Lung function in adult idiopathic scoliosis: a 20 year follow up

Kerstin Pehrsson, Björn Bake, Sven Larsson, Alf Nachemson

Abstract
Severe idiopathic scoliosis may lead to respiratory failure, which can be treated by assisted ventilation. Twenty four patients with surgically untreated idiopathic scoliosis who had been examined in 1968 were re-examined in 1988 to assess changes in lung function and risk factors for respiratory failure. The patients were aged 15-67 years in 1968 and had a scoliotic angle of 10-190° and a vital capacity of 1.0-6.0 litres. Spirometric values and scoliotic angles were determined in 1968 and 1988, and arterial blood gas tensions in 1988. The decline in spirometric values over the 20 years was of the same magnitude as the predicted decline due to aging. Arterial blood gas tensions in 1988 were strongly correlated with the scoliotic angles and spirometric indices recorded in 1968. Hypoxaemia and hypercapnia was seen in four patients in 1988 (then aged 43-67 years) and these were the four patients who had a vital capacity below 43% predicted in 1968. The remaining 20 patients had blood gas values within normal limits. Two further patients had died from respiratory failure before 1988, so a total of six patients had developed respiratory failure. In a multiple logistic analysis vital capacity expressed as % predicted in 1968 was the strongest predictor of the development of respiratory failure, followed by the scoliotic angle. Respiratory failure occurred only in patients who had a vital capacity below 45% predicted in 1968 and an angle greater than 110°. Thus respiratory failure develops in adults with scoliosis with a large angle and a low vital capacity when normal aging reduces the ventilatory capacity further. Such individuals merit close follow up.

Patients with untreated scoliosis run an increased risk of developing respiratory failure1-3 and of premature death.4,5 Surgical treatment with Harrington instrumentation and fusion has been used in Sweden since 1965. In these patients the risk of severe impairment of lung function6 is low. There are still patients older than 40 years, however, who have not undergone surgery and who run an increased risk of developing respiratory failure. We decided to study the long term changes in lung function and its relation to respiratory failure in patients with untreated idiopathic scoliosis.

In 1968 a group of patients with scoliosis was studied in Göteborg and scoliotic angles, lung function, and respiratory symptoms were assessed.6,7 We have now re-examined those with unfused idiopathic scoliosis and analysed the data on change in lung function, presence of respiratory failure, and death. The purpose was to investigate the decline in lung function and to identify risk factors for the development of respiratory failure.

Methods
PATTERNS
The patients in the present study were taken from a group of 45 patients with scoliosis studied in 1968 by Bjure7 et al and Bake et al.8

Between 1968 and 1988 eight patients died, all with unfused idiopathic scoliosis. Two patients could not be traced, one patient did not wish to take part in the present investigation, and seven patients born in the 1940s or 1950s had undergone spinal fusion. Three were excluded because they had paralytic scoliosis. Hence 24 patients with unfused idiopathic scoliosis remained for follow up in 1988.

The age of the 24 patients ranged from 15 to 67 years in 1968, the scoliotic angles from 10° to 190° and the vital capacity from 1.0 to 6.0 litres.

The scoliotic curves were classified as thoracic if the apical vertebra was between the third and 10th thoracic vertebrae and as thoracolumbar if the apex of the curve was between the 11th thoracic and the second lumbar vertebrae. No pure lumbar curves were seen but one patient had a double primary curve.

STUDY PROTOCOL
In both 1988 and 1968 we elicited (1) scoliotic angles; (2) respiratory symptoms and smoking habits according to a questionnaire; (3) quasi-static vital capacity (VC), functional residual capacity (FRC), residual volume (RV), total lung capacity (TLC), and forced expiratory volume in one second (FEV1). 1988 we obtained in addition (1) diagnoses according to death certificates; (2) available case records; (3) VC in supine position, maximal inspiratory pressure (MIP), maximal expiratory pressure (MEP), and arterial blood gas tensions.
Lung function in adult idiopathic scoliosis: a 20 year follow up

Table 1  Lung function results obtained in 1968 and in 1988 in 24 patients with unfused idiopathic scoliosis

<table>
<thead>
<tr>
<th></th>
<th>1968</th>
<th>1988</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean SD n</td>
<td>Mean SD n</td>
</tr>
<tr>
<td>VC (%)</td>
<td>25 12 20</td>
<td>21 1 20</td>
</tr>
<tr>
<td>VC pred</td>
<td>65 24 20</td>
<td>64 27 20</td>
</tr>
<tr>
<td>FEV1</td>
<td>2.0 0.9 16</td>
<td>2.0 0.8 16</td>
</tr>
<tr>
<td>FRC (%)</td>
<td>1.3 0.5 16</td>
<td>1.6 0.5 16</td>
</tr>
<tr>
<td>TLC (%)</td>
<td>3 7 1.7 16</td>
<td>3.9 1.5 16</td>
</tr>
<tr>
<td>VC supine (%)</td>
<td>2 0 1.5 20</td>
<td>2 0 1.5 20</td>
</tr>
<tr>
<td>MIP (%)</td>
<td>47 28 20</td>
<td>51 29 20</td>
</tr>
<tr>
<td>MEP (%)</td>
<td>10 4 1.9 24</td>
<td>10 4 1.9 24</td>
</tr>
<tr>
<td>Paco2 (kPa)</td>
<td>5 5 1.0 24</td>
<td>25 4 3.0 24</td>
</tr>
</tbody>
</table>

VC — vital capacity; FEV1 — forced expiratory volume in one second; FRC — functional residual capacity; RV — residual volume; TLC — total lung capacity; MIP — maximum inspiratory pressure; MEP — maximum expiratory pressure; Paco2 — arterial carbon dioxide tension.

Determination of the degree of scoliosis (Cobb)

The scoliotic angle was determined by the same orthopaedic surgeon in 1988 as in 1968. Determination of the apical vertebra and angle was made according to the method of Cobb from radiographs taken in the standing position.

Lung function investigation

Static lung volumes were determined by the helium dilution technique. FEV1 and VC were measured with a water spirometer (Bernstein) in the sitting position on both occasions and in the supine position in 1988. The same laboratory technician performed the investigations in 1968 and 1988. Normal values were predicted according to formulae from Berglund et al. and were corrected for VC for loss of height due to scoliosis according to the formula of Lindh and Bjure.

Maximal inspiratory pressure and maximal expiratory pressure were obtained at FRC. Normal values were predicted from Decramer et al. and Lurie et al.

Arterial blood gas measurements, including oxygen tension (Pao2), carbon dioxide tension (Paco2), and standard bicarbonate, were determined (Radiometer ABL2) in samples of blood obtained from the patient when semirecumbent after 10 minutes' rest. Respiratory failure was defined as Pao2 below 8 kPa or Paco2 above 6.5 kPa, or both.

Statistics

Fisher’s non-parametric permutation test was used for comparison between groups. A multivariate analysis of predictors for respiratory failure was carried out with a stepwise logistic model.

Results

The eight patients studied in 1968 (five women and three men) who had died during the follow up period had a mean age at death of 67 years. Respiratory failure due to scoliosis was the cause of death in two patients (aged 54 and 75 years) according to their death certificates and case records. They are included in the analysis of risk for development of respiratory failure (see below). The mean age of the 24 patients at follow up in 1988 was 62 years. There were 20 women and four men. Twenty of the 24 patients were able to complete the study protocol and four patients cooperated only with the blood gas determination.

Measurements performed in 1988 (Table 1, Fig 1).

Mean VC was 2.1 litres (64% predicted) and mean TLC 3.9 litres (75% predicted).

Respiratory failure was present in four of the 24 patients. Their blood gas values showed a combination of a low Pao2 (5.9–7.7 kPa) and an increased Paco2 (6.4–8.6 kPa).

Mean supine VC was 2.0 l in the 20 patients who were able to cooperate. In three patients

Figure 1 Individual results of some lung function tests from 1988 expressed as % predicted. The horizontal lines give mean values. The four patients with respiratory failure (*) are in the low range, especially with regard to vital capacity (VC) and total lung capacity (TLC). FEV1—forced expiratory volume in one second as percentage of VC; MIP—maximum inspiratory pressure; MEP—maximum expiratory pressure.
VC fell by more than 15% on lying supine (VC sitting - VC supine) x 100/VC sitting).

MIP and MEP showed a wide variation (fig 1). Mean MIP was 47% of predicted (range 11-124%), and mean MEP 51% of predicted (range 5-97%). There was no significant correlation between arterial blood gas tensions in 1988 and MIP or MEP.

COMPARISON BETWEEN RESULTS IN 1968 AND IN 1988
The scoliotic angle increased in four patients (from 30° to 40°, 40° to 70°, 40° to 55°, and 100° to 125°) and was unchanged in the rest of the group. This resulted in a mean (SD) increase from 79° (49°) to 86° (46°).

The respiratory symptoms and smoking habits, reported in the questionnaires in 1968 and 1988 by 14 patients (it was possible to trace only 14 questionnaires from 1968), are summarised in table 2. Wheezing and dyspnoea were common symptoms on both occasions; the number of smokers had decreased considerably by 1988.

The mean decline in both VC and FEV1 was 0.4 l (table 1).

PROGNOSTIC IMPORTANCE OF RESULTS OBTAINED IN 1968
Arterial blood gas tensions obtained in 1988 are plotted in figure 2 against the scoliotic angles and VC % predicted determined in 1968. Both scoliotic angles and spirometric results showed strong non-linear correlations with blood gas tensions (p < 0.001). There is a threshold value for the development of respiratory failure at a VC recorded in 1968 of around 43%. The four patients with a VC below 43% predicted
Lung function in adult idiopathic scoliosis: a 20 year follow up

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Comparison between various variables determined in 1968 in patients with and without respiratory failure in 1988</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respiratory failure (n = 6)</td>
</tr>
<tr>
<td></td>
<td>No respiratory failure (n = 20)</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
</tr>
<tr>
<td>Angle (°)</td>
<td>137</td>
</tr>
<tr>
<td>VC (l)</td>
<td>1.3</td>
</tr>
<tr>
<td>VC (% pred)</td>
<td>76</td>
</tr>
<tr>
<td>VC (% pred, no correction*)</td>
<td>41</td>
</tr>
<tr>
<td>FEV(1)</td>
<td>1.1</td>
</tr>
<tr>
<td>TLC (l)</td>
<td>2.3</td>
</tr>
<tr>
<td>Dyspnoea</td>
<td>3.2</td>
</tr>
<tr>
<td>Wheezing</td>
<td>1.0</td>
</tr>
</tbody>
</table>

*For loss of height due to scoliosis.

\( n = 4 \) and 17. 

\( n = 6 \) and 15. Dyspnoea was ranked from 1 to 5, with increasing severity. Absence of wheezing was graded as 0 and wheezing as 1.

\( FRC, RV, \) and smoking habit differences were non-significant.

Abbreviations as in table 1.

in 1968 had hypoxaemia and hypercapnia in 1988. The remaining 20 patients had normal PaO2 and PaCO2 values.

Six of the patients (two dead and four living) with unfused idiopathic scoliosis developed respiratory failure during the follow up period; 20 patients remained without respiratory failure. The results of the analysis designed to predict the development of respiratory failure are as follows.

A univariate analysis between respiratory failure and the different variables obtained in 1968 was carried out initially and showed that large angle, low spirometric values and low TLC were strong predictors of the development of respiratory failure (table 3). When respiratory symptoms and smoking habits in 1968 were related to respiratory failure there was a statistical correlation for dyspnoea and wheezing but not for smoking habits.

The relative order of importance of the different risk factors was then described on the basis of a multivariate stepwise logistic analysis. VC % predicted in 1968 was the strongest predictor and was the only variable selected by this procedure. This variable correctly predicted the presence or absence of respiratory failure in 1988 in all patients. The scoliotic angle in 1968 classified 25 of 26 patients correctly. The spirometric results and the angle were highly correlated; hence they excluded each other in the multivariate analysis.

Discussion

The lung function results recorded in 1988 in this study are in line with results reported by other investigators in cross sectional studies of patients with idiopathic scoliosis. The scoliosis was classified as idiopathic on the basis of a detailed clinical examination. We found restrictive ventilatory impairment with low mean VC and TLC (table 1, fig 1). These measurements were strongly and inversely related to the scoliotic angle. There was a wide range of MIP and MEP in our patients (table 1, fig 1), as in the normal population. The mean values were reduced, however, to 47% and 51% predicted, indicating low respiratory muscle efficiency in our patients. This is also in line with results of other studies. The mechanical efficiency of the respiratory muscles, especially the diaphragm, is probably reduced by the unfavourable position of the diaphragm in a severely distorted chest. Lisboa et al found a significant correlation between MIP and both PaO2 and PaCO2 in patients with severe scoliosis. The present study did not confirm those results, as we found no correlation between blood gases and either MIP or MEP.

The strongest predictors of respiratory failure in 1988 were a large scoliotic angle and low spirometric results in 1968. The patients in this study had reached skeletal maturity in 1968 without developing respiratory failure. In such patients respiratory failure might develop when there is a further reduction of VC. Theoretically VC might deteriorate in these patients more rapidly than in people without scoliosis because of increasing deformity of the chest or other factors, or it might decline as expected as a result of aging.

In the present study there was no support for the first possibility. None of the patients who developed respiratory failure had progression of the thoracic curves. Increasing curves have been reported by Weinstein and Ponsetti, especially in the apical curves that had reached 50–80° at skeletal maturity. Our results show that respiratory failure may develop despite an unchanged scoliotic angle.

An exaggerated decline in VC due to other factors might also in some cases lead to respiratory failure. This was suggested by Branthwaite, who retrospectively collected lung function values from a group of patients with idiopathic scoliosis. Two patients (fig 3) in the present study showed an exaggerated decline of spirometric values despite an unchanged scoliotic angle. In one the decline might be related to the scoliotic process as she had reduced mobility of the right hemidiaphragm and a large diaphragmatic hernia. Poor diaphragmatic function in this patient might be related to the scoliosis. The other patient was an obese smoker.

The expected reduction of VC resulting from increasing age might provoke respiratory failure in patients with severe idiopathic scoliosis. In our study the patients as a group showed only age predicted changes between 1968 and 1988 (table 1) and the same is true for the patients who developed respiratory failure (fig 3). The expected decline due to increasing
Failure (broken lines) 3 measurements capacity (VC) and forced patients with respiratory failure (broken lines) started with the lowest values and declined according to the age prediction.

The study was supported by the Swedish Heart-Lung Foundation and the Göteborg Medical Society. We thank laboratory technician Eivör Jonasson for her skilful technical assistance and Nils-Gunnar Pehrsson for expert statistical guidance.

Lung function in adult idiopathic scoliosis: a 20 year follow up.

K Pehrsson, B Bake, S Larsson and A Nachemson

doi: 10.1136/thx.46.7.474