Effect of helium breathing on intercostal and quadriceps muscle blood flow during exercise in COPD patients

Ioannis Vogiatzis,1,2 Helmut Habazettl,3,4 Andrea Aliverti,5 Dimitris Athanasopoulos,1,2 Zafeiris Louvaris,1,2 Antonella LoMauro,5 Harrieth Wagner, 6 Charis Roussos,6 Peter D. Wagner,6 and Spyros Zakynthinos1

1 Department of Critical Care Medicine and Pulmonary Services, Evangelismos Hospital, “M. Simou, and G.P. Livanos Laboratories,” National and Kapodistrian University of Athens, Greece; 2 Department of Physical Education and Sport Sciences, National and Kapodistrian University of Athens, Athens, Greece; 3 Institute of Physiology, Charité Campus Benjamin Franklin, Berlin, Germany; 4 Institute of Anesthesiology, German Heart Institute, Berlin, Germany; 5 Dipartimento di Bioingegneria, Politecnico di Milano, Milano, Italy; and 6 Department of Medicine, University of California San Diego, La Jolla, California

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Vogiatzis I, Habazettl H, Aliverti A, Athanasopoulos D, Louvaris Z, LoMauro A, Wagner H, Roussos C, Wagner PD, Zakynthinos S. Effect of helium breathing on intercostal and quadriceps muscle blood flow during exercise in COPD patients. Am J Physiol Regul Integr Comp Physiol 300: R1549–R1559, 2011. First published March 16, 2011; doi:10.1152/ajpregu.00671.2010.—Emerging evidence indicates that, besides dyspnea relief, an improvement in locomotor muscle oxygen delivery may also contribute to enhanced exercise tolerance following normoxic helium (replacement of inspired nitrogen by helium) administration in patients with chronic obstructive pulmonary disease (COPD). Whether blood flow redistribution from intercostal to locomotor muscles contributes to this improvement currently remains unknown. Accordingly, the objective of this study was to investigate whether such redistribution plays a role in improving locomotor muscle oxygen delivery while breathing helium at near-maximal [75% peak work rate (WRpeak)] maximal (100%WRpeak), and supramaximal (115%WRpeak) exercise in COPD. Intercostal and vastus lateralis muscle perfusion was measured in 10 COPD patients (FEV1 = 50.5 ± 5.5% predicted) by near-infrared spectroscopy using indocyanine green dye. Patients undertook exercise tests at 75 and 100%WRpeak breathing either air or helium and at 115%WRpeak breathing helium only. Patients did not exhibit exercise-induced hyperinflation. Normoxic helium reduced respiratory muscle work and relieved dyspnea across all exercise intensities. During near-maximal exercise, quadriceps and intercostal muscle blood flows were greater, while breathing normoxic helium compared with air (35.8 ± 7.0 vs. 29.0 ± 6.5 and 6.0 ± 1.3 vs. 4.9 ± 2.0 ml·min−1·100 g−1, respectively; P < 0.05; mean ± SE). In addition, compared with air, normoxic helium administration increased arterial oxygen content, as well as oxygen delivery to quadriceps and intercostal muscles (from 47 ± 9 to 60 ± 12, and from 8 ± 1 to 13 ± 3 mlO2·min−1·100 g−1, respectively; P < 0.05). In contrast, normoxic helium had neither an effect on systemic nor an effect on quadriceps or intercostal muscle blood flow and oxygen delivery during maximal or supramaximal exercise. Since intercostal muscle blood flow did not decrease by normoxic helium administration, blood flow redistribution from intercostal to locomotor muscles does not represent a likely mechanism of improvement in locomotor muscle oxygen delivery. Our findings might not be applicable to patients who hyperinflate during exercise.

work of breathing; near-infrared spectroscopy; cardiac output; muscle oxygen delivery; respiratory muscle blood flow

DURING EXERCISE, EXPIRATORY flow limitation is present in a significant fraction of patients with chronic obstructive pulmo-

nary disease (COPD) and is associated with impaired exercise performance (5, 25, 29). In these patients, replacement of nitrogen by helium in the inspired gas, known as normoxic heliox, decreases turbulence within medium to large airways, increases expiratory flow rate, reduces the work of breathing, as well as the degree of exercise-induced dynamic hyperinflation and the intensity of dyspnea, thereby enhancing exercise tolerance (13, 23, 30, 31, 33).

There is emerging evidence (7), indicating that enhanced exercise tolerance by heliox is also due to an increase in locomotor muscle oxygen delivery, as inferred by deoxyhemoglobin kinetics, an index of tissue oxygen extraction (7, 15), determined by near-infrared spectroscopy during constant-work rate near-maximal exercise (70–80% of peak work rate) (7). Enhanced oxygen delivery to peripheral muscles following administration of heliox during exercise in COPD may occur via a number of mechanisms, namely: 1) improved cardiac output secondary to reduced intrathoracic pressures and/or pleural pressure swings (26, 27, 34), 2) improved arterial oxygen content (6, 30), and 3) blood flow redistribution from respiratory to peripheral muscles secondary to reduction in the mechanical load of the respiratory muscles (9, 17, 18). To date, the latter mechanism has never been investigated due to lack of simultaneous measurements of blood flow to respiratory and locomotor muscles. Therefore, the potential contribution of blood flow redistribution from respiratory to peripheral muscles to the improvement in leg muscle oxygen delivery with heliox during near-maximal exercise remains unknown.

Accordingly, the primary purpose of the present study was to investigate whether blood flow redistribution from respiratory (i.e., the intercostal muscles) to locomotor muscles contributes to the suggested (7) improvement in peripheral muscle oxygen delivery with heliox during near-maximal exercise in COPD patients. In addition, because the role of this mechanism during maximal exercise has not been previously examined and as heliox is expected to enhance exercise tolerance (13, 23, 31), we also aimed to investigate the contribution of this mechanism to leg muscle oxygen delivery during maximal and supramaximal exercise. To accomplish our goal, we performed simultaneous measurements of systemic, quadriceps, and intercostal muscle blood flow and oxygen delivery, as well as measurements of respiratory muscle power during exercise ranging from near-maximal to supramaximal levels in room air and during heliox breathing in COPD patients. It was reasoned that, if at the same leg exercise intensity, intercostal muscle blood flow during heliox breathing is less than that during air

Address for reprint requests and other correspondence: Corresponding author: Dr. Spyros Zakynthinos, Univ. of Athens Medical School, Dept. of Critical Care and Pulmonary Services, Evangelismos Hospital, 45-47 Ipsilando Str, GR 106 75, Athens, Greece. (e-mail: szakynthinos@yahoo.com).

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breathing, while quadriceps muscle blood flow increases, there is possible redistribution of blood flow from the respiratory (i.e., intercostals) to leg muscles.

METHODS

Subjects. Ten patients (1 female) with clinically stable COPD participated in the study, according to the following inclusion criteria: 1) a postbronchodilator forced expiratory volume in 1 s (FEV1) <80% predicted without significant reversibility (<12% change of the initial FEV1 value or <200 ml); 2) optimal medical therapy according to Global Initiative for Chronic Obstructive Lung Disease (GOLD) (14); and 3) the absence of other significant diseases that could contribute to exercise limitation. Their physical characteristics and pulmonary function are given in Table 1. The same patients were also included in our previous study (39). The study was approved by the University Hospital Ethics Committee and was conducted in accordance with the guidelines of the Declaration of Helsinki. Prior to participation in the study, all patients were informed of any risks and discomforts associated with the experiments and gave written, signed, informed consent.

Experimental design. Experiments were conducted in two visits. In visit 1, patients underwent an incremental preliminary exercise test to the limit of tolerance [peak work rate (WRpeak)] breathing room air. In visit 2, patients undertook in a balanced ordering sequence two exercise protocols where the inspired gas mixture was either room air or normoxic heliox (see Supplemental Fig. S1). The two protocols were separated by 60 min of rest. In room air (protocol 1), patients initially performed a constant-work rate near-maximal exercise bout corresponding to 75% WRpeak for 3–4 min and 30 min later, a second constant-work bout of maximal exercise corresponding to 100% WRpeak for 2–3 min. During normoxic heliox breathing (protocol 2), subjects exercised first at 75% WRpeak and 30 min later at 100% WRpeak. Following 30 min of rest, patients performed a third constant-work rate supramaximal exercise bout sustained at 115% WRpeak for 1–2 min. Prior to imposing the target load on the bicycle ergometer, patients were asked to perform unloaded cycling for 60 s reaching and maintaining a cadence of ~50 rpm. Heliox supplementation was achieved by having subjects inspire from a Douglas bag containing a gas mixture of 21% oxygen and 79% helium that was connected to the inspiratory port of a nonbreathing two-way valve by a piece of tubing. The same apparatus was utilized during room air breathing to ensure a blinding strategy of administration of the inspired gas mixture. During protocols, vastus lateralis and intercostal muscle blood flow [assessed by near-infrared spectroscopy (NIRS) and the light-absorbing tracer indocyanine green (ICG) dye], as well as cardiac output (assessed by the dye dilution method again using ICG), were measured during the final minute of each of the exercise bouts. End-inspiratory and end-expiratory compartmental (rib cage and abdominal) chest wall volumes (measured by optoelectronic plethysmography), as well as esophageal and gastric pressures (to assess respiratory muscle load) were continuously recorded during the exercise trials.

Preliminary testing. In visit 1, the incremental exercise tests were performed on an electromagnetically braked cycle ergometer (Ergoline 800; Sensor Medics, Anaheim, CA) with a ramp increase of load increments of 5 or 10 W/min to the limit of tolerance (the point at which the work rate could not be tolerated due to severe sensation of dyspnea and/or leg fatigue; peak exercise data are included in Table 1), with the patients maintaining a pedaling frequency of 40–50 rpm. Tests were preceded by a 3-min rest period, followed by 3 min of unloaded pedaling. The following pulmonary gas exchange and ventilatory variables were recorded breath by breath (Vmax 229; Sensor Medics): oxygen uptake, carbon dioxide elimination, minute ventilation, tidal volume, breathing frequency, and respiratory exchange ratio. Heart rate and percentage of arterial oxygen saturation (%SpO2) were determined using the R-R interval from a 12-lead on-line electrocardiogram (Marquette Max; Marquette Hellige, Freiburg, Germany) and a pulse oximeter (Nonin 8600; Nonin Medical, North Plymouth, MN, respectively).

Subject preparation. Subjects were prepared first with radial arterial and femoral venous catheters and then with esophageal and gastric balloons for assessment of esophageal and gastric pressures. Using local anesthesia (2% lidocaine) and a sterile technique, we introduced identical catheters percutaneously into the left femoral vein and the right radial artery, both oriented in the proximal direction. The catheters were used to collect arterial and venous blood samples and also to inject ICG dye into the venous line and sample blood after each injection from the arterial line for cardiac output measurement and muscle blood flow calculation. The catheters were kept patent throughout the experiment by periodic flushing with heparinized (1 unit/ml) saline.

Esophageal and gastric pressures were assessed by thin-walled balloon catheters (Ackrad Laboratories, Cranford, NJ) coupled to differential pressure transducers (MP-45, ± 250 cmH2O; Validyne, Northridge, CA). The balloons were inserted by nasal intubation following the application of 2% lidocaine anesthetic gel to the nose and with the assistance of continuous pressure monitoring. Esophageal and gastric balloons were positioned in the middle third of the esophagus and stomach, respectively.
Exercise protocols. During these tests, recordings of pulmonary gas exchange and ventilatory variables were performed breath by breath as during the preliminary testing. Arterial blood pressure was measured by a sphygmomanometer, and blood gas analysis was made in blood samples drawn from the radial artery and femoral vein during the final minute of each of the exercise bouts. Air flow was measured with a hot wire pneumotachograph (Vmax 229; Sensor Medics) near the mouthpiece, and tidal volume changes were obtained by integrating the flow signal. Before each protocol, pneumotachograph and gas analyzers of the system (Vmax 229; Sensor Medics) were calibrated with the experimental gas mixture. Esophageal and gastric pressures and flow rates were displayed on a computer screen and digitized at 60 Hz using an analog-to-digital converter connected to the same computer used for optoelectronic plethysmography (OEP system; BTS, Milan, Italy). End-inspiratory and end-expiratory compartmental (rib cage and abdominal) chest wall volume changes during exercise were determined by optoelectronic plethysmography (37–39). In brief, the movement of 89 retroreflective markers placed front and back over the chest wall from clavicles to pubis was recorded. Markers were tracked by six video cameras, three in front of the subject and three behind. Dedicated software recognized in real time the markers on each camera, reconstructed their three-dimensional coordinates by stereophotogrammetry and calculated volume changes. Ventilatory variables (tidal volume, breathing frequency, and breathing pattern parameters) reported in the manuscript were those recorded by using optoelectronic plethysmography during the final minute of each of the exercise bouts.

Esophageal and gastric pressures were averaged over 30-s breath samples in every minute of the exercise tests. The mechanical power of breathing (total respiratory muscle power) was determined at each exercise level by ensemble-averaging several breaths to integrate the average tidal volume-esophageal pressure loop multiplied by the breathing frequency and expressed in Cal/min (39). More specifically, respiratory muscle power was calculated as the area enclosed by the tidal chest wall volume change-esophageal pressure dynamic loops multiplied by respiratory frequency. We considered the entire loops (i.e., both inspiration and expiration); therefore, our respiratory muscle power represents the total power developed by all (both inspiratory and expiratory) respiratory muscle groups. The lung-apposed (41) rib cage muscle power was calculated as the area enclosed by the tidal lung-apposed rib cage volume change—esophageal pressure dynamic loops multiplied by respiratory frequency. We also considered the entire loops (i.e., both inspiration and expiration); therefore, our rib cage muscle power represents the total power developed by all (both inspiratory and expiratory) rib cage muscle groups. Transdiaphragmatic pressure (Pdi) was obtained by subtracting esophageal from gastric pressure. Tidal excursion in Pdi (Pdi) was taken as peak Pdi. The pressure-time products for transdiaphragmatic pressure (Pdi) and pressure-time product were calculated as the area enclosed by the tidal excursion in Pdi minus baseline Pdi. The pressure-time products for the diaphragm (PTPdi) and expiratory abdominal muscles (PTPab) were obtained by multiplying the area subtended by each trace (i.e., the integral of Pdi and gastric pressure, respectively, over time) by the respiratory frequency and had units of cmH2O·s/min (22). The baseline for PTPdi and PTPab was determined for each breath as the level observed at the start of inspiration and expiration, respectively.

Cardiac output. Cardiac output was determined by the dye dilution method (11), using known volumes of ICG (1.0 ml at 5 mg/ml) injected into the left femoral vein followed by a rapid 10-ml flush of isotonic saline. Blood was withdrawn from the right radial artery using an automated pump (Harvard Apparatus, Holliston, MA, USA) at 20 ml/min through a linear photodensitometer (Pulsion ICG; Hamamatsu Photonics KK, Hamamatsu, Japan), which was used to measure ICG concentration following the same 5-ml bolus injection of ICG in the left femoral vein used for cardiac output assessment. Tissue microcirculatory ICG was detected cutaneously by measuring light attenuation with NIRS at 775-, 813-, and 850-nm wavelengths and analyzed using an algorithm incorporating the Modified Beer-Lambert Law (3, 12, 21, 36), as previously described (16, 38, 39).

Blood flow was calculated from the rate of tissue ICG accumulation over time measured by NIRS according to the Sapirstein principle (35). Accordingly, for any time interval less than the time to reach peak tissue accumulation of tracer, the tissue receives the same fraction of the ICG bolus as quantified in arterial blood (input function). Two separate time points within the first half of the curve were used to calculate flow, and the average value was taken to represent the tissue ICG accumulation. Total blood flow was then calculated, as previously reported (3).

Systemic, quadriceps, and intercostal muscle vascular conductance was calculated by dividing the cardiac output and the quadriceps and intercostal muscle blood flow by the mean arterial blood pressure, respectively. Systemic, quadriceps, and intercostal muscle oxygen delivery was calculated as the product of the cardiac output, the quadriceps and intercostal muscle blood flow, and arterial oxygen content, respectively.

Blood analysis and calculations. Radial arterial and femoral venous tensions of O2 and CO2, pH, hemoglobin concentration, lactate concentration, and percentage of arterial and venous oxygen saturation were measured from 2-ml blood samples using a blood gas analyzer combined with a cooximeter (ABL 625; Radiometer, Copenhagen, Denmark) within 10 s of collection. Arterial and venous O2 content were computed from standard equations (39). Arterio-venous O2 content difference was divided by arterial O2 content to give leg O2 extraction.

Statistical analysis. Data are reported as means ± SE, unless otherwise stated. The minimum sample size was calculated on the basis of 80% power and a two-sided 0.05 significance level. Sample size capable of detecting between-condition (i.e., air, heliox) difference of 30% was estimated for the change in intercostal muscle blood flow at WRpeak using the standard deviations from our previous study (38). The critical sample size was estimated to be nine patients. To compare responses between air and heliox at different fractions of WRpeak, paired t-tests were carried out and followed by Bonferroni adjustment for multiple comparisons. The level of significance for all analyses was set at P < 0.05.

RESULTS

Subject characteristics and baseline exercise capacity. Patients had moderate to severe airflow obstruction with increased static lung volumes, moderate reductions in carbon monoxide diffusion capacity, and mildly reduced arterial oxygen tension (Table 1). Four patients were GOLD stage II, three were GOLD stage III, and the remaining three were GOLD stage IV (14). Subjects exhibited reduced maximal exercise capacity with moderate hemoglobin desaturation (Table 1).

Effect of heliox on respiratory muscle loading and kinematics. While breathing normoxic heliox, total respiratory muscle power was lower compared with room air during exercise sustained at 75, 100, and 115% WRpeak (Fig. 1A). This was due to unloading of both inspiratory and expiratory muscles. Indeed, tidal excursion in transdiaphragmatic pressure (ΔPdi) and pressure-time product
for the diaphragm (PTPdi) (Fig. 1, E and C), as well as peak expiratory gastric pressure and pressure-time product for the expiratory abdominal muscles (PTPab) (Fig. 1, D and F) were lower during heliox compared with air breathing. Similarly, power produced by the rib cage muscles, both inspiratory and expiratory (reflecting, in part, due to the contribution of other respiratory muscles, the activity of the external and internal intercostals), was lower while breathing heliox than air at 100% WRpeak (Fig. 1B). During heliox breathing, improvements in peak expiratory gastric pressure and PTPab were larger than those in ΔPdi and PTPdi, respectively. In fact, mean peak expiratory gastric pressure during exercise bouts was reduced by 22.5%, whereas mean ΔPdi was reduced by only 8.9%. Mean PTPab during exercise bouts was reduced by 32.3%, whereas mean PTPdi was reduced by only 6.3%. Heliox breathing compared with air reduced the degree of exercise-induced hyperinflation of the rib cage compartment as indicated by the decrease in both end-expiratory and end-inspiratory rib cage volumes (Fig. 2A) but had no effect on the abdominal or total chest wall volume regulation (Fig. 2, B and C). Notably, our patients did not exhibit exercise-induced hyperinflation at any percentage of WRpeak as total chest wall end-expiratory volume did not increase during exercise while breathing room air (Fig. 2C). At 75% WRpeak, heliox breathing increased arterial oxygen partial pressure and minute ventilation due to an increase in tidal volume (Table 2). Dyspnea and leg effort sensation scores were lower during exercise sustained at 75 and 100% WRpeak, while breathing heliox compared with room air. In addition, at 115% WRpeak during heliox breathing, intensity of dyspnea remained lower compared with 100% WRpeak in room air (Table 2).

Effect of heliox on central hemodynamic responses. While breathing normoxic heliox compared with room air, stroke
volume increased during exercise sustained at 75 and 100% $\text{WR}_{\text{peak}}$ (Fig. 3B), but because of inverse change in heart rate (Fig. 3D), the increase in cardiac output (absolute by 1 l/min, relative by $\sim$10%) during heliox breathing failed to reach the level of statistical significance ($P = 0.08$) (Fig. 3A). Cardiac output demonstrated a plateau at all exercise intensities examined, either during heliox or air breathing. As mean arterial pressure was not different between interventions, systemic vascular conductance exhibited trends identical to cardiac output (Fig. 3E). Arterial oxygen content was significantly greater while breathing heliox compared with room air both at rest and during exercise sustained at 75% $\text{WR}_{\text{peak}}$ (Fig. 3C). Systemic oxygen delivery was significantly improved by heliox administration only during near-maximal exercise (i.e., 75% $\text{WR}_{\text{peak}}$) (Fig. 3F).

**Effect of heliox on leg and respiratory muscle hemodynamic responses.** Quadriceps muscle vascular conductance, blood flow, and oxygen delivery during exercise sustained at 75% $\text{WR}_{\text{peak}}$ were greater while receiving normoxic heliox compared with room air. However, there was no difference in any of these variables either between heliox and air breathing at 100% $\text{WR}_{\text{peak}}$ or between heliox at 115% $\text{WR}_{\text{peak}}$ and air at 100% $\text{WR}_{\text{peak}}$ (Fig. 4, A–C). Similarly, intercostal muscle vascular conductance, blood flow, and oxygen delivery were greater with heliox breathing compared with room air during exercise sustained at 75% $\text{WR}_{\text{peak}}$, whereas there was no difference in any of these variables either between heliox and air breathing at 100% $\text{WR}_{\text{peak}}$ or between heliox at 115% $\text{WR}_{\text{peak}}$ and air at 100% $\text{WR}_{\text{peak}}$ (Fig. 4, D–F). No difference between interventions was detected in leg arteriovenous oxygen content difference, oxygen extraction, and venous lactate (see Supplemental Table S1).

**DISCUSSION**

It has been documented that lightening the work of breathing by the administration of normoxic heliox enhances exercise tolerance in patients with COPD (1, 7, 13, 30, 31, 33) and that besides its respiratory effects, which ultimately reduce the intensity of dyspnea (1, 13, 30, 31, 33), heliox enhances exercise tolerance by increasing locomotor muscle oxygen delivery (1, 7). The present study investigated whether the potential increase in locomotor muscle oxygen delivery with heliox breathing is due to an improvement in cardiac output and/or in arterial oxygen content or alternatively is due to blood flow redistribution from intercostal to locomotor muscles. We demonstrated that intercostal muscle blood flow did not decrease with heliox during exercise intensities ranging from near-maximal to supramaximal levels, and therefore, according to our reasoning, blood flow redistribution from the intercostal to locomotor muscles did not represent a probable mechanism of leg muscle hemodynamic improvement during exercise in COPD patients. More specifically, the novel findings of the study were the following. First, during near-maximal exercise (i.e., at 75% $\text{WR}_{\text{peak}}$), both quadriceps and intercostal muscle blood flow were greater while breathing heliox compared with room air. As expected, normoxic heliox reduced total respiratory muscle power by unloading both inspiratory and expiratory muscles. These changes in lung mechanics most likely improved stroke volume and cardiac output, and combined with increased arterial oxygen content, increased systemic oxygen delivery. We also confirmed the increase in locomotor muscle oxygen delivery (7) during heliox breathing that should be the result of improvements in both systemic oxygen delivery and locomotor muscle blood flow. Second, during maximal and supramaximal exercise (i.e., at 100 and 115% $\text{WR}_{\text{peak}}$), quadriceps and intercostal muscle blood flow were not different during heliox compared with room air breathing. Despite the decrease in total respiratory muscle loads by heliox administration, neither systemic oxygen delivery nor quadriceps or intercostal muscle oxygen delivery was improved. Thus, it is suggested that in patients with COPD, the beneficial effects of heliox on respiratory and peripheral muscle hemodynamics and oxygen delivery are limited to near-maximal exercise.

Normoxic heliox administration enhances exercise tolerance in patients with COPD, mainly owing to its effects on reducing the degree of dynamic hyperinflation and the intensity of dyspnea sensations (13, 31). However, the effect of heliox on systemic and peripheral muscle blood flow and oxygen delivery remains less well understood, as there are conflicting lines of evidence, either suggesting no effects on cardiac output and...
Table 2. Ventilatory and gas exchange responses during exercise in room air and heliox

<table>
<thead>
<tr>
<th>Work rate (% peak) in room air</th>
<th>75</th>
<th>100</th>
<th>75</th>
<th>100</th>
<th>115</th>
</tr>
</thead>
<tbody>
<tr>
<td>( V_t ), l/min</td>
<td>47.8 ± 6.7</td>
<td>49.6 ± 6.7</td>
<td>54.1 ± 5.7†</td>
<td>48.3 ± 7.2</td>
<td>48.7 ± 5.6</td>
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<tr>
<td>( V_t ), liters</td>
<td>1.57 ± 0.2</td>
<td>1.57 ± 0.18</td>
<td>1.65 ± 0.14†</td>
<td>1.53 ± 0.17</td>
<td>1.56 ± 0.16</td>
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<tr>
<td>( T_i ), s</td>
<td>0.84 ± 0.04</td>
<td>0.85 ± 0.04</td>
<td>0.81 ± 0.06</td>
<td>0.85 ± 0.04</td>
<td>0.81 ± 0.06</td>
</tr>
<tr>
<td>( T_e ), s</td>
<td>1.19 ± 0.10</td>
<td>1.23 ± 0.09</td>
<td>1.19 ± 0.11</td>
<td>1.26 ± 0.09</td>
<td>1.23 ± 0.11</td>
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<tr>
<td>( T_{i/T_{tot}} ), %</td>
<td>42.0 ± 1.6</td>
<td>43.0 ± 1.4</td>
<td>33.0 ± 3.0</td>
<td>32.0 ± 3.0</td>
<td>31.0 ± 2.0</td>
</tr>
<tr>
<td>( V_{O_2}, ml/min</td>
<td>1005 ± 174</td>
<td>1069 ± 167</td>
<td>1114 ± 168</td>
<td>1010 ± 148</td>
<td>1022 ± 145</td>
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<td>( P_{A_{CO_2}}, Torr</td>
<td>80.5 ± 5.6</td>
<td>78.6 ± 4.3</td>
<td>87.9 ± 8.5†</td>
<td>81.2 ± 5.7</td>
<td>84.4 ± 6.8</td>
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<td>( P_{A_{CO_2}}, Torr</td>
<td>41.0 ± 1.0</td>
<td>39.9 ± 1.2</td>
<td>40.3 ± 1.1</td>
<td>39.2 ± 1.5</td>
<td>38.1 ± 1.4</td>
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<td>( S_{A_{O_2}}, %</td>
<td>93.3 ± 1.2</td>
<td>93.2 ± 0.8</td>
<td>94.1 ± 1.3</td>
<td>93.5 ± 1.1</td>
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<td>Arterial lactate, mmol/l</td>
<td>3.6 ± 0.5</td>
<td>3.9 ± 0.5</td>
<td>3.5 ± 0.6</td>
<td>3.8 ± 0.6</td>
<td>4.6 ± 0.7</td>
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<td>Dyspnea scores</td>
<td>7 ± 2</td>
<td>8 ± 2</td>
<td>5 ± 1†</td>
<td>6 ± 1†</td>
<td>6 ± 2*</td>
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<td>Leg effort scores</td>
<td>6 ± 2</td>
<td>7 ± 2</td>
<td>4 ± 1†</td>
<td>5 ± 1†</td>
<td>6 ± 2</td>
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Values are means ± SE for 10 subjects. Exercise data depict the results of the exercise tests during air and heliox at specific percentage of peak work rate breathing in room air measured during the final minute of each of the exercise bouts. \( V_t \), minute ventilation; \( V_t \), tidal volume; \( T_i \), time of inspiration; \( T_e \), time of expiration; \( T_{i/T_{tot}} \), duty cycle; \( f \), breathing frequency; \( V_{O_2} \), oxygen uptake; \( P_{A_{CO_2}} \), partial pressure of arterial oxygen; \( P_{A_{CO_2}} \), partial pressure of arterial carbon dioxide; \( S_{A_{O_2}} \), arterial oxygen saturation. *P < 0.05 vs. exercise at 100% of peak work rate in air. †P < 0.05 vs. exercise at 100% of peak work rate in air.
matic contractions with a consequent increase in sympathetic outflow to the working limbs (9, 17, 18), and heliox breathing could potentially decrease this sympathetic outflow and increase locomotor muscle blood flow by decreasing diaphragmatic workload and perfusion. Indeed, strong inferences about diaphragmatic perfusion cannot be made from intercostal muscle blood flow measurements, especially in patients with COPD. It has been shown in healthy humans that as ventilation rose, intercostal muscle blood flow was linearly correlated with the work of breathing and transdiaphragmatic pressure (16), but we are unaware of similar findings in patients with COPD, where blood flow to the diaphragm and intercostals might even change in opposite directions, as intercostals try to compensate for a functionally impaired diaphragm (10, 32).

The increase in intercostal muscle vascular conductance during heliox breathing (Fig. 4D) could be attributed to decreased sympathetic nerve activation due to the increased arterial oxygen partial pressure (Table 2) and the mitigation on the strain placed on central hemodynamics (1, 7) (Fig. 3A) during helium breathing. In addition, increased expiratory muscle activity per se has been found to enhance sympathetic outflow (8), and heliox breathing by decreasing this activity (Fig. 1, D and F) might have lessened sympathetic activation. All of these factors, by increasing intercostal muscle vascular conductance, could potentially contribute to the increase in intercostal muscle blood flow during near-maximal exercise. Moreover, direct mechanical factors could have allowed better perfusion of the intercostal muscles during heliox breathing. Indeed, intercostal muscle blood flow may be reduced by local compressive factors associated with increased intramuscular tension and changes in intercostal muscle fibers orientation, and heliox breathing may have diminished intramuscular ten-

Fig. 3. Central hemodynamic responses. A: cardiac output; B: stroke volume; C: arterial oxygen content (CaO₂); D: heart rate; E: systemic vascular conductance; and F: systemic oxygen delivery measured at different fractions of peak work rate (WRpeak) during exercise while breathing normoxic heliox (△) or room air (▲). Values are expressed as means ± SE for 10 subjects. *Significant differences (P < 0.05) between exercise while breathing heliox vs. exercise in room air at an identical fraction of WRpeak.
sion (Fig. 1, B and D) and changed rib cage geometry and/or operational volumes (Fig. 2A), thus decreasing intercostal muscle vascular compression and increasing blood flow.

**Intercostal and peripheral muscle hemodynamic responses during maximal and supramaximal exercise.** During maximal exercise, total respiratory muscle power remained lower during heliox breathing compared with room air as a result of unloading of both inspiratory and expiratory muscles (Fig. 1). Stroke volume increased with heliox compared with air breathing, most probably as a result of the same reasons reported above for near-maximal exercise (24, 26, 27, 34), but the numerical increase in cardiac output by 10% failed to reach statistical significance (Fig. 3). In addition, neither quadriceps nor intercostal muscle vascular conductance, blood flow, or oxygen delivery improved by heliox administration, as they reached similar values to those seen at maximal exercise in room air (Fig. 4), most likely reflecting the upper limits by which sympathetic and cardiovascular responses are matched to the highest exercise intensities in humans (19).

On the basis of the findings by Richardson et al. (33), showing that heliox administration improved exercise tolerance by 15%, we decided to subject our patients to a short bout of supramaximal exercise sustained at 115% of peak work capacity to identify the mechanisms by which exercise tolerance is enhanced in COPD. We were surprised to find that although total respiratory muscle power remained lower during supramaximal exercise with heliox breathing compared with room air (Fig. 1), neither central [i.e., cardiac output, systemic oxygen delivery (Fig. 3)] nor peripheral or intercostal muscle hemodynamic responses [i.e., quadriceps and intercostal muscle blood flow and oxygen delivery (Fig. 4), leg muscle oxygen extraction (see Supplemental Table S1)] improved. Conversely, dyspnea sensation during supramaximal exercise with heliox was lower compared with maximal exercise in room air.

Figure 4. Quadriceps and intercostal muscle blood flow and oxygen delivery. A: quadriceps muscle vascular conductance; B: quadriceps muscle blood flow; C: quadriceps muscle oxygen delivery; D: intercostal muscle vascular conductance; E: intercostal muscle blood flow; and F: intercostal muscle oxygen delivery measured at different fractions of peak work rate (WRpeak) during exercise while breathing normoxic heliox (▵) or room air (▲). Values are expressed as means ± SE for 10 subjects. *Significant differences (P < 0.05) between exercise while breathing heliox vs. exercise in room air at an identical fraction of WRpeak.
(Table 2), thereby confirming previous suggestions that the major improvement seen by heliox administration during exercise in patients with COPD is primarily due to reduced intensity of dyspnea sensations (7, 13, 23, 31).

**Dyspnea and heliox breathing.** Heliox breathing reduced dyspnea perception for the same or even higher workload (Table 2). Heliox reduces the pressure required to overcome frictional resistance by decreasing the degree of turbulence, and this effect is more important in flow-limited COPD patients at high flow rates and during expiration with consequent increases in maximal expiratory flow (31). Therefore, the most likely explanation for our finding is that heliox by reducing turbulent airway resistances and respiratory impedance decreased the total power of the respiratory muscles because of unloading of inspiratory and mainly expiratory muscles (Fig. 1). It is notable that heliox decreased the power of the respiratory muscles during exercise sustained at 75% WRpeak despite an increment in minute ventilation (Table 2). This increment in minute ventilation was due to an increase in tidal volume, a finding compatible with that of other studies using heliox during submaximal or near-maximal exercise in COPD patients (1, 7).

Perception of leg discomfort and dyspnea are recognized as two major contributors to exercise limitation in COPD (29), and their relief by heliox administration (Table 2) is expected to improve exercise performance (1). Although we did not measure this effect in the present study, several investigations using heliox breathing in patients with COPD have reported prolongation in time to exhaustion (e.g., Refs. 7, 23, 31). Therefore, clinical implications may be derived by using heliox in ventilatory limited COPD patients, allowing them to sustain a high-power output for a period of time long enough to induce a significant training effect during rehabilitation (31) and/or to have a significant impact on daily exercise performance and health status beyond that possible with ambulatory oxygen alone, provided that heliox can be administered in a way patients find acceptable (23).

**Study limitations.** First, because the intensive and exhausting nature of the study, and for patient safety, repeated testing across the different work rates so as to establish reproducibility of cardiac output and regional muscle blood flow measurements in patients with COPD was not performed. Second, because our patients did not exhibit exercise-induced hyperinflation, as assessed by optoelectronic plethysmography, at any percentage of WRpeak (Fig. 2C), most of them should belong to those who strongly recruit their abdominal muscles (the so-called nonhyperinflators) (40), and the present results might not be so pertinent to patients who progressively hyperinflate during exercise (the so-called hyperinflators), when hyperinflation is also evaluated by optoelectronic plethysmography. Indeed, unloading the expiratory abdominal muscles during heliox breathing in the so-called nonhyperinflators of the present study had potentially major advantage on central hemodynamic responses (e.g., increase in stroke volume and cardiac output), and such an advantage may not be so prominent in the so-called hyperinflators who do not recruit strongly their expiratory abdominal muscles. On the other hand, dynamic hyperinflation has adverse effects on central hemodynamic responses (26, 27, 34), and the reduction of the degree of exercise-induced dynamic hyperinflation during heliox breathing could still improve cardiac output and muscle blood flow. Nevertheless, this reservation may only be relevant when optoelectronic plethysmography is used to evaluate the exercise-induced dynamic hyperinflation, because many of our patients, who were deemed as not exhibiting exercise-induced dynamic hyperinflation with optoelectronic plethysmography, would be considered as exhibiting hyperinflation if the degree of dynamic hyperinflation was assessed by decreases in inspiratory capacity during exercise. Indeed, different results of the degree of exercise-induced dynamic hyperinflation in COPD patients are reported by authors (29), who measure inspiratory capacity by integrating flow at the mouth (spirometry) as an index of hyperinflation and those authors who use optoelectronic plethysmography to measure chest wall volumes (25). This difference can be explained by the discrepancy between the methods used to measure dynamic hyperinflation, as optoelectronic plethysmography can potentially underestimate and/or spirometry can potentially overestimate dynamic hyperinflation (25). Spirometry measures the volume of gas entering or leaving the lungs at the mouth, whereas optoelectronic plethysmography measures the volume of the trunk, which includes volume changes at the mouth, but also two other variables—gas compression and decompression in the lungs—and blood shifts between the trunk and extremities (25). It has been calculated (25) that for peak expiratory abdominal (or pleural, as during expiration the diaphragm is relaxed and abdominal pressure is freely transmitted into the pleural space) pressures of about 22 cmH2O at maximal exercise workload [our peak expiratory abdominal pressures at the end of exercise bouts were even higher reaching ~30 cmH2O during air breathing (Fig. 1D)], optoelectronic plethysmography would measure an end-expiratory chest wall volume that would be 330 ml less than that measured by spirometry, and thus optoelectronic plethysmography would not detect 89% of the reduction in inspiratory capacity (mean value = 370 ml) measured by spirometry (29). Finally, because some of our patients were neither particularly obstructed nor nutritionally depleted (Table 1), the findings of the present study might not be so applicable in other COPD populations.

**Perspectives and Significance**

The present study constitutes the first experimental demonstration that intercostal muscle blood flow does not decrease with heliox during exercise intensities ranging from near-maximal to supramaximal levels, and therefore, blood flow redistribution from the intercostal to locomotor muscles does not represent a likely mechanism of leg muscle hemodynamic improvement with heliox during exercise in COPD patients. We confirm that heliox reduces respiratory muscle power and relieves dyspnea sensations during near-maximal, maximal, and supramaximal exercise. However, only during near-maximal exercise does heliox improve peripheral and respiratory muscle blood flow and oxygen delivery, as well as systemic oxygen delivery, whereas during maximal and supramaximal exercise, heliox has no effect on central and peripheral muscle hemodynamics. Because our patients did not exhibit exercise-induced hyperinflation, as assessed by optoelectronic plethysmography, the present results might not be applicable to patients who hyperinflate during exercise, when hyperinflation is also measured with the same technique. Nevertheless, since heliox breathing relieved the perception of leg discomfort and...
dyspnea, two recognized major determinants of exercise limitation in COPD (29), heliox administration is anticipated to improve exercise performance and prolong the time to exhaustion, thus enhancing the training effect during rehabilitation (31) and/or improve daily exercise performance and health status (23).

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DISCLOSURES

No conflicts of interest, financial or otherwise, are declared by the authors.

REFERENCES


