Measuring Breathing Pattern in Patients With Chronic Obstructive Pulmonary Disease by Electrical Impedance Tomography

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ABSTRACT

Background and Objective: The measurement of breathing pattern in patients with chronic obstructive pulmonary disease (COPD) by electrical impedance tomography (EIT) requires the use of a mathematical calibration model incorporating not only anthropometric characteristics (previously evaluated in healthy individuals) but probably functional alterations associated with COPD as well. The aim of this study was to analyze the association between EIT measurements and spirometry parameters, static lung volumes, and carbon monoxide diffusing capacity (DLCO) in a group of male patients to develop a calibration equation for converting EIT signals into volume signals.

Materials and Methods: We measured forced vital capacity (FVC), forced expiratory volume in 1 second (FEV1), FEV1/FVC, residual volume, total lung capacity, DLCO, carbon monoxide transfer coefficient (KCO) and standard anthropometric parameters in 28 patients with a FEV1/FVC ratio of <70%. We then compared tidal volume measurements from a previously validated EIT unit and a standard pneumotachometer.

Results: The mean (SD) lung function results were FVC, 72 (16%); FEV1, 43% (14%); FEV1/FVC, 42% (9%); residual volume, 161% (44%); total lung capacity, 112% (17%); DLCO, 58% (17%); and KCO, 75% (25%). Mean (SD) tidal volumes measured by the pneumotachometer and the EIT unit were 0.697 (0.181) L and 0.515 (0.223) L, respectively (P<.001). Significant associations were found between EIT measurements and CO transfer parameters. The mathematical model developed to adjust for the differences between the 2 measurements (R2=0.568; P<.001) was compensation factor=1.81 – 0.82 × height (m) – 0.004×KCO (%).

Conclusions: The measurement of breathing pattern by EIT in patients with COPD requires the use of a previously calculated calibration equation that incorporates not only individual anthropometric characteristics but gas exchange parameters as well.

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Introduction

The measurement, and, in particular, the monitoring of breathing pattern for long periods of time are processes that respiratory medicine has not yet fully resolved. Pneumotachography, which is the current method of choice, alters breathing dynamics as it requires the use of a mouthpiece or a mask. Alternative methods, in particular respiratory-inductive plethysmography, have been all but abandoned because of calibration problems, which in many cases, are unsurmountable. Another more recently proposed alternative is the use of vibration response imaging, although further analysis of this system for measuring breathing pattern over long periods of time is required. Studies of the use of electrical impedance tomography (EIT) to measure single lung function and, more recently, breathing pattern in healthy individuals have shown that system calibration is a major problem in EIT as well.

EIT converts an output impedance signal into a series of chest images, which must subsequently be converted into a volume signal. This conversion requires the use of mathematical models that incorporate key anthropometric variables for the individual being studied. Our studies of healthy individuals have shown that these variables are sex (calibration is more difficult in female patients), skinfold thickness (front, side, back, and subscapula), and chest circumference (different fat distribution and presence of mammary glands).

Our initial observations in patients with respiratory disease indicated that the calibration of EIT units would be further complicated by internal chest alterations, which, like external factors, vary from patient to patient. The presence and extent of air trapping in

Materials and Methods

EIT-4

The EIT-4 is a fourth-generation EIT prototype unit designed by the electronic engineering department at Universitat Politécnica de Catalunya, Spain. It permits the recording of volume-time signals from a sequence of images obtained using 16 electrodes (Red Dot 2560; 3 M, London, Ontario, Canada) arranged on the chest of the individual being studied.

The images are obtained following the injection of a 1-mA current at a frequency of 48 kHz through the 16 electrodes. The current is routed to a pair of multiplexers, which subsequently inject the current into the individual’s body through a pair of electrodes. Using a special detector system, the other electrodes sequentially measure the voltages generated on the chest surface. Once the measurements have been recorded for this pair of electrodes, the injection and detection points are moved to an adjacent pair of electrodes and a new cycle begins. This procedure is repeated until all the electrodes have been used as injectors and detectors. The EIT-4 has been tested in previous studies and is used for other measurements at the lung function laboratory at our center.

The procedure described produces a matrix of surface transconductances, which are converted into regional changes in conductivity inside the body using an appropriate reconstruction algorithm. Finally, the scale of impedance values must be individualized as these values, as has already been mentioned, vary according to the physical characteristics of each person. The tidal volume for healthy males is thus estimated using the following formula:

$$\Delta V_{male} = (\Delta IC)/(2908 - 13.2 \times W(kg) - 3.7 \times SS_{Sk} (mm))$$

Where $\Delta IC$ is the sum of the conductivity changes in the region studied, $W$ is the weight, and $SS_{Sk}$ is the subcapular skinfold.

Volunteers

We studied 28 men with an existing diagnosis of COPD (forced expiratory volume in 1 second [FEV$_1$]/forced vital capacity [FVC] <70%) who were consecutively enrolled as they visited our laboratory for lung function tests. All the tests were performed between 9 AM and noon in a quiet room at sea level with an ambient temperature of 25°C and a relative humidity of 60%. The patients all voluntarily consented to participate in the study, which had been previously approved by the ethics committee at our center.

Procedure

The pneumotachometer and the EIT-4 were mounted in parallel and operated independently of each other, with no mutual influence. Prior to use, they were calibrated as follows:
• The pneumotachometer was calibrated using a 3-L gas syringe in accordance with standard laboratory protocols (acceptable deviation, <1%).
• The EIT-4 was calibrated using a previously validated equation for healthy individuals.\(^6\,\!^7\) Finally, image capture speed (16-18 images per second) was tested at the moment of measurement.

Before each measurement, we recorded anthropometric data (age, weight, height, and body mass index) and measured skinfolds (front, side, back, and subscapula) using electronic skinfold calipers. We then performed the corresponding lung function tests (spirometry, static lung volumes, and carbon monoxide transfer), and finally, following a 15-minute rest period, proceeded to measure breathing pattern. For each patient, once the 16 electrodes had been positioned and the units calibrated and connected, 3 different readings were recorded and stored in txt- and asc-extension files for subsequent processing. Tidal volume measurements over periods of 30 seconds (between 5 and 8 respiratory cycles) were recorded both graphically and numerically, with a 3-minute interval between measurements. A total of 20 to 25 cycles were recorded for each patient.

Statistical Analysis

Data were expressed as means (SD), and pneumotachometer and EIT-4 measurements were compared using the \(t\) test for nonparametric variables. Relationships between variables were analyzed using the Spearman correlation coefficient and differences in tidal volume measurements were evaluated using Bland-Altman analysis. Statistical significance was set at a value of \(P\) less than .05 in all cases. Finally, all the variables were studied using multivariate regression analysis to obtain an equation model that could be used to calibrate the EIT-4 for patients with COPD.

Results

The mean (SD) anthropometric parameters for the series (which included men only) were an age of 69 (9) years, a height of 1.65 (0.07) m, a weight of 76 (12) kg, and a body mass index of 28 (4.2) kg/m\(^2\). The skinfold measurements were 23 (6) mm (front), 25 (8) mm (side), 24 (8) mm (back), and 26 (9) mm (subscapula).

FVC and FEV\(_1\) values were 72% (16%) and 43% (14%) of predicted, respectively, and the FEV\(_1)/FVC ratio was 42% (9%). For the 22 patients in whom we were able to measure static lung volumes, we found a mean residual volume of 161% (44%) of predicted and a total lung capacity of 112% (17%) of predicted. Based on CO transfer measurements performed in 19 patients, we found a mean carbon monoxide diffusing capacity (DLCO) of 58% (17%) of predicted and a CO transfer coefficient (KCO) of 76% (25%) of predicted (Table 1).

Mean tidal volume measured by the pneumotachometer and the EIT-4, respectively, was 0.697 (0.181) L and 0.515 (0.223) L (\(P<.001\)). The mean of the differences between the measurements obtained using both units was 0.182 (0.125) L, with a Spearman correlation coefficient of \(r=0.825\ (P<.01)\).

The correlation between the lung function parameters studied and the impedance index, together with the differences in tidal volume measurements from both units, are shown in Table 2. Statistically significant correlations were found between the impedance index and FEV\(_1)/FVC, DLCO, and KCO on the one hand and between the difference in tidal volume measurements from the 2 systems and DLCO and KCO, on the other.

The Figure shows the differences in tidal volume measurements from both units with respect to values obtained using the pneumotachometer. The mean of the differences was 0.432 L, with limits of agreement ranging from +0.422 to –0.068 L. All the measurements fell within this interval. Nonetheless, this mean difference can be corrected using the following expression: \(R=0.568, P<.01\).

Differences \(= 1.81 - 0.82 \times \text{height (cm)} - 0.004 \times \text{KCO (\%)}\)

The estimation for COPD patients would therefore be as follows:

\[ \Delta V_{\text{COPD}} = \Delta V_{\text{min}} + \text{Differences} \]

Discussion

The findings of the present study indicate not only that tidal volume measured by EIT in patients with COPD should be adjusted for external factors (basically height) but also that lung alterations,
expressed in terms of reduced gas exchange area, change the value of the EIT signal recorded.

These conclusions are essentially based on the association observed between the overall impedance value and variables that reflect the size of the gas exchange area. Although we also observed a significant relationship between impedance and airflow obstruction, this parameter was not included in the final equation. No significant correlation was found between impedance and residual volume, indicating that air trapping, regardless of its extent, does not have a significant effect on the transmission of the electrical signal.

While tidal volume measurements obtained using both the pneumotachometer and the EIT-4 were, logically, significantly associated, the distribution of these measurements on a Bland-Altman plot (Figure) shows that almost all of the EIT measurements were lower than those obtained using the pneumotachometer. Furthermore, the difference between the measurements was statistically significant. Nonetheless, as shown in the multivariate equation, this difference can be compensated for with a mathematical process that corrects this practically systematic error.

The main problem associated with using EIT to measure tidal volume during breathing at rest lies in the difficulty of calibrating the electrical signal and obtaining a comparable and lasting volume signal. Anthropometric parameters, and particularly those that refer to the chest (skinfolds and weight) must be taken into account when adjusting EIT measurements in healthy individuals. The complexity of the methods described, and finally, the need to find a simple solution to adjust EIT measurements to changes in lung volume. The only efforts made in this respect in recent years have been by Nebuya et al. and Zlochiver et al. Our findings are both novel and practical as our method involves the use of simple variables (anthropometric data) and basic lung function parameters, readily available for patients with COPD. They do, however, need to be validated in a second group of patients with COPD and similar physical characteristics.

The behavior of an electric current flowing through body tissue is influenced by the characteristics of the current. A wide range of factors such as the distribution of body fat around the chest, lung volume, skin rigidity, height, and weight all influence current transmission, and consequently, changes in tissue impedance. Other factors that occur within the chest in different diseases, such as rigidity, obstruction, and air trapping, can also alter current flow. This complicates the matter of calibration even further as different diseases alter lung tissues in a different manner, meaning that separate calibration systems would be required for different types of disease.
One solution would be to use EIT to monitor breathing pattern only and not to measure volume. Given the lack of a simple, quick procedure that could be used to evaluate from the outset the main variables that might modify current flow through the chest, EIT should be used only to assess changes over time, regardless of true tidal volume. An alternative would be to perform measurements simultaneously with an EIT unit and a pneumotachometer, but this would not eliminate the need for consecutive measurements over a long period of time.

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