

Concise Clinical Review

Examination of the Carbon Monoxide Diffusing Capacity (DL_{CO}) in Relation to Its K_{CO} and V_A Components

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The single-breath carbon monoxide diffusing capacity (DL_{CO}) is the product of two measurements during breath holding at full inflation: (1) the rate constant for carbon monoxide uptake from alveolar gas (k_{CO} [minute^{-1}]) and (2) the “accessible” alveolar volume (V_A). k_{CO} expressed per mm Hg alveolar dry gas pressure (P_{b^*}) as k_{CO}/P_{b^*} , and then multiplied by V_A , equals DL_{CO} ; thus, DL_{CO} divided by V_A (DL_{CO}/V_A , also called K_{CO}) is only k_{CO}/P_{b^*} in different units, remaining, essentially, a rate constant. The notion that DL_{CO}/V_A “corrects” DL_{CO} for reduced V_A is physiologically incorrect, because DL_{CO}/V_A is not constant as V_A changes; thus, the term K_{CO} reflects the physiology more appropriately. Crucially, the same DL_{CO} may occur with various combinations of K_{CO} and V_A , each suggesting different pathologies. Decreased K_{CO} occurs in alveolar–capillary damage, microvascular pathology, or anemia. Increased K_{CO} occurs with (1) failure to expand normal lungs to predicted full inflation (extrapulmonary restriction); or (2) increased capillary volume and flow, either globally (left-to-right intracardiac shunting) or from flow and volume diversion from lost or damaged units to surviving normal units (e.g., pneumonectomy). Decreased V_A occurs in (1) reduced alveolar expansion, (2) alveolar damage or loss, or (3) maldistribution of inspired gases with airflow obstruction. K_{CO} will be greater than 120% predicted in case 1, 100–120% in case 2, and 40–120% in case 3, depending on pathology. K_{CO} and V_A values should be available to clinicians, as fundamental to understanding the clinical implications of DL_{CO} . The diffusing capacity for nitric oxide (DL_{NO}), and the DL_{NO}/DL_{CO} ratio, provide additional insights.

Keywords: diffusing capacity for carbon monoxide (DL_{CO}); diffusing capacity for nitric oxide (DL_{NO}); DL_{CO}/V_A (K_{CO}); pulmonary function tests; alveolar gas exchange

The single-breath diffusing capacity for carbon monoxide (DL_{CO}) (known in Europe as the transfer factor, TL_{CO}) is, after spirometry and lung volumes, the most clinically useful routine pulmonary function test. The DL_{CO} , as pointed out by its originator, Marie Krogh (1), is the product of two separate but simultaneous measurements (Figure 1): the rate constant k_{CO} (the rate of uptake of CO from alveolar gas), and the alveolar volume (V_A). The important point is that K_{CO} (k_{CO} reexpressed per mm Hg alveolar P_{CO}) is linearly related to the alveolar uptake efficiency for carbon monoxide (2, 3). Because of the special properties of carbon

monoxide, K_{CO} directly reflects the quality of alveolar–capillary gas uptake. Many articles and pulmonary function testing (PFT) laboratories do not quote V_A and K_{CO} from which the DL_{CO} is derived; this may result in significant loss of clinical information.

MEASUREMENT OF K_{CO} AND V_A

Rate of Uptake of Alveolar Carbon Monoxide (k_{CO})

During breath holding in the single-breath DL_{CO} , CO is removed from alveolar gas at an exponential rate [$\log_e(CO_0/CO_t)/BHT$], where CO_0 and CO_t are the alveolar concentrations at the start and finish of the breath-holding time (BHT). This expression is a rate constant with units of minute^{-1} or second^{-1} ; in Figure 1 it is represented by the slope, k_{CO} .

Alveolar Volume (V_A)

The DL_{CO} is measured during breath holding at full inflation; in absolute terms, this represents total lung capacity (TLC). The lung volume during breath holding is measured simultaneously by dilution of any nonabsorbable gas, most commonly helium (He) (Figure 1), at the same time as the k_{CO} is measured (4). The alveolar volume (V_A) is an “accessible” volume, that is, that seen by the gas-exchanging surface, derived from the single-breath helium dilution volume after subtracting an “estimated” anatomic dead space ($V_{D_{anat}}$) from the inspired volume (V_I) (Figure 1). The V_I starts from residual volume and finishes at maximal inflation ($\sim$ TLC); the inspiration should be made as rapidly as possible. In normal subjects, V_A is within 10% of TLC, with a mean V_A/TLC ratio (combining men and women) of $93.5\% \pm 6.6$ (1 SD) (5); the V_A/TLC ratio has no significant dependence on age, sex, height, or weight (5), but decreases substantially when there is intrapulmonary airflow obstruction and maldistribution of ventilation. $V_{D_{anat}}$ represents 2–3% of the TLC in normal subjects, the remaining 4% of the V_A/TLC difference occurring because gas mixing in the 10-second breath hold is incomplete. In disease, the difference between the single-breath V_A and the multibreath or plethysmographic TLC, and the V_A/TLC ratio, deserves more study (5) as an index of gas mixing efficiency.

Combining V_A and k_{CO}

Equation 1 is the first step in the calculation of the DL_{CO} :

$$V_A \times k_{CO} = \dot{V}_{CO} \quad (1)$$

$$\text{ml (STPD)} \times \text{min}^{-1} = \text{ml min}^{-1},$$

where k_{CO} is the fractional change in CO concentration, expressed in minute^{-1} , and $\dot{V}_{CO}$ is the uptake of CO from alveolar gas during breath holding at TLC. Equation 1 gives a large value for $\dot{V}_{CO}$ because, as pointed out by Marie Krogh (1), the calculation implies that all alveolar gas is pure CO. For the second step, to obtain DL_{CO} , both sides of the equation are divided by P_{b^*} , where P_{b^*} is

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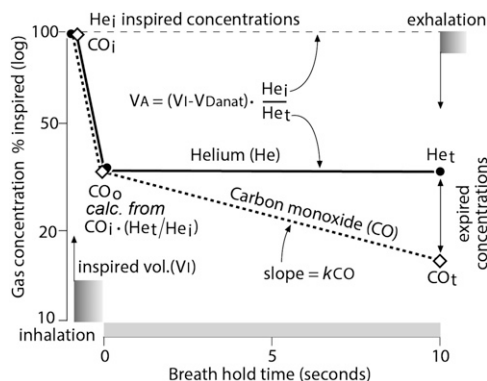


Figure 1. Carbon monoxide (CO) and helium (He) kinetics in the single-breath DL_{CO} : concentrations of the marker gases CO and He after rapid inspiration from residual volume to TLC, plotted against breath hold time, showing the origin and calculation of the components (k_{CO} and V_A) from which DL_{CO} is derived. *Definitions of abbreviations:* BHT = breath-holding time; CO_0 , CO_t = alveolar concentration of CO at the start and finish of the breath-holding time, respectively; CO_i = inspired concentration of carbon monoxide; DL_{CO} = carbon monoxide diffusing capacity; He_i , He_t = inspired and expired concentrations of inert marker gas helium, respectively; k_{CO} = rate constant for carbon monoxide uptake; K_{CO} = rate constant for carbon monoxide uptake per unit barometric pressure ($k_{CO}/Pb^* \sim DL_{CO}/V_A$); V_A = alveolar volume; V_i = inspired volume; V_{Danat} = anatomical dead space. *Calculations:* The rate constant k_{CO} equals $\log_e(CO_0/CO_t)/BHT$; for points $t = 0$ and $t = 10$ seconds and gas concentrations as fractions (not %), $k_{CO} = \log_e(0.35/0.16)/10 = 0.08 \text{ second}^{-1}$ or ($\times 100$) 8% per second or ($\times 60$) 4.8 minute^{-1} . $k_{CO}/Pb^* = 4.8/713 = 0.0067 \text{ minute}^{-1} \text{ mm Hg}^{-1}$. For V_A 5,000 (ml STPD), $DL_{CO} = k_{CO}/Pb^* \times V_A = 5,000 \times 0.0067 = 33.5 \text{ ml minute}^{-1} \text{ mm Hg}^{-1}$. $K_{CO} = DL_{CO}/V_{A,BTPS} = 33.5/(5,000 \times 1.2/1,000) = 5.58 \text{ ml minute}^{-1} \text{ mm Hg}^{-1} \text{ L}^{-1}$. The ratio $K_{CO}/k_{CO} = 1.16$, and $K_{CO}/(k_{CO}/Pb^*) = 883$.

barometric pressure, usually approximately 760 mm Hg, minus water vapor pressure at 37°C in alveolar gas ($Pb - P_{H_2O}$), Thus:

$$[V_A \times k_{CO}]/Pb^* = DL_{CO} \quad (2)$$

$$\text{ml (STPD)} \times \text{min}^{-1} \text{ mm Hg}^{-1} = \text{ml min}^{-1} \text{ mm Hg}^{-1},$$

where $\dot{V}_{CO}/Pb^*$ is the alveolar CO uptake per minute per mm Hg P_{CO} , which, as a conductance, defines the DL_{CO} . In pulmonary function reports DL_{CO} is divided by V_A with ml STPD exchanged for L BTPS:

$$DL_{CO}/V_{A,BTPS} = [k_{CO}/Pb^*] \cdot 1000/1.2 = K_{CO}, \quad (3)$$

where DL_{CO}/V_A and K_{CO} have units of $\text{ml minute}^{-1} \text{ mm Hg}^{-1} \text{ L}^{-1}$, 1,000 converts milliliters to liters, and 1.2 is the STPD-to-BTPS factor. These units, as reported in pulmonary function laboratories, give the impression of a volume “adjustment,” leading to much confusion, whereas it is obvious from equation 3 that k_{CO} (the rate constant) only differs from $DL_{CO}/V_A (= K_{CO})$ by three constant factors (Pb^* , 1,000, and 1.2) and in its units. The ratios $DL_{CO}/V_A (= K_{CO})$ to CO_0 and to k_{CO}/Pb^* (both constant except for minor variations in Pb) are given in the legend to Figure 1. Therefore, $DL_{CO}/V_A (= K_{CO})$ is effectively the rate constant, representing alveolar carbon monoxide uptake efficiency. Unless required by the context, this review uses the term K_{CO} in preference to DL_{CO}/V_A .

WHAT DOES THE K_{CO} SIGNIFY?

The previous section has shown that k_{CO} (second^{-1} or minute^{-1}), k_{CO}/Pb^* ($\text{minute}^{-1} \cdot \text{mm Hg}^{-1}$), and $DL_{CO}/V_A (= K_{CO})$ (ml

$\text{minute}^{-1} \text{ mm Hg}^{-1} \text{ L}^{-1}$ BTPS) are physiologically equivalent, except in their units, to the rate of removal of CO from alveolar gas, that is, the slope (on a semilogarithmic plot) of carbon monoxide uptake in Figure 1, labeled k_{CO} . K_{CO} , expressed as DL_{CO}/V_A , is the carbon monoxide diffusing capacity per unit alveolar volume, at the alveolar volume (V_A) at which the measurement is made; it remains, in essence, a pressure-adjusted rate constant for alveolar carbon monoxide uptake. The difficulty, or confusion, stems from the notion that “per unit volume” implies DL_{CO} corrected for lung volume, a concept that is wrong because DL_{CO} measured at a different volume, at a different level of $V_A/V_{A,TLC}$, would yield a different value for $DL_{CO}/V_A (= K_{CO})$ (see Figures 2 and 3). Paradoxically, DL_{CO}/V_A contains no information about the value of V_A , being a weighted mean value of the rate of CO uptake in the “accessible” V_A . Therefore, it would be prudent to replace the misleading (although physiologically correct) “diffusing capacity per unit alveolar volume” by K_{CO} , which, unlike the earlier term k_{CO} , is numerically the same as DL_{CO}/V_A .

How should the K_{CO} be defined? Krogh (1) called $k (= k_{CO})$ “permeability,” and K_{CO} has been referred to as the Krogh factor (6). Cotes (7) and others (8) refer to $TL_{CO}/V_A (\sim DL_{CO}/V_A)$ as the “transfer coefficient.” Hughes and Pride (2) referred to K_{CO} as “essentially the rate constant for alveolar CO uptake.” No clarifying definition has emerged from the American Thoracic Society/European Respiratory Society (ATS/ERS) Task Force on Standardization of Lung Function Testing (9, 10), who still refer to K_{CO} or DL_{CO}/V_A , like most authors, as “diffusing capacity per unit alveolar volume.” We regard the K_{CO} as an index of the efficiency of alveolar transfer of carbon monoxide (approximately the rate of CO uptake); “transfer” is a better term than “diffusion” because of the importance of the reaction rate of carbon monoxide with pulmonary capillary blood (see Equation 4). Nevertheless, “rate constant for carbon monoxide uptake” is probably the best operational definition for the K_{CO} .

DETERMINANTS OF K_{CO} IN NORMAL SUBJECTS

Effect of Lung Volume

As the lung volume decreases from TLC to FRC, the DL_{CO} falls and K_{CO} rises (8, 11) (Figure 2). Expressed as a percentage of the value at predicted TLC ($\sim V_{Amax}$), DL_{CO} at 50% V_{Amax} is 79%, and K_{CO} is 158% (8). This increased efficiency of alveolar uptake of carbon monoxide (K_{CO}) at resting breathing volumes protects the DL_{CO} against undue volume dependence, that is, DL_{CO} is 80% of its TLC value at 50% V_{Amax} rather than the expected 50%. The physiological reason for the increase in K_{CO} with decreasing alveolar expansion is given in the Roughton–Forster (12) equation ($1/DL = 1/DM + 1/\theta \cdot V_c$), normalized to V_A :

$$V_A/DL_{CO} = 1/K_{CO} = V_A/DM_{CO} + V_A/\theta_{bl_{CO}} \cdot V_c, \quad (4)$$

where DM is the membrane diffusing capacity; $\theta_{bl_{CO}}$ is the reaction rate of carbon monoxide with blood ($\text{minute}^{-1} \text{ mm Hg}^{-1}$), adjusted to a standard hemoglobin (Hb) concentration; and V_c is the pulmonary capillary volume. With a decrease in alveolar expansion, the ratio V_A/DM remains almost constant (13), so the fall in $V_A/DL_{CO} (= \text{rise in } K_{CO})$ is caused by the decrease in $V_A/V_c (= \text{rise in } V_c/V_A)$, with V_c remaining constant as V_A decreases (13). The change in V_c/V_A is consistent with the stability of pulmonary blood flow (approximately the cardiac output) during lung volume changes.

Changes on Exercise

During exercise, DL_{CO} (and K_{CO}) rises at constant V_A (14). This was first shown by M. Krogh in 1915 (1). The reason is that the rise of pulmonary artery (and, to a lesser extent, pulmonary

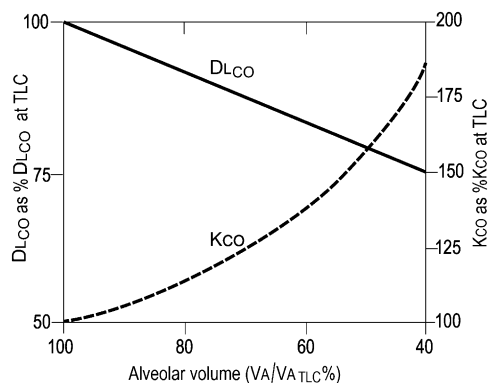


Figure 2. Effect of voluntary lung volume change on DL_{CO} and K_{CO} , plotted as a percentage of the value at full inflation (approximately TLC) against alveolar expansion expressed as alveolar volume as percent maximum ($VA/VA_{TLC} \sim 93.5\%$ TLC). $K_{CO}/K_{CO_{TLC}}$ at various values of VA/VA_{TLC} was calculated from Equation 7 [$K_{CO}/K_{CO_{TLC}} = 0.43 + 0.57/(VA/VA_{TLC})$], and $DL_{CO}/DL_{CO(TLC)}$ as $K_{CO}/K_{CO_{TLC}} \times VA/VA_{TLC}$. *Definitions of abbreviations:* DL_{CO} = carbon monoxide diffusing capacity; K_{CO} = rate constant for carbon monoxide uptake per unit barometric pressure ($k_{CO}/Pb^* \sim DL_{CO}/VA$); VA = alveolar volume.

venous) pressure, which accompanies the increase in pulmonary blood flow, distends the pulmonary capillary bed and recruits additional alveolar septal vessels (15). This increases capillary volume (V_c) and the membrane diffusing capacity (DM) (14). On exercise at constant VA , V_c/VA increases; DM/VA also increases because vascular distension expands the alveolar surface available for gas exchange. Thus, DL_{CO}/VA (K_{CO}) increases. With the rebreathing technique, usually used in exercise studies for measuring DL_{CO} (14), mean VA does not change from rest to exercise (14, 16), being mostly constrained by the volume of the rebreathing bag, but VA did increase on exercise according to the open-circuit DL_{CO} method (16); in this case, the increase in VA would itself contribute to the increase in DL_{CO} , although its effect would be reduced by a fall in K_{CO} accompanying the rise in VA .

Variables That Can Be Controlled

Other factors that influence K_{CO} (but not VA) are anemia and alveolar PO_2 because $\theta_{b_{CO}}$ (see Equation 4) decreases as $[Hb]$ falls or as alveolar PO_2 rises. A rise in the steady state P_{CO} in plasma (called the “back-pressure”), due to recent cigarette smoking or multiple preceding measurements of DL_{CO} , also lowers the DL_{CO} . Standard corrections for these three factors are available (9). The test gas includes 21–25% oxygen (depending on the helium concentration), so K_{CO} is usually measured at a normal alveolar PA_{O_2} . K_{CO} is greater supine than erect, but clinical measurements are always made in the seated upright posture.

Reference Values

The predictions for DL_{CO} depend on age, sex, and height (17). Of the components of the DL_{CO} , VA depends on sex and height but not on age, and, in adults, K_{CO} depends inversely on age and height but, in a review of the literature, hardly at all on sex (18). The highest values for K_{CO} have been found in boys and girls before the age of puberty (6), suggesting that the pulmonary capillary bed has developed earlier than alveolar volume. The decline in K_{CO} in adults with age may be related to changes in the microvasculature, secondary to the loss of lung elasticity with aging. The inverse relationship with height for K_{CO} may be because the apices of the lungs are less well perfused in the

upright position in taller people for gravitational reasons. There is considerable scatter in the predicted values for different reference equations for DL_{CO} and K_{CO} , and there is no consensus on the “best choice” (10). Thus, there is a need to acquire new reference values for DL_{CO} and for its components. The European Standardization Working Party (17) recommends that K_{CO} (predicted) be calculated as DL_{CO} (predicted)/TLC (predicted), from measurements made at different times and often in different places. Predicted values for K_{CO} would be better based on the two simultaneous measurements, that is, from DL_{CO} divided by single-breath “accessible” VA rather than from two separate procedures (DL_{CO} and TLC).

Nomenclature and Units

This review refers to the DL_{CO} as the carbon monoxide diffusing capacity, and uses traditional units (ml and mm Hg). In Europe, the DL_{CO} is termed the “carbon monoxide transfer factor” (TL_{CO}) and SI units are used for gas uptake (mmol) and pressure (kPa). Divide by 3.0 to convert traditional to SI units.

CHANGES IN K_{CO} AND “ACCESSIBLE” VA IN DISEASE

Clinical Causes of Decreases or Increases in K_{CO}

Alveolar and/or microvascular damage and destruction, leading to loss of alveolar or capillary surface area, affecting both DM and V_c , reduce the rate of carbon monoxide uptake per unit volume, leading to a low K_{CO} as a percentage of the predicted value; in some circumstances, K_{CO} may exceed the upper limit of normal at predicted TLC, and this has clinical significance Table 1 [19–32]).

In relation to increases in K_{CO} , incomplete alveolar expansion, without compromise of alveolar structure, elevates K_{CO} by increasing V_c/VA ; a lesser increase in V_c/VA is also largely responsible for the increase in K_{CO} with increases in pulmonary blood flow, either through the whole lung, as in a left-to-right shunt, or through part of the lung, as after a pneumonectomy. The increase in K_{CO} (and also DL_{CO}) in asthma is probably linked to better perfusion of the apices of the lungs (27), and this may explain, in part, the increase in K_{CO} in some obese patients, although a raised capillary volume and low DM have been found (33), suggesting an element of pulmonary vascular congestion as in chronic heart failure (34, 35).

Diversion of blood flow from a resected lung, for example, pneumonectomy, increases perfusion per unit volume in the remaining lung by 80–100%, depending on the preoperative partitioning of flow between the two lungs, and assuming total pulmonary blood flow ($\sim$ cardiac output) remains the same postpneumonectomy. This will increase the K_{CO} in the lung that remains. Corris and colleagues (30) established an empirical relationship in 28 patients for the increase in K_{CO} that occurred postpneumonectomy:

$$\Delta K_{CO}(\% \text{ predicted}) = 0.4x + 2.1, \quad (5)$$

where x was the percentage flow (%) to the resected lung, based on a preoperative radioisotope lung perfusion scan. K_{CO} postpneumonectomy was 110–131% predicted (mean K_{CO} preoperatively for both lungs averaged 98%); in the case in which flow to both lungs was equal preoperatively ($x = 50\%$), Equation 5 predicts the K_{CO} in the remaining nonresected lung to increase by +22%, that is, in an average case to 120% predicted ($98 + 22\%$). The reason for this increase in K_{CO} is the expected doubling of blood flow per unit volume in the remaining lung. This ΔK_{CO} is consistent with the 20% increase in K_{CO} when pulmonary blood flow in normal lungs increases from 5 L minute^{-1} at rest to 10 L minute^{-1} on moderate exercise (14). VA after pneumonectomy averaged 50% of the preoperative value; thus, the remaining lung was expanded to its predicted TLC when the K_{CO} was measured

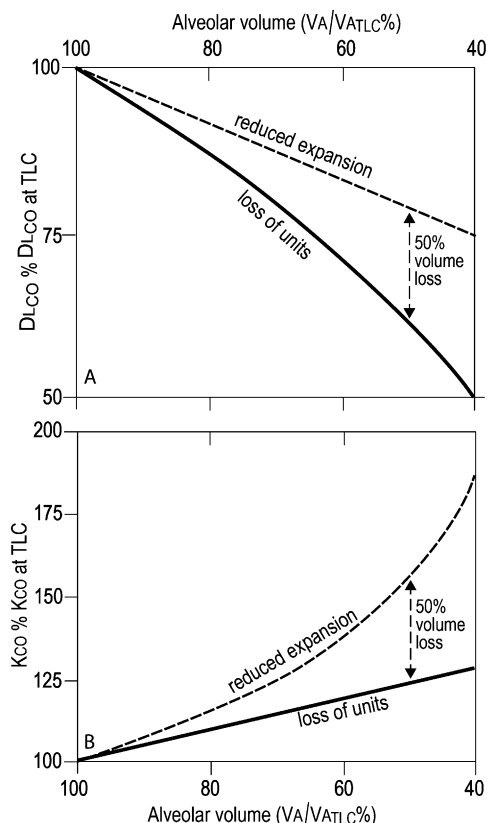


Figure 3. $DL_{CO}/DL_{CO(TLC)}$ and $K_{CO}/K_{CO(TLC)}$ plotted against volume loss (VA/VA_{TLC}) from two causes: (A) reduced alveolar expansion (e.g., FRC vs. TLC), and (B) loss of units as in lobectomy or pneumonectomy. Reduced expansion calculations are from Figure 2. Loss of units calculated from Equation 5 ($\Delta K_{CO} [\% \text{ predicted}] = 0.4x + 2.1$) on the assumption that “x” (% blood flow to lung to be resected) reflects percent lung volume to be resected; $DL_{CO}/DL_{CO(TLC)}$ calculated as $K_{CO}/K_{CO(TLC)} \times VA/VA_{TLC}$. Note difference between $DL_{CO}/DL_{CO(TLC)}$ and $K_{CO}/K_{CO(TLC)}$ for 50% volume loss according to the mechanism of the volume deficit.

postoperatively. Note that for a similar reduction of overall VA to 50% predicted, but applied to both lungs by underexpansion (e.g., neuromuscular disease), the increase in K_{CO} at 50% VA/VA_{TLC} is considerably greater (+58%; see Figure 2) than the +22% occurring postpneumonectomy.

The effect of 50% volume loss from two different causes, (1) reduced alveolar expansion and (2) “loss of units” (pneumonectomy), is illustrated for DL_{CO} in Figure 3A and for K_{CO} in Figure 3B. The difference for K_{CO} in Figure 3B arises from different changes in the two components of the K_{CO} from the Roughton–Forster formula (Equation 4), VA/DM and VA/V_c . With restricted alveolar expansion, DM/VA (inverse of VA/DM) and V_c (13) remain relatively constant; hence halving lung volume (to 50% VA/VA_{TLC}) will increase V_c/VA to 200% and increase K_{CO} to 158% (Figure 3B). After pneumonectomy, the whole cardiac output must be distributed to the remaining lung whose blood flow, per unit volume, probably doubles. A doubling of pulmonary blood flow during moderate exercise in normal subjects increases the K_{CO} to 120%; this arises from changes in both the DM and V_c components of the Roughton–Forster equation: DM/VA increases to 133% and V_c/VA to 141% of their resting values (14). The larger increase in V_c/VA at 50% VA/VA_{TLC} with underexpansion (200%) compared with exercise (141%), and, by implication, postpneumonectomy may arise because the number of alveoli and alveolar capillaries in two lungs is twice the number postpneumonectomy.

The increase in K_{CO} postpneumonectomy (30) (increased blood flow per unit volume) is a general phenomenon in many lung diseases in which blood flow is redistributed to less diseased areas with an increase in local flow and blood volume per unit alveolar volume; this redistribution may be the explanation for increases in K_{CO} seen occasionally in other conditions in which interstitial or vascular disease, in its early stages, is patchy, leading to blood flow diversion to the remaining normal lung. Thus, a normal or mildly elevated K_{CO} is seen in a proportion of cases with sickle cell disease (36), interstitial lung disease, and sarcoidosis (37).

Pulmonary hemorrhage (32), in which blood recently shed from capillaries takes up carbon monoxide, is the one example of a raised K_{CO} that is not linked to an increased rate of alveolar–capillary uptake. K_{CO} is more sensitive than DL_{CO} in detecting pulmonary hemorrhage (38) because of a small accompanying fall in VA . In 39 patients, the maximal increase above baseline averaged 219% for K_{CO} but only 182% for DL_{CO} . In nine patients the peak rise in DL_{CO} was less than 50%, but the rise in K_{CO} above baseline always exceeded 50%.

Clinical Causes of a Low “Accessible” Alveolar Volume (VA)

In the single-breath DL_{CO} , there are three distinct causes of a low VA (as a percentage of V_{Amax} predicted, $\sim 93.5\% \pm 6.6$

TABLE 1. PATHOPHYSIOLOGY AND CLINICAL EXAMPLES OF AN ABNORMAL K_{CO}

Low Kco		High Kco	
Mechanism	Clinical Examples	Mechanism	Clinical Examples
With Normal or Near Normal VA			
Microvascular destruction	Idiopathic pulmonary hypertension (19) Pulmonary vasculitis (20)	Increased pulmonary blood flow or redistribution	Left-to-right intracardiac shunts (26) Asthma (27)
Microvascular remodeling and dilation	Hepatopulmonary syndrome (21, 22) Pulmonary arteriovenous malformations (23)		
With Reduced VA			
Alveolar destruction	Emphysema (low “accessible” VA)	Incomplete alveolar expansion to TLC	Inspiratory muscle weakness (28) Chest wall restriction (29) Poor cooperation or comprehension
Alveolar destruction	Diffuse interstitial lung disease with fibrosis	Increased pulmonary blood flow Microvascular congestion/dilation Alveolar hemorrhage	Pneumonectomy (30)
Microvascular destruction	Bronchiolitis obliterans (24)		Obesity (31)
Microvascular destruction	Chronic heart failure (severe) (25)		Anti-GBM disease (32), SLE

Definition of abbreviations: GBM = glomerular basement membrane; SLE = systemic lupus erythematosus.

Clinical examples are not an exhaustive list.

[1.0 SD] TLC) (Table 2) resulting in different values for the K_{CO} (see Table 1):

1. Incomplete alveolar expansion (K_{CO} > 120% predicted).
2. Loss of lung units (K_{CO} 100–120% predicted). Besides pneumonectomy, localized destruction of lung ± fibrosis, infiltration with granulomas or inflammatory exudates, atelectasis, alveolar edema, and pneumonic consolidation are other causes.
3. Poor mixing with maldistribution of inspired gas. This is most obvious in the case of a bulla. But, intrapulmonary airflow obstruction from any of the major causes (emphysema, bronchitis, bronchiolitis, bronchiectasis, asthma) generally lowers the V_A/TLC ratio, when V_A is measured with 10-second helium dilution and TLC with body plethysmography or multibreath inert gas wash-in or washout (4). V_A, even in normal subjects, is an “accessible” rather than an absolute volume. The K_{CO} is variable and depends on the pathology (Table 2). But, clearly there is a continuum in the sense of different values of V_A and K_{CO} within a single diagnostic category.

These three causes may coexist: causes 1 and 2 in interstitial lung disease, and causes 2 and 3 in COPD or bronchiectasis.

K_{CO} ENHANCES UNDERSTANDING OF DL_{CO}

The DL_{CO} is the product of its two components, K_{CO} and V_A (Equation 1). The most compelling argument in favor of the K_{CO} (unadjusted) is set out in Table 3, where the same value of DL_{CO} (as a percentage of the predicted value) may occur from different combinations of its components (K_{CO} and V_A). The combination of low V_A and high K_{CO} has a different clinical significance (extrapulmonary restriction) compared with the combination of low K_{CO} and normal V_A (microvascular injury), although the DL_{CO} is practically the same.

In chronic inspiratory muscle weakness (28, 39), the K_{CO} is usually less (120–130%) (Table 3, diagnosis A) than that predicted from the decrease of V_A (K_{CO} predicted would be 150%; Figure 3B), presumably due to secondary changes stemming from microatelectasis, retention of secretions, and infection. In interstitial lung disease (Table 3, diagnosis C), especially preceding the overt fibrotic phase, the K_{CO} may be within the “normal” range (say 80–100%), but in the presence of a low V_A, this could be interpreted as “abnormal” because the expected compensation via the “loss of units” model is lacking. In emphysema (in this example) (Table 3, diagnosis D) there is relatively little gas mixing deficit after inspiration to TLC, and K_{CO} predicted is less than V_A predicted, suggesting disorganization of peripheral airspaces, which remain

(mostly) ventilated. This contrasts with Table 3, diagnosis C, in which the DL_{CO} is similar, but K_{CO} is higher than the V_A. This suggests that the disease is more localized with up to 30% of alveolar units destroyed or infiltrated with inflammatory exudate (gas mixing from the V_A/TLC ratio [data not shown] is normal), and that the remaining alveolar units are functioning well, even if not entirely normally, as gas exchange units. The analysis adds less in Table 3, diagnosis E, in which a low DL_{CO} in the presence of normal lung volumes without airflow obstruction suggests straightaway some pulmonary vascular pathology.

CURRENT VIEWS ON DL_{CO}/V_A (= K_{CO})

In an earlier section (MEASUREMENT OF K_{CO} AND V_A: COMBINING V_A AND K_{CO}) we pointed out that current practice reports DL_{CO}/V_A (= K_{CO}) literally as DL_{CO} divided by V_A with units ml minute⁻¹ mm Hg⁻¹ L⁻¹; this redundancy of units (the units of DL_{CO}/V_A and K_{CO} are essentially minute⁻¹ mm Hg⁻¹, that is, kco/Pb*; see Equation 2) has led to the idea that DL_{CO}/V_A “adjusts” or “corrects” the DL_{CO} when the V_A is lower than predicted. Because DL_{CO}/V_A (= K_{CO}) is not a constant function versus V_A (Figures 2 and 3), several authors (40–42) have claimed that DL_{CO}/V_A has no clinical value, and even that the K_{CO} is an “arithmetically flawed” index (7) (if this were the case, we would expect K_{CO} × V_A [= DL_{CO}] to share this flaw). The confusion arises from the substitution for K_{CO} of its equivalent (DL_{CO}/V_A), which gives the impression of a “volume correction.” The ATS/ERS Task Force (9, 10) counsels caution in the use of the DL_{CO}/V_A ratio, but nowhere is the connection made that the DL_{CO}/V_A is essentially a rate constant, similar to kco and kco/Pb* except in its units. It is clear that the nonlinear relationship between K_{CO} and lung volume (Figure 2) precludes DL_{CO}/V_A from being a “volume correction” for the DL_{CO} when V_A is reduced, but K_{CO} remains a true reflection of alveolar CO uptake efficiency at a given volume. In our opinion, the emphasis on DL_{CO}/V_A as a correction factor for lung volume is misconceived, and reflects a misapprehension of the physiology. Hence, we believe the term DL_{CO}/V_A should be replaced by the more informative term, K_{CO}.

SHOULD THE K_{CO} BE CORRECTED FOR A LOW V_A?

Corrections have been proposed on the basis of the relationship in normal subjects between change of lung volume and the change in DL_{CO}/V_A (K_{CO}). A typical relationship (data from 24 subjects) is as follows (8):

$$DL_{CO}/DL_{CO_{TLC}} = 0.58 + 0.42 \cdot (V_A/V_{ATLC}), \quad (6)$$

where DL_{CO_{TLC}} and V_{ATLC} are expected values for DL_{CO} and V_A at a normal predicted TLC. For a V_A/V_{ATLC} ratio of 0.5,

TABLE 2. CAUSES OF LOW V_A AND TYPICAL K_{CO} FINDINGS

Pathophysiology	Clinical Examples	K _{CO} as % K _{CO} at Predicted TLC
Restrictive (Reduced TLC)		
Incomplete alveolar expansion	Inspiratory muscle weakness Chest wall, pleural restriction Inadequate inspiration to TLC	120–140 (28)
Loss of units “localized”	Pneumonectomy, local destructive or infiltrative pathology	100–120 (30)
Loss of units “diffuse”	Interstitial lung disease with fibrosis	<80
Obstructive (Normal/High TLC)		
Poor mixing + normal alveolar function	Asthma	100–120 (27)
Poor mixing + localized loss of units	Bronchiectasis	90–100 [†]
Poor mixing + some alveolar loss/disorganization	Bronchiolitis obliterans	70–100 (24)
Poor mixing + diffuse alveolar disorganization	COPD (chronic bronchitis and emphysema)	40–90

Definition of abbreviations: COPD = chronic obstructive pulmonary disease; K_{CO} = rate constant for carbon monoxide uptake per unit barometric pressure (kco/Pb* ~ DL_{CO}/V_A); V_A = alveolar volume.

[†]D. Cramer, Royal Brompton Hospital, London, UK, personal communication.

TABLE 3. VARIOUS K_{CO}–V_A PATTERNS AND PATHOLOGIES, BUT SIMILAR D_{LCO}

Diagnosis	D _{LCO} % Predicted	K _{CO} % Predicted	V _A % Predicted	Comment
A. Inspiratory muscle weakness	59	120	50	Lack of alveolar expansion
B. Pneumonectomy	58	111	51	Localized loss of lung units
C. Diffuse interstitial lung disease	54	84	66	Alveolar capillary damage (±loss of units)
D. Emphysema	54	59	91	Alveolar capillary damage
E. Idiopathic pulmonary hypertension	56	58	96	Microvascular damage

Definition of abbreviations: D_{LCO} = single-breath diffusing capacity for carbon monoxide; K_{CO} = rate constant for carbon monoxide uptake per unit barometric pressure (k_{CO}/Pb* ~ D_{LCO}/V_A); V_A = alveolar volume.

D_{LCO} would be multiplied by 1.26 to adjust for the volume reduction. The relationship for K_{CO} was

$$K_{CO}/K_{CO_{TLC}} = 0.43 + 0.57/(V_A/V_{ATLC}) \quad (7)$$

Thus, K_{CO} would be adjusted down at 0.5 V_A/V_{ATLC} by multiplying by 0.64 (1/1.57). Johnson (8) studied retrospectively the pulmonary function records of 2,313 patients, and analyzed subgroups of patients with asthma, emphysema, extrapulmonary restriction, interstitial lung disease, and lung resection. Before adjustment, there was wide dispersion between D_{LCO} and K_{CO} (as a percentage of the predicted value), with K_{CO} (%) exceeding D_{LCO} (%) by up to 50%. After adjustment of K_{CO} for a low V_A, D_{LCO} and K_{CO} tended to converge. Using a similar approach, Frans and colleagues (43) reported convergence of D_{LCO} and K_{CO} values after adjustment of both for the low V_A in diffuse interstitial lung disease. Basically, these “corrections” return a high K_{CO} in extrapulmonary restriction to values in the 90–100% predicted range, and in interstitial lung disease and sarcoidosis they adjust the K_{CO} down from 75–105% predicted to 50–75% predicted, more in line with the uncorrected D_{LCO}. The authors (8, 43) argue that “normal” values for D_{LCO}/V_A (unadjusted) in interstitial lung disease give the clinician a “false” impression that the gas-exchanging part of the lung is “healthy.” Stam and colleagues (44) studied patients who developed alveolar injury after bleomycin treatment. After bleomycin, the K_{CO} reduction was greater (by up to 11%) if its value was referenced to the K_{CO} at the actual lung volume rather than the predicted TLC. They concluded, like others (8, 43), that the volume restriction had “misleadingly” increased the K_{CO}.

The flaw in the argument is that alveolar restriction by underexpansion is only one of at least three mechanisms causing a low V_A (Table 2). For example, it is unlikely that the majority of the alveolar units contributing to the K_{CO} in interstitial lung disease, pneumonectomy, or airflow obstruction from various causes are “underexpanded.” Hughes and Pride (2) presented corrections for a high K_{CO} and low V_A using two models (alveolar underexpansion, and increased pulmonary blood flow; based on Equation 5; see their Table 3), but this is hardly a practical solution for the clinician, and does not address the question of low V_A caused by poor gas mixing.

It is not unreasonable to seek an interpretation of, or correction for, the D_{LCO} when V_A is reduced. For example, it would be legitimate to correct D_{LCO} and K_{CO}, using Equations 6 and 7, for underexpansion of the lung during breath holding (due to extrapulmonary restriction or technical artifact) provided that alveolar deflation was the sole cause of the low V_A. Our contention is that any “correction” of the D_{LCO} for volume (V_A) must take into account the reason for the volume deficit—for 50% volume loss (V_A = 0.5 V_{ATLC}) D_{LCO}/V_A (= K_{CO}) will be significantly greater in extrapulmonary restriction than after a pneumonectomy or maldistribution of inspired gas as in bullous emphysema. There is no easy solution to this problem. There is no “correct” way in which the rate constant (k_{CO} ~ k_{CO}/Pb* ~ K_{CO}) can be properly adjusted for all the causes of low alveolar

volume. A grasp of physiological principles (*see* DETERMINANTS OF K_{CO} IN NORMAL SUBJECTS) is the best way to understand the clinical significance of D_{LCO}, K_{CO}, and V_A.

THE DIFFUSING CAPACITY FOR NITRIC OXIDE (D_{LNO})

In the last two decades, the measurement of pulmonary diffusing capacity using nitric oxide (D_{LNO}) has been introduced (45, 46). D_{LNO} is 4 to 4.5 times greater than D_{LCO}, partly because the physical diffusivity of nitric oxide is about twice that of carbon monoxide, and partly because red cell resistance to nitric oxide uptake is less than that to carbon monoxide (47) owing mostly to the much faster combination (by 280-fold) of nitric oxide with hemoglobin (Hb). Unlike D_{LCO}, D_{LNO} is PO₂ independent (48). The low red cell resistance suggests that D_{LNO} is measuring mostly the diffusive component of the alveolar to red cell transfer pathway, related to the surface area/thickness ratio of the blood gas barrier. Since the work of Roughton and Forster (12) this has been referred to as the membrane diffusing capacity (D_M). D_{MNO} is related to the better known D_{MCO} by α (= 1.97), the ratio of the physical diffusivities of nitric oxide and carbon monoxide in plasma, that is, D_{MNO}/α = D_{MCO}.

Guenard and colleagues (45) measured D_{LNO} and D_{LCO} simultaneously by the classical single-breath technique. Assuming D_{MNO}/α = D_{MCO}, they showed that the Roughton–Forster formulation (1/D_{LCO} = 1/D_{MCO} + 1/θ_{b_{LCO}} V_c) could be rearranged:

$$1/V_c = \theta_{b_{LCO}} (1/D_{LCO} - \alpha/D_{LNO}) \quad (8)$$

Reasonable values of D_{MCO} and V_c were obtained in normal subjects (45).

Although, for clinical interpretation, D_{LNO} may be regarded as a surrogate for the membrane diffusing capacity (D_M), the notion that θ_{b_{LNO}} is infinite has been called into question. Measurements of D_{LNO} before and after experimentally induced hemolysis (49) and after blood substitution, in anesthetized dogs, with cell-free heme-based oxyglobin (50), suggest that D_{LNO} is not entirely “red cell independent.” After oxyglobin exchange transfusion, in the red cell-free state, D_{LNO} increased 1.5 times (D_{LCO} did not change), which suggests that D_{MNO} is 1.5 times D_{LNO} rather than its equivalent. It was suggested previously that D_{LNO} might be a surrogate for D_{LO₂} (51).

THE D_{LNO}/D_{LCO} RATIO

Because of reservations about the relevance of *in vitro* measurements of θ_{b_{LCO}} and θ_{b_{LNO}} to the *in vivo* situation (49, 50), interest is shifting from estimates of D_M and V_c toward the D_{LNO}/D_{LCO} ratio. Assuming, for clinical purposes, that θ_{b_{LNO}} is infinite so that D_{LNO} = D_{MNO} = D_{MCO}·α, and from the Roughton–Forster equation for carbon monoxide (12):

$$D_{LNO}/D_{LCO} = \alpha(1 + D_{MCO}/\theta_{b_{LCO}} \cdot V_c) \quad (9)$$

Thus, the D_{LNO}/D_{LCO} ratio is weighted toward the D_M/V_c ratio and α (the NO/CO physical solubility ratio). It is also equivalent

to the K_{NO}/K_{CO} ratio because $DL = K \times V_A$, and V_A is common to DL_{NO} and DL_{CO} when measured simultaneously by the standard single-breath technique with inhalation of nitric oxide and carbon monoxide. Measurements of the DL_{NO}/DL_{CO} ratio have been performed in normal subjects, at rest and during exercise (53–55), and over a range of lung volumes (56, 57). The DL_{NO}/DL_{CO} ratio has been studied in several clinical situations. For example, the DL_{NO}/DL_{CO} ratio is increased in heavy smokers (58), otherwise healthy, and in diffuse parenchymal disease (59) and in chronic thromboembolic pulmonary hypertension (59), possibly because V_c/V_A is reduced more than DM/V_A . In contrast, the DL_{NO}/DL_{CO} ratio is decreased at FRC versus TLC (56), the explanation being that DL_{NO} is more sensitive to alveolar under-expansion than DL_{CO} . For example, from V_{ATLC} to $V_{A50\% TLC}$ the DL_{NO} declines by 43% versus 29% for DL_{CO} (56). The reason is that the fall in DL_{CO} is buffered by an increase in K_{CO} (+35%) whereas K_{NO} (being less influenced by the rise in V_c/V_A) increases by only 10% (56). Thus, the DL_{NO}/DL_{CO} ratio could become a marker for extrapulmonary restriction.

The DL_{NO}/DL_{CO} ratio gives some insights into the components (DM and V_c) of the Roughton–Forster equation in a single maneuver without the two-step approach with carbon monoxide at different alveolar PO_2 as well as by-passing θ_{blco} , the value of which is somewhat controversial (51, 52). Experience to date with DM and V_c partitioning has been disappointing because commonly both change equally (the only notable example of discordance [$DM\downarrow$, $V_c\uparrow$] being chronic heart failure [34, 35]); thus, we would expect a low DL_{NO}/DL_{CO} ratio in chronic heart failure, at least in the early stages. It is also possible that by factoring out V_A , the DL_{NO}/DL_{CO} ratio ($= K_{NO}/K_{CO}$) may provide additional insight into other respiratory diseases.

CONCLUSIONS

The single-breath DL_{CO} is, physiologically, the product of two simultaneous measurements: the rate of carbon monoxide uptake from alveolar gas to pulmonary capillary blood (k_{CO}), reexpressed per mm Hg alveolar dry gas pressure (Pb^*) as k_{CO}/Pb^* , and the “accessible” alveolar volume (V_A), which approaches, in normal subjects, TLC. k_{CO}/Pb^* is linked mathematically to DL_{CO}/V_A ($= K_{CO}$). The term DL_{CO}/V_A is misleading because, as k_{CO}/Pb^* , it reflects the rate of alveolar uptake of CO.

The common causes of a low V_A are (1) underexpansion of alveoli in relation to their predicted TLC, (2) loss of alveolar units by destruction or infiltration with exudates or transudates, (3) poor gas mixing and penetration during the 10-second single-breath maneuver, and (4) some combination of cases 1, 2, and 3. Thus, there is no single factor or equation with which the pulmonary function laboratory can “correct” or “adjust” DL_{CO} for all the causes of a low V_A , and the use of the term DL_{CO}/V_A should be replaced by its alternative, K_{CO} .

Clinical interpretation of a low DL_{CO} (as a percentage of the predicted value) stems from inspection of the components of the DL_{CO} (K_{CO} and V_A) and knowledge of physiological principles. From a consideration of the K_{CO} and V_A (as a percentage of the predicted value), together with spirometry and lung volume measurements, it should be possible to distinguish emphysema from bronchiectasis, bronchiectasis from asthma, diffuse interstitial lung disease from extrapulmonary restriction, and both from pulmonary microvascular disease.

In the future, the diffusing capacity for nitric oxide (DL_{NO}) may enable us to focus on alveolar structure differently from the DL_{CO} . The DL_{NO}/DL_{CO} ratio may be a surrogate for the DM/V_c ratio and DL_{NO} may provide information on total barrier (tissue and blood) thickness, largely independent of any chemical resistance introduced by the presence of hemoglobin.

Author disclosures are available with the text of this article at www.atsjournals.org.

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