Unit 9: Cardiorespiratory System

Ms. Randall

Essential Questions:

- How does the circulatory system distribute heat and transport nutrients and waste products throughout the body?
- How does the respiratory system support exchange of gases between the body and outside environment?

Unit Objectives:

- ➢ Identify the primary functions of blood, its fluid and cellular components, and its physical characteristics
- ➢ Describe the anatomy of erythrocytes and the function of hemoglobin
- ➢ Classify leukocytes according to their lineage, their main structural features, and their primary functions
- ➢ Identify the basic structure and function of platelets

Unit Vocabulary:

Pulmonary
Pericardium
Myocardium
Endocardium
Atria
Ventricle Septum
Erythrocyte
Leukocyte
Platelet
Artery
Arteriole
Vein
Capillary
Venule
Aorta
Systole
Diastole
Vasoconstriction
Vasodilation
Hemoglobin
Antigen
Antibody
Respiration
Tidal Volume
Diaphragm
Nose
Bronchi
Bronchiole
Alveoli
Lungs
Pleura
Inspiration
Expiration

Lesson 1: Blood

Objective:

- ➢ Identify the primary functions of blood, its fluid and cellular components, and its physical characteristics
- ➢ Describe the anatomy of erythrocytes and the function of hemoglobin
- ➢ Classify leukocytes according to their lineage, their main structural features, and their primary functions
- ➢ Identify the basic structure and function of platelets

Recall that **blood** is a connective tissue. Like all connective tissues, it is made up of cellular elements and an extracellular matrix. The cellular elements—referred to as the **formed elements**—include **red blood cells (RBCs)**, **white blood cells (WBCs)**, and cell fragments called **platelets**. The extracellular matrix, called **plasma**, makes blood unique among connective tissues because it is fluid. This fluid, which is mostly water, continuously suspends the formed elements and enables them to circulate throughout the body within the cardiovascular system.

Functions of Blood

The primary function of blood is to deliver oxygen and nutrients to and remove wastes from body cells, but that is only the beginning of the story. The specific functions of blood also include defense, distribution of heat, and maintenance of homeostasis.

Transportation

Nutrients from the foods you eat are absorbed in the digestive tract. Most of these travel in the bloodstream directly to the liver, where they are processed and released back into the bloodstream for delivery to body cells. Oxygen from the air you breathe diffuses into the blood, which moves from the lungs to the heart, which then pumps it out to the rest of the body. Moreover, endocrine glands scattered throughout the body release their products, called hormones, into the bloodstream, which carries them to distant target cells. Blood also picks up cellular wastes and byproducts and transports them to various organs for removal. For instance, blood moves carbon dioxide to the lungs for exhalation from the body, and various waste products are transported to the kidneys and liver for excretion from the body in the form of urine or bile.

Defense

Many types of WBCs protect the body from external threats, such as disease-causing bacteria that have entered the bloodstream in a wound. Other WBCs seek out and destroy internal threats, such as cells with mutated DNA that could multiply to become cancerous, or body cells infected with viruses.

When damage to the vessels results in bleeding, blood platelets and certain proteins dissolved in the plasma, interact to block the ruptured areas of the blood vessels involved. This protects the body from further blood loss.

Maintenance of Homeostasis

Recall that body temperature is regulated via a classic **negative-feedback loop**. If you were exercising on a warm day, your rising core body temperature would trigger several homeostatic mechanisms, including increased transport of blood from your core to your body periphery, which is typically cooler. As blood passes through the vessels of the skin, heat would be dissipated to the environment, and the blood returning to your body core would be cooler. In contrast, on a cold day, blood is diverted away from the skin to maintain a warmer body core. In extreme cases, this may result in frostbite.

Blood also helps to maintain the chemical balance of the body. Proteins and other compounds in blood act as **buffers,** which thereby help to regulate **the pH** of body tissues. Blood also helps to regulate the water content of body cells.

Characteristics of Blood

When you think about blood, the first characteristic that probably comes to mind is its color. Blood that has just taken up oxygen in the lungs is bright red, and blood that has released oxygen in the tissues is a duskier red. This is because **hemoglobin**, the molecule in RBCs that carries oxygen is a pigment that changes color, depending upon the degree of oxygen saturation.

Blood is viscous and somewhat sticky to the touch. It has a viscosity approximately five times greater than water. Viscosity is a measure of a fluid's thickness or resistance to flow and is influenced by the presence of the plasma proteins and formed elements within the blood. The viscosity of blood has a dramatic impact on blood pressure and flow. Consider the difference in flow between water and honey. The more viscous honey would demonstrate a greater resistance to flow than the less viscous water. The same principle applies to blood.

The normal temperature of blood is slightly higher than normal body temperature—about 38 °C (or 100.4 °F), compared to 37 °C (or 98.6 °F) for an internal body temperature reading, although daily variations of 0.5 °C are normal. Although the surface of blood vessels is relatively smooth, as blood flows through them, it experiences some friction and resistance, especially as vessels age and lose their elasticity, thereby producing heat. This accounts for its slightly higher temperature.

The pH of blood averages about 7.4; however, it can range from 7.35 to 7.45 in a healthy person. Blood is therefore somewhat more basic (alkaline) on a chemical scale than pure water, which has a pH of 7.0. Blood contains numerous buffers that help to regulate pH.

Blood constitutes approximately 8 percent of adult body weight. Adult males typically average about 5 to 6 liters of blood. Females average 4–5 liters.

Blood Plasma

Like other fluids in the body, plasma is composed primarily of water: In fact, it is about 92 percent water. Dissolved or suspended within this water is a mixture of substances, most of which are proteins. There are literally hundreds of substances dissolved or suspended in the plasma, although many of them are found only in very small quantities.

Plasma Proteins

About 7 percent of the volume of plasma—nearly all that is not water—is made of proteins. These include several plasma proteins (proteins that are unique to the plasma), plus a much smaller number of regulatory proteins, including enzymes and some hormones.

The three major groups of plasma proteins are as follows:

- **Albumin** is the most abundant of the plasma proteins. Manufactured by the liver, albumin molecules serve as binding proteins—transport vehicles for fatty acids and steroid hormones. Recall that lipids are **hydrophobic;** however, their binding to albumin enables their transport in the watery plasma. Albumin is also the most significant contributor to the **osmotic pressure** of blood; that is, its presence holds water inside the blood vessels and draws water from the tissues, across blood vessel walls, and into the bloodstream. This in turn helps to maintain both blood volume and blood pressure. Albumin normally

accounts for approximately 54 percent of the total plasma protein content, in clinical levels of 3.5–5.0 g/dL blood.

- The second most common plasma proteins are the **globulins**. A heterogeneous group, there are three main subgroups known as alpha, beta, and gamma globulins. The alpha and beta globulins transport iron, lipids, and the fat-soluble vitamins A, D, E, and K to the cells; like albumin, they also contribute to osmotic pressure. The gamma globulins are proteins involved in immunity and are better known as an **antibodies** or **immunoglobulins**. Although other plasma proteins are produced by the liver, immunoglobulins are produced by specialized leukocytes known as plasma cells. Globulins make up approximately 38 percent of the total plasma protein volume, in clinical levels of 1.0–1.5 g/dL blood.
- The least abundant plasma protein is **fibrinogen**. Like albumin and the alpha and beta globulins, fibrinogen is produced by the liver. It is essential for blood clotting, a process described later in this chapter. Fibrinogen accounts for about 7 percent of the total plasma protein volume, in clinical levels of 0.2–0.45 g/dL blood.

Other Plasma Solutes

In addition to proteins, plasma contains a wide variety of other substances. These include various electrolytes, such as sodium, potassium, and calcium ions; dissolved gases, such as oxygen, carbon dioxide, and nitrogen; various organic nutrients, such as vitamins, lipids, glucose, and amino acids; and metabolic wastes. All these nonprotein solutes combined contribute approximately 1 percent to the total volume of plasma.

Sites of Hemopoiesis

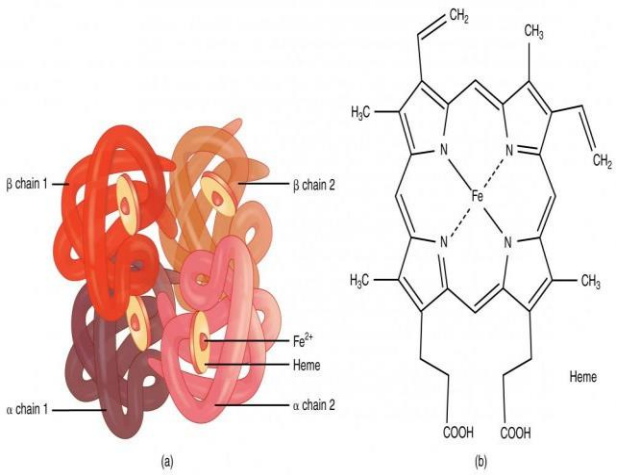
Prior to birth, **hemopoiesis**, the production of blood, occurs in several tissues, beginning with the yolk sac of the developing embryo, and continuing in the fetal liver, spleen, lymphatic tissue, and eventually the red bone marrow. Following birth, most hemopoiesis occurs in the red marrow, a connective tissue within the spaces of spongy (cancellous) bone tissue. In children, hemopoiesis can occur in the **medullary cavity** of **long bones**; in adults, the process is largely restricted to the cranial and pelvic bones, the vertebrae, the sternum, and the proximal **epiphyses** of the femur and humerus.

Throughout adulthood, the **liver** and **spleen** maintain their ability to generate the formed elements. This process is referred to as **extramedullary hemopoiesis** (meaning hemopoiesis outside the medullary cavity of adult bones). When a disease such as bone cancer destroys the bone marrow, causing hemopoiesis to fail, extramedullary hemopoiesis may be initiated.

Erythrocytes (RBCs)

Erythrocytes are biconcave disks; that is, they are plump at their periphery and very thin in the center. Since they lack most organelles and do not contain a nucleus, so there is more interior space for the presence of the hemoglobin molecules that transport gases. The biconcave shape also provides a greater surface area across which gas exchange can occur. In the capillaries, the oxygen carried by the erythrocytes can diffuse into the plasma and then through the capillary walls to reach the cells, whereas some of the carbon dioxide produced by the cells as a waste product diffuses into the capillaries to be picked up by the erythrocytes.

Hemoglobin is a large molecule made up of proteins and iron. It consists of four folded chains of a protein called **globin**, designated alpha 1 and 2, and beta 1 and 2 (Figure 3a). Each of these globin molecules is bound to a red pigment molecule called **heme**, which contains an ion of iron (Fe^{2+}).



Changes in the levels of RBCs can have significant effects on the body's ability to effectively deliver oxygen to the tissues. Ineffective hematopoiesis results in insufficient numbers of RBCs and results in one of several forms of **anemia.** An overproduction of RBCs produces a condition called polycythemia. The primary drawback with polycythemia is not a failure to directly deliver enough oxygen to the tissues, but rather the increased viscosity of the blood, which makes it more difficult for the heart to circulate the blood.

Leukocytes

The **leukocyte**, commonly known as a **white blood cell** (or WBC), is a major component of the body's defenses against disease. Leukocytes protect the body against invading microorganisms and body cells with mutated DNA, and they clean up debris.

Although leukocytes and erythrocytes both originate from **hematopoietic stem cells** in the bone marrow, they are very different from each other in many significant ways. For instance, leukocytes are far less numerous than erythrocytes: Typically, there are only 5000 to 10,000 per μL. They are also larger than erythrocytes and are the only formed elements that are complete cells, possessing a nucleus and organelles. And although there is just one type of erythrocyte, there are many types of leukocytes. Most of these types have a much shorter lifespan than that of erythrocytes, some as short as a few hours.

When scientists first began to observe stained blood slides, it quickly became evident that leukocytes could be divided into two groups, according to whether their cytoplasm contained highly visible granules.

The most common of all the leukocytes, **neutrophils** will normally comprise 50–70 percent of total leukocyte count. They are 10–12 μm in diameter, significantly larger than erythrocytes. They are called neutrophils because their granules show up most clearly with stains that are chemically neutral (neither acidic nor basic). The granules are numerous but quite fine and normally appear light lilac. The nucleus has a distinct lobed appearance and may have two to five lobes, the number increasing with the age of the cell. Older neutrophils have increasing numbers of lobes and are often referred to as **polymorphonuclear** (a nucleus with many forms), or simply "polys." Younger and immature neutrophils begin to develop lobes and are known as "bands."

Neutrophils are rapid responders to the site of infection and are efficient phagocytes with a preference for bacteria. Their granules include **lysozyme**, an enzyme capable of lysing, or breaking down, bacterial cell walls; oxidants such as hydrogen peroxide; and **defensins**, proteins that bind to and puncture bacterial and fungal plasma membranes, so that the cell contents leak out.

Eosinophils typically represent 2–4 percent of total leukocyte count. They are also 10–12 μm in diameter. The granules of eosinophils stain best with an acidic stain known as eosin. The nucleus of the eosinophil will typically have two to three lobes and, if stained properly, the granules will have a distinct red to orange color.

The granules of eosinophils include **antihistamine** molecules, which counteract the activities of **histamines,** inflammatory chemicals produced by **basophils** and **mast cells**. Some eosinophil granules contain molecules toxic to parasitic worms, which can enter the body through the integument, or when an individual consumes raw or undercooked fish or meat. Eosinophils are also capable of **phagocytosis** and are particularly effective when antibodies bind to the target and form an antigen-antibody complex. High counts of eosinophils are typical of patients experiencing allergies, parasitic worm infestations, and some autoimmune diseases. Low counts may be due to drug toxicity and stress.

Basophils are the least common leukocytes, typically comprising less than one percent of the total leukocyte count. They are slightly smaller than neutrophils and eosinophils at 8–10 μm in diameter. The granules of basophils stain best with basic (alkaline) stains. Basophils contain large granules that pick up a dark blue stain and are so common they may make it difficult to see the two-lobed nucleus.

In general, basophils intensify the inflammatory response. They share this trait with mast cells. In the past, mast cells were basophils that left the circulation. However, this appears not to be the case, as the two cell types develop from different lineages.

The granules of basophils release **histamines,** which contribute to inflammation, and heparin, which opposes blood clotting. High counts of basophils are associated with allergies, parasitic infections, and hypothyroidism. Low counts are associated with pregnancy, stress, and hyperthyroidism.

Lymphocytes are the only formed element of blood that arises from lymphoid stem cells. Although they form initially in the bone marrow, much of their subsequent development and reproduction occurs in the lymphatic tissues. Lymphocytes are the second most common type of leukocyte, accounting for about 20–30 percent of all leukocytes and are essential for the immune response.

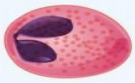
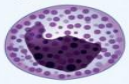
Abnormally high lymphocyte counts are characteristic of viral infections as well as some types of cancer. Abnormally low lymphocyte counts are characteristic of prolonged (chronic) illness or immunosuppression, including that caused by HIV infection and drug therapies that often involve steroids.

Monocytes normally represent 2–8 percent of the total leukocyte count. They are typically easily recognized by their large size of 12–20 μm and indented or horseshoe-shaped nuclei. **Macrophages** are monocytes that have left the circulation and phagocytize debris, foreign pathogens, worn-out erythrocytes, and many other dead, worn out, or damaged cells. Macrophages also release antimicrobial defensins and chemicals that attract other leukocytes to the site of an infection. Some macrophages occupy fixed locations, whereas others wander through the tissue fluid. Abnormally high counts of monocytes are associated with viral or fungal infections, tuberculosis, and some forms of leukemia and other chronic diseases. Abnormally low counts are typically caused by suppression of the bone marrow.

Platelets

You may occasionally see platelets referred to as **thrombocytes**, but because this name suggests they are a type of cell, it is not accurate. A platelet is not a cell but rather a fragment of the cytoplasm of a cell called a **megakaryocyte** that is surrounded by a plasma membrane and located in the bone marrow. Platelets are relatively small, 2–4 μm in diameter, but numerous, with typically 150,000–160,000 per μL of blood. After entering the circulation, approximately one-third migrate to the spleen for storage for later release in response to any rupture in a blood vessel. They then become activated to perform their primary function, which is to limit blood loss. Platelets remain only about 10 days, then are phagocytized by macrophages.

Platelets are critical to **hemostasis**, the stoppage of blood flow following damage to a vessel. They also secrete a variety of growth factors essential for growth and repair of tissue, particularly connective tissue. Infusions of concentrated platelets are now being used in some therapies to stimulate healing.

Formed element	Major subtypes	Numbers present per microliter (μL) and mean (range)	Appearance in a standard blood smear	Summary of functions	Comments
Erythrocytes (red blood cells)		5.2 million (4.4–6.0 million)	Flattened biconcave disk; no nucleus; pale red color	Transport oxygen and some carbon dioxide between tissues and lungs	Lifespan of approximately 120 days
Leukocytes (white blood cells)		7000 (5000–10,000)	Obvious dark-staining nucleus	All function in body defenses	Exit capillaries and move into tissues; lifespan of usually a few hours or days
	Granulocytes including neutrophils, eosinophils, and basophils	4360 (1800–9950)	Abundant granules in cytoplasm; nucleus normally lobed	Nonspecific (innate) resistance to disease	Classified according to membrane-bound granules in cytoplasm
	Neutrophils 	4150 (1800–7300)	Nuclear lobes increase with age; pale lilac granules	Phagocytic; particularly effective against bacteria. Release cytotoxic chemicals from granules	Most common leukocyte; lifespan of minutes to days
	Eosinophils 	165 (0–700)	Nucleus generally two-lobed; bright red-orange granules	Phagocytic cells; particularly effective with antigen- antibody complexes. Release antihistamines. Increase in allergies and parasitic infections	Lifespan of minutes to days
	Basophils 	44 (0–150)	Nucleus generally two-lobed but difficult to see due to presence of heavy, dense, dark purple granules	Promotes inflammation	Least common leukocyte; lifespan unknown
	Agranulocytes including lymphocytes and monocytes	2640 (1700–4950)	Lack abundant granules in cytoplasm; have a simple-shaped nucleus that may be indented	Body defenses	Group consists of two major cell types from different lineages
	Lymphocytes 	2185 (1500–4000)	Spherical cells with a single often large nucleus occupying much of the cell's volume; stains purple; seen in large (natural killer cells) and small (B and T cells) variants	Primarily specific (adaptive) immunity: T cells directly attack other cells (cellular immunity); B cells release antibodies (humoral immunity); natural killer cells are similar to T cells but nonspecific	Initial cells originate in bone marrow, but secondary production occurs in lymphatic tissue; several distinct subtypes; memory cells form after exposure to a pathogen and rapidly increase responses to subsequent exposure; lifespan of many years
	Monocytes 	455 (200–950)	Largest leukocyte with an indented or horseshoe-shaped nucleus	Very effective phagocytic cells engulfing pathogens or worn out cells; also serve as antigen-presenting cells (APCs) for other components of the immune system	Produced in red bone marrow; referred to as macrophages after leaving circulation
Platelets 		350,000 (150,000–500,000)	Cellular fragments surrounded by a plasma membrane and containing granules; purple stain	Hemostasis plus release growth factors for repair and healing of tissue	Formed from megakaryocytes that remain in the red bone marrow and shed platelets into circulation

Lesson 2: Blood Typing

Objective:

- ➢ Explain the significance of AB and Rh blood groups in blood transfusions

Blood **transfusions** in humans were risky procedures until the discovery of the major human blood groups by Karl Landsteiner, an Austrian biologist and physician, in 1900. Until that point, physicians did not understand that death sometimes followed blood transfusions, when the type of donor blood infused into the patient was incompatible with the patient's own blood. Blood groups are determined by the presence or absence of specific marker molecules on the plasma membranes of erythrocytes. With their discovery, it became possible for the first time to match patient-donor blood types and prevent transfusion reactions and deaths.

Antigens, Antibodies, and Transfusion Reactions

Antigens are substances that the body does not recognize as belonging to the "self" and that therefore trigger a defensive response from the leukocytes of the immune system. Here, we will focus on the role of immunity in blood transfusion reactions. With RBCs, you may see the antigens referred to as **isoantigens or agglutinogens** (surface antigens) and the **antibodies** referred to as **isoantibodies or agglutinins**. We will use the more common terms **antigens and antibodies**.

Antigens are generally large **proteins**, but may include other classes of organic molecules, including carbohydrates, lipids, and nucleic acids. Following an infusion of incompatible blood, **erythrocytes** with foreign antigens appear in the bloodstream and trigger an immune response. Proteins called **antibodies** (immunoglobulins), which are produced by certain **B lymphocytes** called **plasma cells**, attach to the antigens on the plasma membranes of the infused erythrocytes and cause them to adhere to one another.

- ➢ Because the arms of the Y-shaped antibodies attach randomly to more than one nonself erythrocyte surface, they form clumps of erythrocytes. This process is called **agglutination**.
- ➢ The clumps of erythrocytes block small blood vessels throughout the body, depriving tissues of oxygen and nutrients.
- ➢ As the erythrocyte clumps are degraded, in a process called **hemolysis**, their **hemoglobin** is released into the bloodstream. This hemoglobin travels to the **kidneys**, which are responsible for filtration of the blood. However, the load of hemoglobin released can easily overwhelm the kidney's capacity to clear it, and the patient can quickly develop kidney failure.

More than 50 antigens have been identified on erythrocyte membranes, but the most significant in terms of their potential harm to patients are classified in two groups: the ABO blood group and the Rh blood group.

The ABO Blood Group

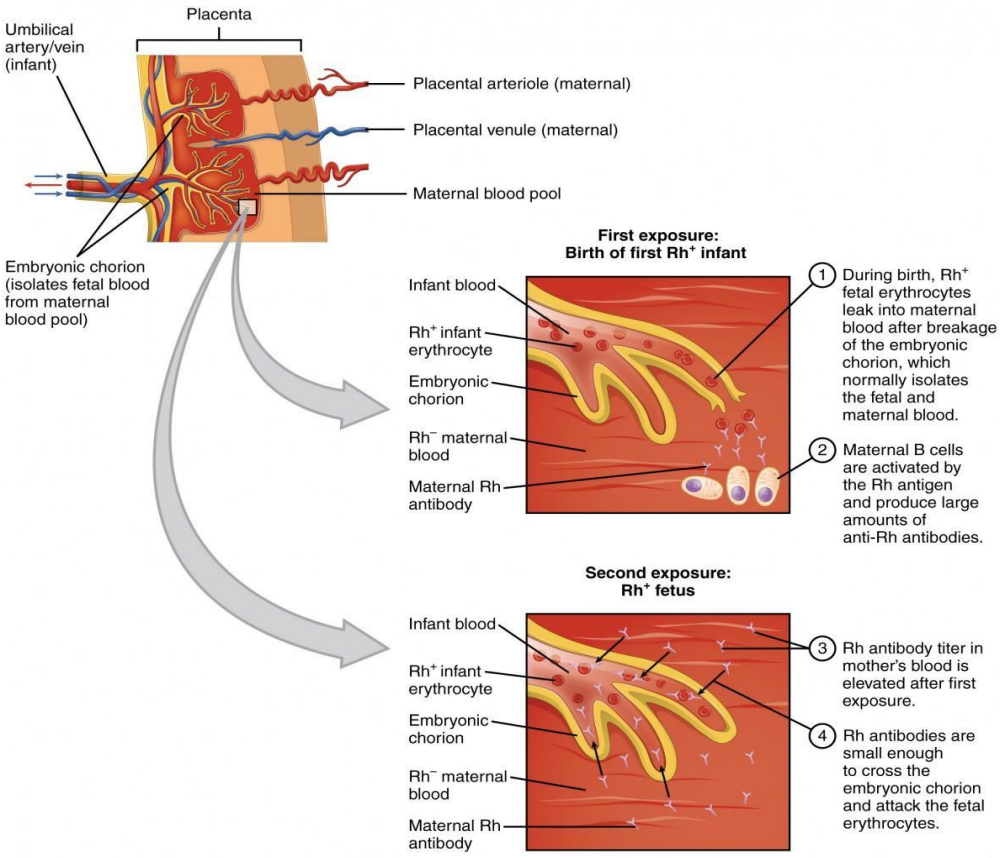
Although the **ABO blood group** name consists of three letters, ABO blood typing designates the presence or absence of just two antigens, **A and B**. Both are **glycoproteins**. People whose erythrocytes have A antigens on their erythrocyte membrane surfaces are designated blood type A, and those whose erythrocytes have B antigens are blood type B. People can also have both A and B antigens on their erythrocytes, in which case they are blood type AB. People with neither A nor B antigens are designated blood type O. ABO blood types are genetically determined.

Normally the body must be exposed to a foreign antigen before an antibody can be produced. This is not the case for the ABO blood group. Individuals with type A blood—without any prior exposure to incompatible blood—have performed antibodies to the B antigen circulating in their blood plasma. These antibodies, referred to as anti-B antibodies, will cause agglutination and hemolysis if they ever encounter erythrocytes with B

antigens. Similarly, an individual with type B blood has pre-formed anti-A antibodies. Individuals with type AB blood, which has both antigens, do not have performed antibodies to either of these. People with type O blood lack antigens A and B on their erythrocytes, but both anti-A and anti-B antibodies circulate in their blood plasma.

Rh Blood Groups

The **Rh blood group** is classified according to the presence or absence of a second erythrocyte antigen identified as Rh. Although dozens of Rh antigens have been identified, only one, designated D, is clinically important. Those who have the Rh D antigen present on their erythrocytes—about 85 percent of Americans—are described as Rh positive (Rh^+) and those who lack it are Rh negative (Rh^-). Note that the Rh group is distinct from the ABO group, so any individual, no matter their ABO blood type, may have or lack this Rh antigen. When identifying a patient's blood type, the Rh group is designated by adding the word positive or negative to the ABO type. For example, A positive (A^+) means ABO group A blood with the Rh antigen present, and AB negative (AB^-) means ABO group AB blood without the Rh antigen.



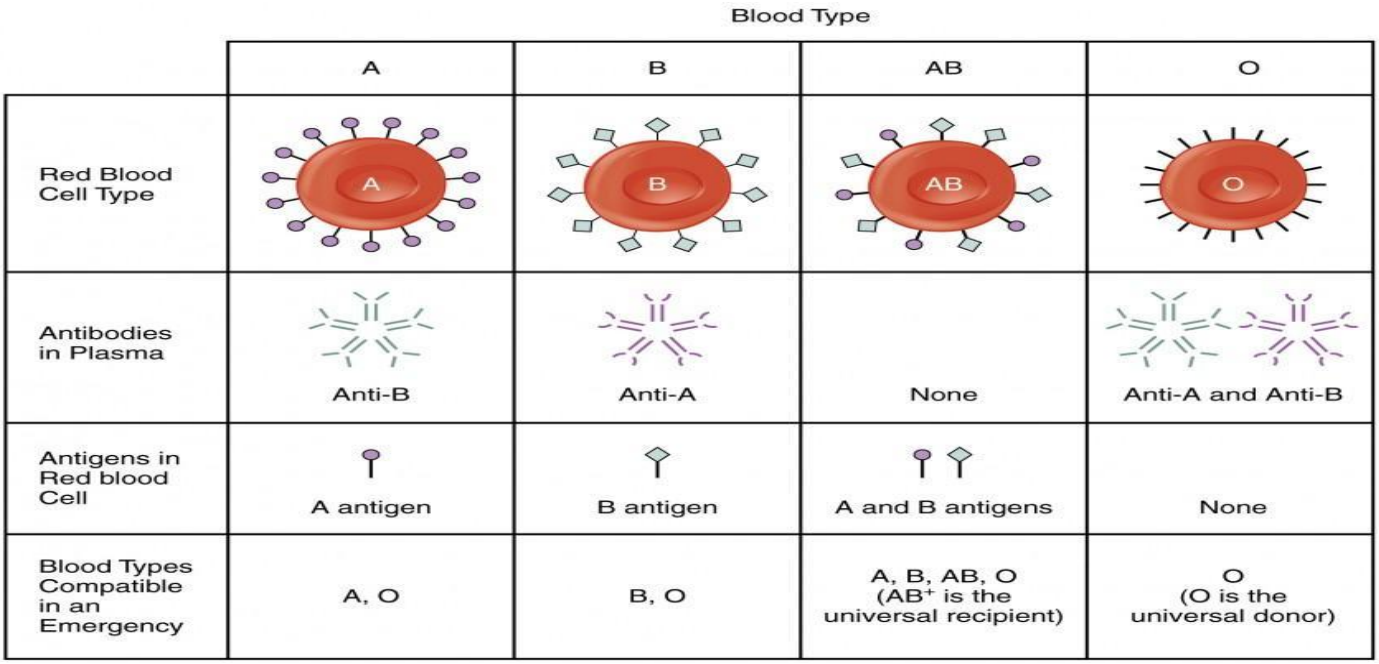
In contrast to the ABO group antibodies, which are preformed, antibodies to the Rh antigen are produced only in Rh^- individuals after exposure to the antigen. This process, called sensitization, occurs following a transfusion with Rh-incompatible blood or, more commonly, with the birth of an Rh^+ baby to an Rh^- mother. Problems are rare in a first pregnancy, since the baby's Rh^+ cells rarely cross the placenta. However, during or immediately after birth, the Rh^- mother can be exposed to the baby's Rh^+ cells. Research has shown that this occurs in about 13−14 percent of such pregnancies. After exposure, the mother's immune system begins to generate anti-Rh antibodies. If the mother should then conceive another Rh^+ baby, the Rh antibodies she has produced can cross the placenta into the fetal bloodstream and destroy the fetal RBCs. This condition, known as **hemolytic disease of the newborn (HDN)** or erythroblastosis fetalis, may cause anemia in mild cases, but the agglutination and hemolysis can be so severe that without treatment the fetus may die in the womb or shortly after birth.

A drug known as RhoGAM, short for Rh immune globulin, can temporarily prevent the development of Rh antibodies in the Rh^- mother, thereby averting this potentially serious disease for the fetus. RhoGAM antibodies destroy any fetal Rh^+ erythrocytes that may cross the placental barrier. RhoGAM is normally administered to Rh^- mothers during weeks 26−28 of pregnancy and within 72 hours following birth. It has proven remarkably effective in decreasing the incidence of HDN. Earlier we noted that the incidence of HDN in an Rh^+ subsequent pregnancy to an Rh^- mother is about 13–14 percent without preventive treatment. Since the introduction of RhoGAM in 1968, the incidence has dropped to about 0.1 percent in the United States.

ABO Transfusion Protocols

To avoid transfusion reactions, it is best to transfuse only matching blood types; that is, a type B^+ recipient should ideally receive blood only from a type B^+ donor and so on. That said, in emergency situations, when acute hemorrhage threatens the patient's life, there may not be time for cross matching to identify blood type. In these cases, blood from a **universal donor**—an individual with type O^- blood—may be transfused. Recall that type O erythrocytes do not display A or B antigens. Thus, anti-A or anti-B antibodies that might be circulating in the patient's blood plasma will not encounter any erythrocyte surface antigens on the donated blood and therefore will not be provoked into a response. One problem with this designation of universal donor is if the O^- individual had prior exposure to Rh antigen, Rh antibodies may be present in the donated blood. Also, introducing type O blood into an individual with type A, B, or AB blood will nevertheless introduce antibodies against both A and B antigens, as these are always circulating in the type O blood plasma. This may cause problems for the recipient, but because the volume of blood transfused is much lower than the volume of the patient's own blood, the adverse effects of the relatively few infused plasma antibodies are typically limited. Rh factor also plays a role. If Rh^- individuals receiving blood have had prior exposure to Rh antigen, antibodies for this antigen may be present in the blood and trigger agglutination to some degree. Although it is always preferable to cross match a patient's blood before transfusing, in a true life-threatening emergency situation, this is not always possible, and these procedures may be implemented.

A patient with blood type AB^+ is known as the **universal recipient**. This patient can theoretically receive any type of blood, because the patient's own blood—having both A and B antigens on the erythrocyte surface—does not produce anti-A or anti-B antibodies. In addition, an Rh^+ patient can receive both Rh^+ and Rh^- blood. However, keep in mind that the donor's blood will contain circulating antibodies, again with possible negative implications.

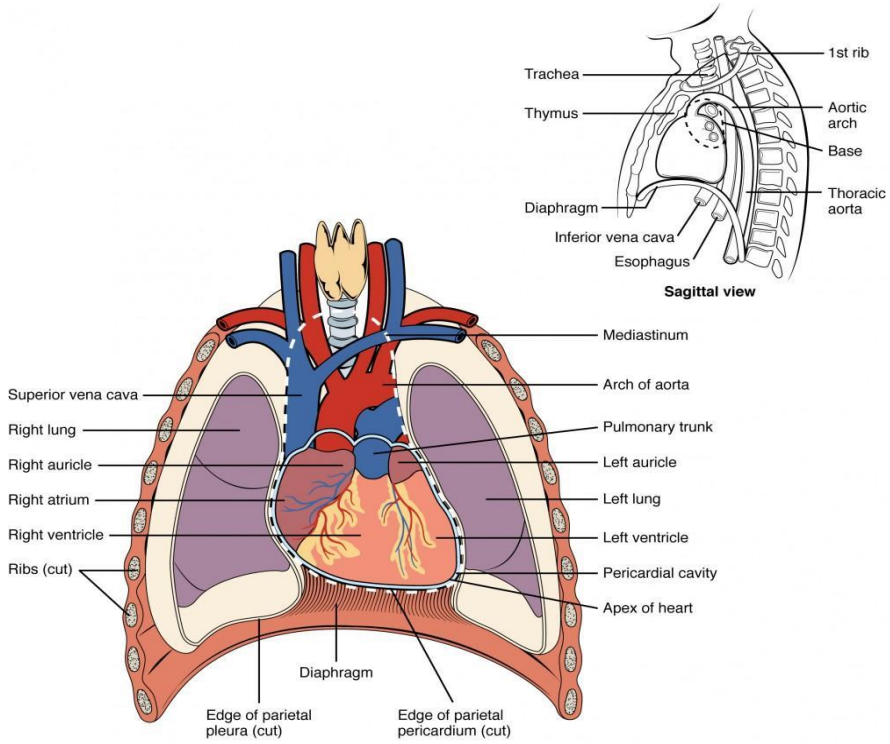


Lesson 3: Structure of the Heart

Objective:

- ➢ Identify and describe the interior and exterior parts of the human heart
- ➢ Relate the structure of the heart to its function as a pump
- ➢ Compare systemic circulation to pulmonary circulation
- ➢ Identify the veins and arteries of the coronary circulation system
- ➢ Trace the pathway of oxygenated and deoxygenated blood thorough the chambers of the heart

The vital importance of the heart is obvious. If one assumes an average rate of contraction of 75 contractions per minute, a human heart would contract approximately 108,000 times in one day, more than 39 million times in one year, and nearly 3 billion times during a 75-year lifespan. Each of the major pumping chambers of the heart ejects approximately 70 mL blood per contraction in a resting adult. This would be equal to 5.25 liters of fluid per minute and approximately 14,000 liters per day. Over one year, that would equal 10,000,000 liters or 2.6 million gallons of blood sent through roughly 60,000 miles of vessels. To understand how that happens, it is necessary to understand the anatomy and physiology of the heart.



Structure of the Heart

The heart is a muscle about the size of a fist and is roughly cone-shaped. It is about 12cm long, 9cm across the broadest point and about 6cm thick. The **pericardium** is a fibrous covering which wraps around the whole heart. It holds the heart in place but allows it to move as it beats. The wall of the heart itself is made up of a special type of muscle called **cardiac muscle.**

Chambers of the Heart

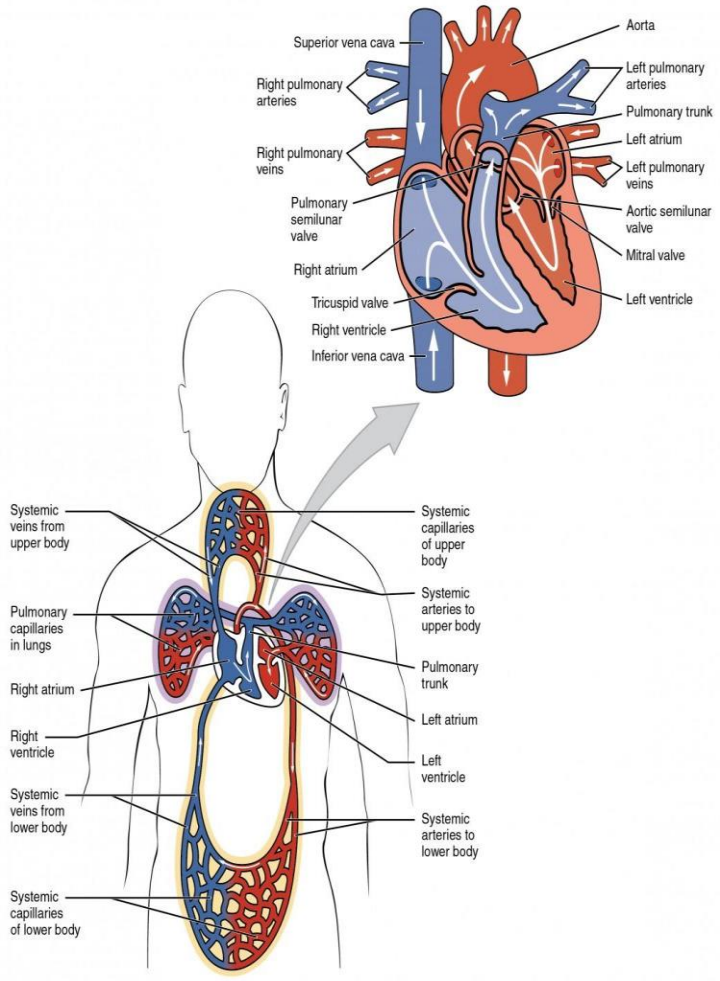
The heart has two sides, the right side and the left side. The heart has four chambers. The left and right side each have two chambers, a top chamber and a bottom chamber. The two top chambers are known as the left and right **atria** (singular: atrium). The atria receive blood from different sources. The left atrium receives blood from the lungs and the right atrium receives blood from the rest of the body. The bottom two chambers are known as the left and right **ventricles.** The ventricles pump blood out to different parts of the body. The right ventricle pumps blood to the lungs while the left ventricle pumps out blood to the rest of the body. The ventricles have much thicker walls than the atria which allows them to perform more work by pumping out blood to the whole body.

Valves

Valves are fibrous flaps of tissue found between the heart chambers and in the blood vessels. They are rather like gates which prevent blood from flowing in the wrong direction. They are found in several places. Valves between the atria and ventricles are known as the right and left **atrioventricular valves**, otherwise known as the **tricuspid and mitral valves** respectively. Valves between the ventricles and the great arteries are known as the **semilunar valves.** The **aortic valve** is found at the base of the **aorta,** while the **pulmonary valve** is found the base of the **pulmonary trunk**. There are also many valves found in veins throughout the body. However, there are no valves found in any of the other arteries besides the aorta and pulmonary trunk.

What is the Cardiovascular System?

The **cardiovascular system** refers to the heart, blood vessels and the blood. Blood contains **oxygen** and other nutrients which your body needs to survive. The body takes these essential nutrients from the blood. At the same time, the body dumps waste products like **carbon dioxide**, back into the blood, so they can be removed. The main function of the cardiovascular system is therefore to maintain blood flow to all parts of the body, to allow it to survive. **Veins** deliver used blood from the body back to the heart. Blood in the veins is low in oxygen (as it has been taken out by the body) and high in carbon dioxide (as the body has unloaded it back into the blood). All the veins drain into the **superior and inferior vena cava** which then drain into the **right atrium**. The right atrium pumps blood into the **right ventricle**. Then the right ventricle pumps blood to the **pulmonary trunk**, through the **pulmonary arteries** and into the lungs. In the lungs the blood picks up oxygen that we breathe in and gets rid of carbon dioxide, which we breathe out. The blood becomes rich in oxygen which the body can use. From the lungs, blood drains into the **left atrium** and is then pumped into the **left ventricle**. The left ventricle then pumps this oxygen-rich blood out into the *aorta* which then distributes it to the rest of the body through other **arteries**. There are also microscopic blood vessels which connect arteries and veins together called **capillaries** The main arteries which branch off the aorta and take blood to specific parts of the body are:

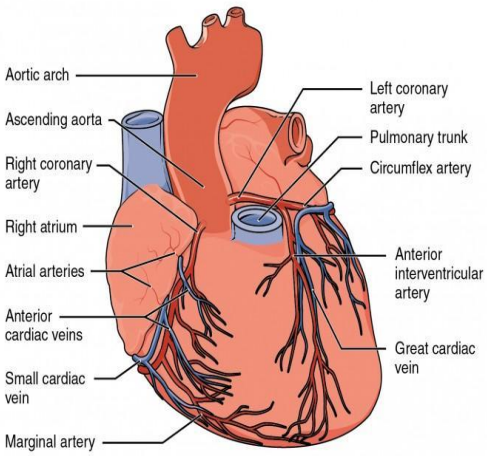


- **Carotid arteries**, which take blood to the neck and head
- **Coronary arteries**, which provide blood supply to the heart itself
- **Hepatic artery,** which takes blood to the liver with branches going to the stomach
- **Mesenteric artery**, which takes blood to the intestines
- **Renal arteries**, which takes blood to the kidneys
- **Femoral arteries,** which take blood to the legs

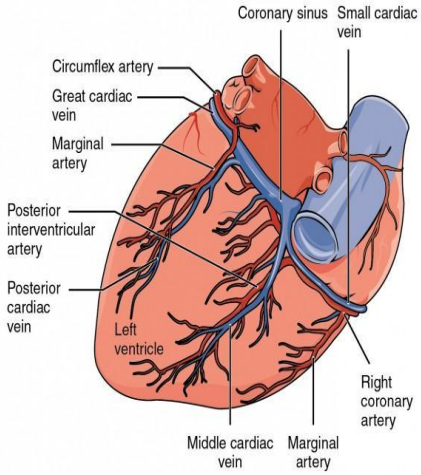
The body is then able to use the oxygen in the blood to carry out its normal functions. This blood will again return to the heart through the veins and the cycle continues.

Structure of Cardiac Muscle

Compared to the giant cylinders of skeletal muscle, cardiac muscle cells, or **cardiomyocytes**, are considerably shorter with much smaller diameters. Cardiac muscle also demonstrates **striations,** the alternating pattern of dark A bands and light I bands attributed to the precise arrangement of the **myofilaments** and fibrils that are organized in **sarcomeres** along the length of the cell. These contractile elements are virtually identical to skeletal muscle. T (transverse) tubules penetrate from the surface plasma membrane, the sarcolemma, to the interior of the cell, allowing the electrical impulse to reach the interior. The T tubules are only found at the Z discs, whereas in skeletal muscle, they are found at the junction of the A and I bands. Therefore, there are one-half as many T tubules in cardiac muscle as in skeletal muscle. In addition, the sarcoplasmic reticulum stores few calcium ions, so most of the calcium ions must come from outside the cells. The result is a slower onset of contraction. Mitochondria are plentiful, providing energy for the contractions of the heart. Typically, cardiomyocytes have a single, central nucleus, but two or more nuclei may be found in some cells.

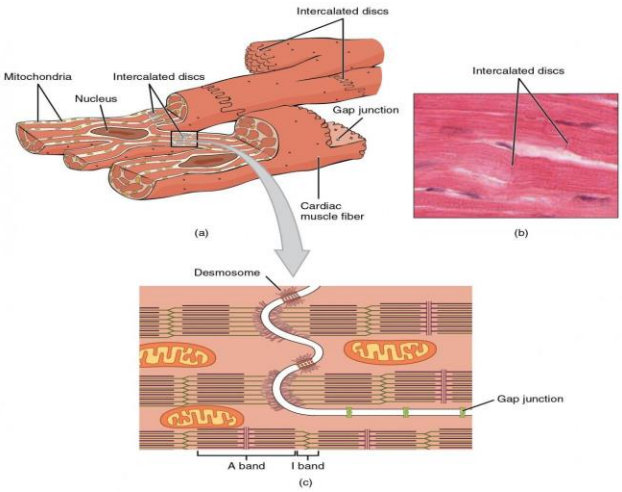


Anterior view



Posterior view

Cardiac muscle cells branch freely. A junction between two adjoining cells is marked by a critical structure called an **intercalated disc**, which helps support the synchronized contraction of the muscle. The sarcolemma from adjacent cells bind together at the intercalated discs. They consist of desmosomes, specialized linking proteoglycans, tight junctions, and large numbers of gap junctions that allow the passage of ions between the cells and help to synchronize the contraction. Intercellular connective tissue also helps to bind the cells together. The importance of strongly binding these cells together is necessitated by the forces exerted by contraction.



Lesson 4: Blood pressure and the cardiac cycle

Objective:

- Describe the relationship between blood pressure and blood flow
- Summarize the events of the cardiac cycle
- Compare atrial and ventricular systole and diastole
- Relate heart sounds detected by auscultation to action of heart's valves

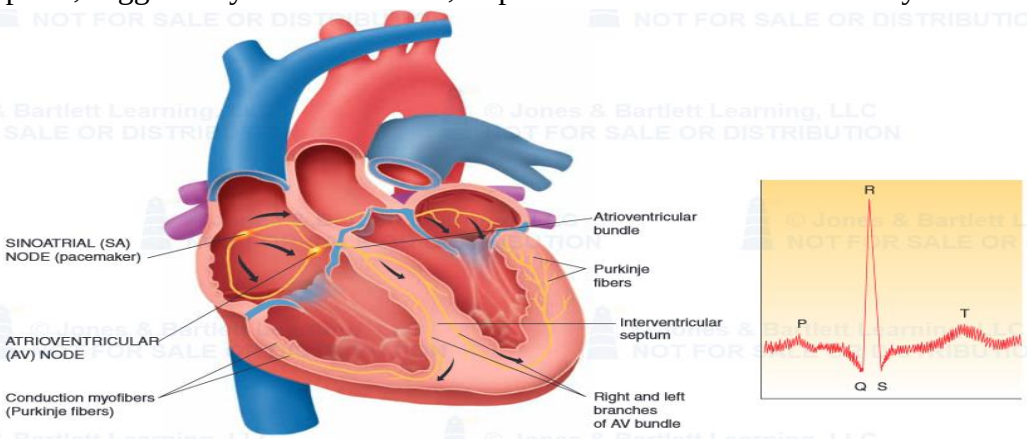
What is the Cardiac Cycle?

The cardiac cycle is the sequence of events that occurs in one complete beat of the heart. The pumping phase of the cycle, also known as **systole,** occurs when heart muscle contracts. The filling phase, which is known as **diastole,** occurs when heart muscle relaxes. At the beginning of the cardiac cycle, both atria and ventricles are in diastole. During this time, all the chambers of the heart are relaxed and receive blood. The atrioventricular valves are open. **Atrial systole** follows this phase. During atrial systole, the left and right atria contract at the same time and push blood into the left and right ventricles, respectively. The next phase is **ventricular systole**. During ventricular systole, the left and right ventricles contract at the same time and pump blood into the aorta and pulmonary trunk, respectively. In ventricular systole, the atria are relaxed and receive blood. The atrioventricular valves close immediately after ventricular systole begins to stop blood going back into the atria. However, the semilunar valves are open during this phase to allow the blood to flow into the aorta and pulmonary trunk. Following this phase, the ventricles relax that is ventricular diastole occurs. The semilunar valves close to stop the blood from flowing back into the ventricles from the aorta and pulmonary trunk. The atria and ventricles once again are in diastole together and the cycle begins again.

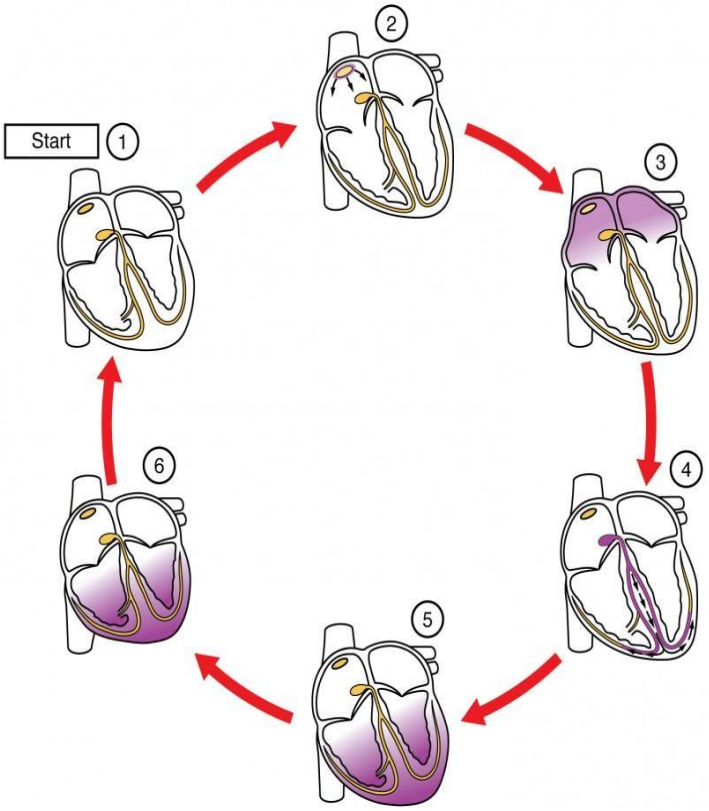
The adult heart beats around 70 to 80 times a minute at rest. When you listen to your heart with a stethoscope you can hear your heart beat. The sound is usually described as "lubb-dupp". The "lubb" also known as the first heart sound, is caused by the closure of the atrioventricular valves. The "dupp" sound is due to the closure of the semilunar valves when the ventricles relax (at the beginning of ventricular diastole). Abnormal heart sounds are known as murmurs. Murmurs may indicate a problem with the heart valves, but many types of murmur are no cause for concern. (For more information see: (see Valvular Heart Disease)

Conduction System of the Heart

If embryonic heart cells are separated into a Petri dish and kept alive, each can generate its own electrical impulse followed by contraction. When two independently beating embryonic cardiac muscle cells are placed together, the cell with the higher inherent rate sets the pace, and the impulse spreads from the faster to the slower cell to trigger a contraction. As more cells are joined together, the fastest cell continues to assume control of the rate. A fully developed adult heart maintains the capability of generating its own electrical impulse, triggered by the fastest cells, as part of the cardiac conduction system. The components of the cardiac conduction system include the **sinoatrial node, the atrioventricular node, the atrioventricular bundle, the atrioventricular bundle branches**, and the **Purkinje cells.**



Strands and clumps of specialized cardiac muscle contain only a few **myofibrils** and are located throughout the heart. These areas initiate and distribute impulses through the myocardium, comprising the cardiac conduction system that coordinates the cardiac cycle. The **sinoatrial node** (SA node) is a small mass of specialized tissue just beneath the **epicardium,** in the right atrium. It is located near the opening of the superior vena cava, with fibers continuous with those of the atrial syncytium. The SA node's cells can reach threshold on their own, initiating impulses through the myocardium, stimulating contraction of cardiac muscle fibers. Its rhythmic activity occurs 70 to 80 times per minute in a normal adult. Since it generates the heart's rhythmic contractions, it is often referred to as the **pacemaker.** The path of a cardiac impulse travels from the SA node into the atrial syncytium, and the atria begin to contract almost simultaneously. The impulse passes along junctional fibers of the conduction system to a mass of specialized tissue called the **atrioventricular node** (AV node), located in the inferior interatrial septum, beneath the endocardium. The AV node provides the only normal conduction pathway between the atrial and ventricular syncytia. Impulses are slightly delayed due to the small diameter of the junctional fibers. The atria, therefore, have more time to contract and empty all their blood into the ventricles before ventricular contraction occurs. When the cardiac impulse reaches the distal AV node, it passes into a large AV bundle (**bundle of His**), entering the upper part of the interventricular septum. Nearly half-way down the septum, these branches spread into enlarged **Purkinje fibers**, extending into the papillary muscles. They continue to the heart's apex, curving around the ventricles and passing over their lateral walls. The Purkinje fibers have numerous small branches that become continuous with cardiac muscle fibers and irregular whorls. Purkinje fiber stimulation causes the ventricular walls to contract in a twisting motion, to force blood into the aorta and pulmonary trunk. An electrocardiogram (EKG) is used to record electrical changes in the myocardium during the cardiac cycle.



Figure

(1) The sinoatrial (SA) node and the remainder of the conduction system are at rest. (2) The SA node initiates the action potential, which sweeps across the atria. (3) After reaching the atrioventricular node, there is a delay of approximately 100 ms that allows the atria to complete pumping blood before the impulse is transmitted to the atrioventricular bundle. (4) Following the delay, the impulse travels through the atrioventricular bundle and bundle branches to the Purkinje fibers, and also reaches the right papillary muscle via the moderator band. (5) The impulse spreads to the contractile fibers of the ventricle. (6) Ventricular contraction begins.

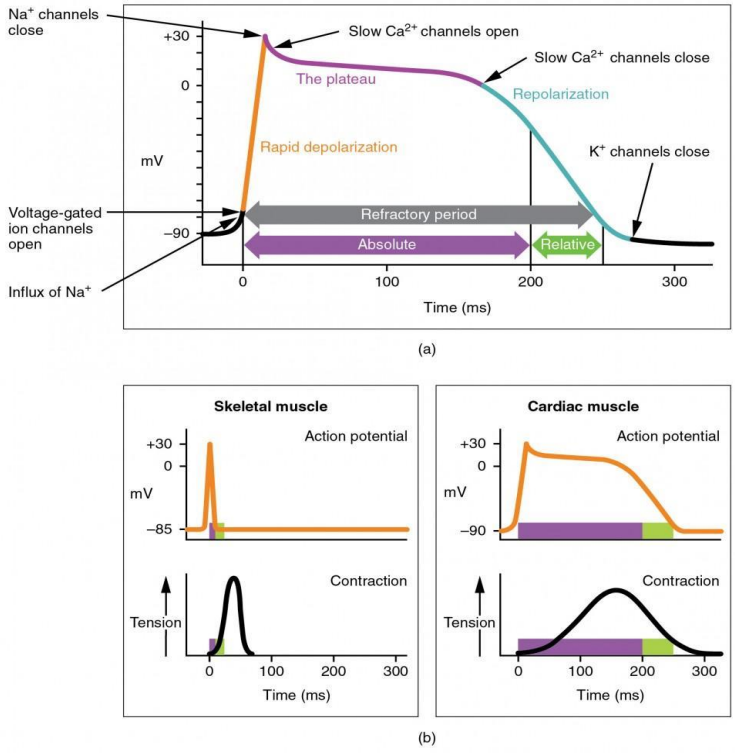
Membrane Potentials and Ion Movement in Cardiac Contractile Cells

There is a distinctly different electrical pattern involving the contractile cells. In this case, there is a rapid depolarization, followed by a plateau phase and then repolarization. This phenomenon accounts for the long refractory periods required for the cardiac muscle cells to pump blood effectively before they are capable of firing for a second time. These cardiac myocytes normally do not initiate their own electrical potential, although they can do so, but rather wait for an impulse to reach them.

Contractile cells demonstrate a much more stable resting phase than conductive cells at approximately −80 mV for cells in the atria and −90 mV for cells in the ventricles. Despite this initial difference, the other components of their action potentials are virtually identical. In both cases, when stimulated by an action potential, voltage-gated channels rapidly open, beginning the positive-feedback mechanism of depolarization. This rapid influx of positively charged ions raises the membrane potential to approximately +30 mV, at which point the sodium channels close. The rapid depolarization period typically lasts 3–5 ms. Depolarization is followed by the plateau phase, in which membrane potential declines relatively slowly. This is due in large part to the opening of the slow Ca^{2+} channels, allowing Ca^{2+} to enter the cell while few K^+ channels are open, allowing K^+ to exit the cell. The relatively long plateau phase lasts approximately 175 ms. Once the membrane potential reaches approximately zero, the Ca^{2+} channels close and K^+ channels open, allowing K^+ to exit the cell. The repolarization lasts approximately 75 ms. At this point, membrane potential drops until it reaches resting levels once more and the cycle repeats. The entire event lasts between 250 and 300 ms.

Calcium Ions

Calcium ions play two critical roles in the physiology of cardiac muscle. Their influx through slow calcium channels accounts for the prolonged plateau phase and absolute refractory period that enable cardiac muscle to function properly. Calcium ions also combine with the regulatory protein troponin in the troponin-tropomyosin complex; this complex removes the inhibition that prevents the heads of the myosin molecules from forming cross bridges with the active sites on actin that provide the power stroke of contraction. This mechanism is virtually identical to that of skeletal muscle. Approximately 20 percent of the calcium required for contraction is supplied by the influx of Ca^{2+} during the plateau phase. The remaining Ca^{2+} for contraction is released from storage in the sarcoplasmic reticulum.

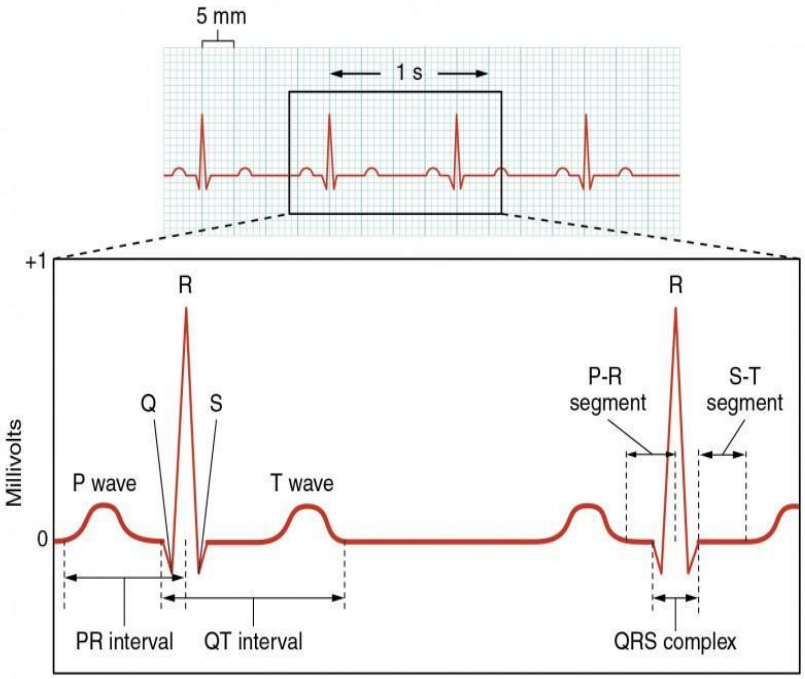


Electrocardiogram

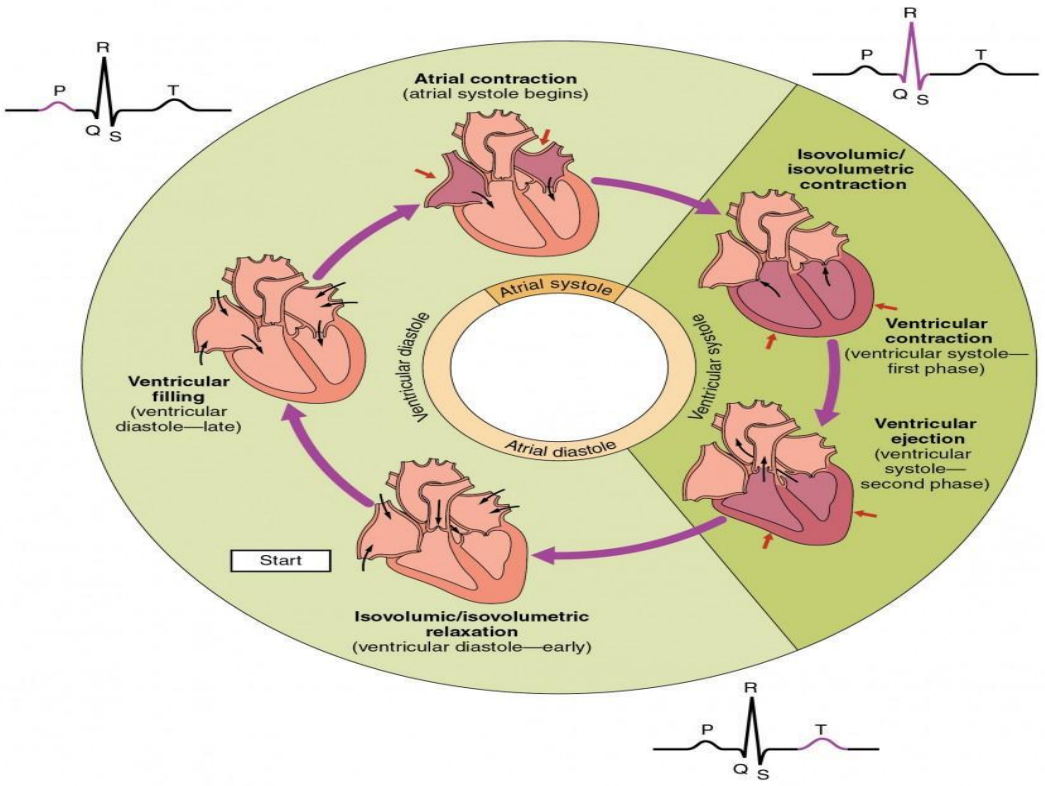
By careful placement of surface electrodes on the body, it is possible to record the complex, compound electrical signal of the heart. This tracing of the electrical signal is the **electrocardiogram (ECG)**, also commonly abbreviated EKG. Careful analysis of the ECG reveals a detailed picture of both normal and abnormal heart function and is an indispensable clinical diagnostic tool. The standard electrocardiograph (the instrument that generates an ECG) uses 3, 5, or 12 leads. The greater the number of leads an electrocardiograph uses, the more information the ECG provides. The term "lead" may be used to refer to the cable from the electrode to the electrical recorder, but it typically describes the voltage difference between two of the electrodes. The 12-lead electrocardiograph uses 10 electrodes placed in standard locations on the patient's skin (Figure 6). In continuous ambulatory electrocardiographs, the patient wears a small, portable, battery-operated device known as a Holter monitor, or simply a Holter, that continuously monitors heart electrical activity, typically for a period of 24 hours during the patient's normal routine.

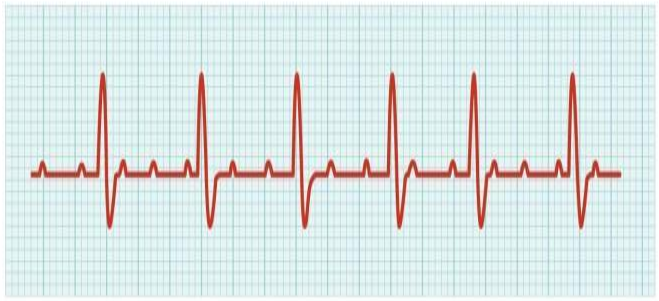
A normal ECG tracing is presented in the figure below. Each component, segment, and interval is labeled and corresponds to important electrical events, demonstrating the relationship between these events and contraction in the heart.

There are five prominent points on the ECG: the P wave, the QRS complex, and the T wave. The small **P wave** represents the depolarization of the atria. The atria begin contracting approximately 25 ms after the start of the P wave. The large **QRS complex** represents the depolarization of the ventricles, which requires a much stronger electrical signal because of the larger size of the ventricular cardiac muscle. The ventricles begin to contract as the QRS reaches the peak of the R wave. Lastly, the **T wave** represents the repolarization of the ventricles. The repolarization of the atria occurs during the QRS complex, which masks it on an ECG.



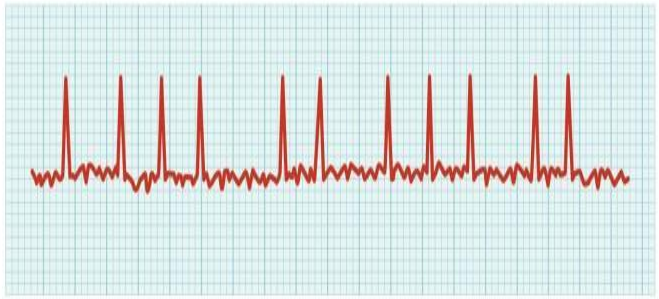
The major segments and intervals of an ECG tracing are indicated in the image below. Segments are defined as the regions between two waves. Intervals include one segment plus one or more waves. For example, the PR segment begins at the end of the P wave and ends at the beginning of the QRS complex. The PR interval starts at the beginning of the P wave and ends with the beginning of the QRS complex. The PR interval is more clinically relevant, as it measures the duration from the beginning of atrial depolarization (the P wave) to the initiation of the QRS complex. Since the Q wave may be difficult to view in some tracings, the measurement is often extended to the R that is more easily visible. Should there be a delay in passage of the impulse from the SA node to the AV node, it would be visible in the PR interval. Figure 8 correlates events of heart contraction to the corresponding segments and intervals of an ECG.





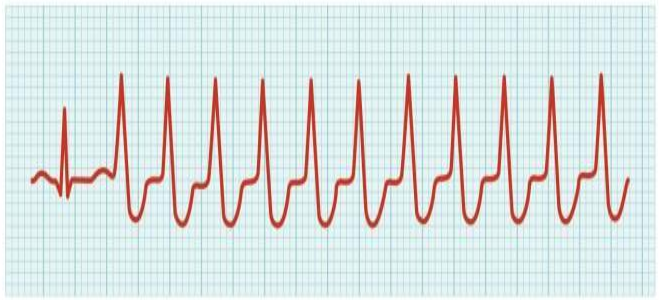
Note how half of the P waves are not followed by the QRS complex and T waves while the other half are.
Question: What would you expect to happen to heart rate (pulse)?

(a) Second-degree (partial) block



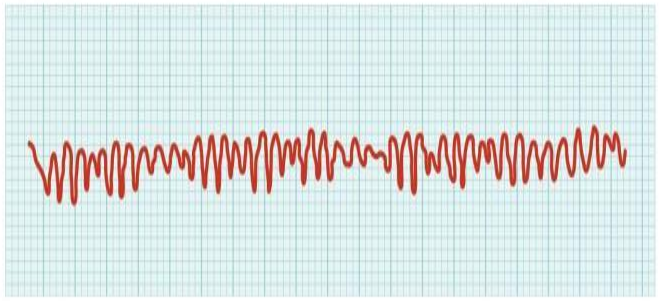
Note the abnormal electrical pattern prior to the QRS complexes. Also note how the frequency between the QRS complexes has increased.
Question: What would you expect to happen to heart rate (pulse)?

(b) Atrial fibrillation



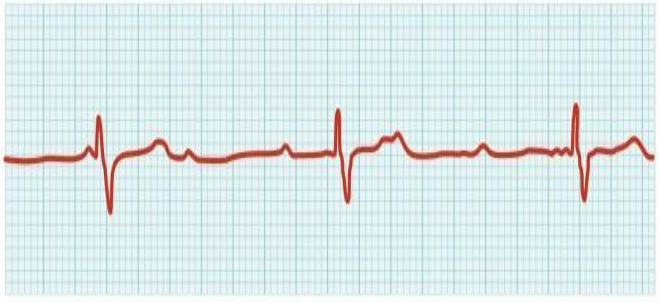
Note the unusual shape of the QRS complex, focusing on the "S" component.
Question: What would you expect to happen to heart rate (pulse)?

(c) Ventricular tachycardia



Note the total lack of normal electrical activity.
Question: What would you expect to happen to heart rate (pulse)?

(d) Ventricular fibrillation



Note that in a third-degree block some of the impulses initiated by the SA node do not reach the AV node while others do. Also note that the P waves are not followed by the QRS complex.
Question: What would you expect to happen to heart rate (pulse)?

(e) Third-degree block

Lesson 5: Respiratory Anatomy

Objective:

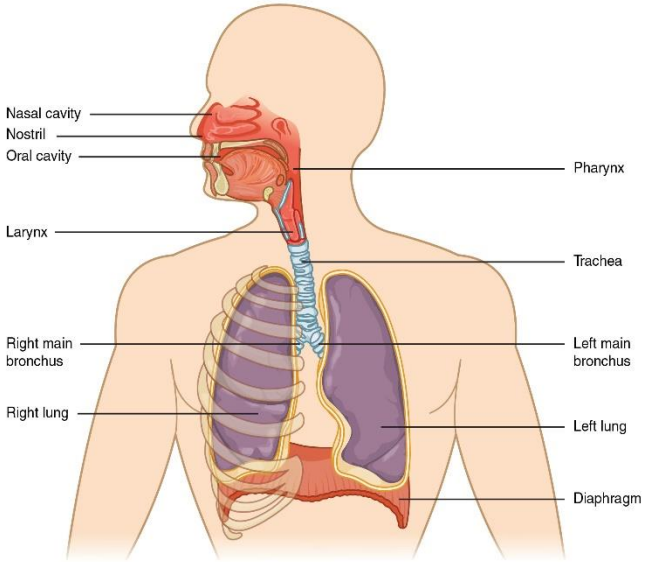
- List the structures that make up the respiratory system
- Describe how the respiratory system processes oxygen and CO_2
- Compare the functions of upper respiratory tract with the lower respiratory tract

he major organs of the respiratory system function primarily to provide oxygen to body tissues for cellular respiration, remove the waste product carbon dioxide, and help to maintain acid-base balance. Portions of the respiratory system are also used for non-vital functions, such as sensing odors, speech production, and for straining, such as during childbirth or coughing.

Functionally, the respiratory system can be divided into a conducting zone and a respiratory zone. The **conducting zone** of the respiratory system includes the organs and structures not directly involved in gas exchange. The gas exchange occurs in the **respiratory zone**.

Conducting Zone

The major functions of the conducting zone are to provide a route for incoming and outgoing air, remove debris and pathogens from the incoming air, and warm and humidify the incoming air. Several structures within the conducting zone perform other functions as well. The epithelium of the nasal passages, for example, is essential to sensing odors, and the bronchial epithelium that lines the lungs can metabolize some airborne carcinogens.

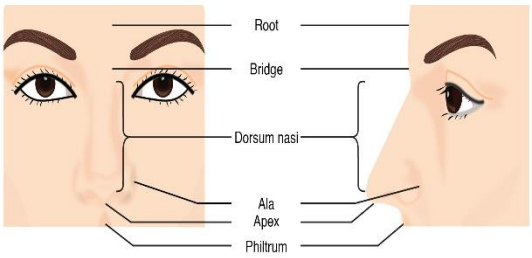


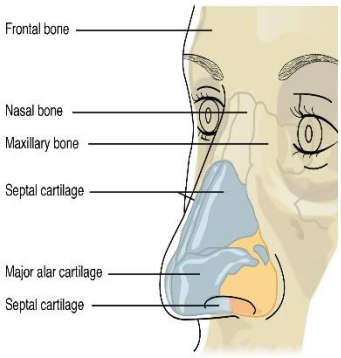
The Nose and its Adjacent Structures

The major entrance and exit for the respiratory system is through the nose. When discussing the nose, it is helpful to divide it into two major sections: the external nose, and the nasal cavity or internal nose.

The **external nose** consists of the surface and skeletal structures that result in the outward appearance of the nose and contribute to its numerous functions (Figure 2). The **root** is the region of the nose located between the eyebrows. The **bridge** is the part of the nose that connects the root to the rest of the nose. The **dorsum nasi** is the length of the nose. The **apex** is the tip of the nose. On either side of the apex, the nostrils are formed by the alae (singular = ala). An **ala** is a cartilaginous structure that forms the lateral side of each **naris** (plural = nares), or nostril opening. The **philtrum** is the concave surface that connects the apex of the nose to the upper lip.

Underneath the thin skin of the nose are its skeletal features. While the root and bridge of the nose consist of bone, the protruding portion of the nose is composed of cartilage. As a result, when looking at a skull, the nose is missing. The **nasal bone** is one of a pair of bones that lies under the root and bridge of the nose. The nasal bone articulates superiorly with the frontal bone and laterally with the maxillary bones. Septal cartilage is flexible hyaline cartilage connected to the nasal bone, forming the dorsum nasi. The **alar cartilage** consists of the apex of the nose; it surrounds the naris.

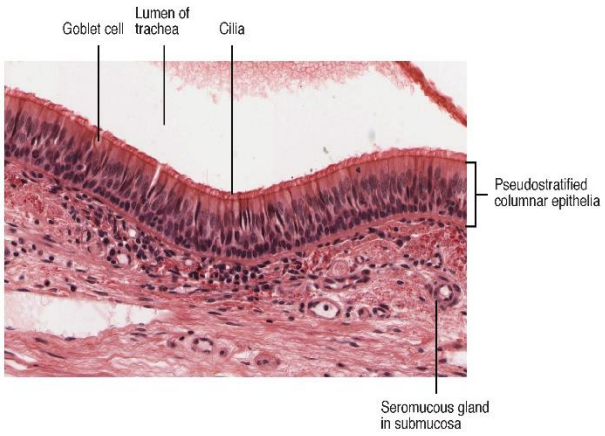




The nares open into the nasal cavity, which is separated into left and right sections by the nasal septum. The **nasal septum** is formed anteriorly by a portion of the septal cartilage (the flexible portion you can touch with your fingers) and posteriorly by the perpendicular plate of the ethmoid bone (a cranial bone located just posterior to the nasal bones) and the thin vomer bones (whose name refers to its plough shape). Each lateral wall of the nasal cavity has three bony projections, called the superior, middle, and inferior nasal **conchae**. The inferior conchae are separate bones, whereas the superior and middle conchae are portions of the **ethmoid bone**. Conchae serve to increase the surface area of the nasal cavity and to disrupt the flow of air as it enters the nose, causing air to bounce along the epithelium, where it is cleaned and warmed. The conchae and **meatuses** also conserve water and prevent dehydration of the nasal epithelium by trapping water during exhalation. The floor of the nasal cavity is composed of the **palate**. The hard palate at the anterior region of the nasal cavity is composed of bone. The soft palate at the posterior portion of the nasal cavity consists of muscle tissue. Air exits the nasal cavities via the internal nares and moves into the pharynx.

Several bones that help form the walls of the nasal cavity have air-containing spaces called the **paranasal sinuses**, which serve to warm and humidify incoming air. Sinuses are lined with a **mucosa.** Each paranasal sinus is named for its associated bone: **frontal sinus, maxillary sinus, sphenoidal sinus, and ethmoidal sinus.** The sinuses produce mucus and lighten the weight of the skull.

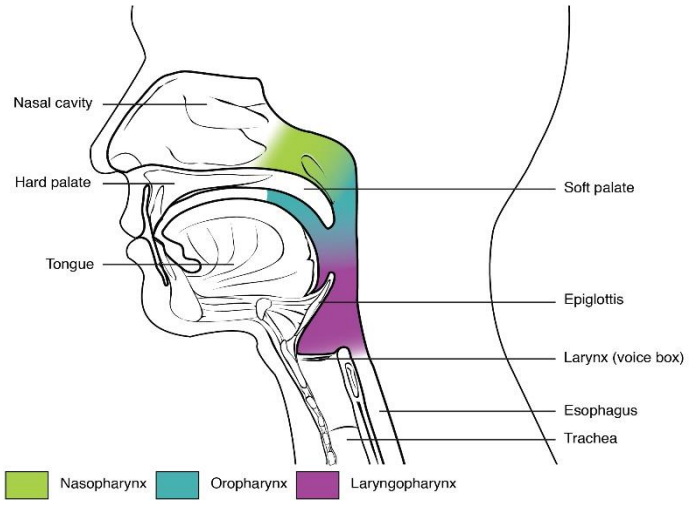
The nares and anterior portion of the nasal cavities are lined with mucous membranes, containing sebaceous glands and hair follicles that serve to prevent the passage of large debris, such as dirt, through the nasal cavity. An olfactory epithelium used to detect odors is found deeper in the nasal cavity.



The conchae, meatuses, and paranasal sinuses are lined by **respiratory epithelium** composed of pseudostratified ciliated columnar epithelium. The epithelium contains **goblet cells**, one of the specialized, columnar epithelial cells that produce mucus to trap debris. The **cilia** of the respiratory epithelium help remove the mucus and debris from the nasal cavity with a constant beating motion, sweeping materials towards the throat to be swallowed. Interestingly, cold air slows the movement of the cilia, resulting in accumulation of mucus that may in turn lead to a runny nose during cold weather. This moist epithelium functions to warm and humidify incoming air. Capillaries located just beneath the nasal epithelium warm the air by convection. Serous and mucus-producing cells also secrete the lysozyme enzyme and proteins called defensins, which have antibacterial properties. Immune cells that patrol the connective tissue deep to the respiratory epithelium provide additional protection.

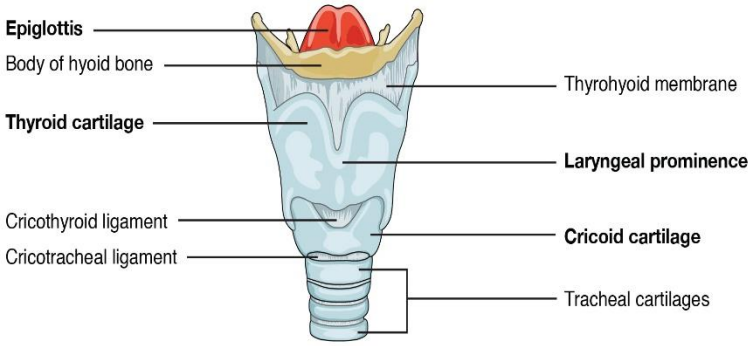
Pharynx

The **pharynx** is a tube formed by skeletal muscle and lined by mucous membrane that is continuous with that of the nasal cavities. The pharynx is divided into three major regions: the nasopharynx, the oropharynx, and the laryngopharynx. The **nasopharynx** is flanked by the conchae of the nasal cavity, and it serves only as an airway. At the top of the nasopharynx are the pharyngeal tonsils. A **pharyngeal tonsil**, also called an adenoid, is an aggregate of lymphoid reticular tissue like a lymph node that lies at the superior portion of the nasopharynx. The function of the pharyngeal tonsil is not well understood, but it contains a rich supply of lymphocytes and is covered with ciliated epithelium that traps and destroys invading pathogens that enter during inhalation. The pharyngeal tonsils are large in children, but interestingly, tend to regress with age and may even disappear. The uvula is a small bulbous, teardrop-shaped structure located at the apex of the soft palate. Both the uvula and soft palate move like a pendulum during swallowing, swinging upward to close off the nasopharynx to prevent ingested materials from entering the nasal cavity. In addition, auditory (Eustachian) tubes that connect to each middle ear cavity open into the nasopharynx. This connection is why colds often lead to ear infections.

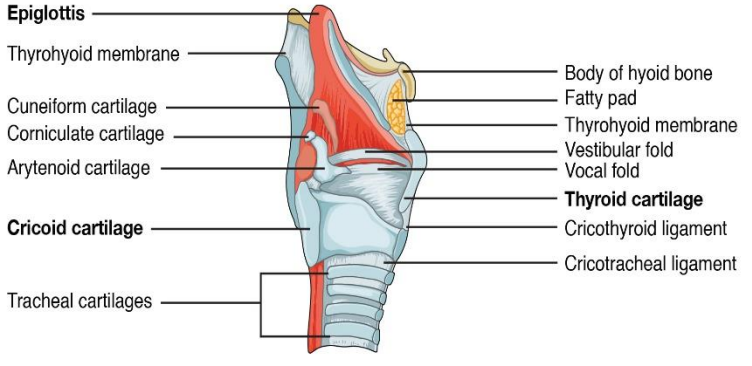


The **oropharynx** is a passageway for both air and food. The oropharynx is bordered superiorly by the nasopharynx and anteriorly by the oral cavity. The **fauces** is the opening at the connection between the oral cavity and the oropharynx. As the nasopharynx becomes the oropharynx, the epithelium changes from pseudostratified ciliated columnar epithelium to stratified squamous epithelium. The oropharynx contains two distinct sets of tonsils, the palatine and lingual tonsils. A **palatine tonsil** is one of a pair of structures located laterally in the oropharynx in the fauces. The **lingual tonsil** is located at the base of the tongue. Like the pharyngeal tonsil, the palatine and lingual tonsils are composed of lymphoid tissue, and trap and destroy pathogens entering the body through the oral or nasal cavities.

The **laryngopharynx** is inferior to the oropharynx and posterior to the larynx. It continues the route for ingested material and air until its inferior end, where the digestive and respiratory systems diverge. The stratified squamous epithelium of the oropharynx is continuous with the laryngopharynx. Anteriorly, the laryngopharynx opens into the larynx, whereas posteriorly, it enters the esophagus.



Anterior view



Right lateral view

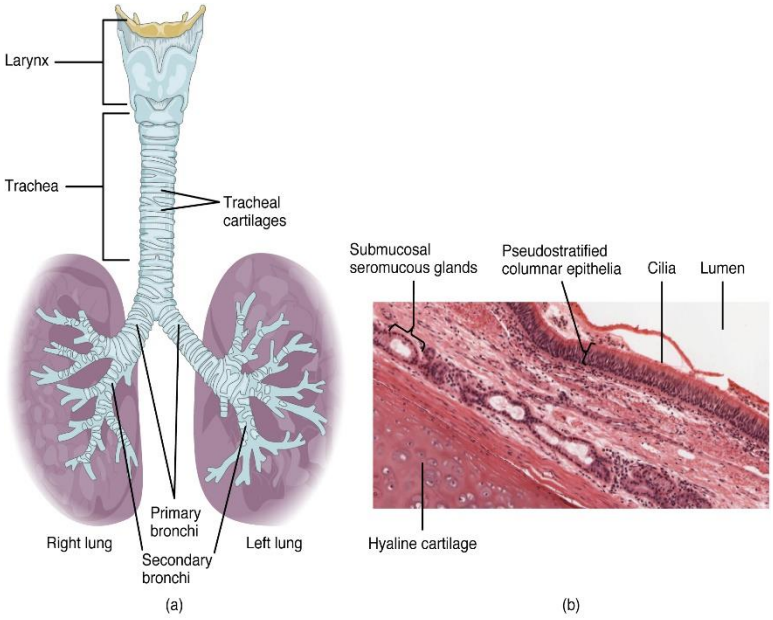
Larynx

The **larynx** is a cartilaginous structure inferior to the laryngopharynx that connects the pharynx to the trachea and helps regulate the volume of air that enters and leaves the lungs. The structure of the larynx is formed by several pieces of cartilage. Three large cartilage pieces—the thyroid cartilage (anterior), epiglottis (superior), and cricoid cartilage (inferior)—

form the major structure of the larynx. The **thyroid cartilage** is the largest piece of cartilage that makes up the larynx. The thyroid cartilage consists of the **laryngeal prominence**, or "Adam's apple," which tends to be more prominent in males. The thick **cricoid cartilage** forms a ring, with a wide posterior region and a thinner anterior region. Three smaller, paired cartilages—the arytenoids, corniculates, and cuneiforms—attach to the epiglottis and the vocal cords and muscle that help move the vocal cords to produce speech.

The **epiglottis**, attached to the thyroid cartilage, is a very flexible piece of elastic cartilage that covers the opening of the trachea. When in the "closed" position, the unattached end of the epiglottis rests on the glottis. The **glottis** is composed of the vestibular folds, the true vocal cords, and the space between these folds. A **vestibular fold**, or false vocal cord, is one of a pair of folded sections of mucous membrane. A **true vocal cord** is one of the white, membranous folds attached by muscle to the thyroid and arytenoid cartilages of the larynx on their outer edges. The inner edges of the true vocal cords are free, allowing oscillation to produce sound. The size of the membranous folds of the true vocal cords differs between individuals, producing voices with different pitch ranges. Folds in males tend to be larger than those in females, which create a deeper voice. The act of swallowing causes the pharynx and larynx to lift upward, allowing the pharynx to expand and the epiglottis of the larynx to swing downward, closing the opening to the trachea. These movements produce a larger area for food to pass through, while preventing food and beverages from entering the trachea.

Continuous with the laryngopharynx, the superior portion of the larynx is lined with stratified squamous epithelium, transitioning into pseudostratified ciliated columnar epithelium that contains goblet cells. Similar to the nasal cavity and nasopharynx, this specialized epithelium produces mucus to trap debris and pathogens as they enter the trachea. The cilia beat the mucus upward towards the laryngopharynx, where it can be swallowed down the esophagus.



Trachea

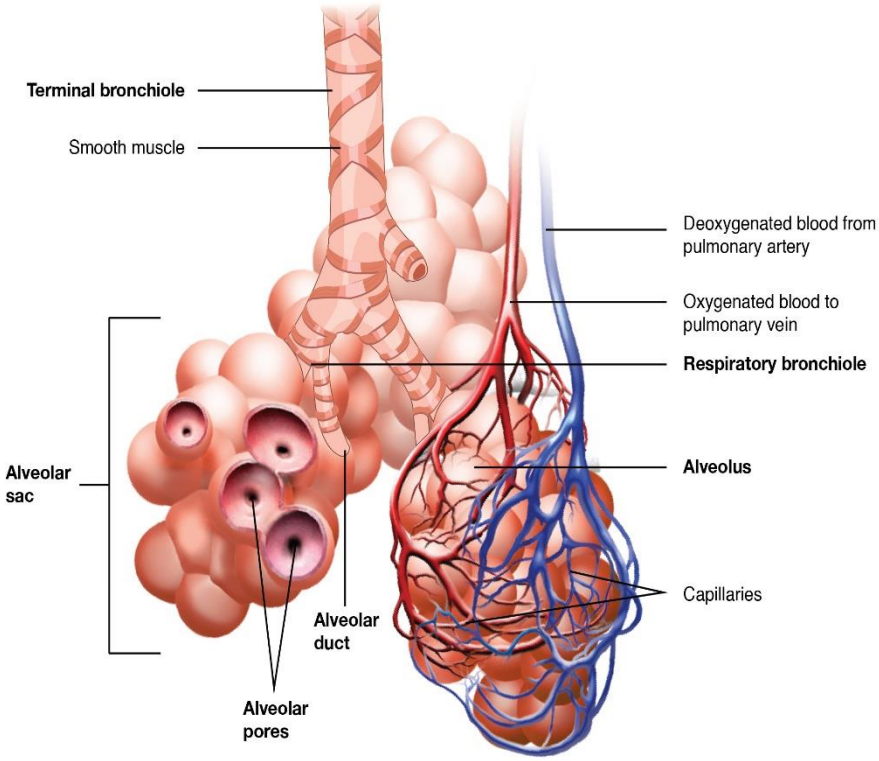
The trachea (windpipe) extends from the larynx toward the lungs. The **trachea** is formed by 16 to 20 stacked, C-shaped pieces of hyaline cartilage that are connected by dense connective tissue. The **trachealis muscle** and elastic connective tissue together form the **fibroelastic membrane**, a flexible membrane that closes the posterior surface of the trachea, connecting the C-shaped cartilages. The fibroelastic membrane allows the trachea to stretch and expand slightly during inhalation and exhalation, whereas the rings of cartilage provide structural support and prevent the trachea from collapsing. In addition, the trachealis muscle can be contracted to force air through the trachea during exhalation. The trachea is lined with pseudostratified ciliated columnar epithelium, which is continuous with the larynx. The esophagus borders the trachea posteriorly.

Bronchial Tree

The trachea branches into the right and left primary **bronchi** at the carina. These bronchi are also lined by pseudostratified ciliated columnar epithelium containing mucus-producing goblet cells. The **carina** is a raised structure that contains specialized nervous tissue that induces violent coughing if a foreign body, such as food, is present. Rings of cartilage, like those of the trachea, support the structure of the bronchi and prevent their collapse. The primary bronchi enter the lungs at the hilum, a concave region where blood vessels, lymphatic vessels, and nerves also enter the lungs. The bronchi continue to branch into bronchial a tree. A **bronchial tree** (or respiratory tree) is the collective term used for these multiple-branched bronchi. The main function of the

bronchi, like other conducting zone structures, is to provide a passageway for air to move into and out of each lung. In addition, the mucous membrane traps debris and pathogens.

A **bronchiole** branches from the tertiary bronchi. Bronchioles, which are about 1 mm in diameter, further branch until they become the tiny terminal bronchioles, which lead to the structures of gas exchange. There are more than 1000 terminal bronchioles in each lung. The muscular walls of the bronchioles do not contain cartilage like those of the bronchi. This muscular wall can change the size of the tubing to increase or decrease airflow through the tube.



Respiratory Zone

In contrast to the conducting zone, the respiratory zone includes structures that are directly involved in gas exchange. The respiratory zone begins where the terminal bronchioles join a **respiratory bronchiole**, the smallest type of bronchiole, which then leads to an alveolar duct, opening into a cluster of alveoli.

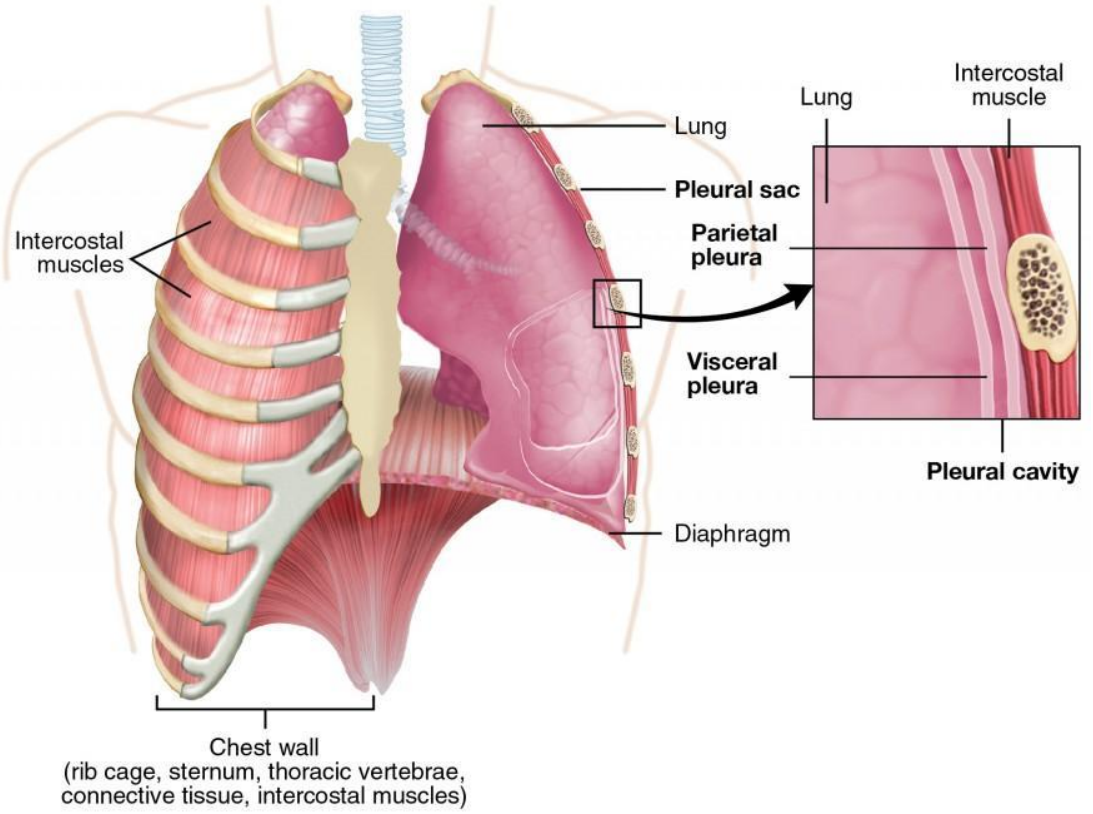
Alveoli

An **alveolar duct** is a tube composed of smooth muscle and connective tissue, which opens into a cluster of alveoli. An **alveolus** is one of the many small, grape-like sacs that are attached to the alveolar ducts.

An **alveolar sac** is a cluster of many individual alveoli that are responsible for gas exchange. An alveolus is approximately 200 μm in diameter with elastic walls that allow the alveolus to stretch during air intake, which greatly increases the surface area available for gas exchange. Alveoli are connected to their neighbors by **alveolar pores**, which help maintain equal air pressure throughout the alveoli and lung.

The alveolar wall consists of three major cell types: type I alveolar cells, type II alveolar cells, and alveolar macrophages. A **type I alveolar cell** is a squamous epithelial cell of the alveoli, which constitute up to 97 percent of the alveolar surface area. These cells are about 25 nm thick and are highly permeable to gases. A **type II alveolar cell** is interspersed among the type I cells and secretes **pulmonary surfactant**, a substance composed of phospholipids and proteins that reduces the surface tension of the alveoli. Roaming around the alveolar wall is the **alveolar macrophage**, a phagocytic cell of the immune system that removes debris and pathogens that have reached the alveoli.

The simple squamous epithelium formed by type I alveolar cells is attached to a thin, elastic basement membrane. This epithelium is extremely thin and borders the endothelial membrane of capillaries. Taken together, the alveoli and capillary membranes form a **respiratory membrane** that is approximately 0.5 mm thick. The respiratory membrane allows gases to cross by simple diffusion, allowing oxygen to be picked up by the blood for transport and CO_2 to be released into the air of the alveoli.



The pleurae perform two major functions: They produce pleural fluid and create cavities that separate the major organs. **Pleural fluid** is secreted by mesothelial cells from both pleural layers and acts to lubricate their surfaces. This lubrication reduces friction between the two layers to prevent trauma during breathing and creates surface tension that helps maintain the position of the lungs against the thoracic wall. This adhesive characteristic of the pleural fluid causes the lungs to enlarge when the thoracic wall expands during ventilation, allowing the lungs to fill with air. The pleurae also create a division between major organs that prevents interference due to the movement of the organs, while preventing the spread of infection.

Lesson 6: Gas exchange and Breathing mechanics

Objective:

- Compare the composition of atmospheric air and alveolar air
- Describe the mechanisms that drive gas exchange

The purpose of the respiratory system is to perform gas exchange. Pulmonary **ventilation** provides air to the alveoli for this gas exchange process. At the respiratory membrane, where the alveolar and capillary walls meet, gases move across the membranes, with oxygen entering the bloodstream and carbon dioxide exiting. It is through this mechanism that blood is oxygenated and carbon dioxide, the waste product of **cellular respiration**, is removed from the body.

Gas Exchange

To understand the mechanisms of gas exchange in the lung, it is important to understand the underlying principles of gases and their behavior. In addition to Boyle's law, several other gas laws help to describe the behavior of gases.

Gas Laws and Air Composition

Gas molecules exert force on the surfaces with which they are in contact; this force is called **pressure**. In natural systems, gases are normally present as a mixture of different types of molecules. For example, the atmosphere consists of oxygen, nitrogen, carbon dioxide, and other gaseous molecules, and this gaseous mixture exerts a certain pressure referred to as atmospheric pressure. **Partial pressure** (P_x) is the pressure of a single type of gas in a mixture of gases. For example, in the atmosphere, oxygen exerts a partial pressure, and nitrogen exerts another partial pressure, independent of the partial pressure of oxygen. **Total pressure** is the sum of all the partial pressures of a gaseous mixture. **Dalton's law** describes the behavior of nonreactive gases in a gaseous mixture and states that a specific gas type in a mixture exerts its own pressure; thus, the total pressure exerted by a mixture of gases is the sum of the partial pressures of the gases in the mixture.

Partial Pressures of Atmospheric Gases (Table 2)

Gas	Percent of total composition	Partial pressure (mm Hg)
Nitrogen (N_2)	78.6	597.4
Oxygen (O_2)	20.9	158.8
Water (H_2O)	0.04	3.0
Carbon dioxide (CO_2)	0.004	0.3
Others	0.0006	0.5
Total composition/total atmospheric pressure	100%	760.0

Partial pressure is extremely important in predicting the movement of gases. Recall that gases tend to equalize their pressure in two regions that are connected. A gas will move from an area where its partial pressure is higher to an area where its partial pressure is lower. In addition, the greater the partial pressure difference between the two areas, the more rapid is the movement of gases.

Solubility of Gases in Liquids

Henry's law describes the behavior of gases when they meet a liquid, such as blood. Henry's law states that the concentration of gas in a liquid is directly proportional to the solubility and partial pressure of that gas. The

greater the partial pressure of the gas, the greater the number of gas molecules that will dissolve in the liquid. The concentration of the gas in a liquid is also dependent on the solubility of the gas in the liquid. For example, although nitrogen is present in the atmosphere, very little nitrogen dissolves into the blood, because the solubility of nitrogen in blood is very low. The exception to this occurs in scuba divers; the composition of the compressed air that divers breathe causes nitrogen to have a higher partial pressure than normal, causing it to dissolve in the blood in greater amounts than normal. Too much nitrogen in the bloodstream results in a serious condition that can be fatal if not corrected. Gas molecules establish an equilibrium between those molecules dissolved in liquid and those in air.

The composition of air in the atmosphere and in the alveoli differs. In both cases, the relative concentration of gases is nitrogen > oxygen > water vapor > carbon dioxide. The amount of water vapor present in alveolar air is greater than that in atmospheric air. Recall that the respiratory system works to humidify incoming air, thereby causing the air present in the alveoli to have a greater amount of water vapor than atmospheric air. In addition, alveolar air contains a greater amount of carbon dioxide and less oxygen than atmospheric air. This is no surprise, as gas exchange removes oxygen from and adds carbon dioxide to alveolar air. Both deep and forced breathing cause the alveolar air composition to be changed more rapidly than during quiet breathing. As a result, the partial pressures of oxygen and carbon dioxide change, affecting the diffusion process that moves these materials across the membrane. This will cause oxygen to enter and carbon dioxide to leave the blood more quickly.

Ventilation and Perfusion

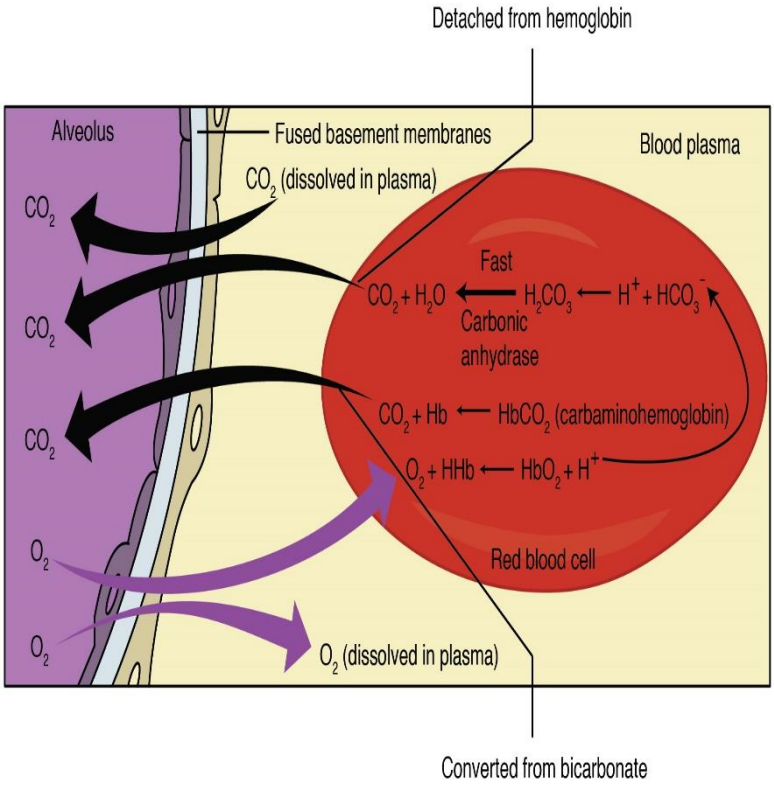
Two important aspects of gas exchange in the lung are ventilation and perfusion. **Ventilation** is the movement of air into and out of the lungs, and **perfusion** is the flow of blood in the pulmonary capillaries. For gas exchange to be efficient, the volumes involved in ventilation and perfusion should be compatible. However, factors such as regional gravity effects on blood, blocked alveolar ducts, or disease can cause ventilation and perfusion to be imbalanced.

The partial pressure of oxygen in alveolar air is about 104 mm Hg, whereas the partial pressure of the oxygenated pulmonary venous blood is about 100 mm Hg. When ventilation is enough, oxygen enters the alveoli at a high rate, and the partial pressure of oxygen in the alveoli remains high. In contrast, when ventilation is insufficient, the partial pressure of oxygen in the alveoli drops. Without the large difference in partial pressure between the alveoli and the blood, oxygen does not diffuse efficiently across the respiratory membrane. The body has mechanisms that counteract this problem. In cases when ventilation is not enough for an alveolus, the body redirects blood flow to alveoli that are receiving enough ventilation. This is achieved by **constricting** the **pulmonary arterioles** that serves the dysfunctional alveolus, which redirects blood to other alveoli that have enough ventilation. At the same time, the pulmonary arterioles that serve alveoli receiving enough ventilation **vasodilate,** which brings in greater blood flow. Factors such as carbon dioxide, oxygen, and pH levels can all serve as stimuli for adjusting blood flow in the capillary networks associated with the alveoli.

Ventilation is regulated by the diameter of the airways, whereas **perfusion** is regulated by the diameter of the blood vessels. The diameter of the **bronchioles** is sensitive to the partial pressure of carbon dioxide in the alveoli. A greater partial pressure of carbon dioxide in the alveoli causes the bronchioles to increase their diameter as will a decreased level of oxygen in the blood supply, allowing carbon dioxide to be exhaled from the body at a greater rate. As mentioned above, a greater partial pressure of oxygen in the alveoli causes the pulmonary arterioles to dilate, increasing blood flow.

Gas Exchange

Gas exchange occurs at two sites in the body: in the **lungs**, where oxygen is picked up and carbon dioxide is released at the respiratory membrane, and at the tissues, where oxygen is released, and carbon dioxide is picked up. **External respiration** is the exchange of gases with the external environment and occurs in the alveoli of the lungs. **Internal respiration** is the exchange of gases with the internal environment and occurs in the tissues. The actual exchange of gases occurs due to simple diffusion. Energy is not required to move oxygen or carbon dioxide across membranes. Instead, these gases follow pressure gradients that allow them to diffuse. The anatomy of the lung maximizes the diffusion of gases: The respiratory membrane is highly permeable to gases; the respiratory and blood capillary membranes are very thin; and there is a large surface area throughout the lungs.



External Respiration

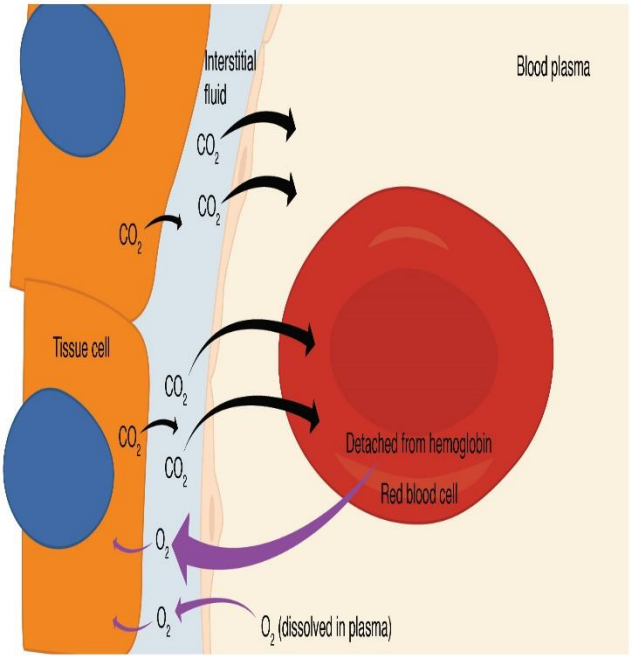
The **pulmonary artery** carries deoxygenated blood into the lungs from the heart, where it branches and eventually becomes the capillary network composed of **pulmonary capillaries.** These pulmonary capillaries create the respiratory membrane with the alveoli. As the blood is pumped through this capillary network, gas exchange occurs. Although a small amount of the oxygen can dissolve directly into plasma from the alveoli, most of the oxygen is picked up by erythrocytes (red blood cells) and binds to a protein called **hemoglobin**. Oxygenated hemoglobin is red, causing the overall appearance of bright red oxygenated blood, which returns to the heart through the **pulmonary veins.** Carbon dioxide is released in the opposite direction of oxygen, from the blood to the alveoli. Some of the carbon dioxide is returned on hemoglobin is mostly dissolved in plasma or is present as a converted form.

External respiration occurs as a function of partial pressure differences in oxygen and carbon dioxide between the alveoli and the blood in the pulmonary capillaries.

Although the solubility of oxygen in blood is not high, there is a drastic difference in the partial pressure of oxygen in the alveoli versus in the blood of the pulmonary capillaries. This difference is about 64 mm Hg: The partial pressure of oxygen in the alveoli is about 104 mm Hg, whereas its partial pressure in the blood of the capillary is about 40 mm Hg. This large difference in partial pressure creates a very strong pressure gradient that causes oxygen to rapidly cross the respiratory membrane from the alveoli into the blood.

The partial pressure of carbon dioxide is also different between the alveolar air and the blood of the capillary. However, the partial pressure difference is less than that of oxygen, about 5 mm Hg. The partial pressure of carbon dioxide in the blood of the capillary is about 45 mm Hg, whereas its partial pressure in the alveoli is about 40 mm Hg. However, the solubility of carbon dioxide is much greater than that of oxygen—by a factor of about 20—in both blood and alveolar fluids. As a result, the relative concentrations of oxygen and carbon dioxide that diffuse across the respiratory membrane are similar.

Internal Respiration



Internal respiration is gas exchange that occurs at the level of body tissues. Like external respiration, internal respiration also occurs as simple diffusion due to a partial pressure gradient. However, the partial pressure gradients are opposite of those present at the respiratory membrane. The partial pressure of oxygen in tissues is low, about 40 mm Hg, because oxygen is continuously used for cellular respiration. In contrast, the partial pressure of oxygen in the blood is about 100 mm Hg. This creates a pressure gradient that causes oxygen to dissociate from hemoglobin, diffuse out of the blood, cross the interstitial space, and enter the tissue. Hemoglobin that has little oxygen bound to it loses much of its brightness, so that blood returning to the heart is more burgundy in color.

Considering that **cellular respiration** continuously produces carbon dioxide, the partial pressure of carbon dioxide is lower in the blood than it is in the tissue, causing carbon dioxide to diffuse out of the tissue, cross the interstitial fluid, and enter the blood. It is then carried back to the lungs either bound to hemoglobin, dissolved in plasma, or in a converted form. By the time blood returns to the heart, the partial pressure of oxygen has returned to about 40 mm Hg, and the partial pressure of carbon dioxide has returned to about 45 mm Hg. The blood is then pumped back to the lungs to be oxygenated once again during external respiration.