Lung Body Plethysmography: From Functional to Clinical Aspects for Prediction of Quality of Life in Patients with Chronic Pulmonary Obstruction

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Keywords: body plethysmography, COPD, quality of life.

COPD currently occupies sixth place on the list of causes of morbidity in the world in the adult population and tends to arrive in third place in the non-smoking 2030 [1]. The cost of the disease is very high [2,3]. Pulmonary functional tests are essential for diagnosis in patients with COPD. Spirometry is considered the most reproducible, and routine test in measuring airflow limitation. In COPD diagnosis relies mainly by highlighting the obstruction using FEV1, [2, 4].

St. George’s Respiratory Questionnaire (SGRQ) was developed by PW Jones et al. being the most commonly used questionnaire in assessing the quality of life in chronic respiratory diseases (bronchial asthma, COPD), particularly in COPD [5]. It includes 76 questions grouped into three areas: symptoms, activity, impact. True or false responses are subsequently converted into numerical scale, resulting in field-specific scores and overall scores, which thus allow statistical processing of patient-provided information. The values of these scores are in the range 0-100, where 0 quantifies perfect quality of life, and 100 a maximum impact on quality of life related to health. The questionnaire can be: self-administered or administered by interview, frequently being self-administered. The time required for administration is approximately 20 minutes. We used a self-administered questionnaire for our research.

During forced expiratory maneuvers, patients with COPD can assist in decreasing FEV1. This occurs with the severity of the disease. Increasing the effort produces a compression on the thorax gas (Boyle’s law): pV = constant (p=pressure, V= volume), which leads to the reduction of the pulmonary volume and implicitly to the reduction of FEV1. This is all the more pronounced as the residual volume (RV) is higher (severe hyperinflation). HRQL is a global measure that integrates more biological effects, unlike spirometric variables (FEV1) that measure a single biological variable [6]. Starting from these premise, HRQL measurement is important for at least two reasons, somewhat related to each other:

- assessing the impact of the disease on the patient’s life, which is of much greater interest to it than the classical assessment of disease severity (FEV1);
- assessing the impact of the disease on the patient’s life, which is of much greater interest to it than the classical assessment of disease severity (FEV1);

Experimental part

In this prospective study, 211 patients with stable COPD (87.7% males) age 61±5 years (mean ± standard deviation), underwent to: spirometry, body plethysmography, electrocardiography. Parameters obtained: residual volume (RV), forced expiratory volume in 1 second (FEV1), were correlated with different parameters and also for prediction of quality of life in COPD patients. In assessing the quality of life we used the St. George’s Respiratory Questionnaire (SGRQ). According to BMI (body mass index) we classify patients in four groups: 1. underweight (< 20, n = 34), 2. normal weight (20-24, n = 79), 3. overweight (25-29.9, n = 58), 4. obese (>30, n = 40), n = number of patients.

Keywords: body plethysmography, COPD, quality of life.

All authors have equal contributions to the study

REV.CHIM.(Bucharest) ♦ 70 ♦ No.11 ♦ 2019 http://www.revistadechimie.ro 3935
second of an expiratory forced maneuver (FEV.), ratio FEV./
VC, maximal expiratory flow at 50% of vital capacity
(MEF50). The parameters values are express in liter (L) or
percent of predicted value. We performed body
plethysmography for measure TLC (total lung capacity),
residual volume (RV), quantify the level of hyperinflation.
We expressed RV as percent of predicted value (VRP%).

The equipment used is a Masterscreen Jaeger body
plethysmograph. It is a plethysmograph equipped with an
automatic calibration system according to temperature
and pressure in the environment. The transparent
plethysmograph allows the contact with the patient to
perform maneuver, both visually and vocally.

Bodyplethysmography technique: we explains in details
for the patient the maneuvers to be executed; the subject
will sit in the body plethysmograph cabin and, after closing
the cabin door, will wait for a minute to breathe quietly;
then the patient is asked to breathe through the mouthpiece
attached to a pneumotograph; from now on, the patient
will have the nostrils until the maneuvers are over [9]. After
some quiet breathing maneuvers the patient will deeply
inhale against a shutter by a technician who interrupts very
short the airflow to the mouth; then exhale and inhale until
the complete maneuvers that allow for a spirometry after
the rupture of the obstacle the patient will be carefully
supervised for the very duration of the tests to achieve
very good cooperation. The physician monitors throughout
the entire sample of the sample and graphically plotted on
the computer monitor and the alveolar volume-volume loop
recording (Figure 1), where VR - residual volume, CI -
inspiratory capacity, VER - spare expiratory volume.

Parameters obtained allow the assessment of the
central resistance to flow (Raw), residual volume (VR) and
total pulmonary capacity, being the only method that allows
the total determination of these pulmonary volumes.
Ecocardiography was done to identify the elements of
chronic cor pulmonare.

We calculate BMI = weight/height² (kg/m²) and
classified patients in four groups according to BMI (n =
number of patients):
BMI<20 (underweight), n = 34
20 ≤ BMI ≤ 25 (normal weight), n = 79
26 ≤ BMI ≤ 29 (overweight), n = 58
BMI ≥ 30 (obese), n = 40

We used the GOLD (Global Initiative for Chronic
Obstructive Lung Disease) classification for severity of
obstruction consider only the post - bronchodilator FEV1
value [10, 11]:
1. FEV1 ≥ 80% of predicted value, n=6
2. 50% ≤ FEV1< 80% of predicted value, n=53
3. 30% ≤ FEV1< 50% of predicted value, n=108
4. FEV1 < 30% of predicted value, n=44

For analyze hyperinflation we used three groups of
severity as VRP% of predicted value:
1. Mild 130% ≤ VRP% < 180%
2. Moderate 180% ≤ VRP% < 240%
3. Severe VRP% ≥ 240%

Data analysis was performed using the EPIINFO6, EXCEL,
SPSS statistical programs using the functions and modules
of these programs. The following statistical tests were used:
- the test χ² (Chi square) and its variants (Yates
corrected, Mantel-Haentszel, exact Fisher) for discrete
variables (categorical, including dichotomous ones)
- the Student (T) test: comparing 2 lots by comparing
their averages for the same variable having a parametric
distribution (normally distributed)
- Mann-Whitney (U) test comparing more than 2 lots by
comparing their averages for the same variable with
nonparametric distribution
- Anova test (A) comparing more than 2 batches by
comparing their averages for the same variable with
parametric distribution.

Results and discussions
211 patients were enrolled according to the inclusion
criteria listed above. The study group has the following
characteristics listed in Table 1.

<table>
<thead>
<tr>
<th>TABLE 1: CLINICAL AND DEMOGRAPHIC DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHARACTERISTICS</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>- male</td>
</tr>
<tr>
<td>- female</td>
</tr>
<tr>
<td>Smoking status</td>
</tr>
<tr>
<td>- smokers</td>
</tr>
<tr>
<td>- exsmokers</td>
</tr>
<tr>
<td>- PA</td>
</tr>
<tr>
<td>Leave</td>
</tr>
<tr>
<td>- urban</td>
</tr>
<tr>
<td>- rural</td>
</tr>
</tbody>
</table>

We obtained the follow values of functional respiratory
parameters for entire group (tabel 2).

<table>
<thead>
<tr>
<th>TABLE 2: FUNCTIONAL RESPIRATORY PARAMETERS FOR ENTIRE GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>----------------</td>
</tr>
<tr>
<td>FEV1(0)</td>
</tr>
<tr>
<td>FEV1%o</td>
</tr>
<tr>
<td>FEV1/VC*100</td>
</tr>
<tr>
<td>MEF20</td>
</tr>
<tr>
<td>VRP%</td>
</tr>
<tr>
<td>TLC%</td>
</tr>
</tbody>
</table>

From Figure 2 it can be seen that FEV, % (vemsmp%)
varies inversely with VRP% values. There is a modest
negative correlation (Pearson) between these two
parameters (R = -0.43). The tendency of the % FEV, %
parameter is descending to VRP% as shown by the
regression equation in the above image
(VRP% = - 1,662 . FEV1% + 297.88)

Related to smoking status we found that men start to
smoke earlier than women (p = 0.0001, S) (table 3).
Analyzing the three groups of hyperinflation severity we
identified that for group 1 (mild hyperinflation 130% ≤ VRP% <
180%) we have a total of 44 patients who consumed a
total of 1545 PA, while patients in group 2 (moderate
hyperinflation $180\% \leq \text{VRP\%} < 240\%$ consumed a total of 3267PA, and the number of patients being analyzed was 81. It results that for the same time period analyzed, the number of patients doubled, whereas between the arithmetic mean of consumption of the packets of the two classes there was a very small difference, its value being 4.05 ($p > 0.001$). Group 3 (severe hyperinflation $\text{VRP\%} \geq 240\%$) contains 75 patients who together consumed the highest number of PA as shows in fig. 3.

Below are the regression equations obtained for the $\text{VRP\%}$ value depending on the four GOLD stages of the obstruction verticality (Table 4). Those with severe ventilator dysfunction (GOLD 4) showed significantly higher pulmonary hyperinflation values than those in GOLD 1 ($p = 0.007$) as shown (Table 5).

Comparing the mean values and standard deviations of $\text{VRP\%}$ (see table 6) for subgroups of patients with different nutritional status (groups BMI 1,3,4) versus those with BMI group 2 (normoponderal) we found no significantly difference in underweight patients versus normoponderal patients ($p = 0.27$, A).

The first sign of the alarm is that 61.6% (130/211) of the subjects analyzed started to smoke before the age of 20 years (table 7). Also, 70% of overweight young people began to smoke before 20 years, and 13% of them had severe hyperinflation. ($\text{VRP\%} > 240\%$ of predicted value).

The $\text{VRP\%}$ analysis with smoker status highlighted a large dispersion of PA values (Figure 4) and a lack of linear correlation between PA and $\text{VRP\%}$ ($R = 0.01$, Pearson).

The same high displacement of $\text{VRP\%}$ by PA was also

<table>
<thead>
<tr>
<th>GOLD STAGES</th>
<th>Regression equation</th>
<th>Correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOLD 1</td>
<td>$\text{VRP%} = -5.663 + \text{FEV1%} + 684.5$</td>
<td>$R = -0.64$ (Pearson)</td>
</tr>
<tr>
<td>n = 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GOLD 2</td>
<td>$\text{VRP%} = -2.005 + \text{FEV1%} + 328.36$</td>
<td>$R = -0.42$ (Pearson)</td>
</tr>
<tr>
<td>n = 53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GOLD 3</td>
<td>$\text{VRP%} = -0.071 + \text{FEV1%} + 261.75$</td>
<td>$R = -0.10$ (Pearson)</td>
</tr>
<tr>
<td>n = 108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GOLD 4</td>
<td>$\text{VRP%} = -3.244 + \text{FEV1%} + 344.82$</td>
<td>$R = -0.17$ (Pearson)</td>
</tr>
<tr>
<td>n = 44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
obtained for patients who were smokers at the time of the determinations (Figure 5).

The additional exposure to industrial chemicals, dust, gases or presence of comorbidities such as diabetes mellitus, hypertension, tuberculosis, pulmonary neoplasm, other neoplasms and infections may be risk factors correlated with the severity of hyperinflation [12-17].

By analyzing the additional exposure to noxious substances we found no contribution as risk factors for the increase in residual volume in patients in the global group (Table 9).

Patients with chronic cor pulmonale have a higher risk to associate severe hyperinflation (table 10) than those who did not have chronic pulmonary heart disease (p = 0.0001).

The analysis of the links between the scores of the quality of life questionnaire (table 10) for the 211 patients who received the questionnaire, found that there were no differences in the impact score (SGRQ), activity score...
Patients with severe hyperinflation (77.5%) had a significantly higher activity score (p = 0.04, A) than those with mild and moderate hyperinflation.

Dividing into two groups (men and women) and studying differences in smoking history allowed a significant difference to be noted between the two groups. These differences were related to the onset of smoking (F = 0.35; p < 0.01) and the number of smoking-year packs: PA (F = 2.28; p < 0.01). This shows for the studied group, a much earlier start of smoking in men than women, a higher quantum of smoked packets, and a different pulmonary function (p < 0.01 for FEV1) and indicates a much higher susceptibility of female gender to develop COPD at a much lower smoker history than male, confirmed information and literature data [18-21].

Comparing the mean values and standard deviations of VRP% for subgroups of patients with different nutritional status (4,3,1) versus those with BMI group 2 (normoponderal), we found a significantly higher value of VRP% in patients with severe hyperinflation. This is consistent with literature data [18-21].
hyperinflation at obese patients versus normoponderal patients (p = 0.046, A). But there is a paradox of obesity in patients with COPD. While in the general population, obesity is associated with an increased risk of mortality, Celli et al [22] finds that overweight and obesity are associated with a lower risk of death in patients with COPD.

Patients with severe hyperinflation had a significantly impact of quality of life activity score. They have a higher activity score (p = 0.04, A) than those with mild and moderate hyperinflation related because of decreasing the daily activities [23,24].

By analyzing the additional presence of noxious or other comorbidities (diabetes mellitus, hypertension, pulmonary neoplasm) on the severity of hyperinflation, we found no contribution as risk factors for increasing the residual volume in patients in the global group [25,26].

Smoking cessation remain an important opportunity in the treatment of patients with COPD to avoid severe functional impairment and reducing the quality of life [27, 28].

Conclusions

The benefits of the approach to investigation (body plethysmography) for assessing and monitoring patients with COPD is very important. These will be taken into account in further investigation protocols because allows the calculation of pulmonary volumes, inaccessible to the routine spirometry method, essential parameters in the evaluation and long-term monitoring of quality of life in patient with COPD, taking into account the limited information value of FEV1, performing a complete functional diagnosis for assessing the patient with COPD.

Only by calculating the residual volume can be found the value of the total pulmonary capacity and, implicitly, the correct assessment of the type of dysfunction, the pattern of patented obstructive ventilator dysfunction, the value of pulmonary hyperinflation, essential in the preoperative assessment and calculation of air-trapping volume.

References

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Table 10

<table>
<thead>
<tr>
<th>Cor pulmonale</th>
<th>Hyperinflation</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>67</td>
<td>0.0001</td>
</tr>
<tr>
<td>NO</td>
<td>9</td>
<td>0.27</td>
</tr>
<tr>
<td>n</td>
<td>7</td>
<td>2.58</td>
</tr>
</tbody>
</table>

Table 11

SGRQ scores based on whether or not severe pulmonary hyperinflation

<table>
<thead>
<tr>
<th>SGRQ scores</th>
<th>VEP% &lt; 150%</th>
<th>VEP% ≥ 150%</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEANS</td>
<td>Standard deviation</td>
<td>MEANS</td>
<td>Standard deviation</td>
</tr>
<tr>
<td>SGRQ1</td>
<td>70.7</td>
<td>18.1</td>
<td>66.2</td>
</tr>
<tr>
<td>n</td>
<td>85</td>
<td>126</td>
<td>85</td>
</tr>
<tr>
<td>SGRQ2</td>
<td>70.3</td>
<td>23.8</td>
<td>72.4</td>
</tr>
<tr>
<td>n</td>
<td>85</td>
<td>126</td>
<td>85</td>
</tr>
<tr>
<td>SGRQ3</td>
<td>48.5</td>
<td>16.9</td>
<td>45.3</td>
</tr>
<tr>
<td>n</td>
<td>85</td>
<td>126</td>
<td>85</td>
</tr>
<tr>
<td>SGRQ4</td>
<td>59.4</td>
<td>15.1</td>
<td>56.8</td>
</tr>
<tr>
<td>n</td>
<td>85</td>
<td>126</td>
<td>85</td>
</tr>
</tbody>
</table>


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Manuscript received: 14.05.2019