Lung volumes and distensibility, and maximum respiratory pressures in thyroid disease before and after treatment

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Freedman, S (1978). Thorax, 33, 785-790. Lung volumes and distensibility, and maximum respiratory pressures in thyroid disease before and after treatment. Lung volumes, static pressure volume curves of the lung, and maximum respiratory pressures were measured in six patients with thyrotoxicosis and three with myxoedema before and after treatment. After treatment three of the thyrotoxic patients had increases in vital capacity of the same order as previously reported, but in contrast to previous reports, the lung volume changes were not associated with, nor due to, concomitant changes in respiratory muscle performance. Static pulmonary compliance increased in four of the six patients. The initial findings were more in keeping with the presence of pulmonary congestion. Only one of the myxoedematous patients had any significant increase in vital capacity after treatment, and in her case this was clearly attributable to increased inspiratory muscle force.

A reduced vital capacity (VC) in patients with thyrotoxicosis was first noted in 1917 by Peabody and Wentworth who examined seven such patients and found that two of them had a VC less than 80% of predicted normal. This observation was confirmed by Rabinowitch (1923) and Lemon and Moersch (1924). The reduction in VC is reversible with successful treatment and is associated with, and attributed to, weakness of the respiratory muscles with reduced maximum respiratory pressures (Stein et al, 1961; Wasserman 1962). The only previous measurements of static pulmonary compliance were by Massey et al (1967) who found that in most cases it was normal although reduced in those patients with the biggest reductions in VC. Stein et al (1961) reported big reductions in dynamic compliance in contrast to McIlroy et al (1956) who found it to be normal in two patients.

In myxoedema, uncomplicated by obesity or respiratory disease, VC has been found to be normal (Wilson and Bedell, 1960).

The objects of the present study were to measure the elastic properties of the lungs and the performance of the respiratory muscles in thyrotoxicosis and myxoedema before and after treatment. A brief report has been published (Freedman, 1977).

Methods

Six patients with thyrotoxicosis and three with myxoedema were studied. They all agreed to take part in the experiments after it had been explained that none of the procedures formed a necessary part of their treatment. Some clinical and biochemical details are given in the table. Initial studies were carried out within a week or two of the diagnosis being established and before specific treatment was started, although the four patients (Wa, Wi, De, Lu) who presented with fast atrial fibrillation or cardiac failure, or both, received digoxin or diuretics and had a period of bed rest before the initial studies. In all cases this successfully reversed any clinical or radiological signs of cardiac failure before the initial studies.

The patients were studied again three to four months later after appropriate treatment (carbamazole or l-thyroxine) and when they were clinically and biochemically euthyroid. Patient De was studied three times—initially on admission to
hospital when she was in cardiac failure and on a further two occasions as described above. The only patient with an associated disease that affected his results was Wa who had moderately severe airways obstruction due to chronic bronchitis.

At each visit, lung volumes, static expiratory pressure-volume curves (PV curves) of the lung, and maximum respiratory pressures were measured.

Forced expiratory volume in one second (FEV₁) and VC were measured on a Vitalograph dry spirometer, with the patients seated. Residual volume was measured by closed circuit helium dilution. Duplicate measurements were made and the results required to agree within 10%. Oesophageal pressures were measured using 10 cm long oesophageal balloons mounted on polyethylene catheters (Milic-Emili et al, 1964) with the tip of the balloon being passed to a depth of 40–45 cm from the nares. The exact depth to which the balloon was passed at the first study was noted and was used again at the second visit. Balloon technique was otherwise as described by Milic-Emili et al, and pressures were measured using a Hewlett-Packard 267B transducer and displayed on the same manufacturers' four-channel recorder together with lung volume changes that were measured using a water spirometer. Static expiratory PV curves were measured by sequential interruption of airflow at the mouth during an expiration from total lung capacity (TLC). Each expiration was preceded by two vital capacity breaths. Sufficient measurements were taken to obtain at least three PV curves that agreed closely, and these were averaged by eye. In two cases (De and Lu) compliance was measured during a slow but uninterrupted expiration because the patients could not co-operate (quasi-static).

Maximum inspiratory and expiratory pressures were measured from the oesophageal balloon, using pleural-to-atmospheric pressure differences. For these measurements, balloon volume was increased to 1 ml. Measurements were made at various lung volumes until the maximum pressures that could be sustained for at least two seconds were obtained with the patients either sucking or blowing against a closed tap. In practice the biggest pressures were found at volumes close to FRC, and it was found helpful to have a pinhole in the mouthpiece and to remove the noseclip during these manoeuvres. Normal values were taken from Cotes (1975).

**Results**

Some anthropometric data, thyroid function tests, and results before and after treatment are presented in the table.

Of the six thyrotoxic patients, only three had appreciable increases in VC with successful treatment. These improvements in VC were achieved largely at the expense of residual volume in De and by increases in TLC in Wi and Jo. Changes in maximum respiratory pressures in all the thyrotoxic patients were inconsistent and unrelated to changes in thyroid function or lung volumes. Generally, maximum pressures were below the normal ranges of Black and Hyatt (1969) even when the patients were euthyroid.

PV curves of the thyrotoxic patients are shown in fig 1. In the three patients who increased their VC (upper 3 panels) successful treatment was accompanied by a shift of the curve to a higher lung volume and with a steeper slope. The slopes were assessed by measuring static compliance between FRC and 0–5 l above it before treatment and at the same lung volume after treatment. There were significant increases in compliance in four of the six patients and these were clearly related to changes in VC (fig 2) excepting Wa in whom the VC was probably more dependent on his airways obstruction than anything else. In De, a quasi-static PV curve was obtained shortly after admission when she was in congestive and left ventricular heart failure. The three PV curves on this patient show a progressive increase in TLC, steepening of slope, and reduction in recoil pressure at TLC.

Of the three myxoedematous patients, only one (Lu) showed any changes between the first and second measurements (fig 3 and table ). She had a big increase in TLC (1·08 l) and VC (0·55 l) with RV/TLC ratio staying almost the same. Maximum respiratory pressures were increased when she was euthyroid, as was recoil pressure at TLC, although the slope of the PV curve was unchanged.

**Discussion**

The initial VC in the six thyrotoxic patients averaged 81% of predicted normal, which is comparable with the mean pretreatment value reported by Stein *et al* (1961) (87%), Wassermann (1962) (88%), and Massey *et al* (1967) (76%). Three of these six patients showed improvements in VC after treatment comparable with those reported by Stein *et al* and by Wasserman, which were on average 0·40 l and 0·26 l respectively, while Richards *et al* (1953) found a mean increase of 0·27 l in 10 patients.

The previous workers found that there were concurrent increases in maximum respiratory pres-
Lung volumes and distensibility, and maximum respiratory pressures in thyroid disease

Fig 1  Static expiratory pressure-volume curves in thyrotoxic patients before —— and after - - - - treatment. In patient De, two sets of measurements were made before treatment: a quasi-static measurement (no 1) when she was in cardiac failure and a static curve (no 2) when the failure had been resolved but before specific treatment.

Fig 2  Relationship between changes in vital capacity and changes in static pulmonary compliance with treatment in thyrotoxic patients.

su(res and consequently attributed the fall in VC in thyrotoxicosis to a myopathy affecting the respiratory muscles. In the present study, changes in maximum respiratory pressures were small and inconsistent and clearly unrelated to changes in VC. Additional evidence against muscle weakness as the cause of the low initial VCs in the present study is provided by the static lung PV curves.

If there had been significant improvements in respiratory muscle performance with successful treatment of thyrotoxicosis there should have been big increases in static recoil pressures at TLC, together with increased TLC and static compliance (Gibson and Pride, 1976; Gibson et al, 1977), but pressures at TLC were the same or smaller after treatment.

An alternative explanation for the changes in lung volume and the PV curve is that they were due to pulmonary vascular engorgement. The pre-and post-treatment PV curves closely resemble those of patients with cardiac failure compared
with normal subjects reported by Brown et al (1954) and those of patients with atrial septal defect and pulmonary hypertension reported by De Troyer et al (1977). Von Basch is credited by Gibson and Pride (1976) with first describing the effects of vascular engorgement on the PV curve—namely, a reduction in lung volumes and distensibility above FRC and a reduced recoil pressure with slightly increased volumes below FRC. I was unable to obtain many measurements below FRC but the size and direction of the changes in the PV curves is otherwise compatible with this explanation, which has the additional merit of fitting in with the known effects of thyrotoxicosis on the pulmonary circulation, which are to increase pulmonary blood flow with a proportional increase in pulmonary artery pressure (Bishop et al, 1955).

Although two of the three patients with appreciable increases in vital capacity were in cardiac failure at the time of presentation, changes in static compliance were not confined to these two patients and, moreover, the clinical signs of failure had resolved with treatment before the initial studies. Thus if pulmonary congestion was the explanation for the changes in the PV curve it can be present without overt signs of cardiac

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**Table Lung function in patients with thyroid disease**

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age (cm)</th>
<th>Height (cm)</th>
<th>FEV₁</th>
<th>VC</th>
<th>TLC</th>
<th>RV</th>
<th>Cst (l) ml/cm H₂O</th>
<th>Max pleural pressures (cm H₂O)</th>
</tr>
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<tr>
<td>Ro</td>
<td>F</td>
<td>46</td>
<td>147</td>
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<td>9</td>
<td>8.7</td>
<td>66</td>
<td>85</td>
<td>145</td>
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<tr>
<td>Wa†</td>
<td>M</td>
<td>63</td>
<td>175</td>
<td>24.0</td>
<td>11</td>
<td>5.2</td>
<td>46</td>
<td>45</td>
<td>261</td>
</tr>
<tr>
<td>Wi*</td>
<td>F</td>
<td>69</td>
<td>167</td>
<td>27.5</td>
<td>9</td>
<td>8.7</td>
<td>103</td>
<td>110</td>
<td>180</td>
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<tr>
<td>Du</td>
<td>F</td>
<td>68</td>
<td>155</td>
<td>27.1</td>
<td>6</td>
<td>4.7</td>
<td>97</td>
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<tr>
<td>Jo</td>
<td>F</td>
<td>53</td>
<td>168</td>
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<td>6.7</td>
<td>70</td>
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<td>F</td>
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<td>157</td>
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<td>(45)</td>
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<td>88</td>
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<tr>
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<td>F</td>
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<td>8</td>
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<td>91</td>
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<tr>
<td>Lu†</td>
<td>F</td>
<td>72</td>
<td>176</td>
<td>2.4</td>
<td>4</td>
<td>10.2</td>
<td>64</td>
<td>77</td>
<td>132</td>
</tr>
</tbody>
</table>

**A Hyperthyroid patients**

**B Hypothyroid patients**

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*In cardiac failure at time of presentation.
†In atrial fibrillation at time of presentation.

For all patients, data before and after treatment are given in each column, the first of each pair of figures being pretreatment.

All lung volumes reported as % predicted normal values. Normal range for free thyroxine Index is 4.2-15.0.

Figures in parenthesis for patient De refer to first study on admission when she was in congestive heart failure. The second study was done a week later after treatment with digitalis and diuretics.
Lung volumes and distensibility, and maximum respiratory pressures in thyroid disease

789

cation from their measurements of maximum inspiratory flow rate of an improvement in respiratory muscle performance with treatment. Additional information is provided by Weg et al (1965) who reported one obese myxoedematous patient in respiratory failure but with normal lung volumes and by Burack et al (1971) who found no change in VC after treatment in five patients.

It thus appears that some non-obese patients with uncomplicated myxoedema may have a low VC that improves with treatment while others have normal lung volumes. The low VC is certainly attributable to respiratory muscle weakness in patient Lu and this would be a feasible mechanism for the reduction in VC previously reported, but the evidence is inconclusive. The position is certainly less clearly defined than has been stated (Bates et al, 1971), both for myxoedema and thyrotoxicosis. The present results in thyrotoxicosis support the view of Lemon and Moersch (1924):

“As to the primary fundamental physicochemical cause of the decreased vital capacity in hyperthyroidism, we are still uncertain and must await further investigation. However, we believe the secondary and direct cause is the cardiac inefficiency which arises from the primary source, the thyroid.”

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References


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