Secondary polycythaemia in chronic respiratory insufficiency

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Vanuxem, D., Guillot, Ch., Fornaris, E., Weiller, P. J., and Grimaud, Ch. (1977). Thorax, 32, 317–321. Secondary polycythaemia in chronic respiratory insufficiency. The relationship between polycythaemia, $P_50$ and Saco (saturation in carboxyhaemoglobin) has been studied in 50 patients who were hypoxaemic due to chronic respiratory insufficiency. These patients were divided into two groups according to their haemoglobin concentration and haematocrit: 21 polycythaemic patients with haemoglobin $\geq 16$ g/dl and haematocrit $\geq 50\%$ and 29 patients without polycythaemia. $\text{PaO}_2$, $\text{PaCO}_2$, plasma and erythrocyte pH, haemoglobin, haematocrit, and carbon monoxide saturation and intraerythrocytic 2-3 diphosphoglycerate concentration were measured during steady-state ventilation.

All polycythaemic patients were smokers and their carbon monoxide level was significantly higher than that observed in patients without polycythaemia. Additionally, their $P_50$ and 2-3 DPG concentration were significantly lower than in patients without polycythaemia.

The correlations between $P_50$ and Hbco and between Hb and Hbco were significant ($r = -0.672$; $r = 0.552$ respectively: $p < 0.001$).

Eleven non-polycythaemic patients who were smokers had a high level of Hbco but normal $P_50$.

A group of 29 normoxic subjects was also studied, 14 non-smokers and 15 smokers with a high Hbco level. The mean value of $P_50$ was lower in smokers and their haematocrit was higher although the difference was not significant for the latter.

The Hbco increase by tobacco seems to be a factor in the occurrence of polycythaemia in patients with chronic respiratory insufficiency.

The level of increase of Hbco and/or its duration and perhaps other individual factors could explain why all patients with high Hbco level and hypoxaemia were not polycythaemic.

Polycythaemia is not observed in all patients with chronic respiratory insufficiency who have the same degree of arterial hypoxaemia, suggesting that hypoxia is not the sole factor responsible for polycythaemia in those patients.

Brewer et al. (1970) have suggested that smoking, by increasing haemoglobin affinity for oxygen, is a possible explanation for the excessive polycythaemia that occurs in some people living permanently at high altitude. In a previous study in patients with chronic bronchitis (Vanuxem et al., 1973) we noticed that haemoglobin affinity for oxygen was higher in smokers than in non-smokers. We found a significant negative correlation between $P_50$, the partial pressure of oxygen at which haemoglobin is half saturated with oxygen (which reflects blood affinity for oxygen), and the percentage saturation of haemoglobin with carbon monoxide (Saco), a direct function of tobacco consumption (Russell et al., 1973; Cole, 1975).

The present study was undertaken in a group of hypoxic patients with chronic respiratory insufficiency, to determine whether a relationship existed between polycythaemia and Saco%.

Methods

Subjects

Fifty hypoxaemic patients (43 with chronic bronchitis and 7 with silicosis) participated in the study (Table 1). They were divided into two groups. Group A consisted of 29 patients without polycythaemia (smokers and non-smokers). Group B consisted of 21 patients with polycythaemia (all were smokers).

In the absence of direct measurement of the red cell mass we arbitrarily defined polycythaemia as a
Table 1  Details of 50 hypoxaemic patients: vital capacity (VC) and forced expiratory volume in one second (FEV1) were expressed as per cent of predicted values (European Coal and Steel Organization): Values are mean ± SE

<table>
<thead>
<tr>
<th>Patients</th>
<th>Age</th>
<th>VC (litres)</th>
<th>FEV1 (litres)</th>
<th>PaO2 (kPa)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypoxaemia without polycythaemia</td>
<td>56</td>
<td>±2</td>
<td>56.5</td>
<td>44.6</td>
</tr>
<tr>
<td>(N=29)</td>
<td></td>
<td>±1.5</td>
<td>±2.6</td>
<td>±3.8</td>
</tr>
<tr>
<td>Hypoxaemia with polycythaemia</td>
<td>48</td>
<td>±2</td>
<td>68.2</td>
<td>51.8</td>
</tr>
<tr>
<td>(N=21)</td>
<td></td>
<td>±3</td>
<td>±4</td>
<td>±5.5</td>
</tr>
<tr>
<td><strong>Group B</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>p &lt; 0.01</td>
<td>p &lt; 0.001 NS</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>

haemoglobin concentration (Hb) equal to or greater than 16 g/dl of blood and haematocrit value (Hct) higher than 50%.

For comparison, 29 normoxic subjects were also examined: 14 were non-smokers (group C: mean age 31 ±1) and 15 were smokers (group D: mean age 41, 5 ±3, daily cigarette consumption 22 ±3).

**TECHNIQUES**

All subjects gave informed consent to the study.

In all hypoxaemic patients (groups A and B) and in 12 normoxic subjects from group D, blood samples were collected from the brachial artery through a catheter during steady-state ventilation (Ve < 10 l min⁻¹). The blood samples were obtained from a forearm vein in 17 normal subjects. In seven of them a sample of arterialised capillary blood was also collected from the ear.

Arterial pH, PO₂, and PCO₂ (pHa—PaO₂—PaCO₂) were measured by means of Radiometer electrodes.

Intraerythrocytic pH (pHi) was measured with the same apparatus after cold haemolysis.

Per cent saturations of haemoglobin were calculated from blood oxygen and capacities measured by a colorimetric procedure (Lex O₂ Con; Lexington Instrument Corporation). This technique enables the calculation of the 'functional haemoglobin', ie, the only haemoglobin able to 'fix' oxygen. Saco₂% was measured with a CO—Oxymerter IL—182. The cyanmethaemoglobin method was used to determine the haemoglobin concentration. The haematocrit ratio (Hct) was determined using the microtechnique. The haemoglobin affinity for oxygen was assessed by measuring PaO₂ according to the technique of Bartels and Harms (1959).

Hill's equation was used to calculate P₅₀ (at pH 7.4) as follows:

\[
\log \frac{\text{HbO}_2}{100-\text{HbO}_2} = n \log \text{PO}_2 + \log K
\]

at P₅₀, HbO₂ = 50%.

hence \[
\log \frac{\text{HbO}_2}{100-\text{HbO}_2} = 0
\]

and \[
\log P_{50} = -\frac{\log K}{n}
\]

where n represents haem-haem interaction.

The following gas mixtures were used for tonometric equilibrations: O₂ = 2.97%; CO₂ = 5.56%; N₂ = 91.47%, and O₂ = 4.36%; CO₂ = 5.52%; N₂ = 90.12%.

An enzymatic method (Krimsky, 1961; Chambron, 1971) which uses phosphoenol pyruvate (PEP) as substrate was used to measure the intracellular concentration of 2-3 diphosphoglycerate (2-3 DPG) in the following manner:

\[
\text{PEP} \rightarrow 2 \text{PGA}
\]

\[
\text{Enolase} \quad \text{PGM}
\]

\[
2 \text{PGA} \rightarrow 3 \text{PGA}
\]

\[
\text{2-3 DPG}
\]

in which 2 PGA = 2 phosphoglycerate, 3 PGA = 3 phosphoglycerate, and PGM = phosphoglycerate mutase.

Optical density readings were done at 240 nm with an ultraviolet spectrophotometer (Jean et Constant).

**Results**

The mean values and standard errors of the measured haematological data are shown in Table 2.

In the hypoxaemic patients, statistical comparisons (Student’s t test) between the two groups A and B showed no difference regarding the degree of ventilatory impairment and the mean value of PaO₂. There was a significant difference in age and smoking habits (Table 1). There were, however, significant differences in the haematological measurements between the two groups: the Hbco level was higher (p < 0.001), the P₅₀ value and the 2-3 DPG concentration lower in group B (p < 0.001 and p < 0.02) (Table 2).

In group A, we separated 11 subjects whose Saco₂% was equal to or higher than 4% and who were smokers (Table 3). In these 11 patients, the Hbco level was lower (p < 0.01) and the P₅₀ higher (p < 0.001) than in the polycythaemic patients; PaO₂, pHi, pHa, and 2-3 DPG were not different.

In the normoxic subjects (Table 2) there was a highly significant difference between smokers (group D) and non-smokers (group C): subjects who smoked.
Table 2  Haematological data in hypoxic patients and normoxic subjects: Values are mean ±SE

<table>
<thead>
<tr>
<th>Subjects</th>
<th>PaO$_2$ (kPa)</th>
<th>PaCO$_2$ (kPa)</th>
<th>pH$_O$</th>
<th>Hb (g/dl)</th>
<th>Hct %</th>
<th>HbCO %</th>
<th>pHi</th>
<th>DPG (mmol/l RBC$^{-1}$)</th>
<th>P$_{50}$ (7-40) (kPa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group A</td>
<td>8.52</td>
<td>5.60</td>
<td>7.400</td>
<td>14.4</td>
<td>45</td>
<td>3.52</td>
<td>7.189</td>
<td>4.31</td>
<td>3.61</td>
</tr>
<tr>
<td>Hypoxaemic without polycythaemia (N=29)</td>
<td>0.18</td>
<td>0.16</td>
<td>0.007</td>
<td>0.2</td>
<td>0.6</td>
<td>3.52</td>
<td>0.007</td>
<td>0.13</td>
<td>0.02</td>
</tr>
<tr>
<td>Group B</td>
<td>8.40</td>
<td>5.97</td>
<td>7.388</td>
<td>17.2</td>
<td>55</td>
<td>9.55</td>
<td>7.189</td>
<td>3.79</td>
<td>3.20</td>
</tr>
<tr>
<td>Hypoxaemic with polycythaemia (N=21)</td>
<td>0.37</td>
<td>0.25</td>
<td>0.008</td>
<td>0.2</td>
<td>0.7</td>
<td>9.55</td>
<td>0.007</td>
<td>0.16</td>
<td>0.04</td>
</tr>
<tr>
<td>Group C</td>
<td>12.2</td>
<td>5.24</td>
<td>7.412</td>
<td>14.5</td>
<td>45.2</td>
<td>2.16</td>
<td>7.128</td>
<td>4.12</td>
<td>3.60</td>
</tr>
<tr>
<td>Normoxic non-smokers (N=14)</td>
<td>0.26</td>
<td>0.10</td>
<td>0.005</td>
<td>0.1</td>
<td>0.4</td>
<td>0.1</td>
<td>0.005</td>
<td>0.06</td>
<td>0.02</td>
</tr>
<tr>
<td>Group D</td>
<td>12.4</td>
<td>4.78</td>
<td>7.400</td>
<td>14.8</td>
<td>47.2</td>
<td>7.66</td>
<td>7.192</td>
<td>4.25</td>
<td>3.44</td>
</tr>
<tr>
<td>Normoxic smokers (N=15)</td>
<td>0.32</td>
<td>0.10</td>
<td>0.008</td>
<td>0.6</td>
<td>2.2</td>
<td>0.66</td>
<td>0.005</td>
<td>0.12</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Table 3  Haematological data in 11 hypoxic patients (non polycythaemias) of group A, with Hbco level >4%; (mean cigarette consumption, 5 daily)

<table>
<thead>
<tr>
<th>PaO$_2$ (kPa)</th>
<th>PaCO$_2$ (kPa)</th>
<th>pH$_O$</th>
<th>Hb (g/dl)</th>
<th>Hct %</th>
<th>HbCO %</th>
<th>pHi</th>
<th>DPG (mmol/l RBC$^{-1}$)</th>
<th>P$_{50}$ (7-40) (kPa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.05</td>
<td>5.70</td>
<td>7.386</td>
<td>14.2</td>
<td>44.3</td>
<td>5.34</td>
<td>7.193</td>
<td>4.12</td>
<td>3.55</td>
</tr>
<tr>
<td>0.29</td>
<td>0.29</td>
<td>0.009</td>
<td>0.35</td>
<td>0.9</td>
<td>0.39</td>
<td>0.009</td>
<td>0.10</td>
<td>0.04</td>
</tr>
</tbody>
</table>

were found to have a higher CO level (p < 0.001) and a lower P$_{50}$ (p < 0.005) than the subjects who did not.

Discussion

Our results show that in two groups of patients with the same degree of hypoxia only one group presented with polycythaemia. All subjects of this group were smokers with a high level of Hbco. Other studies in apparently healthy smokers living at altitude have demonstrated a similar correlation between polycythaemia and smoking with increased Hbco (Brewer et al., 1970). In the present work normal subjects who are smokers (group D) had a higher haematocrit than non-smoking subjects (group C) although the difference was not significant. Similar observations in apparently healthy smokers have been reported by other authors (Eisen and Hammond, 1956; Russell and Conley, 1964; Sagone et al., 1973; Sagone and Balcerzak, 1975).

In the two groups of hypoxic patients, the haemoglobin level was correlated with the Hbco level (p < 0.001) (Fig. 1).

All these findings strongly suggest that increased Hbco may play an important role in determining polycythaemia when associated with hypoxaemia.

Polycythaemia in patients with hypoxia is thought to be due to excess erythropoietin release by an indirect mechanism relating to the influence of tissue hypoxia (Fried et al., 1957; Adamson and Finch, 1975).

Furthermore, it is known that the fixation of CO on haemoglobin leads to a decrease of the quantity of functional haemoglobin and a shift to the left of the haemoglobin dissociation curve (ie, an increased affinity of haemoglobin for O$_2$) (Roughton, 1964; Astrup et al., 1966; Goldsmith and Landaw, 1968).

There was a significant decrease in P$_{50}$ in patients with polycythaemia and the P$_{50}$ value of the group of normal smokers with an increased Hbco level was also found to be lower than the P$_{50}$ observed in normal non-smokers.

However, factors other than Hbco could shift the Hbo$_2$ dissociation curve to the left and must be

Fig. 1  Relationship between haemoglobin concentration (g/dl) and Hbco level (%).
considered. There was no significant difference between the two groups of patients in plasma and intraerythrocytic pH and PaCO₂, so that these factors can be excluded (Astrup, 1970; Bellingham, et al., 1971; Vanuxem et al., 1975). The concentration of 2-3 DPG was found to be significantly lower in patients with polycythaemia, probably due to the inhibitory influence of CO on 2-3 DPG synthesis (Asakura et al., 1966; Morena et al., 1974). However, as the mean difference is only about 0.56 mmol/l RBC⁻¹ it cannot account for the observed decrease in P₅₀ of 0.4 kPa, since a decrease of 2-3 DPG of 1 mmol/l RBC⁻¹ results in a decrease of only 0.21 kPa (Vanuxem et al., 1975). Furthermore, no correlation was found in the polycythaemic group between P₅₀ and 2-3 DPG. This lack of correlation contrasts with the results obtained by Edwards et al. (1972) and with our own observations in normal subjects and in patients without polycythaemia (p<0.001).

In patients with respiratory insufficiency, the strong correlation between P₅₀ and SacO₂ (Fig. 2) shows the determinant role of haemoglobin for oxygen. We calculate that a 1% increase in Hbco level causes a decrease in P₅₀ of 0.04 kPa which agrees with other findings (Robert, 1975).

It is interesting to notice that 11 patients of group A were smokers and had raised Hbco levels, but not polycythaemia. It is possible that polycythaemia was undetected in our study because we measured only haematocrit and haemoglobin concentration since Shaw and Simpson (1961) and Murray (1965) have found that, in some cases, there is a parallel increase in erythrocytic mass and plasma volume. There are nevertheless several other explanations; first, it is possible that their Hbco level was not high enough to lead to polycythaemia since it was lower than that observed in group B; secondly, the duration of hypoxia and/or increased Hbco could also be important; thirdly, these differences could be related to variable individual susceptibility by a still unknown mechanism.

Our results show that each time polycythaemia is observed in patients with chronic respiratory insufficiency the Hbco level is greatly increased, but, on the other hand, a high Hbco level can be found without polycythaemia. This latter condition has harmful haemodynamic consequences (Cotes, 1975) and so it is an additional reason why patients with respiratory impairment should avoid smoking.

Our thanks are due to Dr. J. Orehek and Dr. A. P. Smith for helpful advice. We are grateful to Mrs. N. Robaglia, Mrs. J. Ohanian, and Mr. C. Varteressian for technical assistance.

References


![Fig. 2. Relationship between P₅₀ (7-40) (kPa) and Hbco level(%)](http://thorax.bmj.com/Thorax: first published as 10.1136/thx.32.3.317 on 1 June 1977. Downloaded from http://thorax.bmj.com/ on October 7, 2023 by guest. Protected by copyright.)
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