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Effect of heterogeneous ventilation and nitric oxide production on exhaled nitric oxide profiles

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Suresh V, Shelley DA, Shin H-W, George SC. Effect of heterogeneous ventilation and nitric oxide production on exhaled nitric oxide profiles. J Appl Physiol 104: 1743–1752, 2008. First published March 20, 2008; doi:10.1152/japplphysiol.01355.2007.—Elevated exhaled nitric oxide (NO) in the breath of asthmatic subjects is thought to be a noninvasive marker of lung inflammation. Asthma is also characterized by heterogeneous bronchoconstriction and inflammation, which impact the spatial distribution of ventilation in the lungs. Since exhaled NO arises from both airway and alveolar regions, and its level in exhaled breath depends strongly on flow, spatial heterogeneity in flow patterns and NO production may significantly affect the exhaled NO signal. To investigate the effect of these factors on exhaled NO profiles, we developed a multicompartment mathematical model of NO exchange using a trumpet-shaped central airway segment that bifurcates into two similarly shaped peripheral airway segments, each of which empties into an alveolar compartment. Heterogeneity in flow alone has only a minimal impact on the exhaled NO profile. In contrast, placing 70% of the total airway NO production in the central compartment or the distal poorly ventilated compartment can significantly increase (35%) or decrease (~10%) the plateau concentration, respectively. Reduced ventilation of the peripheral and acinar regions of the lungs with concomitant elevated NO production delays the rise of NO during exhalation, resulting in a positive phase III slope and reduced plateau concentration (~11%). These features compare favorably with experimentally observed profiles in exercise-induced asthma and cannot be simulated with single-path models. We conclude that variability in ventilation and NO production in asthmatic subjects impacts the shape of the exhaled NO profile and thus impacts the physiological interpretation.

Glossary

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$A(z)$</td>
<td>Total cross-sectional area of airway compartment at location $z$ (cm$^2$)</td>
</tr>
<tr>
<td>$A_1(z)$</td>
<td>Cross-sectional area of airway compartment 1 at location $z$ (cm$^2$)</td>
</tr>
<tr>
<td>$A_2(z)$</td>
<td>Cross-sectional area of airway compartment 2 at location $z$ (cm$^2$)</td>
</tr>
<tr>
<td>$C(z,t)$</td>
<td>Concentration of NO in airway compartment at location $z$ and time $t$ (ppb)</td>
</tr>
<tr>
<td>$C_{ANO,1}$</td>
<td>Steady-state concentration of NO in alveolar compartment 1 (ppb)</td>
</tr>
<tr>
<td>$C_{ANO,2}$</td>
<td>Steady-state concentration of NO in alveolar compartment 2 (ppb)</td>
</tr>
<tr>
<td>$C_{ANO}$</td>
<td>Volume-weighted average alveolar concentration (ppb)</td>
</tr>
<tr>
<td>$D_{airNO}$</td>
<td>Molecular diffusivity of NO in air (cm$^2$/s)</td>
</tr>
<tr>
<td>$f$</td>
<td>Fraction of total maximum airway flux in compartment 1</td>
</tr>
<tr>
<td>$F_{ENO,50}$</td>
<td>Plateau fractional concentration of NO at constant exhalation flow of 50 ml/s (ppb)</td>
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</tbody>
</table>

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Fractional concentration of NO in phase III at a constant exhalation flow

Forced expiratory volume in 1 s (%predicted)

Forced vital capacity (%predicted)

Total maximum airway wall flux of NO (pl/s)

Maximum airway wall flux of NO in central airway compartment 0 (pl/s)

Maximum airway wall flux of NO in airway compartment 1 (pl/s)

Maximum airway wall flux of NO in airway compartment 2 (pl/s)

Flow-weighted maximal airway wall flux for the whole airway tree (pl/s)

Ratio of steady-state NO concentration in alveolar compartment 1 to that in alveolar compartment 2

Normalized phase III slope of exhaled nitrogen (dimensionless)

Normalized phase III slope of exhaled NO (dimensionless)

Normalized phase III slope of exhalation flow (dimensionless)

Index of ventilation heterogeneity in acinar airways (liters⁻¹)

Index of ventilation heterogeneity in conducting airways (liters⁻¹)

Total volume of alveolar compartments (ml)

Volume of alveolar compartment 1 (ml)

Volume of alveolar compartment 2 (ml)

Total airway volume (ml)

Volume of airway compartment 0 (ml)

Volume of airway compartment 1 (ml)

Volume of airway compartment 2 (ml)

Volume of air exhaled (ml)

Normalized exhaled volume of air (number of exhaled airway volumes) required for the exhaled NO concentration to reach 90% of its plateau value (dimensionless)

Total exhalation flow (ml/s)

Flow in airway compartment 1 at time t (ml/s)

Flow in airway compartment 2 at time t (ml/s)

Initial (time 0) flow in compartment 1 (ml/s)

Initial (time 0) flow in compartment 2 (ml/s)

Steady-state flow in compartment 1 (ml/s)

Steady-state flow in compartment 2 (ml/s)

Mean exhalation flow during phase III (ml/s)

Fraction of the total airway cross-section area at bifurcation point in multicompartment model assigned to compartment I

Characteristic time constant of \( \dot{V}_1(t) \) and \( \dot{V}_2(t) \) (s)

Methods

A simple model of the human lung incorporating airway and alveolar heterogeneity in ventilation and NO production was developed. The model consists of a trumpet-shaped central airway compartment (compartment 0) which bifurcates into two trumpet-shaped lower airway compartments, 1 and 2 (Fig. 1). Each of the lower compartments empties into a well-mixed alveolar compartment.

Geometry. The model geometry is based on the symmetric bifurcating data of Weibel (38). A continuous airway cross-sectional area \( A(z) \) was obtained as a function of the distance \( z \) from the oropharynx by interpolating the Weibel data using a piecewise cubic Hermite polynomial. The airway volume at a location \( z \) is then given by \( V_{aw}(z) = \int_0^z A(z)dz \). The volume of the conducting airways (generations 0–16) in the Weibel model is approximately equal to 175 cm³. The linear dimension of the Weibel data was scaled by \((181/175)^{1/3}\) to simulate a lung with a total airway tree linear dimension of 181 cm. The volume of the alveolar compartments \( V_{al} \) was set equal to 2,500 ml to simulate a typical adult functional residual capacity (FRC).

The central airway compartment incorporates the first \( N \) generations of the airway tree with volume \( V_{aw0} \). Distal to generation \( N \), the airway tree is split into two compartments characterized by different flow dynamics. Thus the lower airway compartments incorporate the remaining \( 17 - N \) airway generations, but with different cross sections \( A_i \) and volumes \( V_{aw}(i = 1,2) \), while the alveolar region is

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Fig. 1. Schematic of the multicompartment model. A trumpet-shaped central airway compartment bifurcates into 2 peripheral airway compartments, each of which empties into an expansile alveolar region. Each airway compartment has a constant airway wall flux of nitric oxide (NO) per unit volume, and each alveolar compartment has a constant NO concentration. Exhalation flow in the alveolar and peripheral airway compartments is time, and thus volume, dependent, while the net exhalation flow is held constant. NO concentration within the model varies as a function of time and distance \( z \) from the mouth. Symbols are defined in Glossary.
divided into two compartments with volumes \( V_{A1} \) and \( V_{A2} \) and represents a functional division of the lungs into two regions (one well ventilated and the other poorly ventilated). A fraction \( \alpha \) of the total cross-sectional area from the Weibel geometry is assigned to compartment 1, and the remainder \((1 - \alpha)\) to compartment 2 so that \( A_1/A_2 = V_{AW1}/V_{AW2} = V_{A1}/V_{A2} = \alpha/(1 - \alpha)\). The overall length of the airway tree, i.e., the sum of the lengths of compartment 0 and compartments 1 or 2, representing the distance from the oropharynx to the respiratory zone, is equal to that of the Weibel model (appropriately scaled). In this construction, \( N \) and \( \alpha \) are free structural parameters whose determination is discussed below.

**Ventilation.** Compartments 1 and 2 are allowed to empty at different time-dependent rates \( \dot{V}_i(t) \) and \( \dot{V}_2(t) \) with the constraint that the total exhalation flow at the mouth, \( \dot{V} = \dot{V}_1(t) + \dot{V}_2(t) \), be constant. This choice makes possible the simulation of constant-flow exhalations commonly used to characterize exhaled NO while simultaneously incorporating the effects of ventilation heterogeneity. Then, the flow in compartment \( i (i = 1, 2) \) is given by (2)

\[
\dot{V}_i = (\dot{V}_{i,0} - \dot{V}_{i,\infty})e^{-\tau_i t} + \dot{V}_{i,\infty}
\]

subject to the constraints
\[
(\dot{V}_{1,0} - \dot{V}_{1,\infty}) + (\dot{V}_{2,0} - \dot{V}_{2,\infty}) = 0 \quad (2)
\]

\[
\dot{V}_{1,\infty} + \dot{V}_{2,\infty} = \dot{V} \quad (3)
\]

In this analysis the pressures in the two compartments are assumed to be equal during the entire exhalation (2). Here \( \dot{V}_{i,0} \) and \( \dot{V}_{i,\infty} \) are the initial \((t = 0)\) and steady-state or infinite time \((t \rightarrow \infty)\) flows in compartment \( i \), and \( \tau \) is a characteristic time constant. These parameters can be expressed in terms of airway resistance \( R_i \) and tissue elastance \( E_z \) of compartment \( i \) (2), which, in turn, are related to both the geometry (i.e., constriction status) of the airways and the material properties of lung tissue. Importantly, when the total flow \( \dot{V} \) is strictly constant, compartments 1 and 2 are tightly coupled, and the system is characterized by a single time constant \( \tau = (R_1 + R_2)/(E_1 + E_2) \). This provides the most flexible structure that may be useful to simulate diseases other than asthma that may have a larger impact on the interstitial tissue. In the case of asthma, flow heterogeneity can be simulated by setting the elastance of the regions to be equal to each other, and then varying the resistance through each compartment. Thus we assume a constant total elastance \( E_T \), or \( \tau = 2(R_1 + R_2)/(E_1 + E_2) \), consistent with previous reports simulating flow heterogeneity in asthma (27). Using this structure, it can be shown that \( \dot{V}_{1,\infty} = \dot{V}_{2,\infty} = \dot{V}/2 \). Hence, we treat \( \dot{V}_{1,0} \) and \( \tau \) as the independent free parameters while \( V_{A,0} \) is determined from the constraint above (Eq. 2). The structure and ventilation of the multicompartment model for asthma is characterized by four independent parameters: \( N \), \( \alpha \), \( \dot{V}_{1,0} \), and \( \tau \).

**NO production.** NO production is characterized by specifying the steady-state NO concentrations \( C_{NO,1} \) and \( C_{NO,2} \) in the alveolar compartments and the maximum airway wall flux \( J_{awNO,i} \) in each airway compartment \( i (i = 0, 1, 2) \). \( J_{awNO,i} \) is obtained by using previously published values of the total airway flux (4, 21–24, 26, 31) and partitioning it between compartments in proportion to their volume:

\[
J_{awNO,i} = \frac{V_{AW,i}}{V_{AW}} J_{awNO}
\]

where \( J_{awNO} = \sum_{i=0}^{2} J_{awNO,i} \). Such a partitioning results in uniform NO production per unit airway volume, and, in combination with the choice \( C_{NO,1} = C_{NO,2} \), is used to simulate a lung with homogeneous NO production.

Heterogeneous NO production is simulated in three different ways: 1) the airway flux in one of the compartments is specified to be a fraction \( f \) of the total flux, and the remaining fraction \((1 - f)\) is partitioned equally between the other two compartments in proportion to their volume; 2) specifying a ratio \( r \) of alveolar NO concentrations \((r \neq 1)\), \( C_{NO,1} = r \times C_{NO,2} \), but maintaining a constant volume-weighted alveolar concentration \( C_{ANO} = C_{NO,1} \times V_{A1}/V_A + C_{NO,2} \times V_{A2}/V_A \); or 3) a combination of 1 and 2. Thus, for these simulations, NO production is specified by two free parameters \( J_{awNO}, C_{ano} \) in the homogeneous case and four free parameters \( J_{awNO}, J_{awNO}, C_{ano}, r \) in the heterogeneous case.

**Governing equations.** The concentration of NO, \( C(t, z) \), at time \( t \) and axial location \( z \) within each compartment is governed by the following convection-diffusion equation (4, 23):

\[
\frac{\partial C}{\partial t} + \frac{\dot{V}(t)}{A_i(z)} \frac{\partial C}{\partial z} = D \frac{\partial}{\partial z} \left( A_i(z) \frac{\partial C}{\partial z} \right) + J_{awNO,i} \frac{C_{ANO}}{V_{awi}}
\]

with \( i = 0, 1, 2 \). Initial and boundary conditions are given by

\[
C(0, z) = 0
\]

\[
\frac{\partial C}{\partial z} = 0 \text{ at } z = 0 \text{ (mouth)}
\]

\[
C = C_{NO,1} \text{ at } z = z_{17}
\]

\[
C = C_{NO,2} \text{ at } z = z_{17}
\]

where \( z_{17} \) represents the location of the alveolar-terminal bronchiule interface situated at the distal end of generation 17 in the Weibel model. A fully time-implicit scheme with upwinding for the convective term was used to discretize the convection-diffusion equation.

Conservation of mass at the intersection of compartments 0, 1, and 2 was enforced by performing a mass balance over a control volume surrounding the intersection point, leading to the following relationship:

\[
\frac{dC_i}{dt} = (V C_{i-1} - V_i C_{i+1} - V_i C_{i+N_i+1}) - D \frac{\partial C}{\partial z} \left|_{z_{i-1}}^{z_{i}} \right.
\]

\[
- A_{i+1} \frac{\partial C}{\partial z} \left|_{z_{i+1}}^{z_{i+N_i+1}} \right. + J_{NO, i}
\]

where \( C_i \) is the concentration at discretization point \( i \), \( V \) is the volume of the control volume, and \( J_{NO, i} \) is the total wall flux in the control volume.

**Multiple-breath nitrogen washout.** Multiple-breath nitrogen washout (MBNW) is a lung function test used to examine ventilation heterogeneity in the proximal and peripheral airways (12, 14, 15, 35). Briefly, patients tidal-breathe pure \( O_2 \), and the exhaled concentration of nitrogen is measured, tracking the nitrogen washout from the lungs (Fig. 2A). The normalized phase III slope for nitrogen is positive and progressively increases with each tidal breath (Fig. 2B). The phase III slope of each exhalation is normalized by the mean concentration of the gas over the region of analysis (typically 50–90% of the exhaled volume). Plotting the normalized phase III slope of nitrogen \( (\text{Slope}_{NO}) \) as a function of functional residual capacity turnover (cumulative exhaled volume divided by functional residual capacity) allows quantification of regional ventilation heterogeneity.

Models have been presented that show that \( \text{Slope}_{NO} \) for early breath numbers is controlled by diffusion and convection-dependent inhomogeneities (DCDI), while \( \text{Slope}_{NO} \) for later breath numbers is controlled by convection-dependent inhomogeneities (CDI) (13–16, 34, 37). These models have been used to explain how the two distinct segments of the \( \text{Slope}_{NO} \) plot represent inhomogeneities in different regions of the lung. \( \text{Slope}_{NO} \) is an index of ventilation inhomogeneity in the acinar airways, while \( \text{Slope}_{NO} \) is an index of inhomogeneity in the conducting airways (see schematic in Fig. 2C).

We first utilize the multicompartment model to simulate the exchange of nitrogen during a MBNW in order to determine model structural and ventilation parameters independent of the NO exchange parameters. The governing equation is identical to the NO exchange equation (Eq. 5) except the source term is removed. At the start of the washout, the fractional nitrogen concentration in the model is uniform.
and equal to the atmospheric concentration. During the simulation, tidal volume is assumed to be 1 liter, and flow is saw tooth at 1.5–6.0 provides an index of ventilation inhomogeneities in the proximal or conducting airways (airway generations 1–16). This index is denoted Scond (liters⁻¹). Furthermore, an index of ventilation inhomogeneity in the acinar region (airway generations 17–23) is denoted Sacin (liters⁻¹, magnitude of dark gray-shaded region) and can be extracted from Sinh in the first breath (after subtracting the component due to Scond multiplied by lung turnover for the first breath).

**Experimental exhaled NO tracings.** Experimental exhaled NO profiles were examined from a previous study investigating the effect of exercise-induced bronchoconstriction on exhaled NO in adults with mild asthma (24). This study enrolled nine subjects with mild exercise-induced bronchoconstriction who managed their symptoms with β-agonists (e.g., Albuterol) only. An inclusion criteria was >10% decrease in FEV₁ following the exercise challenge (10 min running on treadmill at 80% of maximum heart rate). The study focused on a single exhalation with a preexercise breathhold to characterize airway and alveolar NO parameters, but we also collected exhaled NO after exercise challenge and these subjects can be characterized by three indexes consistent with previous reports (4, 30): 1) the fractional concentration of phase III at a constant exhalation flow (FENO₃/V˙), defined as the mean concentration over the window 2 < Vex/Vaw < 3; 2) the normalized phase III slope (SNO), defined as the slope of the exhaled concentration over the window 2 < Vex/Vaw < 3 divided by FENO₃; and 3) the rise volume (V₉₀NO), defined as the number of exhaled airway volumes needed to reach 90% of FENO₃. In a similar fashion, the mean exhalation flow, V₉₀, and normalized phase III slope of the flow, SNO, can also be defined over the window 2 < Vex/Vaw < 3.

**RESULTS**

**Experimental exhaled NO profiles.** Experimental exhaled NO profiles from the six mild asthmatic subjects are shown in Fig. 3, A–F. Note that for each subject, the exhalation flow is constant near the target flow of 50 ml/s (Fig. 3A, inset) and does not change between baseline (58.0 ± 8.9 ml/s) and postexercise challenge (58.6 ± 12.2 ml/s). Exhaled NO profiles at baseline are generally characterized by an initial rapid rise in NO concentration (Vex/Vaw < 2) followed by a region that approaches a constant or plateau concentration (Vex/Vaw > 2). Baseline FENO₃ values for these subjects lie between 18 and 40 ppb with a mean (±SD) of 28 ± 7 ppb (Fig. 4B). Both SNO and V₉₀NO are not statistically different from zero (−0.037 ± 0.031 and 0.0067 ± 0.056, respectively), and V₉₀NO is 1.3 ± 0.26 (Fig. 4C).

Different patterns are observed after exercise challenge and can generally be characterized by a slower rise of the exhaled NO concentration with exhaled volume, resulting in a decrease in FENO₃ and a more positive slope in phase III of exhalation. Mean (±SD) for FENO₃, SNO, and V₉₀NO after exercise challenge are 23 ± 8.1 ppb, 0.035 ± 0.044, 0.12 ± 0.066, and 1.8 ± 0.2, respectively, which are all statistically different from baseline. Of note, SNO is statistically different from zero (positive), but SNO is not (Fig. 4, D and E).

**Ventilation and structural parameters.** MBNW simulations allow for quantification of the model ventilation and structural...
parameters. Reported values of Sacin and Scond for both asthmatic and normal subjects were used to generate ventilation and structural parameters for four cases: healthy (Sacin = 0.068, Scond = 0.033), proximal airway heterogeneity (Sacin = 0.068, Scond = 0.060), peripheral airway heterogeneity (Sacin = 0.18, Scond = 0.033), and both proximal and peripheral heterogeneity (Sacin = 0.18, Scond = 0.06) (5, 35–37). We determined optimal values of ventilation and structural parameters (N, α, V1,0, and τ) for each of the three cases above (Table 1) using nonlinear regression to obtain the desired values of Scond and Sacin. These simulations were performed before simulating NO exchange. In addition, with the assumption of equal elastances in the two compartments, the steady-state flows in each compartment are equal. Figure 5, A–C, shows the flow through each airway compartment as a function of time for each condition (healthy, abnormal Sacin, abnormal Scond, and abnormal Sacin and Scond). In each case, the flow through compartment 1 is always higher than that in compartment 2, and thus compartment 1 represents the better ventilated region of the lung.

Model-simulated exhaled NO profiles. Exhaled NO profiles were simulated using the model geometry and ventilation parameters representative of healthy and abnormal ventilation distributions. Reasonable values for JawNO (1,100 pl/s) and CANO (3 ppb) were chosen on the basis of reports in the literature for healthy and asthmatic subjects as well as to achieve FENO50 similar to that observed in our group of asthmatic subjects. The goal of the simulations was not to precisely replicate the experimental tracings but rather to simulate the major features (e.g., SINO).

Figure 6A shows that when NO production is homogeneous (equal volume-weighted airway flux, equal alveolar concentrations), ventilation heterogeneity has only a small effect on the exhaled NO profiles. The healthy case results in a slightly negative phase III slope for NO (SINO = 0.002), FENO50 = 29.5 ppb, and V90NO = 0.675. When a greater degree of heterogeneity is present in either the conducting airways (abnormal Scond), the peripheral region (abnormal Sacin), or both (abnormal Sacin and Scond), there is essentially no change to the exhalation profile.

Figure 6, B and C, shows the effect of heterogeneous NO production in the airways and the alveolar regions, respectively, with healthy ventilation parameters. When 70% of JawNO is placed in the central compartment, FENO50 increases 35% to 39.8 ppb compared with the homogeneous case, while a larger flux in one of the peripheral compartments results in a decrease of 11.5 and 8.4% in FENO50 relative to the homogeneous case for compartments 1 and 2, respectively (Fig. 6B). SINO is near zero for all three cases, but V90NO is increased when the NO flux is weighted in the poorly ventilated com-

Fig. 3. Experimental NO tracings at constant exhalation flow preexercise (blue lines) and postexercise (red lines) for 6 subjects (A–F). Insets show exhalation flow for each maneuver. Each tracing represents the average of 2–3 consecutive maneuvers for each subject. The fractional exhaled NO concentration (FENO) is plotted as a function of exhaled volume (Vex) normalized by an estimate of the subject’s airway (dead space) volume (Vaw).
partment 2 ($V_{90\text{NO}} = 0.8$) and decreased when the NO flux is weighted in the central compartment ($V_{90\text{NO}} = 0.55$).

Figure 6C shows the effect of heterogeneous alveolar NO concentrations, which are modest. When the volume-weighted mean alveolar concentration is held constant (3 ppb), but the alveolar concentration is larger in the slow (and smaller) emptying compartment ($C_{\text{ANO,1}} = 0.94$, $C_{\text{ANO,2}} = 7.5$), $S_{\text{IIINO}}$ becomes positive, $V_{90\text{NO}}$ increases (0.75), and there is a small 3.4% increase in $F_{\text{ENO,50}}$ (30.4 ppb). When the fast (and larger) emptying compartment has a larger concentration ($C_{\text{ANO,1}} = 4.14$, $C_{\text{ANO,2}} = 0.52$), the trends are the opposite: $S_{\text{IIINO}}$ remains slightly negative, $V_{90\text{NO}}$ decreases (0.625), and $F_{\text{ENO,50}}$ decreases slightly (1.9% to 29 ppb).

Figure 6, D and E, shows the combined effects of heterogeneity in ventilation and NO production. Although there are many possible combinations, we focused on five illustrative cases that are consistent with the pathophysiology of asthma. Figure 6D combines lower airway ventilation heterogeneity (abnormal Sacin) with either an increased NO airway flux or an increased alveolar concentration in the slower-emptying branch of the model (compartment 2). Figure 6E combines proximal ventilation heterogeneity (abnormal Scond) with an increased NO flux in either the central compartment or the slow-emptying compartment. Figure 6E also includes a simulated tracing for abnormal Sacin and Scond with an increased flux and alveolar concentration in the slow-emptying branch. The latter case simulates global ventilation and inflammation heterogeneity.

Peripheral ventilation heterogeneity with enhanced alveolar NO tends to create a positive $S_{\text{IIINO}}$ (0.013) with a small increase in $F_{\text{ENO,50}}$ (30.3 ppb). In contrast, peripheral ventilation heterogeneity with enhanced lower airway NO flux sig-

### Table 1. Ventilation parameters

<table>
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<th></th>
<th>Healthy (Sacin = 0.068; Scond = 0.033)</th>
<th>Abnormal Sacin (Sacin = 0.18; Scond = 0.033)</th>
<th>Abnormal Scond (Sacin = 0.068; Scond = 0.06)</th>
<th>Abnormal Scond and Sacin (Sacin = 0.18; Scond = 0.06)</th>
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<tr>
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<td>$V_{1.0}/V_{0.5}$</td>
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<td>$\alpha(V_{\text{aw}}/V)$</td>
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<td>$\alpha$</td>
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<td>$N$</td>
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<td>$V_{\text{aw2}}$, ml</td>
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See Glossary for definitions.
HETEROGENEITY AND EXHALED NO

Fig. 5. Exhalation flow through each airway compartment as a function of time for different structural and ventilation parameters. In A–C, healthy ventilation (Sacin = 0.068, Scond = 0.033) is shown as a solid black line. A: enhanced heterogeneity in the peripheral conducting airways and alveolar region (Sacin = 0.18, Scond = 0.033). B: enhanced heterogeneity in the proximal airways (Sacin = 0.068, Scond = 0.06). C: enhanced heterogeneity in both the proximal and peripheral regions of the lungs (Sacin = 0.18, Scond = 0.033). In each case the total flow through the central airway compartment is held constant at 50 ml/s. V₁ and V₂ are flow in airway compartments 1 and 2, respectively.

Effect of ventilation and NO production heterogeneity. The primary aim of the present study is to illustrate the effect of spatial heterogeneity in ventilation and NO production on exhaled NO dynamics using a simple model. Our results show that the exhaled NO profile is strongly affected by the interplay between structure, ventilation (flow), and NO production.

Both experimental and simulated exhaled NO tracings can be characterized by two phases: 1) a dynamic phase, corresponding to phases I and II of the classic tracing from an inert gas such as N₂, in which the exhaled concentration is changing rapidly with time or exhaled volume (characterized by V₉₀ NO); and 2) a nearly steady-state phase, corresponding to phase III of an inert gas profile, in which the exhaled concentration approaches a constant (or plateau) value (characterized by FENO, V̇ and S). The dynamic phase is due to three factors. First, the initial airway compartment that is emptied (Vex/Vaw < 1) has a steep axial gradient of NO beginning with inspired air of zero NO at the mouth and increasing with z-position due to the increased residence time during inspiration. Second, the flow in each compartment is changing in time with a characteristic time constant, τ, that captures the resistance of the alveolar and airway regions (Table 1 and Fig. 5).

In contrast to ventilation, NO production heterogeneity had a significant impact on exhaled NO profiles. Different airway fluxes were assigned to different compartments while holding the total airway flux constant. A compartment with a higher flux compared with the homogeneous case could represent a locally inflamed region. This condition resulted in significant alterations to the plateau concentration of NO. When the higher flux was localized to the central airway compartment, the plateau concentration was significantly increased. In contrast, when the higher flux was localized in one of the lower compartments, the plateau concentration was reduced to varying degrees. When the total NO flux is homogeneously distributed, the magnitude of the source term (JawNO/Vaw, flux of NO per unit airway volume) in Eq. 1 is identical in all three
airway compartments. When the fraction of the flux assigned to a particular compartment is larger than its fraction of the total airway volume, the source term is disproportionately increased in this compartment and results in a higher NO flux within that compartment. Since the total flux is held constant, this increase is offset by corresponding decreases in the fluxes in the other compartments. However, the contribution of a compartment to the overall exhaled NO depends both on the NO source within that compartment and the flow through it. For example, a compartment with a large source term but zero flow would not contribute to the exhaled NO.

To explain the effect of different spatial flux distributions, we define a flow-weighted average NO source for the whole airway tree as the sum of the source terms in each compartment weighted by the exhalation flow in each compartment: \[ J'aw_{NO} = \sum_{i=1}^{2} (J'aw_{NO,i}/Vaw_i) \times (V_i/V). \] When the NO flux is homogeneously distributed \((J'aw_{NO,i}/Vaw_i = \text{constant})\), this quantity is equal to \(2 \times J'aw_{NO}/Vaw\), i.e. two times the flux per unit volume of the airway tree. The factor of 2 accounts for the serial nature of the flow between the lower and central compartments.

First consider the case when 70% of the total flux is localized in the central compartment. Since the volume of the central compartment (51 ml) represents only 28% of the total airway volume, the flux per unit volume is increased by 150%. Since all the exhaled air passes through this compartment \((V = V_1 + V_2)\), there is a net increase of 150% in the contribution of the central compartment to \(J'aw_{NO}\). This increase is offset
by corresponding decreases of the contributions from compartments 1 and 2. However, the net effect is a 46% increase in $J_{awNO}$ compared with the homogeneous case. In contrast, when 70% of the flux is localized in compartments 1 or 2, similar calculations show that $J_{awNO}$ is reduced by 11% and 14%, respectively. Thus the magnitude of the decrease depends on the relative flux per unit volume and flows in each compartment. This reasoning does not precisely explain the magnitude of change in $F_{ENO,50}$ when the NO flux is spatially heterogeneous. For instance, when the higher flux is localized in the central compartment, $F_{ENO,50}$ increases by 35% while $J_{awNO}$ increases by 46%. This is a result of neglecting axial diffusion in defining the effective NO source. Axial diffusion would tend to make the spatial NO concentrations more homogeneous and thus reduce the magnitude of changes compared with the homogeneous case. Nonetheless, this reasoning provides an intuitive explanation of the direction of changes in $F_{ENO,50}$ when the NO flux is spatially heterogeneous.

Distributing the total alveolar concentration heterogeneously has only a modest impact on the exhalation NO profile in these simulations due primarily to the relative contribution (1–8 ppb) of the alveolar NO to $F_{ENO}$ (~30 ppb). However, if an inflamed peripheral region (higher alveolar NO concentration) empties slower, the exhaled NO concentration will tend to increase with exhaled volume, creating a positive $\Delta t_{INO}$.

The most significant changes in the exhaled NO profile are observed when both NO production and ventilation are heterogeneous. This physiological condition might occur if an inflamed region enhances the production of NO, but also results in bronchoconstriction, thus reducing ventilation. The underlying mechanisms are the same as that discussed for isolated heterogeneity in flow and NO production; that is, the plateau concentration will depend on the relative weighting of the total airway NO flux per unit volume and flow within the airway compartments. Since ventilation is also heterogeneous, there is a larger range of residence times, and thus a larger range of plateau concentrations. For example, when $Scond$ is abnormal, only 5% of the flow (2.5 ml/s) at steady state is in compartment 2 (Table 1). Hence, when 70% of the total airway NO flux is placed in this compartment, the result is a significant decrease in the plateau concentration (Fig. 5D).

All of the experimental asthmatic profiles in Fig. 3 have a positive $\Delta t_{INO}$ postexercise, resulting in a delay in the appearance of NO (increased $V_{0,NO}$) and decrease in $F_{ENO,50}$. Our model indicates this scenario is consistent with ventilation heterogeneity in either the proximal or peripheral airway combined with enhanced NO airway flux in the slower emptying compartment relative to the remaining lung. The enhanced heterogeneity in NO production may be due to the enhanced rate of ventilation during exercise, which would preferentially washout NO stores in well-ventilated airways, resulting in a higher NO flux in the poorly ventilated region. Note that these observations cannot be explained with single-path models that utilize a single airway compartment and a single homogeneous alveolar region.

The multicompartment model represents the simplest generalization of the existing two-compartment model of pulmonary NO exchange (4, 23, 28) that could incorporate ventilation heterogeneity by considering two airway compartments that empty at different rates. This model for asthma is characterized by four independent structural and ventilation parameters ($\alpha$, $\tau$, and $\bar{V}_{1,0}$), whose values were chosen to generate reasonable values for $S_{cond}$ and $S_{cond}$ in healthy and asthmatic lungs. The set of values for the structural and ventilation parameters are not unique but do represent values that are physiological. Thus, although a different set of ventilation and structural parameters could have been chosen, the simulations represent a realistic prediction of how ventilation and NO production heterogeneity can impact the exhaled NO profile. Further, the results indicate that incorporating information about ventilation heterogeneity obtained from multiple-breath nitrogen washout into models of NO exchange dynamics may improve the interpretation of exhaled NO profiles. Although beyond the scope of the present study, future studies may describe a more rigorous approach to determine the structural and ventilation parameters for each subject on the basis of nonlinear regression techniques to fit the model MBNW profiles to experimental tracings. A similar approach might be employed to determine unique and subject-specific values for the five NO production parameters.

In conclusion, we have developed the first model of pulmonary NO exchange that incorporates heterogeneity in ventilation and NO production. Model simulations suggest that the combination of ventilation and NO production heterogeneity may significantly affect the magnitude and shape of exhaled NO profiles in patterns that are consistent with experimental observations in mild asthmatic subjects following an exercise challenge. This result confounds the interpretation of the plateau NO concentration. Hence, characterizing NO exchange dynamics with region-specific alveolar NO concentrations and airway flux of NO in the multicompartment model may provide more useful physiological information than either plateau concentration alone, or an airway flux and alveolar concentration from the single-path, two-compartment model.

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GRANTS

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