

39.1 | Systems of Gas Exchange

By the end of this section, you will be able to do the following:

- Describe the passage of air from the outside environment to the lungs
- Explain how the lungs are protected from particulate matter

The primary function of the respiratory system is to deliver oxygen to the cells of the body's tissues and remove carbon dioxide, a cell waste product. The main structures of the human respiratory system are the nasal cavity, the trachea, and lungs.

All aerobic organisms require oxygen to carry out their metabolic functions. Along the evolutionary tree, different organisms have devised different means of obtaining oxygen from the surrounding atmosphere. The environment in which the animal lives greatly determines how an animal respire. The complexity of the respiratory system is correlated with the size of the organism. As animal size increases, diffusion distances increase and the ratio of surface area to volume drops. In unicellular organisms, diffusion across the cell membrane is sufficient for supplying oxygen to the cell (**Figure 39.2**). Diffusion is a slow, passive transport process. In order for diffusion to be a feasible means of providing oxygen to the cell, the rate of oxygen uptake must match the rate of diffusion across the membrane. In other words, if the cell were very large or thick, diffusion would not be able to provide oxygen quickly enough to the inside of the cell. Therefore, dependence on diffusion as a means of obtaining oxygen and removing carbon dioxide remains feasible only for small organisms or those with highly-flattened bodies, such as many flatworms (Platyhelminthes). Larger organisms had to evolve specialized respiratory tissues, such as gills, lungs, and respiratory passages accompanied by complex circulatory systems, to transport oxygen throughout their entire body.



Figure 39.2 The cell of the unicellular alga *Ventricaria ventricosa* is one of the largest known, reaching one to five centimeters in diameter. Like all single-celled organisms, *V. ventricosa* exchanges gases across the cell membrane.

Direct Diffusion

For small multicellular organisms, diffusion across the outer membrane is sufficient to meet their oxygen needs. Gas exchange by direct diffusion across surface membranes is efficient for organisms less than 1 mm in diameter. In simple organisms, such as cnidarians and flatworms, every cell in the body is close to the external environment. Their cells are kept moist and gases diffuse quickly via direct diffusion. Flatworms are small, literally flat worms, which 'breathe' through diffusion across the outer membrane (**Figure 39.3**). The flat shape of these organisms increases the surface area for diffusion, ensuring that each cell within the body is close to the outer membrane surface and has access to oxygen. If the flatworm had a cylindrical body, then the cells in the center would not be able to get oxygen.



Figure 39.3 This flatworm's process of respiration works by diffusion across the outer membrane. (credit: Stephen Childs)

Skin and Gills

Earthworms and amphibians use their skin (integument) as a respiratory organ. A dense network of capillaries lies just below the skin and facilitates gas exchange between the external environment and the circulatory system. The respiratory surface must be kept moist in order for the gases to dissolve and diffuse across cell membranes.

Organisms that live in water need to obtain oxygen from the water. Oxygen dissolves in water but at a lower concentration than in the atmosphere. The atmosphere has roughly 21 percent oxygen. In water, the oxygen concentration is much lower than that. Fish and many other aquatic organisms have evolved gills to take up the dissolved oxygen from water (**Figure 39.4**). Gills are thin tissue filaments that are highly branched and folded. When water passes over the gills, the dissolved oxygen in water rapidly diffuses across the gills into the bloodstream. The circulatory system can then carry the oxygenated blood to the other parts of the body. In animals that contain coelomic fluid instead of blood, oxygen diffuses across the gill surfaces into the coelomic fluid. Gills are found in mollusks, annelids, and crustaceans.



Figure 39.4 This common carp, like many other aquatic organisms, has gills that allow it to obtain oxygen from water. (credit: "Guitardude012"/Wikimedia Commons)

The folded surfaces of the gills provide a large surface area to ensure that the fish gets sufficient oxygen. Diffusion is a process in which material travels from regions of high concentration to low concentration until equilibrium is reached. In this case, blood with a low concentration of oxygen molecules circulates through the gills. The concentration of oxygen molecules in water is higher than the concentration of oxygen molecules in gills. As a result, oxygen molecules diffuse from water (high concentration) to blood (low concentration), as shown in **Figure 39.5**. Similarly, carbon dioxide molecules in the blood diffuse from the blood (high concentration) to water (low concentration).

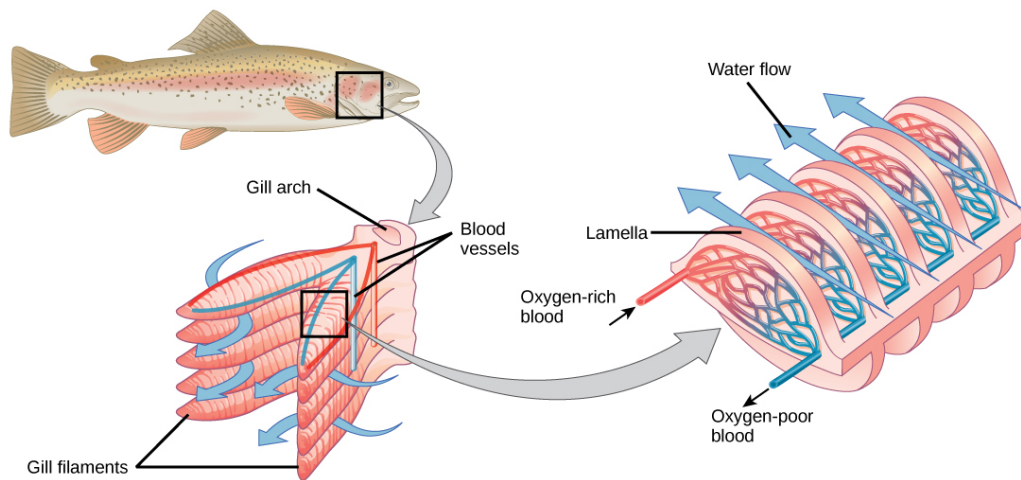


Figure 39.5 As water flows over the gills, oxygen is transferred to blood via the veins. (credit "fish": modification of work by Duane Raver, NOAA)

Tracheal Systems

Insect respiration is independent of its circulatory system; therefore, the blood does not play a direct role in oxygen transport. Insects have a highly specialized type of respiratory system called the tracheal system, which consists of a network of small tubes that carries oxygen to the entire body. The tracheal system is the most direct and efficient respiratory system in active animals. The tubes in the tracheal system are made of a polymeric material called chitin.

Insect bodies have openings, called spiracles, along the thorax and abdomen. These openings connect to the tubular network, allowing oxygen to pass into the body (**Figure 39.6**) and regulating the diffusion of CO_2 and water vapor. Air enters and leaves the tracheal system through the spiracles. Some insects can ventilate the tracheal system with body movements.

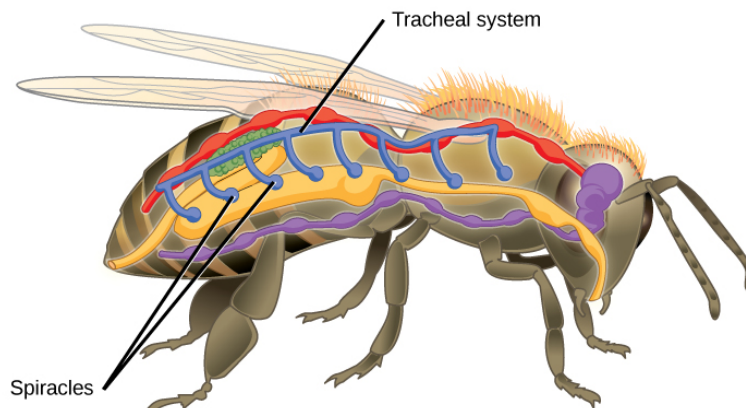


Figure 39.6 Insects perform respiration via a tracheal system.

Mammalian Systems

In mammals, pulmonary ventilation occurs via inhalation (breathing). During inhalation, air enters the body through the **nasal cavity** located just inside the nose (**Figure 39.7**). As air passes through the nasal cavity, the air is warmed to body temperature and humidified. The respiratory tract is coated with mucus to seal the tissues from direct contact with air. Mucus is high in water. As air crosses these surfaces of the mucous membranes, it picks up water. These processes help equilibrate the air to the body conditions, reducing any damage that cold, dry air can cause. Particulate matter that is floating in the air is removed in the nasal passages via mucus and cilia. The processes of warming, humidifying, and removing particles are important protective mechanisms that prevent damage to the trachea and lungs. Thus, inhalation serves several purposes in addition to bringing oxygen into the respiratory system.

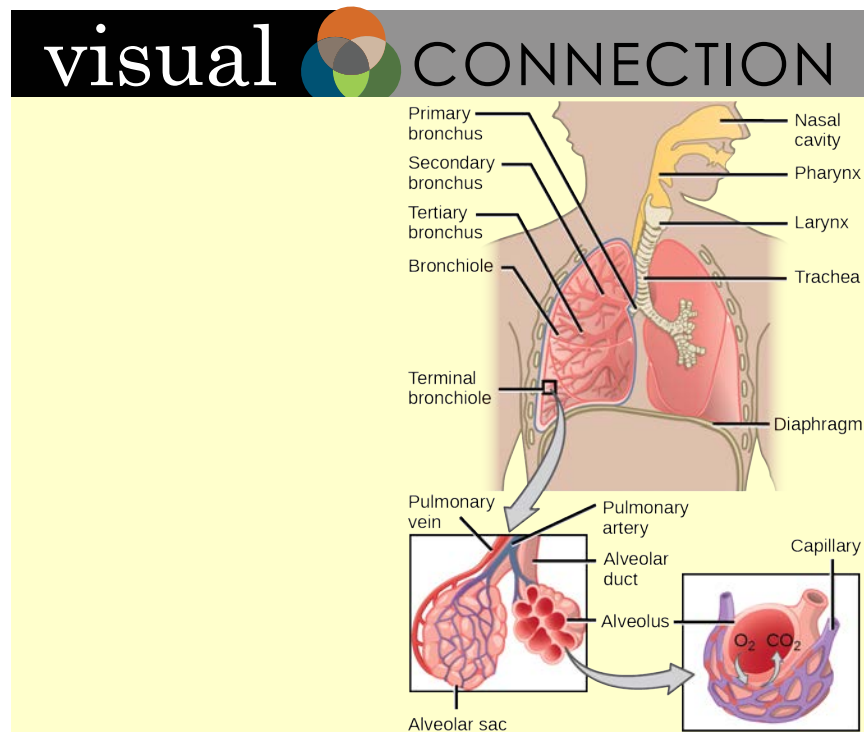


Figure 39.7 Air enters the respiratory system through the nasal cavity and pharynx, and then passes through the trachea and into the bronchi, which bring air into the lungs. (credit: modification of work by NCI)

Which of the following statements about the mammalian respiratory system is false?

- When we breathe in, air travels from the pharynx to the trachea.
- The bronchioles branch into bronchi.
- Alveolar ducts connect to alveolar sacs.
- Gas exchange between the lung and blood takes place in the alveolus.

From the nasal cavity, air passes through the **pharynx** (throat) and the **larynx** (voice box), as it makes its way to the **trachea** (Figure 39.7). The main function of the trachea is to funnel the inhaled air to the lungs and the exhaled air back out of the body. The human trachea is a cylinder about 10 to 12 cm long and 2 cm in diameter that sits in front of the esophagus and extends from the larynx into the chest cavity where it divides into the two primary bronchi at the midthorax. It is made of incomplete rings of hyaline cartilage and smooth muscle (Figure 39.8). The trachea is lined with mucus-producing goblet cells and ciliated epithelia. The cilia propel foreign particles trapped in the mucus toward the pharynx. The cartilage provides strength and support to the trachea to keep the passage open. The smooth muscle can contract, decreasing the trachea's diameter, which causes expired air to rush upwards from the lungs at a great force. The forced exhalation helps expel mucus when we cough. Smooth muscle can contract or relax, depending on stimuli from the external environment or the body's nervous system.

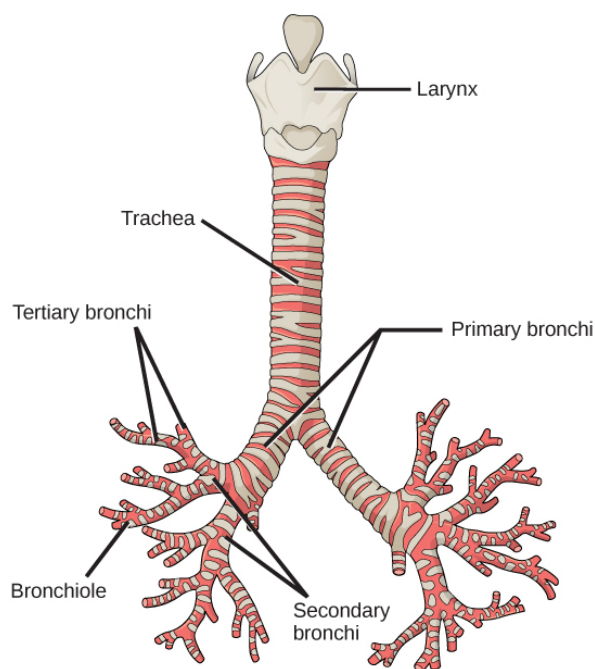


Figure 39.8 The trachea and bronchi are made of incomplete rings of cartilage. (credit: modification of work by Gray's Anatomy)

Lungs: Bronchi and Alveoli

The end of the trachea bifurcates (divides) to the right and left lungs. The lungs are not identical. The right lung is larger and contains three lobes, whereas the smaller left lung contains two lobes (**Figure 39.9**). The muscular **diaphragm**, which facilitates breathing, is inferior to (below) the lungs and marks the end of the thoracic cavity.

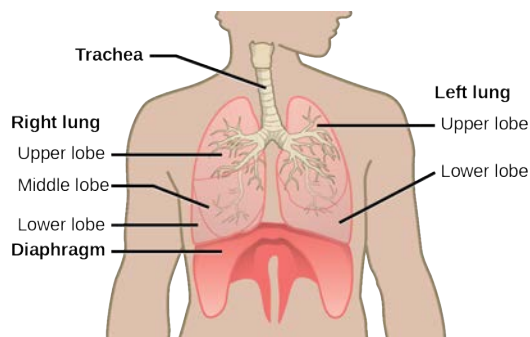


Figure 39.9 The trachea bifurcates into the right and left bronchi in the lungs. The right lung is made of three lobes and is larger. To accommodate the heart, the left lung is smaller and has only two lobes.

In the lungs, air is diverted into smaller and smaller passages, or **bronchi**. Air enters the lungs through the two **primary (main) bronchi** (singular: bronchus). Each bronchus divides into secondary bronchi, then into tertiary bronchi, which in turn divide, creating smaller and smaller diameter **bronchioles** as they split and spread through the lung. Like the trachea, the bronchi are made of cartilage and smooth muscle. At the bronchioles, the cartilage is replaced with elastic fibers. Bronchi are innervated by nerves of both the parasympathetic and sympathetic nervous systems that control muscle contraction (parasympathetic) or relaxation (sympathetic) in the bronchi and bronchioles, depending on the nervous system's cues. In humans, bronchioles with a diameter smaller than 0.5 mm are the **respiratory bronchioles**. They lack cartilage and therefore rely on inhaled air to support their shape. As the passageways decrease in diameter, the relative amount of smooth muscle increases.

The **terminal bronchioles** subdivide into microscopic branches called respiratory bronchioles. The respiratory bronchioles subdivide into several alveolar ducts. Numerous alveoli and alveolar sacs surround the alveolar ducts. The alveolar sacs resemble bunches of grapes tethered to the end of the bronchioles (**Figure 39.10**). In the acinar region, the **alveolar ducts** are attached to the end of each bronchiole. At the end of each duct are approximately 100 **alveolar sacs**, each containing 20 to 30 **alveoli** that are 200 to 300 microns in diameter. Gas exchange occurs only in alveoli. Alveoli are made of thin-walled parenchymal cells, typically one-cell thick, that

look like tiny bubbles within the sacs. Alveoli are in direct contact with capillaries (one-cell thick) of the circulatory system. Such intimate contact ensures that oxygen will diffuse from alveoli into the blood and be distributed to the cells of the body. In addition, the carbon dioxide that was produced by cells as a waste product will diffuse from the blood into alveoli to be exhaled. The anatomical arrangement of capillaries and alveoli emphasizes the structural and functional relationship of the respiratory and circulatory systems. Because there are so many alveoli (~300 million per lung) within each alveolar sac and so many sacs at the end of each alveolar duct, the lungs have a sponge-like consistency. This organization produces a very large surface area that is available for gas exchange. The surface area of alveoli in the lungs is approximately 75 m². This large surface area, combined with the thin-walled nature of the alveolar parenchymal cells, allows gases to easily diffuse across the cells.

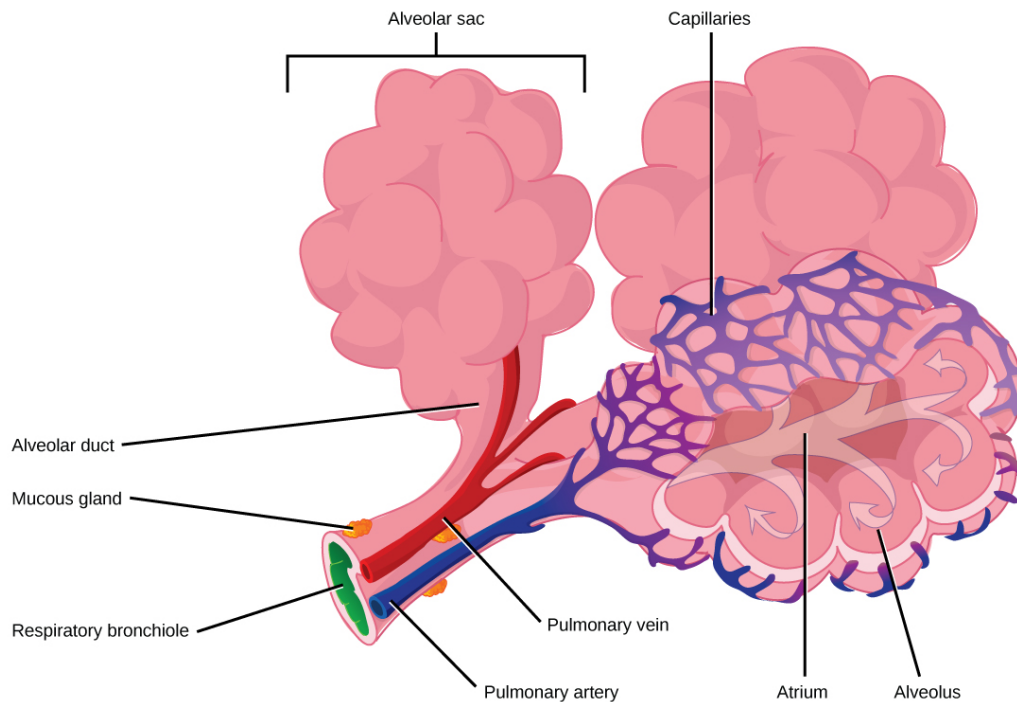


Figure 39.10 Terminal bronchioles are connected by respiratory bronchioles to alveolar ducts and alveolar sacs. Each alveolar sac contains 20 to 30 spherical alveoli and has the appearance of a bunch of grapes. Air flows into the atrium of the alveolar sac, then circulates into alveoli where gas exchange occurs with the capillaries. Mucous glands secrete mucous into the airways, keeping them moist and flexible. (credit: modification of work by Mariana Ruiz Villareal)



Watch the following video to review the respiratory system. (This multimedia resource will open in a browser.) (<http://cnx.org/content/m66645/1.3/#eip-id1171744721747>)

Protective Mechanisms

The air that organisms breathe contains **particulate matter** such as dust, dirt, viral particles, and bacteria that can damage the lungs or trigger allergic immune responses. The respiratory system contains several protective mechanisms to avoid problems or tissue damage. In the nasal cavity, hairs and mucus trap small particles, viruses, bacteria, dust, and dirt to prevent their entry.

If particulates do make it beyond the nose, or enter through the mouth, the bronchi and bronchioles of the lungs also contain several protective devices. The lungs produce **mucus**—a sticky substance made of **mucin**, a complex glycoprotein, as well as salts and water—that traps particulates. The bronchi and bronchioles contain

cilia, small hair-like projections that line the walls of the bronchi and bronchioles (**Figure 39.11**). These cilia beat in unison and move mucus and particles out of the bronchi and bronchioles back up to the throat where it is swallowed and eliminated via the esophagus.

In humans, for example, tar and other substances in cigarette smoke destroy or paralyze the cilia, making the removal of particles more difficult. In addition, smoking causes the lungs to produce more mucus, which the damaged cilia are not able to move. This causes a persistent cough, as the lungs try to rid themselves of particulate matter, and makes smokers more susceptible to respiratory ailments.

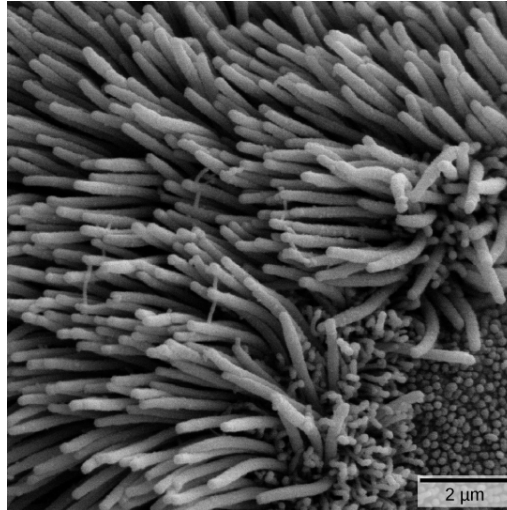


Figure 39.11 The bronchi and bronchioles contain cilia that help move mucus and other particles out of the lungs. (credit: Louisa Howard, modification of work by Dartmouth Electron Microscope Facility)

39.2 | Gas Exchange across Respiratory Surfaces

By the end of this section, you will be able to do the following:

- Name and describe lung volumes and capacities
- Understand how gas pressure influences how gases move into and out of the body

The structure of the lung maximizes its surface area to increase gas diffusion. Because of the enormous number of alveoli (approximately 300 million in each human lung), the surface area of the lung is very large (75 m^2). Having such a large surface area increases the amount of gas that can diffuse into and out of the lungs.

Basic Principles of Gas Exchange

Gas exchange during respiration occurs primarily through diffusion. Diffusion is a process in which transport is driven by a concentration gradient. Gas molecules move from a region of high concentration to a region of low concentration. Blood that is low in oxygen concentration and high in carbon dioxide concentration undergoes gas exchange with air in the lungs. The air in the lungs has a higher concentration of oxygen than that of oxygen-depleted blood and a lower concentration of carbon dioxide. This concentration gradient allows for gas exchange during respiration.

Partial pressure is a measure of the concentration of the individual components in a mixture of gases. The total pressure exerted by the mixture is the sum of the partial pressures of the components in the mixture. The rate of diffusion of a gas is proportional to its partial pressure within the total gas mixture. This concept is discussed further in detail below.

Lung Volumes and Capacities

Different animals have different lung capacities based on their activities. Cheetahs have evolved a much higher lung capacity than humans; it helps provide oxygen to all the muscles in the body and allows them to run very fast. Elephants also have a high lung capacity. In this case, it is not because they run fast but because they have

a large body and must be able to take up oxygen in accordance with their body size.

Human lung size is determined by genetics, sex, and height. At maximal capacity, an average lung can hold almost six liters of air, but lungs do not usually operate at maximal capacity. Air in the lungs is measured in terms of **lung volumes** and **lung capacities** (Figure 39.12 and Table 39.1). Volume measures the amount of air for one function (such as inhalation or exhalation). Capacity is any two or more volumes (for example, how much can be inhaled from the end of a maximal exhalation).

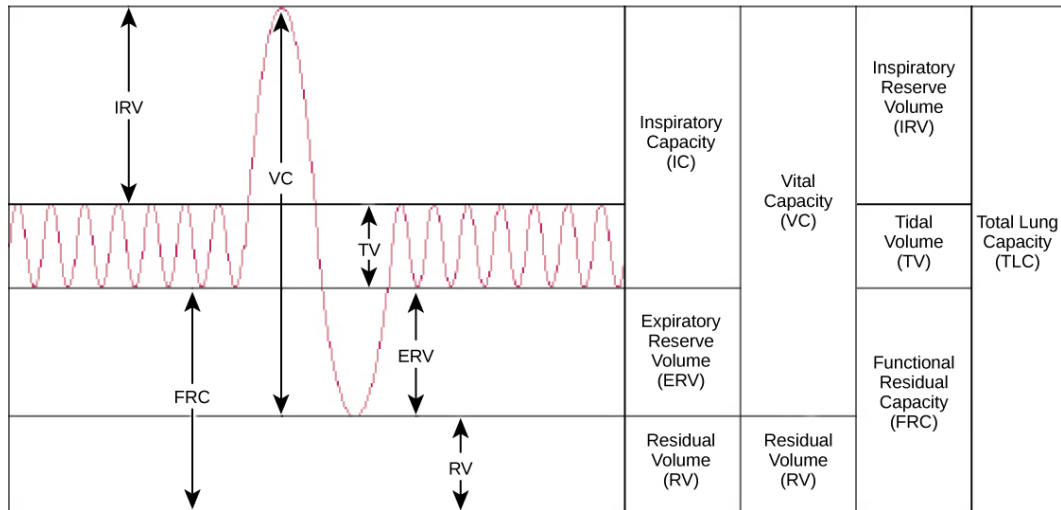


Figure 39.12 Human lung volumes and capacities are shown. The total lung capacity of the adult male is six liters. Tidal volume is the volume of air inhaled in a single, normal breath. Inspiratory capacity is the amount of air taken in during a deep breath, and residual volume is the amount of air left in the lungs after forceful respiration.

Lung Volumes and Capacities (Avg Adult Male)

Volume/ Capacity	Definition	Volume (liters)	Equations
Tidal volume (TV)	Amount of air inhaled during a normal breath	0.5	-
Expiratory reserve volume (ERV)	Amount of air that can be exhaled after a normal exhalation	1.2	-
Inspiratory reserve volume (IRV)	Amount of air that can be further inhaled after a normal inhalation	3.1	-
Residual volume (RV)	Air left in the lungs after a forced exhalation	1.2	-
Vital capacity (VC)	Maximum amount of air that can be moved in or out of the lungs in a single respiratory cycle	4.8	$ERV + TV + IRV$
Inspiratory capacity (IC)	Volume of air that can be inhaled in addition to a normal exhalation	3.6	$TV + IRV$
Functional residual capacity (FRC)	Volume of air remaining after a normal exhalation	2.4	$ERV + RV$
Total lung capacity (TLC)	Total volume of air in the lungs after a maximal inspiration	6.0	$RV + ERV + TV + IRV$
Forced expiratory volume (FEV1)	How much air can be forced out of the lungs over a specific time period, usually one second	~4.1 to 5.5	-

Table 39.1

The volume in the lung can be divided into four units: tidal volume, expiratory reserve volume, inspiratory reserve

volume, and residual volume. **Tidal volume (TV)** measures the amount of air that is inspired and expired during a normal breath. On average, this volume is around one-half liter, which is a little less than the capacity of a 20-ounce drink bottle. The **expiratory reserve volume (ERV)** is the additional amount of air that can be exhaled after a normal exhalation. It is the reserve amount that can be exhaled beyond what is normal. Conversely, the **inspiratory reserve volume (IRV)** is the additional amount of air that can be inhaled after a normal inhalation. The **residual volume (RV)** is the amount of air that is left after expiratory reserve volume is exhaled. The lungs are never completely empty: There is always some air left in the lungs after a maximal exhalation. If this residual volume did not exist and the lungs emptied completely, the lung tissues would stick together and the energy necessary to reinflate the lung could be too great to overcome. Therefore, there is always some air remaining in the lungs. Residual volume is also important for preventing large fluctuations in respiratory gases (O_2 and CO_2). The residual volume is the only lung volume that cannot be measured directly because it is impossible to completely empty the lung of air. This volume can only be calculated rather than measured.

Capacities are measurements of two or more volumes. The **vital capacity (VC)** measures the maximum amount of air that can be inhaled or exhaled during a respiratory cycle. It is the sum of the expiratory reserve volume, tidal volume, and inspiratory reserve volume. The **inspiratory capacity (IC)** is the amount of air that can be inhaled after the end of a normal expiration. It is, therefore, the sum of the tidal volume and inspiratory reserve volume. The **functional residual capacity (FRC)** includes the expiratory reserve volume and the residual volume. The FRC measures the amount of additional air that can be exhaled after a normal exhalation. Lastly, the **total lung capacity (TLC)** is a measurement of the total amount of air that the lung can hold. It is the sum of the residual volume, expiratory reserve volume, tidal volume, and inspiratory reserve volume.

Lung volumes are measured by a technique called **spirometry**. An important measurement taken during spirometry is the **forced expiratory volume (FEV)**, which measures how much air can be forced out of the lung over a specific period, usually one second (FEV1). In addition, the forced vital capacity (FVC), which is the total amount of air that can be forcibly exhaled, is measured. The ratio of these values (**FEV1/FVC ratio**) is used to diagnose lung diseases including asthma, emphysema, and fibrosis. If the FEV1/FVC ratio is high, the lungs are not compliant (meaning they are stiff and unable to bend properly), and the patient most likely has lung fibrosis. Patients exhale most of the lung volume very quickly. Conversely, when the FEV1/FVC ratio is low, there is resistance in the lung that is characteristic of asthma. In this instance, it is hard for the patient to get the air out of his or her lungs, and it takes a long time to reach the maximal exhalation volume. In either case, breathing is difficult and complications arise.



Respiratory Therapist

Respiratory therapists or respiratory practitioners evaluate and treat patients with lung and cardiovascular diseases. They work as part of a medical team to develop treatment plans for patients. Respiratory therapists may treat premature babies with underdeveloped lungs, patients with chronic conditions such as asthma, or older patients suffering from lung disease such as emphysema and chronic obstructive pulmonary disease (COPD). They may operate advanced equipment such as compressed gas delivery systems, ventilators, blood gas analyzers, and resuscitators. Specialized programs to become a respiratory therapist generally lead to a bachelor's degree with a respiratory therapist specialty. Because of a growing aging population, career opportunities as a respiratory therapist are expected to remain strong.

Gas Pressure and Respiration

The respiratory process can be better understood by examining the properties of gases. Gases move freely, but gas particles are constantly hitting the walls of their vessel, thereby producing gas pressure.

Air is a mixture of gases, primarily nitrogen (N_2 ; 78.6 percent), oxygen (O_2 ; 20.9 percent), water vapor (H_2O ; 0.5 percent), and carbon dioxide (CO_2 ; 0.04 percent). Each gas component of that mixture exerts a pressure. The pressure for an individual gas in the mixture is the partial pressure of that gas. Approximately 21 percent of atmospheric gas is oxygen. Carbon dioxide, however, is found in relatively small amounts, 0.04 percent. The partial pressure for oxygen is much greater than that of carbon dioxide. The partial pressure of any gas can be calculated by:

$$P = (P_{\text{atm}}) \times (\text{percent content in mixture}).$$

P_{atm} , the atmospheric pressure, is the sum of all of the partial pressures of the atmospheric gases added together,

$$P_{\text{atm}} = P_{\text{N}_2} + P_{\text{O}_2} + P_{\text{H}_2\text{O}} + P_{\text{CO}_2} = 760 \text{ mm Hg}$$

× (percent content in mixture).

The pressure of the atmosphere at sea level is 760 mm Hg. Therefore, the partial pressure of oxygen is:

$$P_{\text{O}_2} = (760 \text{ mm Hg}) (0.21) = 160 \text{ mm Hg}$$

and for carbon dioxide:

$$P_{\text{CO}_2} = (760 \text{ mm Hg}) (0.0004) = 0.3 \text{ mm Hg}.$$

At high altitudes, P_{atm} decreases but concentration does not change; the partial pressure decrease is due to the reduction in P_{atm} .

When the air mixture reaches the lung, it has been humidified. The pressure of the water vapor in the lung does not change the pressure of the air, but it must be included in the partial pressure equation. For this calculation, the water pressure (47 mm Hg) is subtracted from the atmospheric pressure:

$$760 \text{ mm Hg} - 47 \text{ mm Hg} = 713 \text{ mm Hg}$$

and the partial pressure of oxygen is:

$$(760 \text{ mm Hg} - 47 \text{ mm Hg}) \times 0.21 = 150 \text{ mm Hg}.$$

These pressures determine the gas exchange, or the flow of gas, in the system. Oxygen and carbon dioxide will flow according to their pressure gradient from high to low. Therefore, understanding the partial pressure of each gas will aid in understanding how gases move in the respiratory system.

Gas Exchange across the Alveoli

In the body, oxygen is used by cells of the body's tissues and carbon dioxide is produced as a waste product. The ratio of carbon dioxide production to oxygen consumption is the **respiratory quotient (RQ)**. RQ varies between 0.7 and 1.0. If just glucose were used to fuel the body, the RQ would equal one. One mole of carbon dioxide would be produced for every mole of oxygen consumed. Glucose, however, is not the only fuel for the body. Protein and fat are also used as fuels for the body. Because of this, less carbon dioxide is produced than oxygen is consumed and the RQ is, on average, about 0.7 for fat and about 0.8 for protein.

The RQ is used to calculate the partial pressure of oxygen in the alveolar spaces within the lung, the **alveolar P_{O_2}** . Above, the partial pressure of oxygen in the lungs was calculated to be 150 mm Hg. However, lungs never fully deflate with an exhalation; therefore, the inspired air mixes with this residual air and lowers the partial pressure of oxygen within the alveoli. This means that there is a lower concentration of oxygen in the lungs than is found in the air outside the body. Knowing the RQ, the partial pressure of oxygen in the alveoli can be calculated:

$$\text{alveolar } P_{\text{O}_2} = \text{inspired } P_{\text{O}_2} - \left(\frac{\text{alveolar } P_{\text{O}_2}}{\text{RQ}} \right)$$

With an RQ of 0.8 and a P_{CO_2} in the alveoli of 40 mm Hg, the alveolar P_{O_2} is equal to:

$$\text{alveolar } P_{\text{O}_2} = 150 \text{ mm Hg} - \left(\frac{40 \text{ mm Hg}}{0.8} \right) = 100 \text{ mm Hg}.$$

Notice that this pressure is less than the external air. Therefore, the oxygen will flow from the inspired air in the lung ($P_{\text{O}_2} = 150 \text{ mm Hg}$) into the bloodstream ($P_{\text{O}_2} = 100 \text{ mm Hg}$) (**Figure 39.13**).

In the lungs, oxygen diffuses out of the alveoli and into the capillaries surrounding the alveoli. Oxygen (about 98 percent) binds reversibly to the respiratory pigment hemoglobin found in red blood cells (RBCs). RBCs carry oxygen to the tissues where oxygen dissociates from the hemoglobin and diffuses into the cells of the tissues. More specifically, alveolar P_{O_2} is higher in the alveoli ($P_{\text{ALVO}_2} = 100 \text{ mm Hg}$) than blood P_{O_2} (40 mm Hg) in the capillaries. Because this pressure gradient exists, oxygen diffuses down its pressure gradient, moving out of

the alveoli and entering the blood of the capillaries where O_2 binds to hemoglobin. At the same time, alveolar P_{CO_2} is lower $P_{ALVO_2} = 40$ mm Hg than blood $P_{CO_2} = (45$ mm Hg). CO_2 diffuses down its pressure gradient, moving out of the capillaries and entering the alveoli.

Oxygen and carbon dioxide move independently of each other; they diffuse down their own pressure gradients. As blood leaves the lungs through the pulmonary veins, the **venous** $P_{O_2} = 100$ mm Hg, whereas the **venous** $P_{CO_2} = 40$ mm Hg. As blood enters the systemic capillaries, the blood will lose oxygen and gain carbon dioxide because of the pressure difference of the tissues and blood. In systemic capillaries, $P_{O_2} = 100$ mm Hg, but in the tissue cells, $P_{O_2} = 40$ mm Hg. This pressure gradient drives the diffusion of oxygen out of the capillaries and into the tissue cells. At the same time, blood $P_{CO_2} = 40$ mm Hg and systemic tissue $P_{CO_2} = 45$ mm Hg. The pressure gradient drives CO_2 out of tissue cells and into the capillaries. The blood returning to the lungs through the pulmonary arteries has a venous $P_{O_2} = 40$ mm Hg and a $P_{CO_2} = 45$ mm Hg. The blood enters the lung capillaries where the process of exchanging gases between the capillaries and alveoli begins again (Figure 39.13).

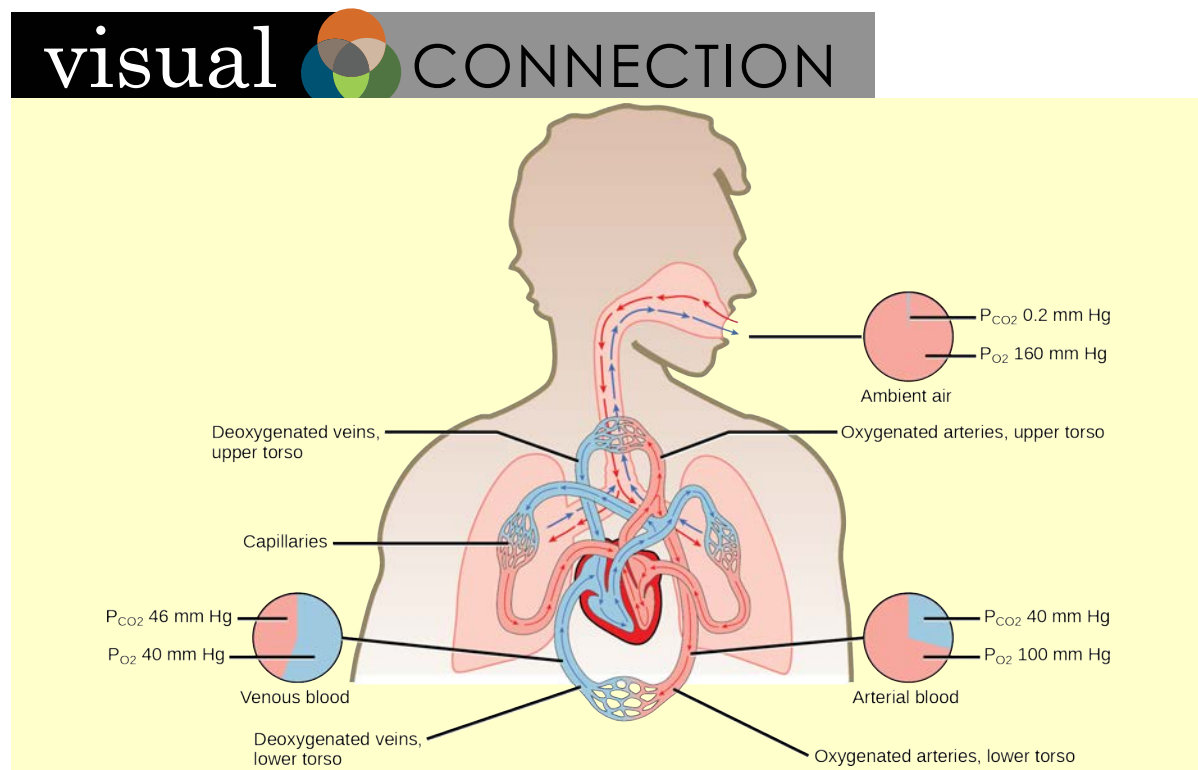


Figure 39.13 The partial pressures of oxygen and carbon dioxide change as blood moves through the body.

Which of the following statements is false?

- In the tissues, P_{O_2} drops as blood passes from the arteries to the veins, while P_{CO_2} increases.
- Blood travels from the lungs to the heart to body tissues, then back to the heart, then the lungs.
- Blood travels from the lungs to the heart to body tissues, then back to the lungs, then the heart.
- P_{O_2} is higher in air than in the lungs.

In short, the change in partial pressure from the alveoli to the capillaries drives the oxygen into the tissues and the carbon dioxide into the blood from the tissues. The blood is then transported to the lungs where differences in pressure in the alveoli result in the movement of carbon dioxide out of the blood into the lungs, and oxygen

into the blood.



Watch this video to learn how to carry out spirometry. **(This multimedia resource will open in a browser.)** (<http://cnx.org/content/m66646/1.3/#eip-id1166886382710>)

39.3 | Breathing

By the end of this section, you will be able to do the following:

- Describe how the structures of the lungs and thoracic cavity control the mechanics of breathing
- Explain the importance of compliance and resistance in the lungs
- Discuss problems that may arise due to a V/Q mismatch

Mammalian lungs are located in the thoracic cavity where they are surrounded and protected by the rib cage, intercostal muscles, and bound by the chest wall. The bottom of the lungs is contained by the diaphragm, a skeletal muscle that facilitates breathing. Breathing requires the coordination of the lungs, the chest wall, and most importantly, the diaphragm.

Types of Breathing

Amphibians have evolved multiple ways of breathing. Young amphibians, like tadpoles, use gills to breathe, and they don't leave the water. Some amphibians retain gills for life. As the tadpole grows, the gills disappear and lungs grow. These lungs are primitive and not as evolved as mammalian lungs. Adult amphibians are lacking or have a reduced diaphragm, so breathing via lungs is forced. The other means of breathing for amphibians is diffusion across the skin. To aid this diffusion, amphibian skin must remain moist.

Birds face a unique challenge with respect to breathing: They fly. Flying consumes a great amount of energy; therefore, birds require a lot of oxygen to aid their metabolic processes. Birds have evolved a respiratory system that supplies them with the oxygen needed to enable flying. Similar to mammals, birds have lungs, which are organs specialized for gas exchange. Oxygenated air, taken in during inhalation, diffuses across the surface of the lungs into the bloodstream, and carbon dioxide diffuses from the blood into the lungs and expelled during exhalation. The details of breathing between birds and mammals differ substantially.

In addition to lungs, birds have air sacs inside their body. Air flows in one direction from the posterior air sacs to the lungs and out of the anterior air sacs. The flow of air is in the opposite direction from blood flow, and gas exchange takes place much more efficiently. This type of breathing enables birds to obtain the requisite oxygen, even at higher altitudes where the oxygen concentration is low. This directionality of airflow requires two cycles of air intake and exhalation to completely get the air out of the lungs.

evolution CONNECTION

Avian Respiration

Birds have evolved a respiratory system that enables them to fly. Flying is a high-energy process and requires a lot of oxygen. Furthermore, many birds fly in high altitudes where the concentration of oxygen is low. How did birds evolve a respiratory system that is so unique?

Decades of research by paleontologists have shown that birds evolved from theropods, meat-eating dinosaurs (**Figure 39.14**). In fact, fossil evidence shows that meat-eating dinosaurs that lived more than 100 million years ago had a similar flow-through respiratory system with lungs and air sacs. *Archaeopteryx* and *Xiaotingia*, for example, were flying dinosaurs and are believed to be early precursors of birds.

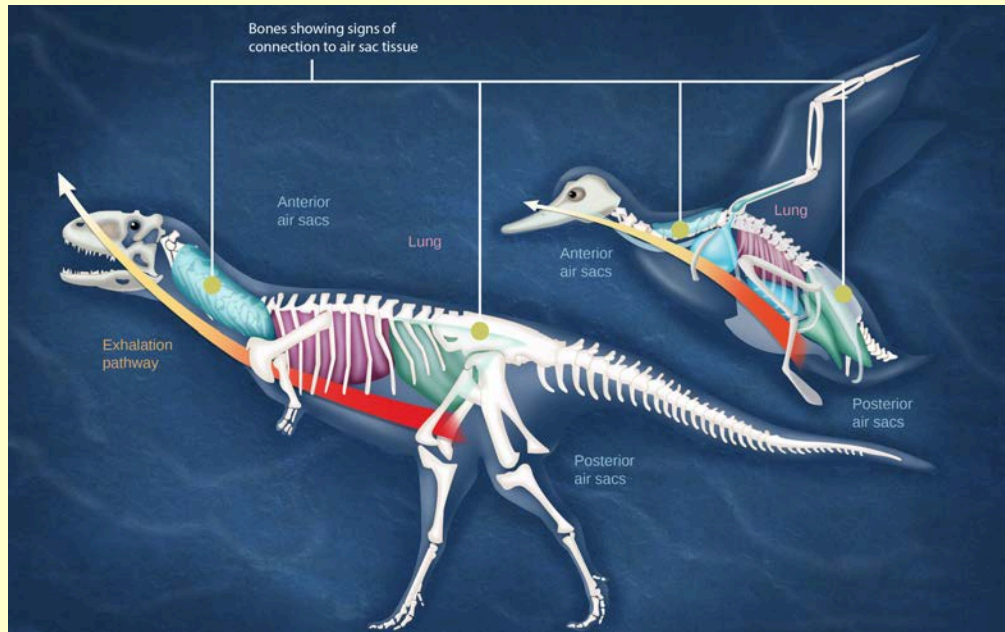


Figure 39.14 Dinosaurs, from which birds descended, have similar hollow bones and are believed to have had a similar respiratory system. (credit b: modification of work by Zina Deretsky, National Science Foundation)

Most of us consider that dinosaurs are extinct. However, modern birds are descendants of avian dinosaurs. The respiratory system of modern birds has been evolving for hundreds of millions of years.

All mammals have lungs that are the main organs for breathing. Lung capacity has evolved to support the animal's activities. During inhalation, the lungs expand with air, and oxygen diffuses across the lung's surface and enters the bloodstream. During exhalation, the lungs expel air and lung volume decreases. In the next few sections, the process of human breathing will be explained.

The Mechanics of Human Breathing

Boyle's Law is the gas law that states that in a closed space, pressure and volume are inversely related. As volume decreases, pressure increases and vice versa (**Figure 39.15**). The relationship between gas pressure and volume helps to explain the mechanics of breathing.

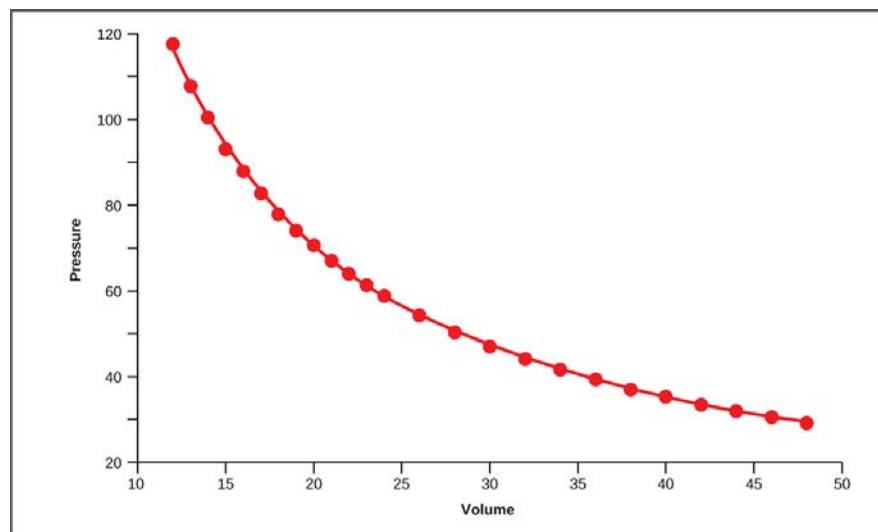


Figure 39.15 This graph shows data from Boyle's original 1662 experiment, which shows that pressure and volume are inversely related. No units are given as Boyle used arbitrary units in his experiments.

There is always a slightly negative pressure within the thoracic cavity, which aids in keeping the airways of the lungs open. During inhalation, volume increases as a result of contraction of the diaphragm, and pressure decreases (according to Boyle's Law). This decrease of pressure in the thoracic cavity relative to the environment makes the cavity less than the atmosphere (**Figure 39.16a**). Because of this drop in pressure, air rushes into the respiratory passages. To increase the volume of the lungs, the chest wall expands. This results from the contraction of the **intercostal muscles**, the muscles that are connected to the rib cage. Lung volume expands because the diaphragm contracts and the intercostal muscles contract, thus expanding the thoracic cavity. This increase in the volume of the thoracic cavity lowers pressure compared to the atmosphere, so air rushes into the lungs, thus increasing its volume. The resulting increase in volume is largely attributed to an increase in alveolar space, because the bronchioles and bronchi are stiff structures that do not change in size.

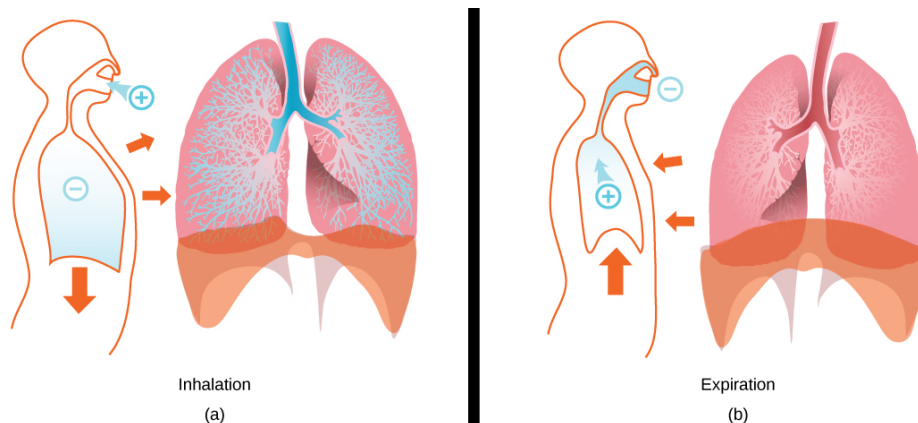


Figure 39.16 The lungs, chest wall, and diaphragm are all involved in respiration, both (a) inhalation and (b) expiration. (credit: modification of work by Mariana Ruiz Villareal)

The chest wall expands out and away from the lungs. The lungs are elastic; therefore, when air fills the lungs, the **elastic recoil** within the tissues of the lung exerts pressure back toward the interior of the lungs. These outward and inward forces compete to inflate and deflate the lung with every breath. Upon exhalation, the lungs recoil to force the air out of the lungs, and the intercostal muscles relax, returning the chest wall back to its original position (**Figure 39.16b**). The diaphragm also relaxes and moves higher into the thoracic cavity. This increases the pressure within the thoracic cavity relative to the environment, and air rushes out of the lungs. The movement of air out of the lungs is a passive event. No muscles are contracting to expel the air.

Each lung is surrounded by an invaginated sac. The layer of tissue that covers the lung and dips into spaces is called the visceral **pleura**. A second layer of parietal pleura lines the interior of the thorax (**Figure 39.17**). The space between these layers, the **intrapleural space**, contains a small amount of fluid that protects the

tissue and reduces the friction generated from rubbing the tissue layers together as the lungs contract and relax. **Pleurisy** results when these layers of tissue become inflamed; it is painful because the inflammation increases the pressure within the thoracic cavity and reduces the volume of the lung.

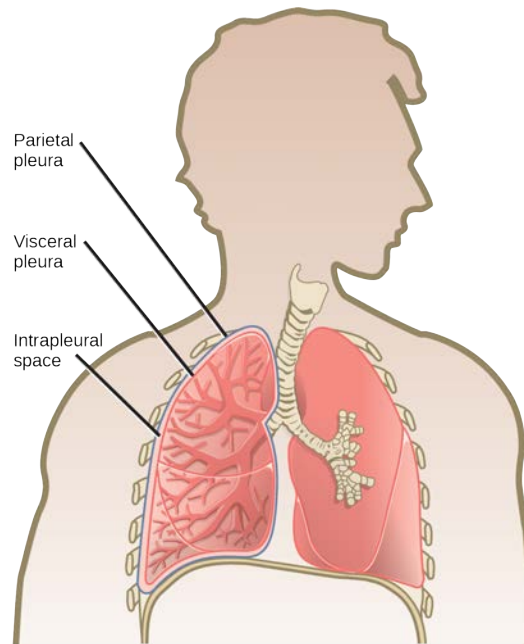


Figure 39.17 A tissue layer called pleura surrounds the lung and interior of the thoracic cavity. (credit: modification of work by NCI)



View how Boyle's Law is related to breathing and watch a [video \(https://www.openstaxcollege.org//boyles_law\)](https://www.openstaxcollege.org//boyles_law) on Boyle's Law. (This multimedia resource will open in a browser.) (<http://cnx.org/content/m66647/1.3/#eip-id1169422250553>)

The Work of Breathing

The number of breaths per minute is the **respiratory rate**. On average, under non-exertion conditions, the human respiratory rate is 12–15 breaths/minute. The respiratory rate contributes to the **alveolar ventilation**, or how much air moves into and out of the alveoli. Alveolar ventilation prevents carbon dioxide buildup in the alveoli. There are two ways to keep the alveolar ventilation constant: increase the respiratory rate while decreasing the tidal volume of air per breath (shallow breathing), or decrease the respiratory rate while increasing the tidal volume per breath. In either case, the ventilation remains the same, but the work done and type of work needed are quite different. Both tidal volume and respiratory rate are closely regulated when oxygen demand increases.

There are two types of work conducted during respiration, flow-resistive and elastic work. **Flow-resistive** refers to the work of the alveoli and tissues in the lung, whereas **elastic work** refers to the work of the intercostal muscles, chest wall, and diaphragm. Increasing the respiration rate increases the flow-resistive work of the airways and decreases the elastic work of the muscles. Decreasing the respiratory rate reverses the type of work required.

Surfactant

The air-tissue/water interface of the alveoli has a high surface tension. This surface tension is similar to the surface tension of water at the liquid-air interface of a water droplet that results in the bonding of the water molecules together. **Surfactant** is a complex mixture of phospholipids and lipoproteins that works to reduce the

surface tension that exists between the alveoli tissue and the air found within the alveoli. By lowering the surface tension of the alveolar fluid, it reduces the tendency of alveoli to collapse.

Surfactant works like a detergent to reduce the surface tension and allows for easier inflation of the airways. When a balloon is first inflated, it takes a large amount of effort to stretch the plastic and start to inflate the balloon. If a little bit of detergent was applied to the interior of the balloon, then the amount of effort or work needed to begin to inflate the balloon would decrease, and it would become much easier to start blowing up the balloon. This same principle applies to the airways. A small amount of surfactant to the airway tissues reduces the effort or work needed to inflate those airways. Babies born prematurely sometimes do not produce enough surfactant. As a result, they suffer from **respiratory distress syndrome**, because it requires more effort to inflate their lungs. Surfactant is also important for preventing collapse of small alveoli relative to large alveoli.

Lung Resistance and Compliance

Pulmonary diseases reduce the rate of gas exchange into and out of the lungs. Two main causes of decreased gas exchange are **compliance** (how elastic the lung is) and **resistance** (how much obstruction exists in the airways). A change in either can dramatically alter breathing and the ability to take in oxygen and release carbon dioxide.

Examples of **restrictive diseases** are respiratory distress syndrome and pulmonary fibrosis. In both diseases, the airways are less compliant and they are stiff or fibrotic. There is a decrease in compliance because the lung tissue cannot bend and move. In these types of restrictive diseases, the intrapleural pressure is more positive and the airways collapse upon exhalation, which traps air in the lungs. Forced or **functional vital capacity (FVC)**, which is the amount of air that can be forcibly exhaled after taking the deepest breath possible, is much lower than in normal patients, and the time it takes to exhale most of the air is greatly prolonged (**Figure 39.18**). A patient suffering from these diseases cannot exhale the normal amount of air.

Obstructive diseases and conditions include emphysema, asthma, and pulmonary edema. In emphysema, which mostly arises from smoking tobacco, the walls of the alveoli are destroyed, decreasing the surface area for gas exchange. The overall compliance of the lungs is increased, because as the alveolar walls are damaged, lung elastic recoil decreases due to a loss of elastic fibers, and more air is trapped in the lungs at the end of exhalation. Asthma is a disease in which inflammation is triggered by environmental factors. Inflammation obstructs the airways. The obstruction may be due to edema (fluid accumulation), smooth muscle spasms in the walls of the bronchioles, increased mucus secretion, damage to the epithelia of the airways, or a combination of these events. Those with asthma or edema experience increased occlusion from increased inflammation of the airways. This tends to block the airways, preventing the proper movement of gases (**Figure 39.18**). Those with obstructive diseases have large volumes of air trapped after exhalation and breathe at a very high lung volume to compensate for the lack of airway recruitment.

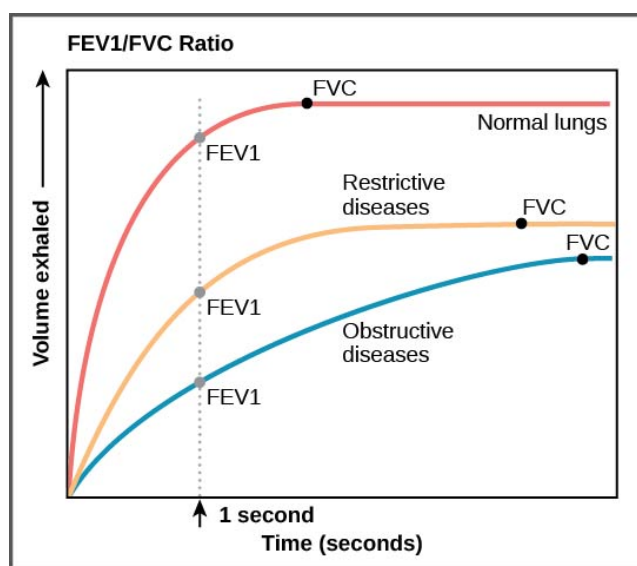


Figure 39.18 The ratio of FEV1 (the amount of air that can be forcibly exhaled in one second after taking a deep breath) to FVC (the total amount of air that can be forcibly exhaled) can be used to diagnose whether a person has restrictive or obstructive lung disease. In restrictive lung disease, FVC is reduced but airways are not obstructed, so the person is able to expel air reasonably fast. In obstructive lung disease, airway obstruction results in slow exhalation as well as reduced FVC. Thus, the FEV1/FVC ratio is lower in persons with obstructive lung disease (less than 69 percent) than in persons with restrictive disease (88 to 90 percent).

Dead Space: V/Q Mismatch

Pulmonary circulation pressure is very low compared to that of the systemic circulation. It is also independent of cardiac output. This is because of a phenomenon called **recruitment**, which is the process of opening airways that normally remain closed when cardiac output increases. As cardiac output increases, the number of capillaries and arteries that are perfused (filled with blood) increases. These capillaries and arteries are not always in use but are ready if needed. At times, however, there is a mismatch between the amount of air (ventilation, V) and the amount of blood (perfusion, Q) in the lungs. This is referred to as **ventilation/perfusion (V/Q) mismatch**.

There are two types of V/Q mismatch. Both produce **dead space**, regions of broken down or blocked lung tissue. Dead spaces can severely impact breathing, because they reduce the surface area available for gas diffusion. As a result, the amount of oxygen in the blood decreases, whereas the carbon dioxide level increases. Dead space is created when no ventilation and/or perfusion takes place. **Anatomical dead space** or anatomical shunt, arises from an anatomical failure, while **physiological dead space** or physiological shunt, arises from a functional impairment of the lung or arteries.

An example of an anatomical shunt is the effect of gravity on the lungs. The lung is particularly susceptible to changes in the magnitude and direction of gravitational forces. When someone is standing or sitting upright, the pleural pressure gradient leads to increased ventilation further down in the lung. As a result, the intrapleural pressure is more negative at the base of the lung than at the top, and more air fills the bottom of the lung than the top. Likewise, it takes less energy to pump blood to the bottom of the lung than to the top when in a prone position. Perfusion of the lung is not uniform while standing or sitting. This is a result of hydrostatic forces combined with the effect of airway pressure. An anatomical shunt develops because the ventilation of the airways does not match the perfusion of the arteries surrounding those airways. As a result, the rate of gas exchange is reduced. Note that this does not occur when lying down, because in this position, gravity does not preferentially pull the bottom of the lung down.

A physiological shunt can develop if there is infection or edema in the lung that obstructs an area. This will decrease ventilation but not affect perfusion; therefore, the V/Q ratio changes and gas exchange is affected.

The lung can compensate for these mismatches in ventilation and perfusion. If ventilation is greater than perfusion, the arterioles dilate and the bronchioles constrict. This increases perfusion and reduces ventilation. Likewise, if ventilation is less than perfusion, the arterioles constrict and the bronchioles dilate to correct the imbalance.



View the mechanics of breathing.

(This multimedia resource will open in a browser.) (<http://cnx.org/content/m66647/1.3/#eip-id1166285291346>)

39.4 | Transport of Gases in Human Bodily Fluids

By the end of this section, you will be able to do the following:

- Describe how oxygen is bound to hemoglobin and transported to body tissues
- Explain how carbon dioxide is transported from body tissues to the lungs

Once the oxygen diffuses across the alveoli, it enters the bloodstream and is transported to the tissues where it is unloaded, and carbon dioxide diffuses out of the blood and into the alveoli to be expelled from the body. Although gas exchange is a continuous process, the oxygen and carbon dioxide are transported by different mechanisms.

Transport of Oxygen in the Blood

Although oxygen dissolves in blood, only a small amount of oxygen is transported this way. Only 1.5 percent of oxygen in the blood is dissolved directly into the blood itself. Most oxygen—98.5 percent—is bound to a protein called hemoglobin and carried to the tissues.

Hemoglobin

Hemoglobin, or Hb, is a protein molecule found in red blood cells (erythrocytes) made of four subunits: two alpha subunits and two beta subunits (**Figure 39.19**). Each subunit surrounds a central **heme group** that contains iron and binds one oxygen molecule, allowing each hemoglobin molecule to bind four oxygen molecules. Molecules with more oxygen bound to the heme groups are brighter red. As a result, oxygenated arterial blood where the Hb is carrying four oxygen molecules is bright red, while venous blood that is deoxygenated is darker red.

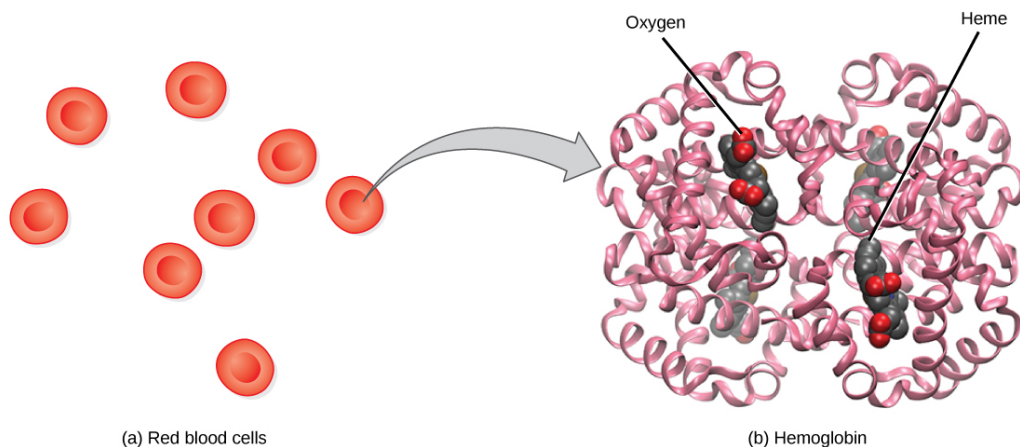


Figure 39.19 The protein inside (a) red blood cells that carries oxygen to cells and carbon dioxide to the lungs is (b) hemoglobin. Hemoglobin is made up of four symmetrical subunits and four heme groups. Iron associated with the heme binds oxygen. It is the iron in hemoglobin that gives blood its red color.

It is easier to bind a second and third oxygen molecule to Hb than the first molecule. This is because the

hemoglobin molecule changes its shape, or conformation, as oxygen binds. The fourth oxygen is then more difficult to bind. The binding of oxygen to hemoglobin can be plotted as a function of the partial pressure of oxygen in the blood (x-axis) versus the relative Hb-oxygen saturation (y-axis). The resulting graph—an **oxygen dissociation curve**—is sigmoidal, or S-shaped (**Figure 39.20**). As the partial pressure of oxygen increases, the hemoglobin becomes increasingly saturated with oxygen.

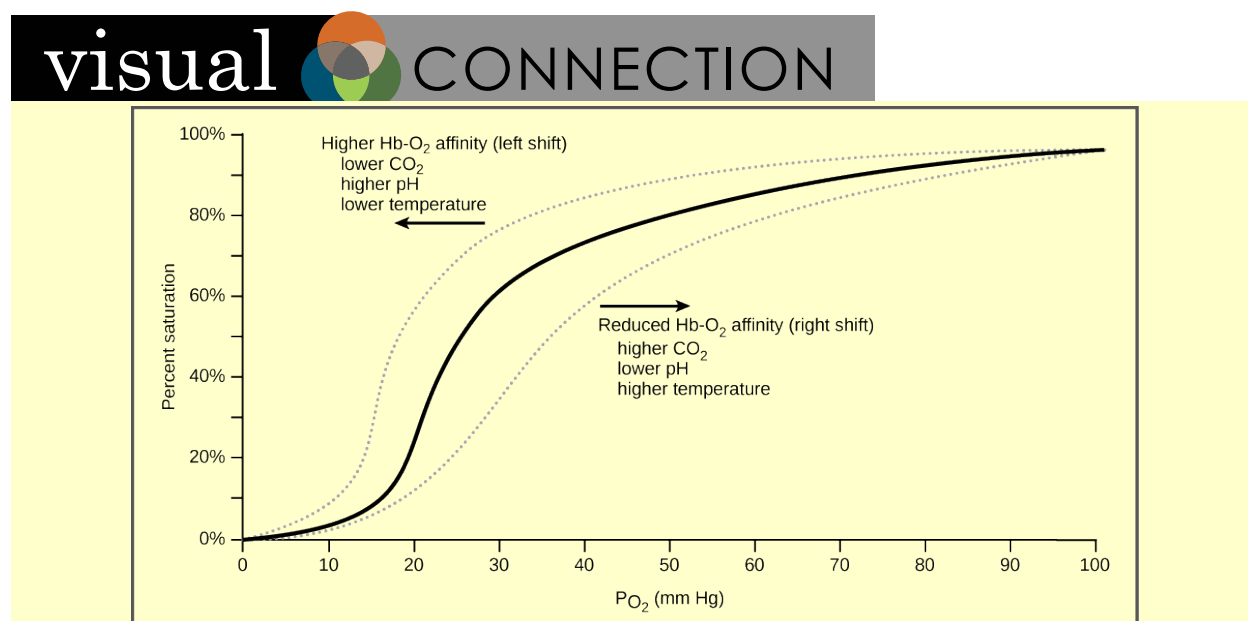


Figure 39.20 The oxygen dissociation curve demonstrates that, as the partial pressure of oxygen increases, more oxygen binds hemoglobin. However, the affinity of hemoglobin for oxygen may shift to the left or the right depending on environmental conditions.

The kidneys are responsible for removing excess H^+ ions from the blood. If the kidneys fail, what would happen to blood pH and to hemoglobin affinity for oxygen?

Factors That Affect Oxygen Binding

The **oxygen-carrying capacity** of hemoglobin determines how much oxygen is carried in the blood. In addition to P_{O_2} , other environmental factors and diseases can affect oxygen carrying capacity and delivery.

Carbon dioxide levels, blood pH, and body temperature affect oxygen-carrying capacity (**Figure 39.20**). When carbon dioxide is in the blood, it reacts with water to form bicarbonate (HCO_3^-) and hydrogen ions (H^+). As the level of carbon dioxide in the blood increases, more H^+ is produced and the pH decreases. This increase in carbon dioxide and subsequent decrease in pH reduce the affinity of hemoglobin for oxygen. The oxygen dissociates from the Hb molecule, shifting the oxygen dissociation curve to the right. Therefore, more oxygen is needed to reach the same hemoglobin saturation level as when the pH was higher. A similar shift in the curve also results from an increase in body temperature. Increased temperature, such as from increased activity of skeletal muscle, causes the affinity of hemoglobin for oxygen to be reduced.

Diseases like sickle cell anemia and thalassemia decrease the blood's ability to deliver oxygen to tissues and its oxygen-carrying capacity. In **sickle cell anemia**, the shape of the red blood cell is crescent-shaped, elongated, and stiffened, reducing its ability to deliver oxygen (**Figure 39.21**). In this form, red blood cells cannot pass through the capillaries. This is painful when it occurs. **Thalassemia** is a rare genetic disease caused by a defect in either the alpha or the beta subunit of Hb. Patients with thalassemia produce a high number of red blood cells, but these cells have lower-than-normal levels of hemoglobin. Therefore, the oxygen-carrying capacity is diminished.

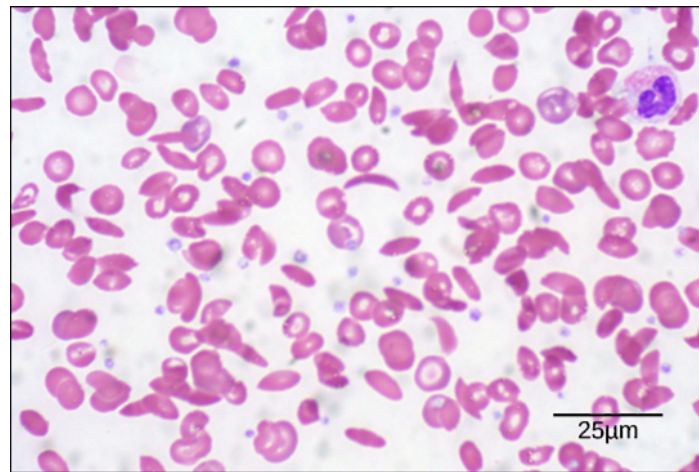


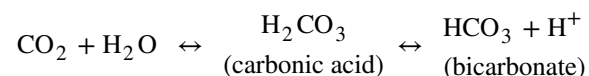
Figure 39.21 Individuals with sickle cell anemia have crescent-shaped red blood cells. (credit: modification of work by Ed Uthman; scale-bar data from Matt Russell)

Transport of Carbon Dioxide in the Blood

Carbon dioxide molecules are transported in the blood from body tissues to the lungs by one of three methods: dissolution directly into the blood, binding to hemoglobin, or carried as a bicarbonate ion. Several properties of carbon dioxide in the blood affect its transport. First, carbon dioxide is more soluble in blood than oxygen. About 5 to 7 percent of all carbon dioxide is dissolved in the plasma. Second, carbon dioxide can bind to plasma proteins or can enter red blood cells and bind to hemoglobin. This form transports about 10 percent of the carbon dioxide. When carbon dioxide binds to hemoglobin, a molecule called **carbaminohemoglobin** is formed. Binding of carbon dioxide to hemoglobin is reversible. Therefore, when it reaches the lungs, the carbon dioxide can freely dissociate from the hemoglobin and be expelled from the body.

Third, the majority of carbon dioxide molecules (85 percent) are carried as part of the **bicarbonate buffer system**. In this system, carbon dioxide diffuses into the red blood cells. **Carbonic anhydrase (CA)** within the red blood cells quickly converts the carbon dioxide into carbonic acid (H_2CO_3). Carbonic acid is an unstable intermediate molecule that immediately dissociates into **bicarbonate ions** (HCO_3^-) and hydrogen (H^+) ions.

Since carbon dioxide is quickly converted into bicarbonate ions, this reaction allows for the continued uptake of carbon dioxide into the blood down its concentration gradient. It also results in the production of H^+ ions. If too much H^+ is produced, it can alter blood pH. However, hemoglobin binds to the free H^+ ions and thus limits shifts in pH. The newly synthesized bicarbonate ion is transported out of the red blood cell into the liquid component of the blood in exchange for a chloride ion (Cl^-); this is called the **chloride shift**. When the blood reaches the lungs, the bicarbonate ion is transported back into the red blood cell in exchange for the chloride ion. The H^+ ion dissociates from the hemoglobin and binds to the bicarbonate ion. This produces the carbonic acid intermediate, which is converted back into carbon dioxide through the enzymatic action of CA. The carbon dioxide produced is expelled through the lungs during exhalation.



The benefit of the bicarbonate buffer system is that carbon dioxide is “soaked up” into the blood with little change to the pH of the system. This is important because it takes only a small change in the overall pH of the body for severe injury or death to result. The presence of this bicarbonate buffer system also allows for people to travel and live at high altitudes: When the partial pressure of oxygen and carbon dioxide change at high altitudes, the bicarbonate buffer system adjusts to regulate carbon dioxide while maintaining the correct pH in the body.

Carbon Monoxide Poisoning

While carbon dioxide can readily associate and dissociate from hemoglobin, other molecules such as carbon monoxide (CO) cannot. Carbon monoxide has a greater affinity for hemoglobin than oxygen. Therefore, when carbon monoxide is present, it binds to hemoglobin preferentially over oxygen. As a result, oxygen cannot bind to hemoglobin, so very little oxygen is transported through the body (**Figure 39.22**). Carbon monoxide is a colorless, odorless gas and is therefore difficult to detect. It is produced by gas-powered vehicles and tools.

Carbon monoxide can cause headaches, confusion, and nausea; long-term exposure can cause brain damage or death. Administering 100 percent (pure) oxygen is the usual treatment for carbon monoxide poisoning. Administration of pure oxygen speeds up the separation of carbon monoxide from hemoglobin.

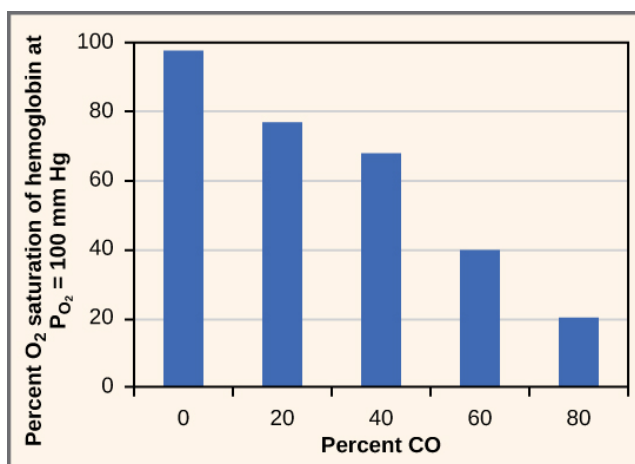


Figure 39.22 As percent CO increases, the oxygen saturation of hemoglobin decreases.

KEY TERMS

alveolar P_{O_2} partial pressure of oxygen in the alveoli (usually around 100 mmHg)

alveolar duct duct that extends from the terminal bronchiole to the alveolar sac

alveolar sac structure consisting of two or more alveoli that share a common opening

alveolar ventilation how much air is in the alveoli

alveolus (plural: alveoli) (also, air sac) terminal region of the lung where gas exchange occurs

anatomical dead space (also, anatomical shunt) region of the lung that lacks proper ventilation/perfusion due to an anatomical block

bicarbonate (HCO_3^-) ion ion created when carbonic acid dissociates into H^+ and (HCO_3^-)

bicarbonate buffer system system in the blood that absorbs carbon dioxide and regulates pH levels

bronchiole airway that extends from the main tertiary bronchi to the alveolar sac

bronchus (plural: bronchi) smaller branch of cartilaginous tissue that stems off of the trachea; air is funneled through the bronchi to the region where gas exchange occurs in alveoli

carbaminohemoglobin molecule that forms when carbon dioxide binds to hemoglobin

carbonic anhydrase (CA) enzyme that catalyzes carbon dioxide and water into carbonic acid

chloride shift exchange of chloride for bicarbonate into or out of the red blood cell

compliance measurement of the elasticity of the lung

dead space area in the lung that lacks proper ventilation or perfusion

diaphragm domed-shaped skeletal muscle located under lungs that separates the thoracic cavity from the abdominal cavity

elastic recoil property of the lung that drives the lung tissue inward

elastic work work conducted by the intercostal muscles, chest wall, and diaphragm

expiratory reserve volume (ERV) amount of additional air that can be exhaled after a normal exhalation

FEV1/FVC ratio ratio of how much air can be forced out of the lung in one second to the total amount that is forced out of the lung; a measurement of lung function that can be used to detect disease states

flow-resistive work of breathing performed by the alveoli and tissues in the lung

forced expiratory volume (FEV) (also, forced vital capacity) measure of how much air can be forced out of the lung from maximal inspiration over a specific amount of time

functional residual capacity (FRC) expiratory reserve volume plus residual volume

functional vital capacity (FVC) amount of air that can be forcibly exhaled after taking the deepest breath possible

heme group centralized iron-containing group that is surrounded by the alpha and beta subunits of hemoglobin

hemoglobin molecule in red blood cells that can bind oxygen, carbon dioxide, and carbon monoxide

inspiratory capacity (IC) tidal volume plus inspiratory reserve volume

inspiratory reserve volume (IRV) amount of additional air that can be inspired after a normal inhalation