Variability of relaxed expiratory volume and forced inspiratory volume

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Measurements of relaxed expiratory volume in one second (REV\textsubscript{1.0}) and forced inspiratory volume in one second (FIV\textsubscript{1.0}) were made on 50 subjects on two occasions to know the variability of these procedures in the individual subject. The mean coefficients of variation for REV\textsubscript{1.0} and FIV\textsubscript{1.0} were 6.74\% and 8.92\%, respectively. The 95\% confidence limit of difference between highest readings obtained on two occasions for REV\textsubscript{1.0} and FIV\textsubscript{1.0} was 0.38 litre and 0.214 litre, respectively. These results compare favourably with similar data reported for other ventilatory tests. We feel that if a little time is spent teaching subjects to produce REVs, then reproducible results may be obtained.

Tracheobronchial collapse during forced expiratory manoeuvres has been shown to occur in some cases of obstructive airway disorders (Dayman, 1951; Gandevia, 1963; Campbell and Faulks, 1965). In addition to other conventional procedures, it has been suggested that in such cases, tests of sub-maximal expiratory effort, i.e., one-second relaxed expiratory volume (REV\textsubscript{1.0}) (Gandevia, 1963; Tandon and Campbell, 1968), and tests involving forced inspiration, i.e., one-second forced inspiratory volume (FIV\textsubscript{1.0}) (Tandon and Campbell, 1968) and peak inspiratory flow rate (Saunders, 1967), should be used.

However, REV\textsubscript{1.0} is difficult to perform properly and FIV\textsubscript{1.0} is effort dependent. Hence these tests may not be so reproducible as tests of forced expiration, which are to some extent independent of the effort applied (Fry and Hyatt, 1960). Therefore, before these two tests can be recommended for general use, their variability should be known. An attempt has been made to determine the variability of REV\textsubscript{1.0} and FIV\textsubscript{1.0} in the individual subject.

SUBJECTS AND METHODS

Fifty subjects from the staff of R.G.H., Heidelberg, Victoria, and the persons attending the Chest Clinic for their annual review of pulmonary tuberculosis, chronic bronchitis, and emphysema were taken in a random fashion to give a wide variety of cases varying from those with no airways obstruction to those with severe airways obstruction. All were men aged 40–60 years.

A water-filled spirometer, with a fast recording drum, was used to measure the REV\textsubscript{1.0} and FIV\textsubscript{1.0}.

PROCEDURE For performing REV\textsubscript{1.0} the subjects were asked to take in as deep a breath as possible, hold the breath, put the mask on the face and, when instructed, breathe all the air out with a deep sigh, letting the chest and abdomen collapse without any effort to force out the air. For FIV\textsubscript{1.0} the instructions given were first to breathe out all air and then, when no more could be exhaled, to hold the breath, put the mask on the face and, when told, to inhale as fast and as deep as possible. All the subjects practised both the manoeuvres till they were familiar with them. Three readings of each REV\textsubscript{1.0} and FIV\textsubscript{1.0} were first recorded and the subjects were asked to rest for half an hour before recording a second set of three readings for both the procedures. Between the recording of the two sets of readings, the subjects were requested to refrain from smoking. The same person performed all the tests on all the subjects.

The time taken for indoctrination of patients before getting a satisfactory reproducible recording of REV varied from 2 to 5 minutes. Only two subjects could not master the technique and these have been excluded. We did not have much difficulty with this procedure, because the person doing these tests had over 10 years’ experience with these procedures.

RESULTS

The coefficient of variation for the six readings for REV\textsubscript{1.0} and FIV\textsubscript{1.0} was calculated for all the cases, and then the mean for the 50 cases was calculated. The mean coefficient of variation for REV\textsubscript{1.0} was 6.74\% and for FIV\textsubscript{1.0} 8.92\%.
On comparing the results obtained on the first occasion with those obtained 30 minutes later, the mean difference between the highest readings obtained on two occasions was 0.026 ± 0.099 litre for FIV1.0 and for REV1.0 it was 0.034 ± 0.173 litre. These differences were not significant (Table I). The 95% confidence limits of difference for FIV1.0 and REV1.0, respectively, were 0.214 and 0.38 litre.

Table II gives the distribution of cases showing improvement, deterioration and no change in their highest readings in the second attempt compared with the highest readings for the first attempts for both tests. While performing REV1.0 there were almost as many who showed improvement as those showing deterioration. Relatively more cases had lower readings for FIV1.0 in the second attempt than those showing improvement in the second attempt.

### DISCUSSION

The coefficients of variation for REV1.0 and FIV1.0 compare favourably with the values reported for FEV1.0 and peak expiratory flow rate (PEF) (Table III).

The values for the 95% confidence limit of the difference for REV1.0 and FIV1.0 are also comparable (Table IV) to those reported for vital capacity (VC) and FEV1.0 (Davidson, 1966).

<table>
<thead>
<tr>
<th>TABLE I</th>
<th>MEAN DIFFERENCE BETWEEN HIGHEST VALUES ON TWO OCCASIONS</th>
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</thead>
<tbody>
<tr>
<td>Mean Difference</td>
<td>Standard Deviation</td>
</tr>
<tr>
<td>FIV1.0 (l.)</td>
<td>0.026</td>
</tr>
<tr>
<td>REV1.0 (l.)</td>
<td>0.034</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>TABLE II</th>
<th>DISTRIBUTION OF CASES FOR RESULTS OF SECOND ATTEMPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement</td>
<td>Deterioration</td>
</tr>
<tr>
<td>REV1.0</td>
<td>21</td>
</tr>
<tr>
<td>FIV1.0</td>
<td></td>
</tr>
</tbody>
</table>

Saunders (1967) observed that the ‘within patient’ variance for peak inspiratory flow rate was not excessive and was not always greater for peak inspiratory flow rate than for peak expiratory flow rate.

Despite the slightly greater complexity in the proper performance of REV1.0 and the effort-dependence of FIV1.0, in experienced hands the variabilities for both these procedures compare favourably with those reported for other ventilatory tests. It seems, therefore, that these tests can be recommended for assessing the ventilatory capacity of cases with chronic bronchitis and emphysema.

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### REFERENCES


