and similarity between the GABA<sub>A</sub> receptors and nAChRs, which belongs to the same ligand-gated ion channel superfamily (GABA<sub>A</sub>, glycine, nicotinic, and serotonin type 3 receptors), it seems reasonable that propofol have an affinity also to the nAChRs.

Supporting our hypothesis, it was shown that propofol blocks the α4β2 neuronal nAChRs expressed in <i>Xenopus</i> oocytes in micromolar concentrations,10,11 and dose-dependently blocks neuronal nAChRs in PC12 cells.12 Furthermore, propofol inhibits carbachol-induced catecholamine release in adrenal medullary cells.52 In humans, physostigmine reverse propofol-induced CNS effects,53 indicating that inhibition of cholinergic transmission might be part of the anesthetic action of propofol. Altogether, our results are in line with the theory that propofol also blocks nicotinic AChRs. The neuronal nAChRs participate in synaptic transmission, both as a postsynaptic mediator of fast synaptic responses and at presynaptic sites, whereas nAChR activation modulates the release of acetylcholine, dopamine, GABA, glutamate, norepinephrine, and serotonin.34 As our experimental protocol tests both presynaptic and postsynaptic neurotransmission our results provide no

---

### Table 2. Analysis from the Perfusion Chamber During the Experiments

<table>
<thead>
<tr>
<th></th>
<th>PCO₂ (mmHg)</th>
<th>pH</th>
<th>Na (mmol/l)</th>
<th>K (mmol/l)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Propofol, 10/30/100/500 μM</td>
<td>32.8 ± 2.0</td>
<td>7.38 ± 0.03</td>
<td>137 ± 1.16</td>
<td>3.9 ± 0.05</td>
</tr>
<tr>
<td>Vehicle (1:560)</td>
<td>33.9 ± 2.8</td>
<td>7.37 ± 0.03</td>
<td>136 ± 0.91</td>
<td>3.9 ± 0.05</td>
</tr>
<tr>
<td>Propofol ± Bicuculline/Picrotoxin</td>
<td>34.6 ± 3.3</td>
<td>7.36 ± 0.04</td>
<td>135 ± 1.46</td>
<td>3.9 ± 0.06</td>
</tr>
<tr>
<td>PO₂ reduction</td>
<td>34.3 ± 2.0</td>
<td>7.36 ± 0.03</td>
<td>136 ± 1.35</td>
<td>3.9 ± 0.05</td>
</tr>
</tbody>
</table>

Data are presented as mean ± SD.

P<sub>CO₂</sub> = partial pressure of carbon dioxide; PO₂ = partial pressure of oxygen.
information as to whether this interaction is attributable to a presynaptic or postsynaptic block (or both).

Plasma concentrations of propofol during anesthesia are in the range of 11–51 μM (2–9 μg/ml), but as the protein-bound fraction is more than 95%, the free plasma concentration of propofol is much smaller.35 In the previous in vivo study,7 no concentrations were measured but the doses were high. However, a direct extrapolation of data in this study to the clinical situation must be viewed with caution because of possible in vitro-in vivo differences, species differences, and the fact that the free plasma concentration of propofol may not be identical with the effect-site concentration of the carotid body in vivo.

This study shows that propofol depresses carotid body chemosensitivity and that the depression is inversely related to the reduction in Po2. From a pharmacological perspective it seems reasonable that a mild physiologic response (i.e., mild reduction in Po2) is more easily blocked than a severe physiologic response. Chemosensitivity was tested at various degrees of Po2 changes; however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the gas mixtures presented (table 1) do not all represent hypoxia. It is important however, one could argue that the g