

Copyright Warning & Restrictions

The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproductions of copyrighted material.

Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specified conditions is that the photocopy or reproduction is not to be “used for any purpose other than private study, scholarship, or research.” If a user makes a request for, or later uses, a photocopy or reproduction for purposes in excess of “fair use” that user may be liable for copyright infringement,

This institution reserves the right to refuse to accept a copying order if, in its judgment, fulfillment of the order would involve violation of copyright law.

Please Note: The author retains the copyright while the New Jersey Institute of Technology reserves the right to distribute this thesis or dissertation

Printing note: If you do not wish to print this page, then select “Pages from: first page # to: last page #” on the print dialog screen

The Van Houten library has removed some of the personal information and all signatures from the approval page and biographical sketches of theses and dissertations in order to protect the identity of NJIT graduates and faculty.

ABSTRACT

A Multicompartmental Model for the Simulation of Soluble Gas Exchange in the Lungs

**by
Chitaranjan Varadhan**

A dynamic multicompartmental model for respiratory exchange of soluble gas is described. The motivation for this new model is the continuing interest in estimating pulmonary system parameters during anesthesia and under diseased conditions.

Here a four compartment model for the blood-tissue gas exchange is described, which will be coupled to a whole body hemodynamic model developed earlier. With this pulmonary model we can simulate the pharmacokinetics of inhaled anesthetic agents at any instant of time. Simulations are computed using the TUTSIM software package. Values for the physiological parameters used in the simulation are estimated from standard physiological sources. Where necessary, parameter values reported for animal studies were adjusted to reflect normal human physiology.

**A MULTICOMPARTMENTAL MODEL FOR THE SIMULATION OF
SOLUBLE GAS EXCHANGE IN THE LUNGS**

by

Chitaranjan Varadhan

**A Thesis
Submitted to the Faculty of
New Jersey Institute of Technology
in Partial Fulfillment of the Requirements for the Degree of
Master of Science in Biomedical Engineering**

Biomedical Engineering Committee

May 1993

Blank Page

APPROVAL PAGE

A Multicompartmental Model for the Simulation of Soluble Gas Exchange in the Lungs

Chitaranjan Varadhan

Dr.Arthur Ritter, Thesis Advisor (Date)
Associate Professor of Physiology
University of Medicine and Dentistry of New Jersey.

Dr.David Kristol, Thesis Advisor and Committee Member (Date)
Professor of Chemistry and Graduate Advisor of Biomedical Engineering
New Jersey Institute of Technology

Dr.Richard Parker, Thesis Advisor and Committee Member (Date)
Professor of Chemistry
New Jersey Institute of Technology

BIOGRAPHICAL SKETCH

Author: Chitaranjan Varadhan

Degree: Master of Science in Biomedical Engineering

Date: May 1993

Date of Birth:

Place of Birth:

Undergraduate and Graduate Education:

- Master of Science in Biomedical Engineering,
New Jersey Institute of Technology, Newark, NJ, 1993
- Bachelor of Science in Electrical and Electronics Engineering
Manipal Institute of Technology, Manipal, India, 1990

Presentations and Publications:

Dr.Ritter, Dr.Kristol, C.Varadhan. "A Multicompartmental Model for the Simulation of Soluble Gas Exchange in the Lungs." *19th Northeast Bioengineering Conference*, New Jersey Institute of Technology, Newark, New Jersey, 18 March 1993.

This thesis is dedicated to my Parents

ACKNOWLEDGMENT

I am grateful to Dr. Arthur Ritter, Dept. of Physiology, University of Medicine and Dentistry, New Jersey, for his moral support, guidance, advice and encouragement throughout this work and to Dr. David Kristol, Director of Biomedical Engineering Program, NJIT, for his helpful discussion during this study.

Special thanks to Dr. Richard Parker for serving as a member of the committee.

I would also like to thank Mr. Alli, System Administrator, Computer Service Department, NJIT, for allowing me to utilize the computational facilities of the university.

TABLE OF CONTENTS

Chapter	Page
1 INTRODUCTION	1
1.1 Review of Models	3
1.3 Terms and Definitions	7
1.3.1 Anatomic Dead Space and Alveolar Ventilation	7
1.3.2 Partial Pressures of Respiratory Gases	8
1.3.3 Airway Resistance	8
1.3.4 Compliance of the lung and chest wall	9
2 METHODS AND MATERIALS	10
2.1 Compartmental Model	10
2.2 Development of the Model	11
2.2.1 Mass Balance Equations	11
2.2.2 TUTSIM Block Diagrams	12
2.2.3 Model Data	12
2.2.4 Model Simulation	12
2.3 TUTSIM	13
3 SIMULATIONS AND RESULTS	15
3.1 Mass Balance Equations	15
3.1.1 For Blood Flow	15
3.1.2 For Blood Side Soluble Gas Exchange	15
3.1.3 For Alveolar side Gas Exchange	15
3.1.4 For Shunt Flow	16
3.1.5 For Gas Exchange in Large Airways	16
3.1.6 For Gas Exchange in Dead Zone	16
3.1.7 For Gas Exchange in Pulmonary Veins	16
3.1.8 For Gas Exchange in Pulmonary Arteries	16
3.2 Parameters and Initial Conditions	17
3.2.1 Pulmonary Blood Flow	17
3.2.2 Alveolar and Capillary Gas Exchange	17
3.2.3 Large Airways and Dead Zone	19
3.2.4 Arteries and Veins	19
3.3 Results	20
4 CONCLUSION	23
APPENDIX I	24
APPENDIX II	31
REFERENCES	48

LIST OF FIGURES

Figure		Page
1	Blood Pressure in Pulmonary Arteries, Veins and Capillaries. . . . .	.25
2	Partial Pressure of Oxygen in Alveolar Zones . . . . .	.26
3	Partial Pressure of Oxygen in Capillary Zones. . . . .	.27
4	Partial Pressure of Oxygen in Large Airways and Dead Zones . . . . .	.28
5	Partial Pressure of Oxygen in Arteries and Veins . . . . .	.29
6	Blood Pressure in Capillary Zones. . . . .	.30
7	Basic Model for Gas Exchange in Lungs . . . . .	.34
8	Tutsim Block Diagram for Pulmonary Blood Flow . . . . .	.35
9	Tutsim Block Diagram for Alveolar and Capillary Gas Exchange . . . . .	.36
10	Tutsim Block Diagram for Large Airways and Dead Zone . . . . .	.37
11	Tutsim Block Diagram for Arterial and Venous Pressures . . . . .	.38

CHAPTER 1

INTRODUCTION

The lung is exquisitely designed to facilitate gas exchange. Its prime function is to allow oxygen to move from the air into the venous blood and carbon dioxide to move in the opposite direction. The lung does other jobs as well. It metabolizes some compounds, filters toxic materials from the circulation, and acts as a reservoir for blood. But its cardinal function is gas exchange.

Exchange of gases such as oxygen in the lungs involves several physico-chemical processes:

- a. Convective transport in the conducting pathways on the gas side of the lungs.
- b. Molecular diffusion in the gas phase in the conducting pathways and alveoli on the gas side of the lungs.
- c. Molecular diffusion across the surfactant layer and tissue space between the gas side and blood side of the lungs.
- d. Possibly uptake by specialized transporters on the blood side of the lungs (e.g. hemoglobin transport of O₂ and CO₂ in the red cell).
- e. Convective transport of the gas by the blood stream and distribution of the gas in various organs and tissues.

If the gas is soluble in lung tissue, blood or any other tissue or is metabolized at a particular site, these processes must also be taken into account. Inspiration, excretion, uptake and metabolism are spatially and temporally separated phenomena. Convective transport (blood flow) is the process that allows coupling among these processes and the proper physiological functioning of all organs and tissues, since they are each dependent on gas exchange.

A model of the lung involves three distinct elements.

a. **Pulmonary Mechanics.** This is a mathematical description of the mechanical motion of chest wall and abdomen or diaphragm to achieve inspiration and expiration of the tidal volume of gas.

The Diaphragm is the most important muscle of inspiration. This consists of a thin dome-shaped sheet of muscle which is inserted into the lower ribs. When it contracts, the abdominal contents are forced downward and forward, and the vertical dimension of the chest cavity is increased. In addition the rib margins are lifted and moved out, causing an increase in the transverse diameter of the thorax. In normal tidal breathing, the level of the diaphragm moves about 1 cm or so, but on forced inspiration and expiration, a total excursion of up to 10 cm may occur. When the diaphragm is paralyzed, it moves up rather than down with inspiration because the intrathoracic pressure falls.

b. **Transport Function.** This is a mathematical description of gas transport from inspiration/expiration through the conducting vessels, into the alveoli, exchange across the lung tissue, uptake by the blood and distribution throughout the various organ and tissue compartments.

The transfer of gas across the blood-gas barrier occurs by diffusion. Diffusion through tissues is described by Fick's law. This states that the rate of transfer of gas through a sheet of tissue is proportional to the tissue area and the difference in gas partial pressure between the two sides and inversely proportional to the tissue thickness. The area of the blood-gas barrier is enormous and barrier thickness is of the order of 1 micron, so the dimensions of the barrier are ideal for diffusion. In addition, the rate of transfer is proportional to a diffusion constant which depends on the properties of the tissue and the particular gas. The constant is proportional to the square root of the molecular weight. This means that CO_2 diffuses about 20 times more rapidly than O_2 through the tissue sheet since it has much higher solubility and similar molecular weight.

c. **Regulation of Respiration.** This is a mathematical description of those factors such as exercise, increased organ metabolism or pathologies which act to change the rate

and depth of respiration (Ventilation) through neural pathways (e.g. peripheral chemoreceptors).

Expiration is passive during normal quiet breathing. The lung and chest wall are elastic and tend to return to their equilibrium position after being actively expanded during inspiration. During exercise and voluntary hyperventilation, expiration becomes active. The most important muscles of expiration are those of the abdominal wall, including the rectus abdominus, internal and external oblique muscles, and transversus abdominus. When these muscles contract, intra-abdominal pressure is raised, and the diaphragm is pushed forward. They also contract forcefully during coughing, vomiting and defecation.

1.1 Review of Models

The uptake of oxygen occurs in one particular organ, the lung, and the oxygen is carried by the arterial blood from the site of uptake to the site of consumption, the tissues. The situation concerning the release of oxygen to and its consumption by the cells in various tissues and organs is much more complicated in so far as there are many kinds of tissue with widely different characteristics. Experimental studies of tissue oxygen supply and demand are numerous but have met with many methodological difficulties and are often not easy to interpret. This is the reason why numerous investigators have taken recourse to modeling and mathematical analysis of tissue oxygen supply and demand.

Kety et al.(1951)¹ developed a dynamic model for respiratory exchange of blood soluble gas, which was based on a well known mathematical model of soluble gas exchange. It was developed as a quantitative description of the pharmacokinetics of inhaled anesthetic agents. Most of its applications, therefore, have addressed the time course of anesthetic uptake with specific attention to concentration in body tissues. The validity of the model for this purpose, as well as for the related problem of inhalation exposure to environmental vapors, has been well established. However, its suitability as

a basis for a pulmonary perfusion was poorly established. Also, his work described the uptake and distribution of an inhaled gas in terms of an equation which is relatively simple but which gives an imperfect fit to experimental data. This is because it assumes in effect that the blood flow per unit volume of tissue is the same throughout the body.

The model developed by Jenkins et al.(1989)² described a general treatment of tidal breathing, in an inhomogeneous lung comprising distensible compartments, and multiple-gas effects. Here the lung was modeled as a set of parallel homogeneous distensible ideal mixing chambers(alveoli), each ventilated through a common series dead space and perfused by a blood flow that is constant within a breath. The body was modeled as a homogeneous ideal mixing chamber(tissue compartment), perfused by a blood flow that is constant within a breath. According to this model, each lung compartment received a constant fraction of the total inspired volume from one breath to another. Hence estimation of the distribution of ventilatory flow to the various lung compartments and changes thereto is a difficult problem.

In the model presented by Mapleson (1963)³ the body is divided into the lungs and a number of tissue compartments such that the blood supply per unit volume is the same throughout each compartment. In this model, ventilation is regarded as continuous instead of cyclic. Failure to consider the effects of cyclic breathing may result in significant errors in the determination of cardiac output. Also in this model the Ostwald tissue-to-gas partition coefficient, which may be defined as the ratio between the volume of agent contained in an equal volume of gas with which the tissue is in equilibrium, for any tissue for any gas, or other agent, is assumed to be independent of concentration. This assumption will generally cease to be true if the concentration is high enough.

The 18-compartment hybrid computer multiple model developed by Fukui et al.(1981)⁴ for the uptake and distribution of halothane is the basis of our present study. This study uses 88 equations and 124 parameter settings which is very complicated and cumbersome to use.

Krogh in association with Danish mathematician Erlang in 1919, developed a theoretical mathematical model for the analysis of tissue oxygen supply (Kreuzer, 1982)⁵. The Krogh-Erlang model is based on a number of simplifying and often unrealistic assumptions. There is an impressive list of 15 assumptions, which in turn raises the question as to how realistic and meaningful the calculations according to the Krogh model might be. For example, one assumption is that of homogeneous oxygen consumption. On the microscopic level there are always discontinuities in the tissue in that the mitochondria are the discrete oxygen sinks. This assumption implies that these minute sinks are evenly distributed in the volume of the tissue. However, the mitochondria must also be viewed in their relationship to the capillaries. Mainwood and Rakusan(1982)²⁷ showed that when the mitochondria are clustered around the capillaries, the Krogh cylinder radius shrinks from the anatomical value to that of the cluster. These authors assumed a lattice of 30-micrometer cells with a 1:1 cell to capillary ratio and a mitochondrial aggregation within 3-micrometers from the capillaries. They calculated a necessary oxygen pressure gradient of 24 mmHg for an homogeneous mitochondrial distribution as against 7.9 mmHg in the presence of mitochondrial aggregation. Thus, in the latter case the capillary oxygen pressure required for an adequate oxygen supply to the tissue was reduced to one third of that in the homogeneous situation.

A model of pulmonary transport was developed by Borovetz et al.(1981)⁶ in which the lung is assumed to consist of four parallel tissue layers. Using a finite difference representation of the governing equations, the concentration distribution of Xenon gas in each of the layers of tissue is obtained for a step change in the Xe concentration in the inspired air space. Although this model gives good agreement with the experimental values it is a bit complicated, i.e. simulation could have been made simpler by using ordinary differential equations rather than partial differential equations.

A one compartment, continuous-time model was proposed for investigation of dynamic gas exchange in the lungs, by Poon et al.(1981)⁷. The main purpose of this

investigation was to demonstrate quantitatively and analytically the underlying mechanism responsible for the concentration and second gas effects during dynamic gas exchange in the lungs. In view of the complexity of the system, several simplifying assumptions were made to facilitate analysis and computation. For example, the effects of dead space ventilation and perfusion, and the storage capacity of lung tissue have been neglected. Likewise, the nonlinear dissociation characteristics of O_2 and CO_2 had been approximated in a linear fashion. Due to these assumptions it should be recognized that the model is unlikely to be applicable to clinical conditions which are characterized by extreme ventilation-perfusion maldistribution or by a significant diffusion limitation across the lungs.

A general dynamic model of ventilation, perfusion, and mass transfer in the lung has been developed by S.A.Barton et al.(1988)⁸, as the theoretical basis for a clinical technique for monitoring on a continuous basis pulmonary performance in terms of the distribution of ventilation and perfusion through the lung. A set of describing equations has been set down with due regard to the conceptual modelers and experimental workers of the past in the field. But this is of no practical use. Before the model can be used as the basis of clinical measurements it must be tested experimentally. Its description and predictions must be compared with experimental observations in a suitable animal or human model. In addition, it must be determined what measurements of clinical interest can be made using the model, and how much the model can be simplified if it is still to yield useful information. If the working model is simple and can be described quantitatively by a small number of parameters then a small number of measurements will be required to yield those parameters. Another drawback of this model is that it does not address the general problem of multiple soluble gas exchange in parallel arrangement of tidally ventilated distensible ideal mixing boxes.

While most analyses of pulmonary gas exchange are based on models in which all of the abnormalities are taken to occur on a parallel basis, the possibility that series

inhomogeneity may be of significance has received serious consideration in recent years. P.D.Wagner and J.W.Evans (1977)⁹ developed conditions for equivalence of gas exchange in series and parallel models of the lung. The Fick principle was applied to series and parallel compartmental lung models to determine whether conditions existed under which their differentiation was theoretically possible. Respiratory and inert gases were examined under assumptions of steady-state gas exchange, continuous ventilation and blood flow, perfect mixing within each compartment and alveolar-endcapillary diffusion equilibration. All of these analyses gave us invaluable information for our multiple compartmental model for soluble gas exchange.

Although the uptake and distribution of soluble gases in the lungs have been modeled by several workers, the characterization of the associated system dynamics has received little attention. This led us to develop a multicompartmental model with lesser number of equations and parameters for gas exchange and system dynamics in the lungs. The advantage of this model is that all parameters required for dynamic simulation can be estimated from standard physiological reference materials.

1.3 Terms and Definitions

1.3.1 Anatomic Dead Space and Alveolar Ventilation.

The volume of air entering and leaving the nose or mouth per minute, the minute volume, is not equal to the volume of air entering and leaving the alveoli per minute. Alveolar ventilation is less than the minute volume because the last part of each inspiration remains in the conducting airways and does not reach the alveoli. Similarly, the last part of each expiration remains in the conducting airways for several anatomic reasons. First, the walls of the conducting airways are too thick for much diffusion to take place; and next, mixed venous blood does not come into contact with air. The conducting airways are, therefore, referred to as the anatomic dead space. The anatomic dead space plus the alveolar dead space is known as the physiological dead space.

Thus for any respiratory cycle, not all of the tidal volume reaches the alveoli because the last part of each inspiration and expiration remains in the dead space. The relationship between the tidal volume (V_T) breathed in and out through the nose or mouth, the dead space volume (V_D), and the volume of gas entering and leaving the alveoli per breath (V_A) is

$$V_A = V_T - V_D$$

By multiplying both sides of the above equation by the breathing frequency (n) in breaths per minute,

$$n(V_A) = n(V_T) - n(V_D)$$

This means that the alveolar ventilation (\dot{V}_A) in liters per minute is equal to the minute volume (\dot{V}_E) minus the volume wasted ventilating the dead space per minute (\dot{V}_D).

$$\dot{V}_A = \dot{V}_E - \dot{V}_D$$

Where: $\dot{V} = nv$

1.3.2 Partial Pressures of Respiratory Gases.

According to Dalton's law, in a dilute gas mixture, the pressure exerted by each individual gas in a space is independent of the pressures of other gases in the mixture. The partial pressure of a particular gas is equal to its fractional concentration times the total pressure of all the gases in the mixture. Thus for any gas, a, in a mixture its partial pressure

$$P_a = \% \text{ of total gas} \times P_{\text{total}}$$

Oxygen constitutes 20.93% of dry atmospheric air. At a standard barometric pressure of 760 mmHg

$$PO_2 = 0.2093 \times 760 \text{ mmHg} = 159 \text{ mmHg}$$

Carbon dioxide constitutes only about 0.04% of dry atmospheric air, and so

$$PCO_2 = 0.0004 \times 760 \text{ mmHg} = 0.3 \text{ mmHg}$$

1.3.3 Airway Resistance

Generally, the relationship between Pressure, Flow and Resistance is stated as

$$\text{Pressure Gradient} = \text{Flow} \times \text{Resistance}$$

Therefore,

$$\text{Resistance} = \frac{\text{Pressure Gradient (cm H}_2\text{O)}}{\text{Flow (liters/s)}}$$

This means that resistance is a meaningful term only during flow. When airflow is considered, the units of resistance are usually cm H₂O/liter/s.

The resistance to airflow is analogous to electrical resistance in that resistance in series add as sums:

$$R_T = R_1 + R_2 + \dots$$

Resistances in parallel add as reciprocals:

$$1/R_T = 1/R_1 + 1/R_2 + \dots$$

1.3.4 Compliance of the lung and chest wall

The slope between two points on a pressure-volume curve of a vessel or organ is known as the compliance of that vessel or organ. Compliance is defined as the change in volume divided by the change in pressure. It is important to remember that compliance is the inverse of elasticity or elastic recoil. Compliance denotes the ease with which something can be stretched or distorted; elasticity refers to the tendency for something to oppose stretch or distortion, as well as to its ability to return to its original configuration after the distorting force is removed.

Compliance of the lung and chest wall provides useful data for the clinical evaluation of a patient's respiratory system, because many diseases or pathological states affect either the compliance of the lung or chest wall or both. The lung and chest wall are physically in series with each other and therefore their compliances add as reciprocals:

$$\frac{1}{\text{Total Compliance}} = \frac{1}{\text{Compliance of the lung}} + \frac{1}{\text{Compliance of the chest wall}}$$

CHAPTER 2

METHODS AND MATERIALS

The objective of this study is to develop a lung model for soluble gas exchange which will allow us to quantitatively estimate the pharmacokinetics of inhaled anesthetic agents.

2.1 Compartmental Model

Theoretically, a compartmental description of a distributed process such as gas exchange/distribution would require many (non-unique) arrangements of series/parallel compartments to provide accurate quantitative assessment. In practice, however, values for many of the parameters in such a model and estimates of initial and boundary conditions would be unavailable. With this in mind, we have used a four compartment model for the blood-tissue exchange with the following elements. On the blood side we have the right ventricles feeding the pulmonary artery which feeds three zones (lower one third, middle one third and upper one third) of pulmonary capillaries and a small shunt flow. This is collected by the pulmonary veins and drained into the left ventricle. On the gas side, we have the airways, the trachea and the alveolar ducts. The airways consist of a series of branching tubes which become narrower, shorter and more numerous as they penetrate deeper into the lung. The trachea divides into right and left main bronchi, which in turn divide into lobar, then segmental bronchi. This process continues down to the terminal bronchioles, which are the smallest airways without alveoli. All these bronchi make up the conducting airways. Their function is to lead inspired air to the gas exchanging regions of the lung. Since the conducting airways contain no alveoli and therefore themselves take no part in gas exchange, they constitute the anatomic dead space. According to the rule of thumb, the amount of gas in ml which remains in the dead space is equal numerically to the total body weight in pounds. In our model it is assumed to be 150 ml (standard body weight of 70 kg).

The terminal bronchioles divide into respiratory bronchioles which have occasional alveoli budding from their walls. Finally, we come to the alveolar ducts completely lined with alveoli. This alveolated region of the lung where the gas exchange occurs is known as the respiratory zone, which makes up most of the lung. Blood-airway gas exchange only takes place in the alveolar-capillary zones.

In our model the capillaries and the alveoli are divided into three compartments corresponding to the 3 physiological zones of the lung¹⁴ to get a better quantitative assessment of gas transport. Mass balances for soluble gas exchange are written for each of the compartments. Parameters and initial conditions for each of the mass balance equations were estimated from various sources¹⁷⁻²⁵. Respiratory mechanics were simulated by a periodic function which described inspiratory and expiratory pressure and flow around normal tidal volume.

The equations were solved on a personal computer using the TUTSIM simulation language.

2.2 Development of the Model

The first step in the development of any model is to define our problem, i.e. to identify what we exactly want to do. For example, in our case we are trying develop a multicompartmental model for soluble gas exchange in the lungs. This involves several steps and procedures. These are described in detail below.

2.2.1 Mass Balance Equations

Mass balance equations for soluble gas exchange were written (see Chapter 3) for:

- (a) Blood flow in the three capillary zones perfusing the alveoli.
- (b) Blood side soluble gas exchange in the three capillary zones.
- (c) Alveolar side soluble gas exchange in the three zones.
- (d) Soluble gas exchange in the large airways, dead zone, pulmonary venous systems and pulmonary arterial system.
- (e) Shunt flow.

2.2.2 TUTSIM Block Diagrams

Block diagrams (see Appendix II) for all of the above models were constructed so as to comply with the requirements of TUTSIM. The functions of the blocks used as well as commands used are listed in Appendix II.

2.2.3 Model Data

Parameters and Initial conditions were extracted from standard physiological references (Particularly references numbered 11-20). All parameters and initial conditions are listed in Chapter 3.

2.2.4 Model Simulation

The model output was simulated on a personal computer using the TUTSIM simulation language. The results are shown in Appendix I.

2.3 TUTSIM

TUTSIM simulation software allows the user to simulate the time response of a process which consists of coupled sets of ordinary differential equations without programming a numerical integration algorithm.

It is a very simple simulation program designed to give transient, time response of linear or non-linear systems. It also has a very simple block diagram syntax. It has 93 defined blocks. Only a few of them are used in our model. The function of all these 93 blocks of TUTSIM and the commands are listed in APPENDIX I. Also, when need arises for functions beyond the capability of TUTSIM, we can write our own functions in C language or FORTRAN and assign it to the USR blocks of TUTSIM.

TUTSIM block diagrams may be written from the equations term by term, or sometimes by direct inspection of the real system.

The flow is simply:

Problem:—>Mathematical Model—>Block Model—>Results

Model parameters such as the initial values of an integration are easily entered and changed. Results are usually time dependent values and are available in graphical display or numerical tables on the screen.

ADVANTAGES OF TUTSIM

The advantage of TUTSIM is that:

1. It is supplied as a run module that can be executed on the IBM compatible class of computers.
2. We can use particular input functions derived from experimental data (ASCII format) for the simulations.
3. We can estimate the parameters from published data.

4. Any or all blocks may be monitored or changed in the course of simulation and the simulation may also be frozen at any moment and interrogated for their output values at that moment.
5. The core of TUTSIM is written in Assembly Language. This allows for the fastest possible program execution and thus achievement of "continuous simulation" of real time systems.
6. It has the convenience of an analog computer and the speed and accuracy of a digital computer.

The only drawback of TUTSIM is its poor graphical resolution.

The most common output of TUTSIM is the graphical output to the screen. Printer plots can be made from the screen output or results may also be sent to a file (ASCII format).

Figures 7-11 show the block diagram used in the simulation.

CHAPTER 3

SIMULATIONS AND RESULTS

3.1 Mass Balance Equations

3.1.1 Mass Balance Equation for Blood Flow

$$\frac{dP_{pc1}}{dt} = \frac{[P_{pa} - P_{pc1}]}{C_{pc1} * R_{pc1}(a)} - \frac{[P_{pc1} - P_{pv}]}{C_{pc1} * R_{pc1}(v)}$$

$$\frac{dP_{pc2}}{dt} = \frac{[P_{pa} - P_{pc2}]}{C_{pc2} * R_{pc2}(a)} - \frac{[P_{pc2} - P_{pv}]}{C_{pc2} * R_{pc2}(v)}$$

$$\frac{dP_{pc3}}{dt} = \frac{[P_{pa} - P_{pc3}]}{C_{pc3} * R_{pc3}(a)} - \frac{[P_{pc3} - P_{pv}]}{C_{pc3} * R_{pc3}(v)}$$

3.1.2 Mass Balance Equation for Blood Side Soluble Gas Exchange

$$\frac{dP_{p02\ c1}}{dt} = \frac{F_1[P_{p02\ a} - P_{p02\ v}] - PS_{021}[P_{p02\ c1} - \gamma_1 P_{p02\ al1}]}{C_{pc1} * Pt_1}$$

$$\frac{dP_{p02\ c2}}{dt} = \frac{F_2[P_{p02\ a} - P_{p02\ v}] - PS_{022}[P_{p02\ c2} - \gamma_2 P_{p02\ al2}]}{C_{pc2} * Pt_2}$$

$$\frac{dP_{p02\ c3}}{dt} = \frac{F_3[P_{p02\ a} - P_{p02\ v}] - PS_{023}[P_{p02\ c3} - \gamma_3 P_{p02\ al3}]}{C_{pc3} * Pt_3}$$

3.1.3 Mass Balance Equation for Alveolar Side Gas Exchange

$$\frac{dP_{p02\ al1}}{dt} = \frac{Q_{i1} * P_{p02}(LA) - Q_{e1} * P_{p02\ al1} + PS_{021}(P_{p02c1} - \gamma_1 P_{p02\ al1})}{C_{al1} * Pt_{al1}}$$

$$\frac{dP_{p02\ al2}}{dt} = \frac{Q_{i2} * P_{p02}(LA) - Q_{e2} * P_{p02\ al2} + PS_{022}(P_{p02c2} - \gamma_2 P_{p02\ al2})}{C_{al2} * Pt_{al2}}$$

$$\frac{dP_{pO_2 \text{ al}_3}}{dt} = \frac{Q_{i3} * P_{pO_2(LA)} - Q_{e3} * P_{pO_2 \text{ al}_3} + P_{SO_2_3}(P_{pO_2c_3} - \gamma_3 P_{pO_2 \text{ al}_3})}{C_{\text{al}_3} * P_{t \text{ al}_3}}$$

3.1.4 Shunt Flow

$$\frac{dP_{pO_2 \text{ sh}}}{dt} = \frac{F_{\text{sh}} * P_{pO_2(a)}}{C_{\text{sh}} * P_{t_{\text{sh}}}}$$

3.1.5 Gas Exchange in Large Airways

$$\frac{dP_{pO_2(LA)}}{dt} = \frac{Q_{i(LA)} [P_{pO_2(DZ)} - P_{pO_2(LA)}] - Q_{e(LA)} [P_{pO_2(LA)} - \gamma_1 * P_{pO_2 \text{ al}_1} - \gamma_2 * P_{pO_2 \text{ al}_2} - \gamma_3 * P_{pO_2 \text{ al}_3}]}{C_{\text{al}_1} * P_{t \text{ al}_1}}$$

3.1.6 Gas Exchange in Dead Zone

$$\frac{dP_{pO_2(DZ)}}{dt} = \frac{Q_i [P_{pO_2(\text{Room})} - P_{pO_2(DZ)}] - Q_e [P_{pO_2(DZ)} - P_{pO_2(LA)}]}{C_{DZ} * P_{DZ}}$$

3.1.7 Gas Exchange in Pulmonary Veins

$$\frac{dP_{pO_2 v}}{dt} = \frac{F_{10} * P_{pO_2 C_1} + F_{20} * P_{pO_2 C_2} + F_{30} * P_{pO_2 C_3} - F_{PV} * P_{pO_2 v} + F_{sh} * P_{pO_2 a}}{C_v * P_{t_v}}$$

3.1.8 Gas Exchange in Pulmonary Arteries

$$\frac{dP_{pO_2 a}}{dt} = \frac{F_{RV} * P_{pO_2 RV} - F_a * P_{pO_2 a}}{C_a * P_{t_a}}$$

3.2 Parameters and Initial Conditions

3.2.1 Pulmonary Blood Flow

$R_{pc1(a)}$ = Pulmonary Capillary Resistance in the arterial side of Zone 1 = 2.5 mmHg/ml-sec

$R_{pc1(v)}$ = Pulmonary Capillary Resistance in the venous side of Zone 1 = 2.0 mmHg/ml-sec

$R_{pc2(a)}$ = Pulmonary Capillary Resistance in the arterial side of Zone 2 = 1.8 mmHg/ml-sec

$R_{pc2(v)}$ = Pulmonary Capillary Resistance in the venous side of Zone 2 = 1.7 mmHg/ml-sec

$R_{pc3(a)}$ = Pulmonary Capillary Resistance in the arterial side of Zone 3 = 1.7 mmHg/ml-sec

$R_{pc3(v)}$ = Pulmonary Capillary Resistance in the venous side of Zone 3 = 1.6 mmHg/ml-sec

$C_{pc1(a)}$ = Pulmonary Capillary Compliance in the arterial side of Zone 1 = 3.0 ml/mmHg

$C_{pc1(v)}$ = Pulmonary Capillary Compliance in the venous side of Zone 1 = 2.0 ml/mmHg

$C_{pc2(a)}$ = Pulmonary Capillary Compliance in the arterial side of Zone 2 = 4.0 ml/mmHg

$C_{pc2(v)}$ = Pulmonary Capillary Compliance in the venous side of Zone 2 = 3.0 ml/mmHg

$C_{pc3(a)}$ = Pulmonary Capillary Compliance in the arterial side of Zone 3 = 5.0 ml/mmHg

$C_{pc3(v)}$ = Pulmonary Capillary Compliance in the venous side of Zone 3 = 4.0 ml/mmHg

$P_{pc1(0)}$ = Partial pressure of blood in the capillary of Zone 1 at time zero = 10 mmHg

$P_{pc2(0)}$ = Partial pressure of blood in the capillary of Zone 2 at time zero = 8.0 mmHg

$P_{pc3(0)}$ = Partial pressure of blood in the capillary of Zone 3 at time zero = 7.0 mmHg

R_c = Total Pulmonary Capillary Resistance = 0.6 mmHg/ml-sec

C_c = Total Pulmonary Capillary Compliance = 12 ml/mmHg

3.2.2 Alveolar and Capillary Gas Exchange

F_1 = Blood Flow into Capillary Zone 1 = 1.25 ml-min

F_2 = Blood Flow into Capillary Zone 2 = 1.75 ml-min

F_3 = Blood Flow into Capillary Zone 3 = 2.0 ml-min

$P_{SO_2 1}$ = Diffusing Capacity of Oxygen in Zone 1 = 105 ml/min

$P_{SO_2 2}$ = Diffusing Capacity of Oxygen in Zone 2 = 125 ml/min

$P_{SO_2 3}$ = Diffusing Capacity of Oxygen in Zone 3 = 150 ml/min

$\lambda_{O_2 1}$ = Partition coefficient for Zone 1 = 0.381

$\lambda_{O_2 2}$ = Partition coefficient for Zone 2 = 0.524

$\lambda_{O_2 3}$ = Partition coefficient for Zone 3 = 0.60

$C_{pc 1}$ = Pulmonary Capillary Compliance in Zone 1 = 3.0 ml/mmHg

$C_{pc 2}$ = Pulmonary Capillary Compliance in Zone 2 = 4.0 ml/mmHg

$C_{pc 3}$ = Pulmonary Capillary Compliance in Zone 3 = 5.0 ml/mmHg

$C_{alv 1}$ = Compliance of Alveolar Zone 1 = 5.44 ml/mmHg

$C_{alv 2}$ = Compliance of Alveolar Zone 2 = 8.16 ml/mmHg

$C_{alv 3}$ = Compliance of Alveolar Zone 3 = 13.6 ml/mmHg

$Q_{I 1}, Q_{I 2}, Q_{I 3}$ = Inspiratory Flow of Oxygen in Zone 1, 2, &3 = 6000 ml/min

$Q_{E 1}, Q_{E 2}, Q_{E 3}$ = Expiratory Flow of Oxygen in Zone 1, 2, &3 = 6000 ml/min

$P_{pO_2 AL 1, 2, \&3}(0)$ = Partial Pressure of Oxygen in alveolar Zone 1, 2, &3 at time Zero = 8.0 mmHg

$P_{pO_2 C 1, 2, \&3}(0)$ = Partial Pressure of Oxygen in Capillary Zone 1, 2, &3 at time Zero = 40.0 mmHg

$P_{t 1, 2, \&3}$ = Total Pressure in Capillary Zone 1, 2, &3 = 90 mmHg

$P_{AL 1}$ = Total Pressure of Oxygen In alveolar Zone 1, 2, &3 = 100 mmHg

$P_{pO_2 A}(0)$ = Partial Pressure of Oxygen in Arteries at time Zero = 40 mmHg

$P_{pO_2 V}(0)$ = Partial Pressure of Oxygen in Veins at time Zero = 104 mmHg

$P_{pO_2 LA}(0)$ = Partial Pressure of Oxygen in Large Airways at time Zero = 100 mmHg

3.2.3 Large Airways and Dead Zone

γ_1 = Mixing (Blood & Gas) Coefficient for Zone 1 = 0.2

γ_2 = Mixing (Blood & Gas) Coefficient for Zone 2 = 0.3

γ_3 = Mixing (Blood & Gas) Coefficient for Zone 3 = 0.5

QE LA = Amount of Expired Air From Large Airways = 800 ml/min

QI LA = Amount of Inspired Air into Large Airways = 200 ml/min

CLA = Compliance of Large Airways = 4.32 ml/mmHg

PtLa = Total Pressure in Large Airways = 100 mmHg

QE DZ = Amount of Expired Air From Dead Zone = 150 ml/min

QI DZ = Amount of Inspired Air into Dead Zone = 300 ml/min

Ppo₂ Room = Partial pressure of Oxygen at Room conditions = 159 mmHg

CDZ = Compliance of Dead Zone = 0.3 ml/mmHg

PDZ = Partial Pressure of Oxygen In Dead Zone = 60 mmHg

3.2.4 Arteries and Veins

F₁₀ = Blood Flow out of Capillary Zone 1 = 500 ml/min

F₂₀ = Blood Flow out of Capillary Zone 2 = 300 ml/min

F₃₀ = Blood Flow out of Capillary Zone 3 = 200 ml/min

F_{pv} = Blood Flow into Pulmonary Veins = 2000 ml/min

C_{pv} = Compliance of Pulmonary Veins = 105 ml/mmHg

P_{tpv} = Total Pressure in Pulmonary Veins = 40 mmHg

F_{rv} = Blood Flow from Pulmonary Veins = 1600 ml/min

F_{pa} = Blood Flow from Pulmonary Arteries = 1800 ml/min

C_{pa} = Compliance of Pulmonary Arteries = 8.4 ml/mmHg

P_{tpa} = Total Pressure in Pulmonary Arteries = 100 mmHg

F_s = Shunt Flow = 100 ml/min

3.3 Results

Figure 1 shows the partial pressure of blood in the pulmonary arteries, veins, and the capillaries. The systolic pressure in the right ventricle of the normal human being averages approximately 25 mmHg, and the diastolic pressure averages about 0 to 1 mmHg, values that are only one fifth those for the left ventricle.

Pressures in the Pulmonary Artery. During systole, the pressure in the pulmonary artery is essentially equal to the pressure in the right ventricle as shown in figure 1. However, after the pulmonary valve closes at the end of systole, the ventricular pressure falls precipitously, whereas the pulmonary arterial pressure falls slowly as blood flows through the capillaries of the lungs. As shown in the figure 1, the systolic pulmonary arterial pressure averages approximately 25 mmHg in the normal human being; the diastolic pulmonary arterial pressure, approximately 15 mmHg.

Pulmonary Capillary and Venous Pressures. The capillary pressure as shown in the figure 1 is approximately 11 mmHg and the pulmonary veins average approximately 8 mmHg. For a normal human being the venous pressure varies from as low as 1 mmHg to as high as 8 mmHg.

The actual transfer of gases occurs in the 250 million or so tiny sacs called alveoli which comprise the terminal ends of the whole branched network of flow passages. The time averaged oxygen and carbon dioxide concentrations in the alveoli are 104 mmHg and 40 mmHg respectively versus 149 mmHg and 0.3 mmHg in the humidified air.

Figure 2 shows the partial pressure of oxygen in the three alveolar zones with respect to time. Because higher ventilation rates and higher metabolic rates usually occur together, we can deduce that on balance oxygen and carbon dioxide partial pressures in the alveoli will stay nearly constant over a wide range of conditions.

Figure 3 shows that the P_{O_2} in a red blood cell entering the capillary is normally about 40 mmHg. Across the blood-gas barrier, less than 1/2 micron away, is the alveolar P_{O_2} of

100 mmHg. Oxygen is transported down this large pressure gradient, and the P_{O_2} in the red blood cell rapidly rises; it nearly reaches the P_{O_2} of alveolar gas by the time the red blood cell is only one-third of its way along the capillary. Thus, under normal circumstances, the difference in P_{O_2} between alveolar gas and end-capillary blood is immeasurably small—a mere fraction of a mmHg. In other words, the diffusion reserves of the normal lung are enormous.

In all the models so far developed for gas exchange in the lungs, the large airways were simply considered as tubes for air to move from the mouth into the alveoli. But in reality there is some gas exchange in the large airways. Figure 4 shows the partial pressure of oxygen in the large airways with respect to time.

At the end of inspiration, the upper airways are filled with inspired gas that has undergone no gas exchange, and alveolar units contain gas that approximates pulmonary capillary blood in composition. Between these two sites, in large airways, the gas partial pressure must vary between these two extremes (between 100 mmHg and 149 mmHg). In our model it stays nearly constant at 105 mmHg.

Not all the air that passes through the mouth reaches the alveoli. Some of the air remains in the dead space where no gas exchange occurs. Figure 4 shows the partial pressure of oxygen during inspiration and expiration. Since no gas exchange occurs in this region the partial pressure also remains constant at 135 mmHg.

Figure 5 shows the partial pressures of oxygen in the arteries and the veins. Under equilibrium conditions, the partial pressure of the gas in the gas phase and in the liquid phase are equal²³. This is because the number of gas molecules leaving the liquid per unit time is equal to the number entering the liquid. So the partial pressure of oxygen in the arteries (Figure 5) is almost equivalent to the blood pressure in pulmonary arteries and veins (Figure 1).

Figure 6 shows the blood pressure in the three capillary zones, which ranges between 9 mmHg and 13 mmHg.

CHAPTER 4

CONCLUSION

The Model developed in this thesis is a physiologically based pharmacokinetic model of inhaled gases in the lung. The model can be used to simulate the blood-alveolar exchange of gases such as oxygen and carbon dioxide as well as a wide variety of anesthetic gases of varying solubility in blood and lung tissue.

The major advantages of the model developed in this work are as follows:

1. The lung compartments are physiologically based. Under normal resting conditions alveolar-blood gas exchange takes place in three physiologically defined zones from the apex to the base of the lung. These are defined as follows:

Zone 1: Approximately, the top 1/3 of lung. No open capillaries. Well ventilated but not perfused.

Zone 2: Approximately, the middle 1/3 of lung. Capillaries only open about half the time. Poorly perfused but well ventilated.

Zone 3: Approximately, the lower 1/3 of lung. All capillaries open all the time. Well perfused and well ventilated.

2. The proportion of the lung which operates in zones 1, 2 and 3 changes with exercise and trauma. The model developed in this thesis simulates these adaptations by changing the proportion of the total blood flow perfusing each zone.

3. Also under normal resting conditions a small proportion of the total blood flow through the lungs occur as an arterial-venous shunt. This proportion can change with various pathologies. The model can readily simulate these changes by changing one variable.

4. Changes in other physiological lung compartments (for example, dead space) can readily be accomplished to simulate other pathologies.

5. Anesthetic gases of varying degrees of blood-tissue solubility can be simulated by changing the solubility coefficient in the mass balance equations.

6. The model can readily be coupled to a whole body hemodynamic model developed earlier to simulate distribution, uptake and metabolism of the inhaled gases by a variety of tissues and organs.

7. The model is implemented using TUTSIM simulation software. This software package runs on a PC and requires no programming experience. Equations are built up using functional blocks. The blocks are symbolic and the software for implementation of each function is transparent to the user. The blocks are interconnected to form the inputs and outputs for each equation. Parameters and initial conditions are associated with each block and can be easily altered to change simulation conditions. The output from the simulation can be sent to a file which can be easily imported by a wide variety of graphics software for preparation of graphs and reports.

APPENDIX I

This section contains the results of TUTSIM simulation program.

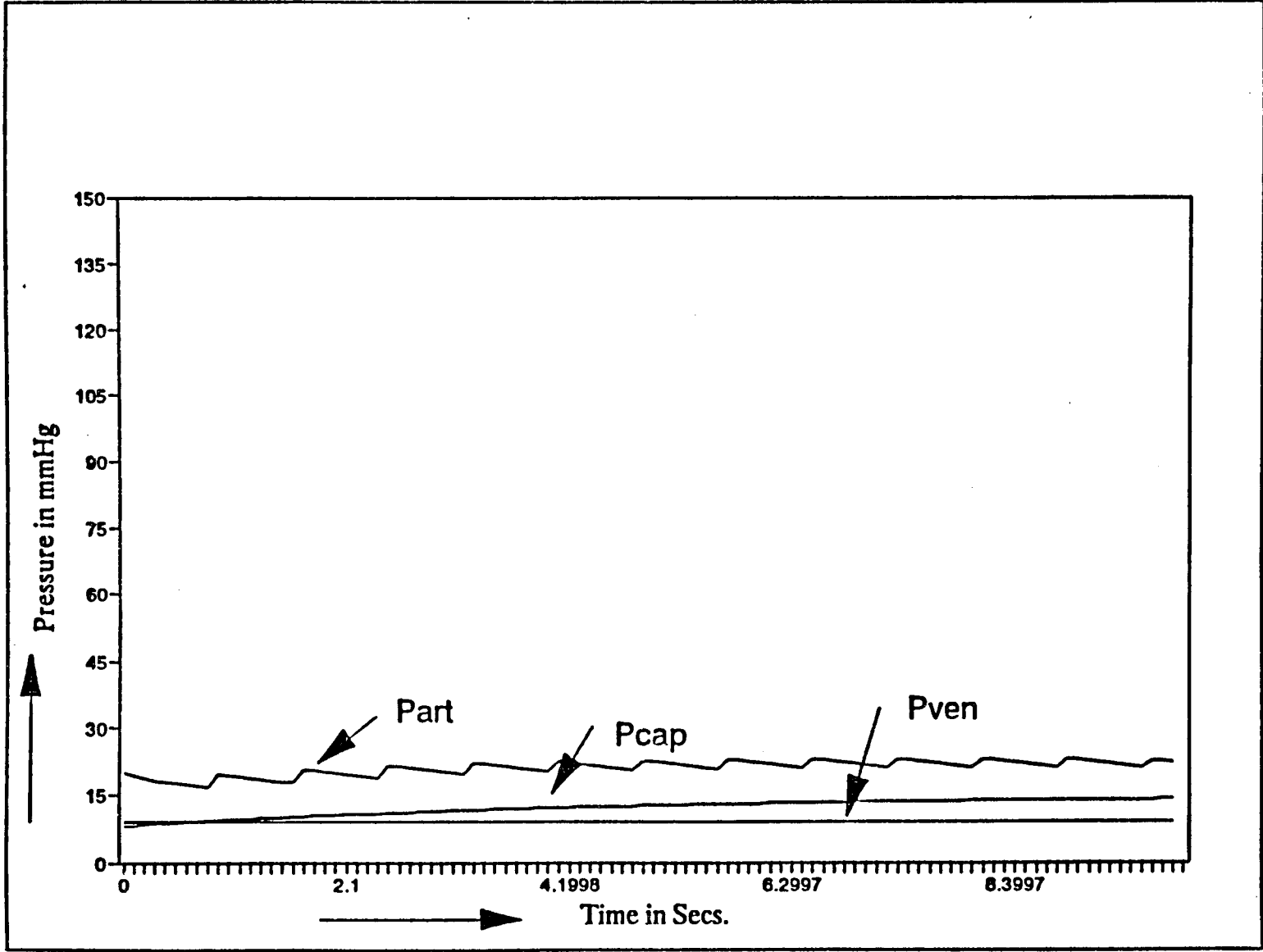


Figure 1 Blood Pressure in Pulmonary Arteries, Veins and Capillaries

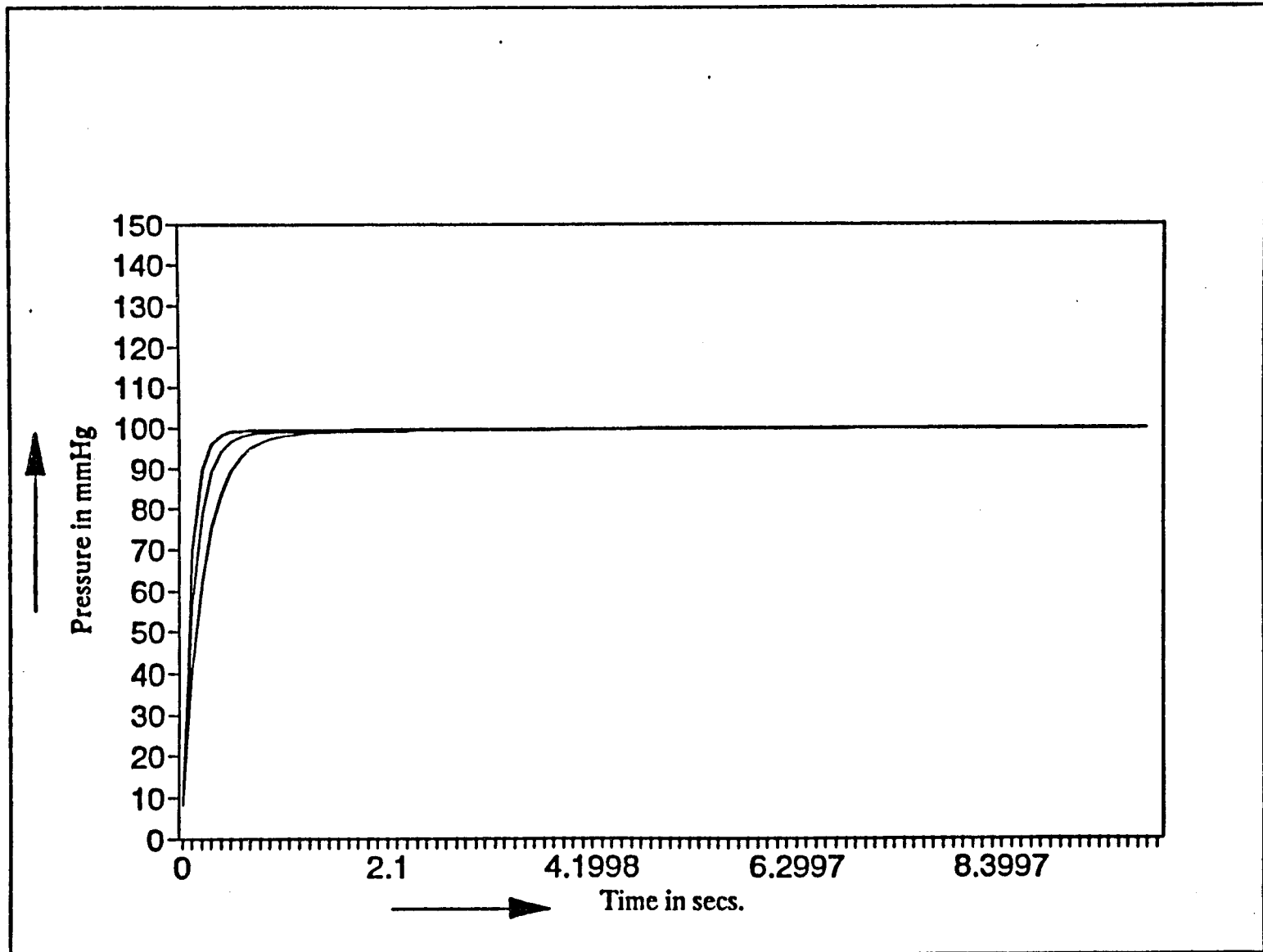


Figure 2 Partial Pressure of Oxygen in Alveolar Zones

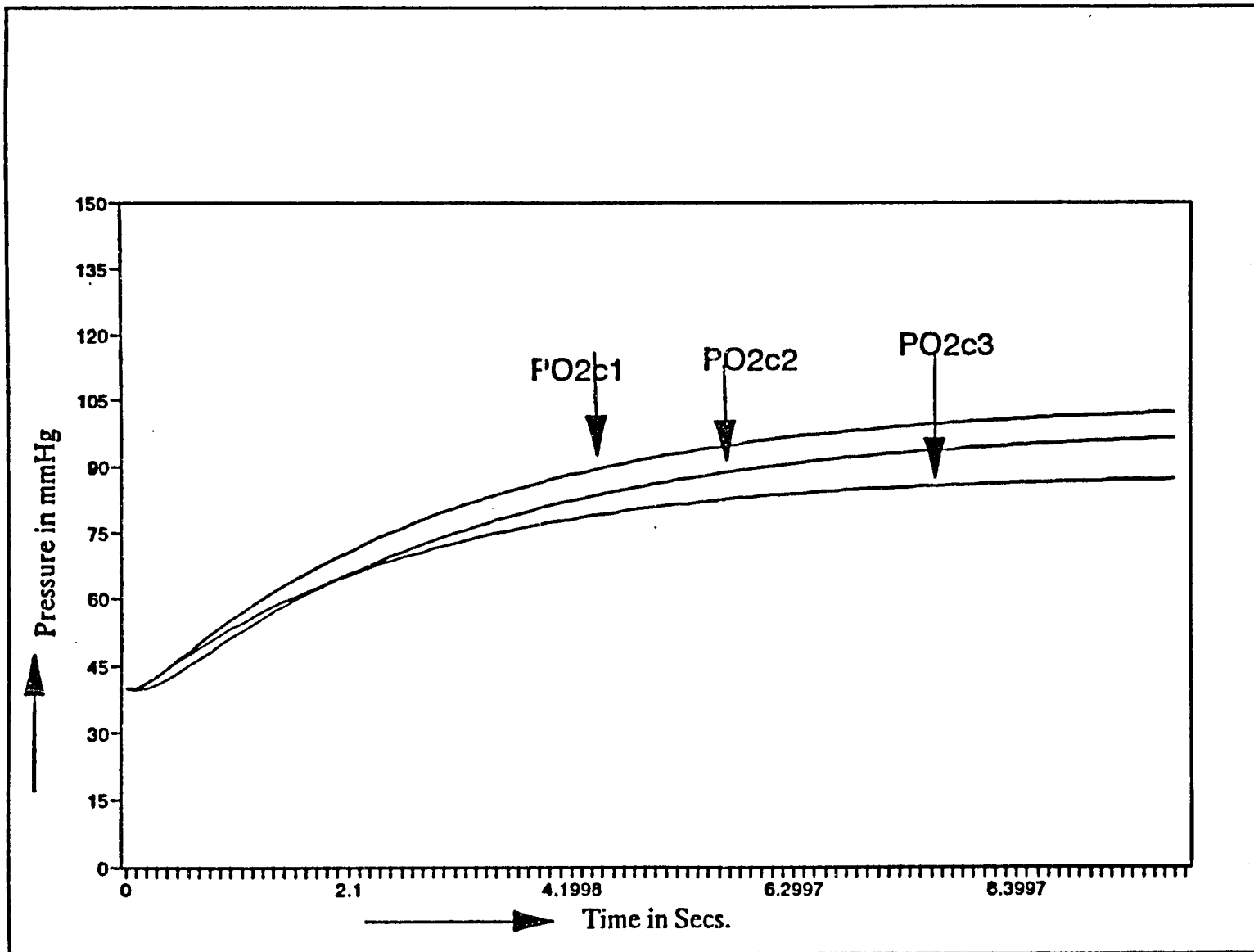


Figure 3 Partial Pressure of Oxygen in Capillary Zones

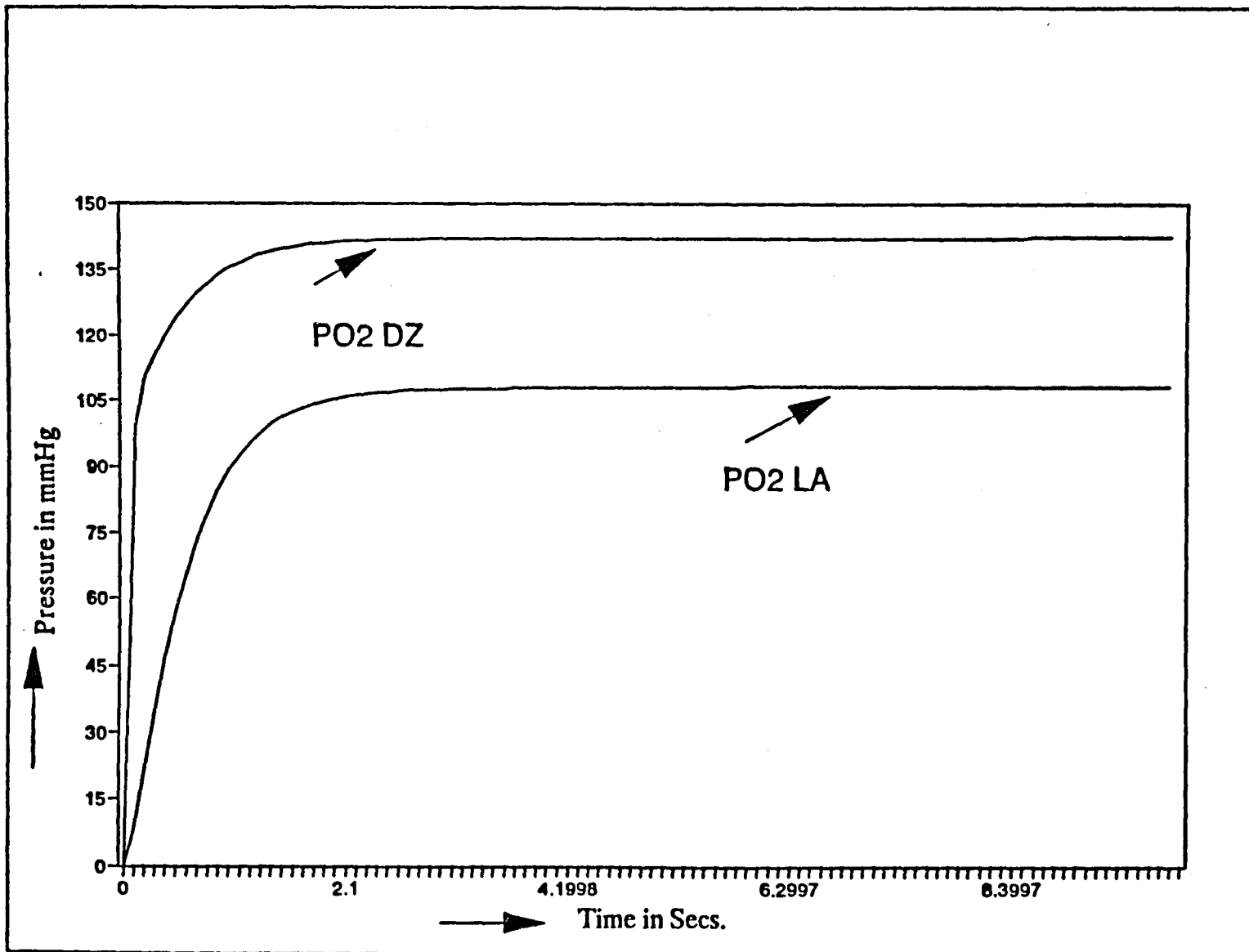


Figure 4 Partial Pressure of Oxygen in Large Airways and Dead Zone

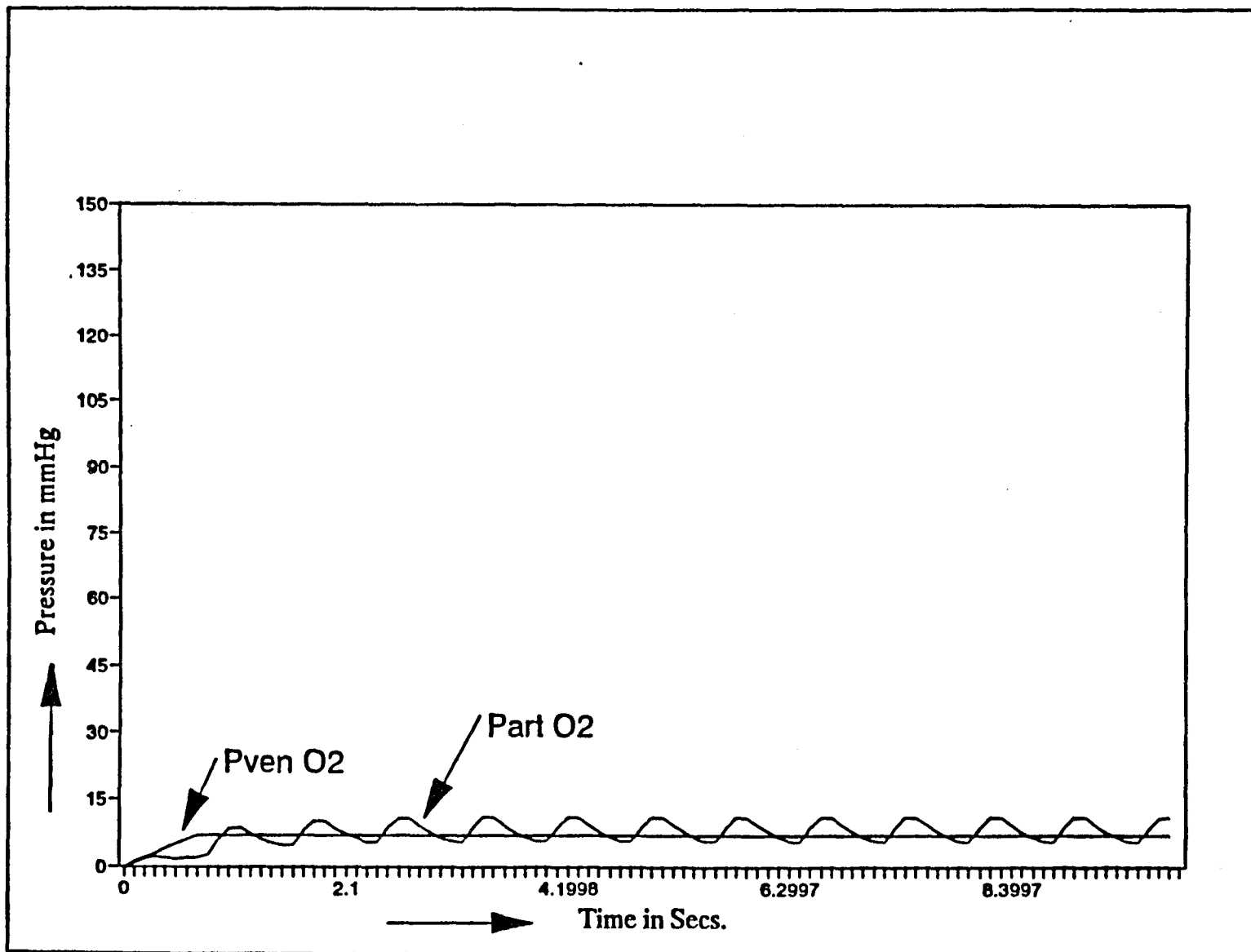


Figure 5 Partial Pressure of Oxygen in Arteries and Veins

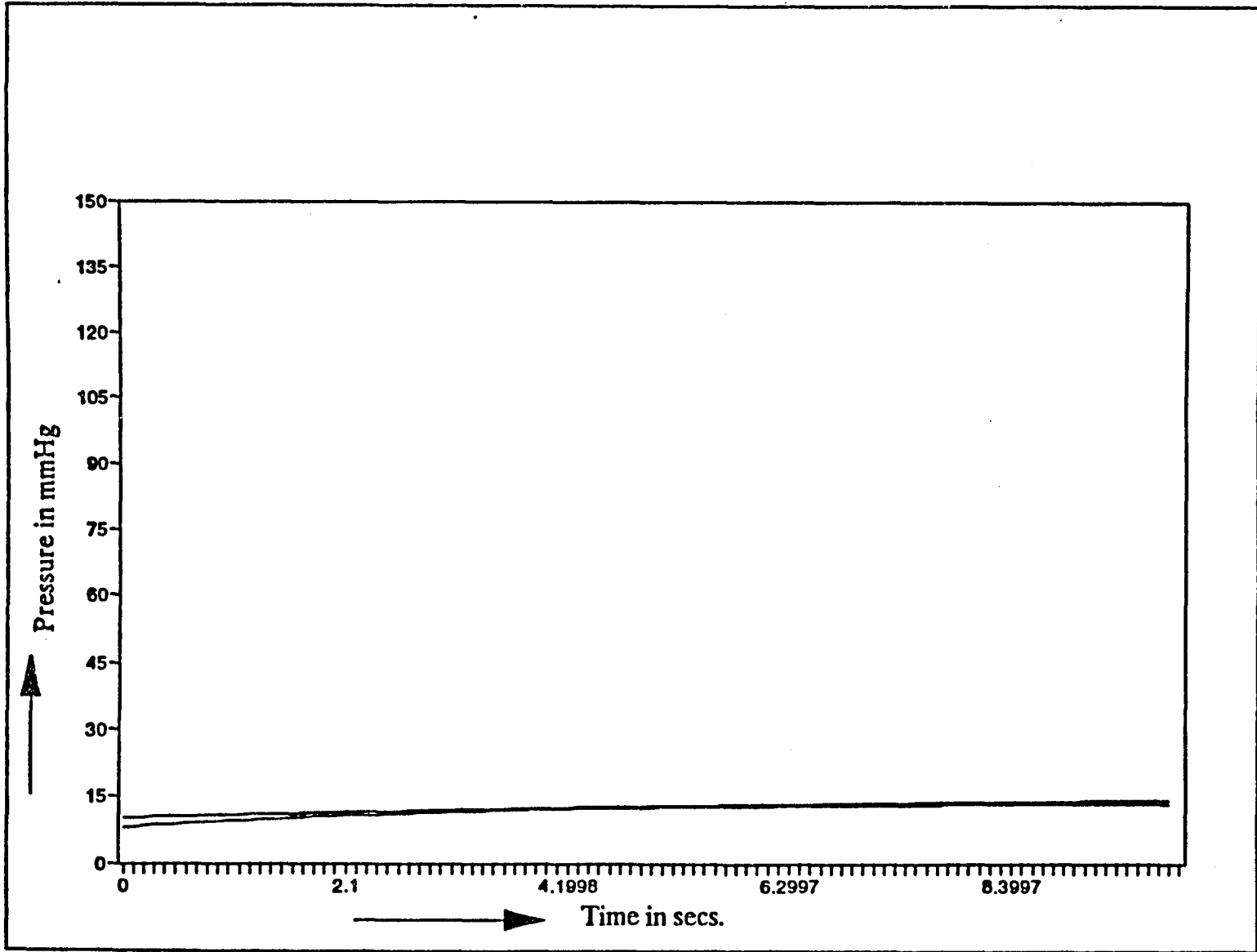


Figure 6 Blood Pressure in Capillary Zones

APPENDIX II

This section contains TUTSIM Block functions, Commands, Simulation Program and the Block diagrams used for Simulation.

TUTSIM BLOCKS

† maximum number of inputs.

NAME	PARAMETERS	FUNCTION	(N)-History Block
ABS	1 none	Absolute Value	
ACC	1 Ic	Accumulate Sum of Inputs (N)	
ADL	1 In	Delay One Step	(N)
AND	2 none	Logical AND of Inputs	
ATN	1 none	Arctangent	
ATT	1 P	Attenuate/Divide by Parameter	
BKL	1 V,Ip	Backlash	
C	1 C,Ic	Electrical Capacitance	(N)
CLX	0 P	Clock/Square Wave Source	
CON	0 C	Constant Source	
COS	1 none	Cosine of Sum of Inputs	
CRP	0 I1,I2,F1,F2	Chirp Source/Sharp Frequency	
DAT	0 Va	Filed Data Input Source	
DEL	1 N,Td,Ic	Delay Td Time Units	(N)
DFF	2 Iic	"D" Type Flip-Flop	
DIF	1 Ic,Ic	Differentiator	(N)
DIV	2 none	Divide Input1 by Input2	
DLT	0 none	Current Delta Time Output	
DTR	0 none	DOS Time/Step Watch	
EUL	1 Ic	Euler Integrator	(N)
EXP	1 none	Exponential (e)	
FIO	1 N,T,Ic	First Order Block	(N)
FIX	1 none	Fix/Truncate Fractional Part	
FNC	1 n,Nn,Vn	Function Generator	
FND	1 bit#	FNC Duplicator	
FRQ	0 F,A	Frequency Source/Sine Wave	
GAI	1 P	Gain/Multiply by Parameter	
GER	1 Th,R	Geared Delta Time	
GSR	1 F	Signed Square Root	
HIS	1 Ic	History	(N)
MLT	1 none	Melt	
MYS	1 V,Ip,h	Magnetic Hysteresis	
IFE	3 none	If Inputc Then In1 Else In2	
INT	1 Ic	Adams-Bashford Integrator (N)	
INV	1 none	Logical Inverter	
INT	1 Ic,Fz,K,Ic	LaPlace Integrator /w Zero(N)	

TUTSIM BLOCKS

† maximum number of inputs.

NAME	PARAMETERS	FUNCTION	(N)-History Block
L	1 L,Ic	Electrical Inductance	(N)
LIM	1 min,max	Min/Max Limit	
LLS	1 Ic,Fz,Fp,Ic	LaPlace Lead/Lag	(N)
LME	1 Ic,min,max	Min/Max EUL	(N)
LMI	1 Ic,min,max	Min/Max INT	(N)
LOC	2 Ic	Latch On Condition	
LOG	1 none	Natural logarithm	
MAX	2 none	Maximum Input	
MIN	2 none	Minimum Input	
MUL	2 none	Multiply Inputs	
NAM	2 none	Logical NOT AND	
NOI	0 none	Random Noise Source	
NOT	2 none	Logical NOT OR	
OP2	1 none	Second Output of BKL or MYS	
ORR	2 none	Logical OR	
PID	1 K,Ti,Td,t,Ic,Icd	PID Controller	
PLS	0 I1,I2,Ap	Pulse/Step Input Source	
PWR	1 P	Ratio to P Power	
R	1 R	Electrical Resistance	
REL	4 Va	Relay/Conditional	
REN	0 none	Remark/Listing Comments	
RES	2 Ic	Resetting Integrator	(N)
RSQ	1 F	Signed Square	
SDO	1 Ic,Z,F,Ic	LaPlace Second Order Block(N)	
SIN	1 none	Sign of Inputs	
SIM	1 none	Sine of Inputs	
SOC	2 Ic	Strobe On Condition	
SPL	1 SI	Sample and Hold	
SQR	1 none	Square Root of Inputs	
SRS	2 Iic	Set/Reset Flip-Flop	
SUM	2 none	Sum of Inputs	
SVC	0 none	Synchronize with DOS Time	
TFF	1 Iic	Trigger Flip-Flop	
TIM	0 none	Time Source	
VDL	2 Rn,Tn,Ic	Variable Delay	(N)
VDT	0 I1,I2,R	Variable Delta Time	
XOR	2 none	Logical EXCLUSIVE OR	

TUTSIM BLOCKS

† maximum number of inputs.

NAME	PARAMETERS	FUNCTION	(N)-History Block
ZAC	1 Ic,a,Ic	Z Accumulator	
ZCC	1 a0-a0	Z Cross Correlation	
ZDF	1 Ic,K,Ic	Z Difference	
ZDL	1 Ic,Dn,Ic	Z Delay	(N)
ZDT	0 Ic,Pz,dz	Z Delta Time	
ZGC	1 Ic,a0-a0,Ic	Z General Correlation	
ZGN	1 Ic,K	Z Gain	
ZHS	1 Ic,Ic	Z History	(N)
ZIR	1 Ic,K,a,Ip	Z Infinite Response	
ZSE	1 Ic,01	Z See Display Function	
ZSP	1 Ic,K,Ic	Z Sample and Hold	
ZUD	1 Ic,Ic	Z Unit Delay	(N)

TUTSIM OPTIONS BLOCKS

† maximum number of inputs.

NAME	PARAMETERS	FUNCTION	(N)-History Block
IN	0 P1,P2	RTIO User Defined Input	
INI	1 P1,P2	RTIO IN with Forced Order	
OUT	1 P1,P2	RTIO User Defined Output	
USA	1 P1,P2	User Defined Algebraic Block	
USR	1 P1,P2,Ic	User Defined History Block (N)	
ZIN	0 Ic,P1	Z Real Time I/O IN block	
ZNI	1 Ic,P1	Z Real Time I/O INI Block	
ZOT	1 Ic,P1	Z Real Time I/O OUT Block	

THE TUTSIM COMMANDS

Change Commands

CS Change the Structure of the model
 CC Change the Comments on a structure line
 CP Change the Parameters of the model
 CB Change the PlotBlocks and Ranges
 CT Change the Timing parameters

Change Structure Subcommands

D Delete a Range of Blocks
 E Exit to Command Mode without Sorting
 L[P][:n..m] List [Print][a Range of] Blocks
 N[P][:n..m] List [Print][a Range of] Unused Blocks
 R Repeat a Range of Blocks

Starting Simulation

SD Start Simulation, Results to Display
 SN Start Simulation with Numerical Results
 SNP Start Simulation /w SN Results to Printer
 SP Start Simulation /w Print-Plot Output
 SPP Start Simulation /w SP Output to Printer
 MR Start Simulation /w Multi-Run Feature
 SF Start Simulation Output to ASCII File
 MF Start Simulation Output to Matlab File
 PE Parameter Estimation Simulations

Proceeding with Simulation after an Interrupt

PD Proceed with Results to Display
 PN Proceed with Numerical Output
 PNP Proceed with Numerical Output to Printer
 PP Proceed with Print-Plot Output
 PPP Proceed with Print-Plot Output to Printer

List Commands

L List the Model File
 LP List the Model File on the Printer
 L:n..m List a Range of Blocks
 LP n..m List a Range of Blocks on the Printer
 LM List a Macro
 LMP List a Macro on the Printer

Typing Commands

TT Type Timing Data
 TTP Type Timing Data on Printer
 TM Type Model Heading Information
 TMP Type Model Heading Information on Printer
 TS Type a Structure Line
 TSP Type a Structure Line on Printer

Model and Macro Filing Commands

DF Save a Model File on Disk
 K Concatenation of Model Files
 SM Save Macro File on Disk
 IM Import Macro into Current Model

THE TUTSIM COMMANDS CONT'D

Simulation Set Up Commands

CO Math Coprocessor Toggle (on/off)
 I Replace Initial Conditions with Outputs
 IC Iteration Counter
 NR/NP Set NOI Block (Random or Repetitive)
 RO Reset OUT Blocks (RTIC Option)
 S Signal Simulation Steps
 (space bar) Interrupt Model Simulation

Utility Commands

CM Compress Block Numbers
 RN Renumber Individual Blocks in a Model
 RN:n..m Renumber a Range of Blocks in a Model
 V Verify Last Block Output Value
 VP Verify Last Block Output Value on Printer
 V:n..m Verify a Range of Output Values
 VP:n..m Verify a Range of Output Values on Printer
 E Restart the TUTSIM Program
 DOS Return to DOS. Leaves TUTSIM Resident.
 Q or A Quit the TUTSIM Program (return to DOS)
 H Help on the Available Commands
 TF Send a Form Feed to the Printer
 (carriage return) Escape from Current Command

Graphic Screen Commands

GD Draw a Grid
 CL Clear the Graphical Screen
 MC Print Hard Copy of the Graphical Screen
 Shift-Print:1 Hard Copy for Hercules Graphics
 RD Return Display in Graphic Mode
 CD Toggles Display, Dot to Line
 X, Y Draw X or Y Center Lines

Function Key Screen Labels

F1 Labels the Y1 curve and displays the structure line comment from that block.
 F2 Labels the Y2 curve.
 F3 Labels the Y3 curve.
 F4 Labels the Y4 curve.
 F5 Labels the horizontal scale.
 F6 Super-imposes the last screen saved with F7 on the present screen.
 F7 Saves the present screen. No other screen will be saved until this screen is restored with F6.
 F8 Clears the screen.
 F9 Gives a 18 point summary of the simulation values.
 F10 Allows the user to enter a title on the present graph.

Graphics Mode Subcommands

C Clear Graph at End of Simulation Run
 E Echo Numeric Output to Printer
 N Turn Off Echo

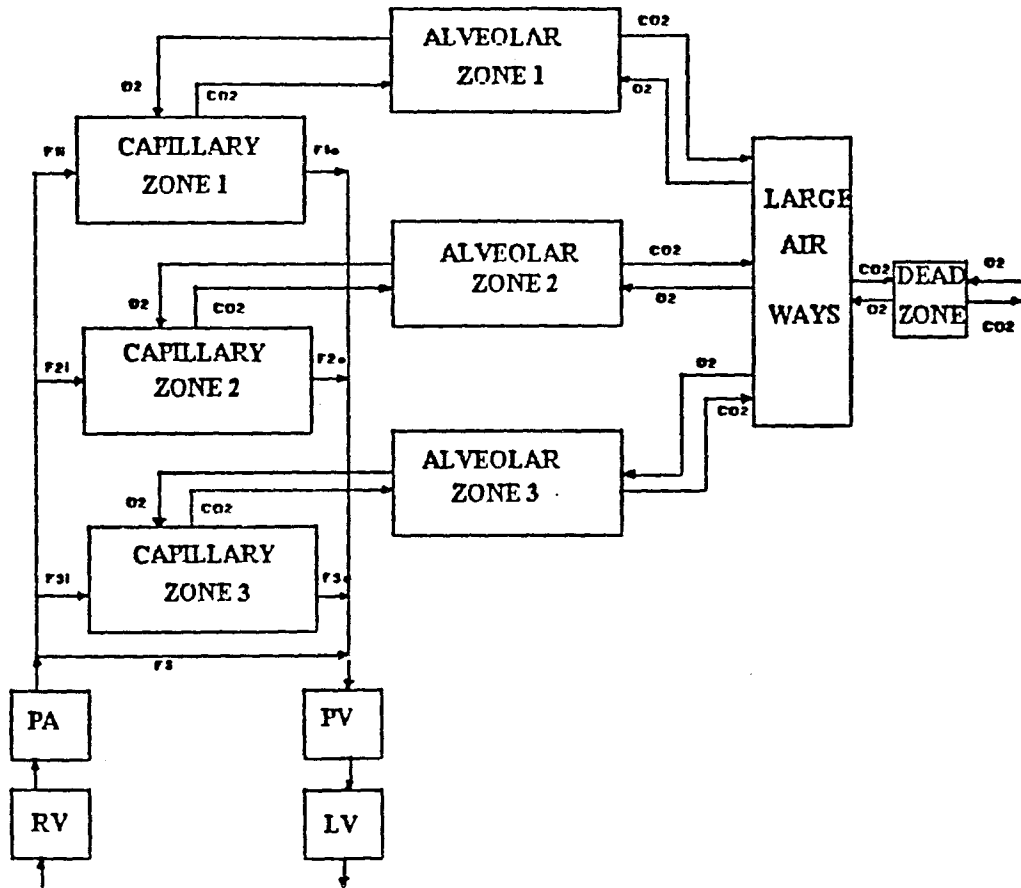


Figure 7 Basic Model for Gas Exchange in Lungs

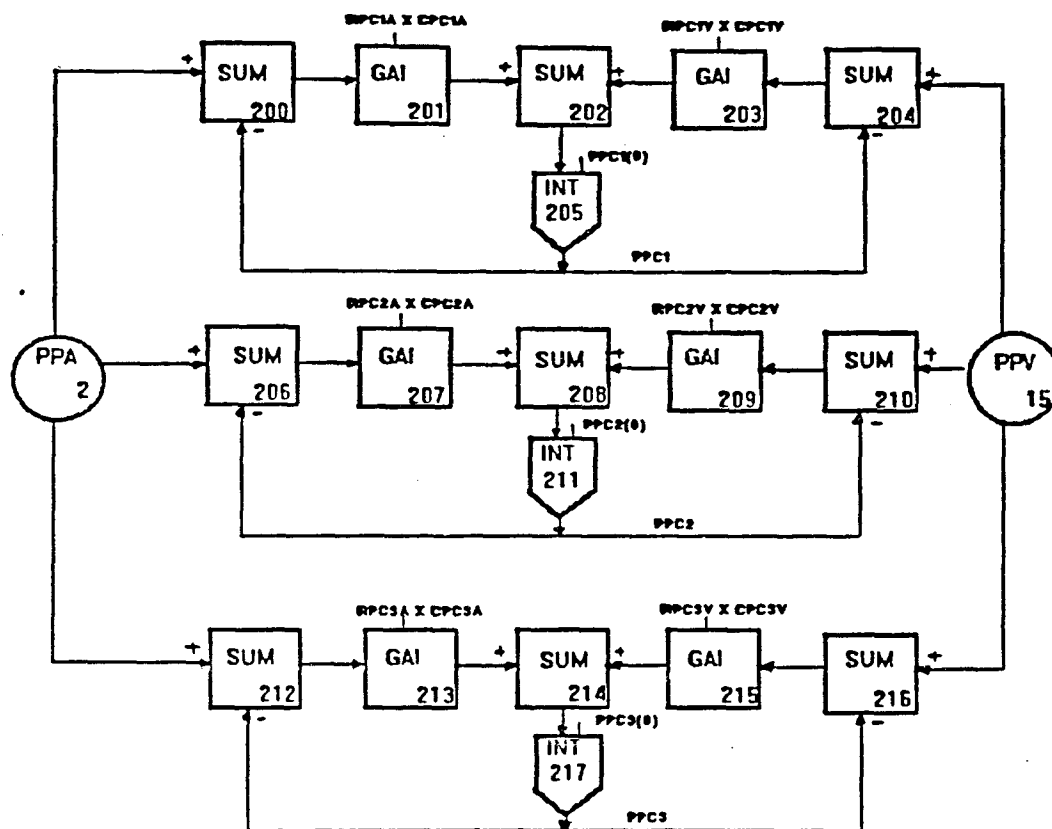


Figure 8 TutSim Block Diagram for Pulmonary Blood Flow

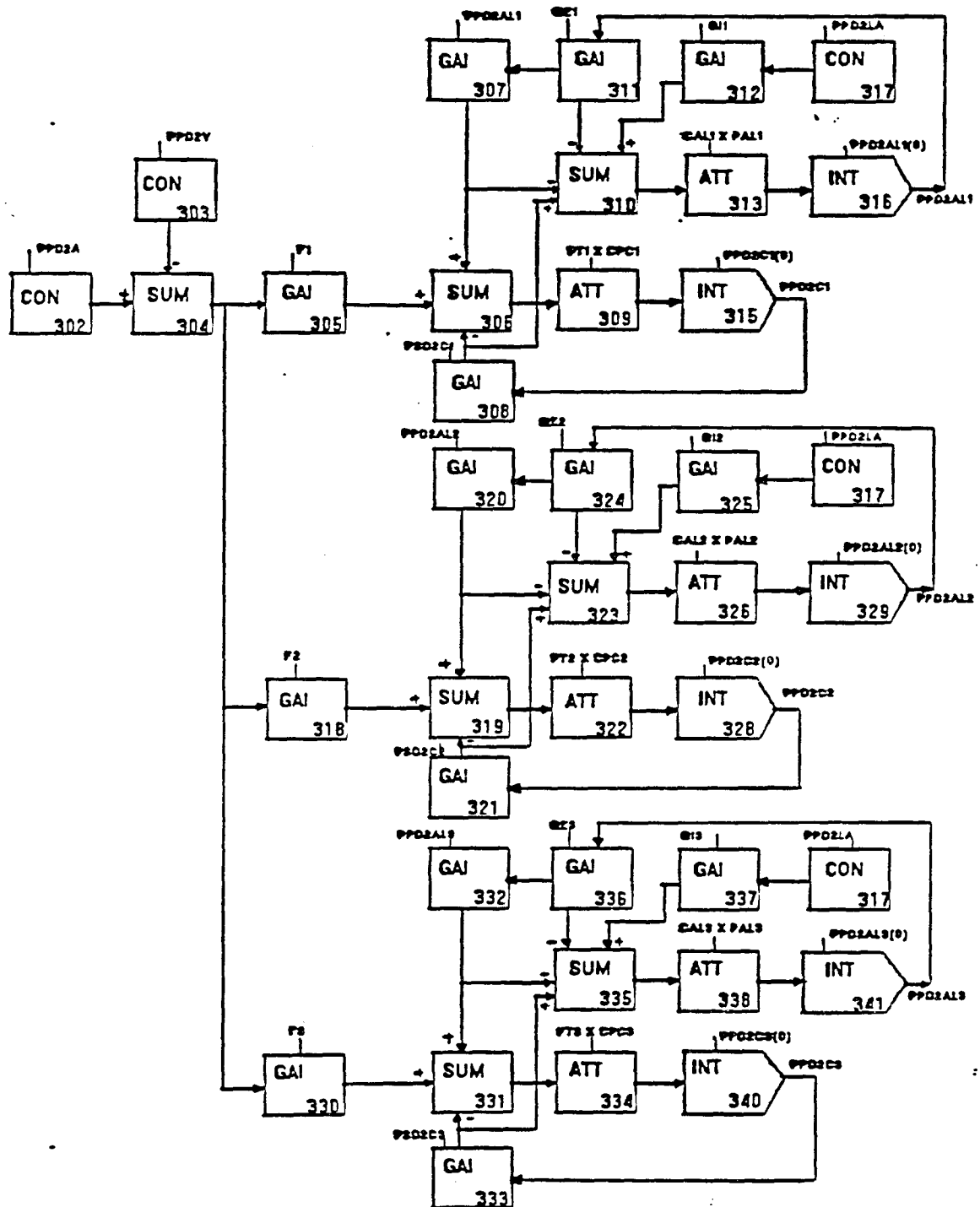


Figure 9 TutSim Block Diagram for Alveolar and Capillary Gas Exchange

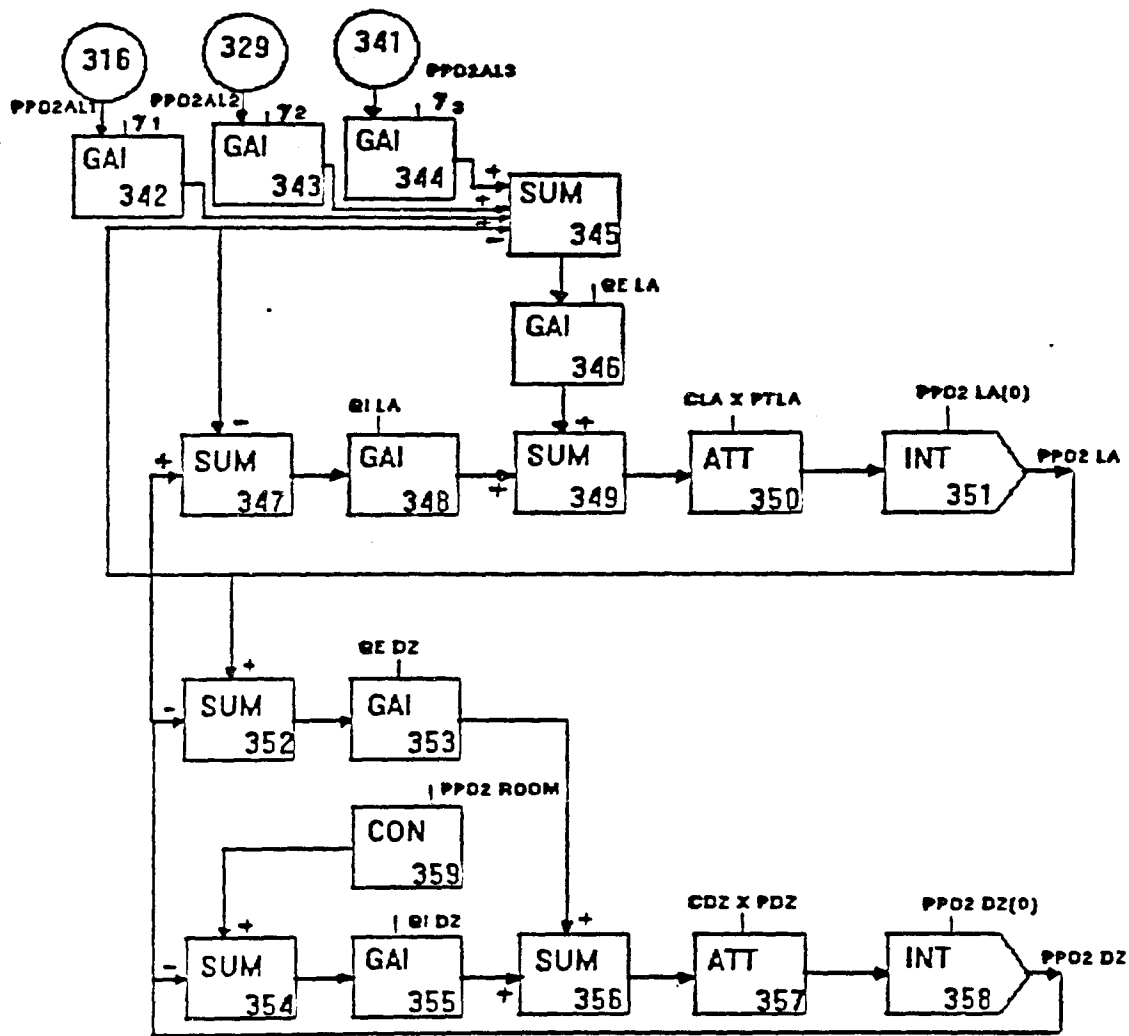


Figure 10 TutSim Block Diagram for Large Airways and Dead Zone

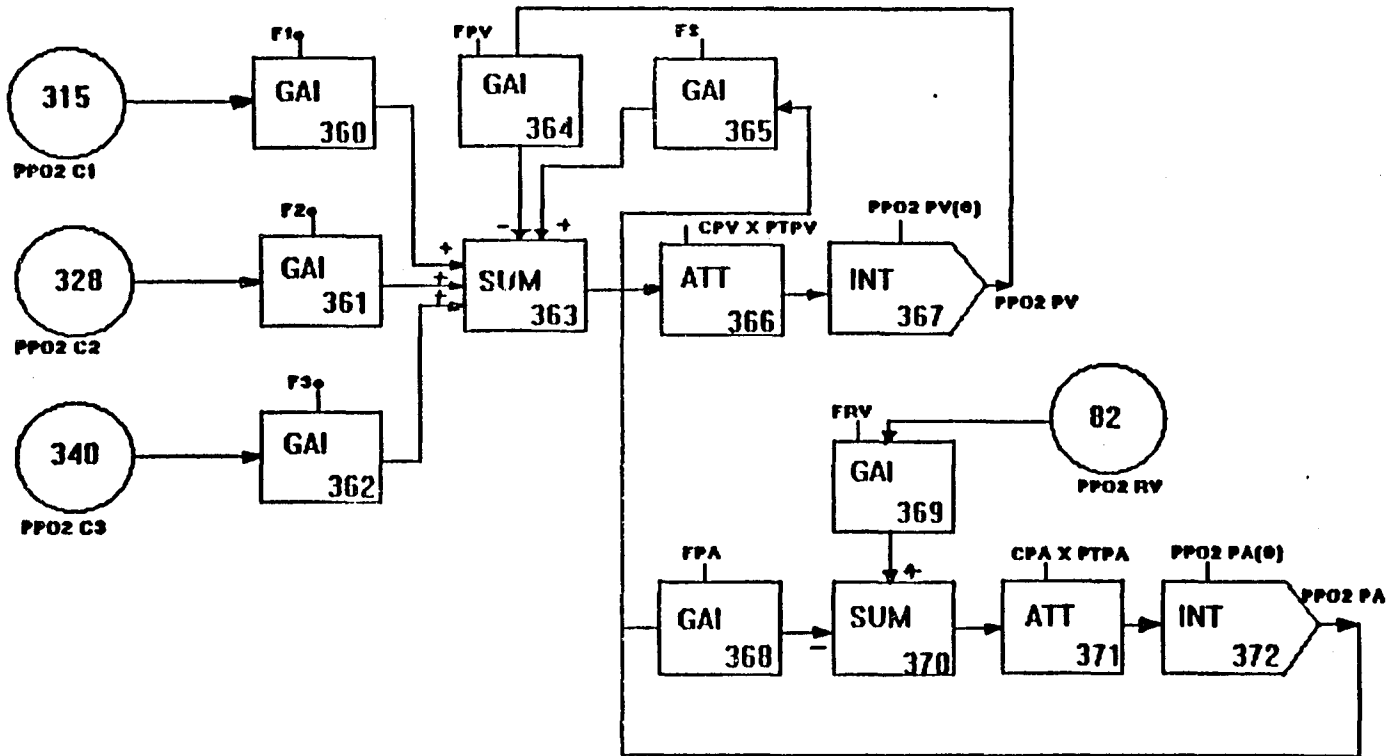


Figure 11 TutSim Block Diagram for Arterial and Venous Pressures

```

-Model File: tot1
-Date:      4 / 11 / 1993
-Time:     15 : 31
-Timing:   0.0010000 ,DELTA ; 10.0000 ,RANGE
-PlotBlocks and Scales:
-Format:
-   BlockNo, Plot-MINimum, Plot-MAXimum; Comment
-Horz:     0 , 0.0000 , 10.0000 ; Time
- Y1:    373 , 0.0000 , 150.0000 ;
- Y2:    372 , 0.0000 , 150.0000 ;

```

1	TIM			
2	INT	6		P1= 20.0000
3	SUM	-2	82	
4	LIM	3		P1= 0.0000 P2= 999.980E+03
5	GAI	4		P1= 200.0000
6	GAI	-9	5	P1= 0.0325000
7	SUM	-10	2	
8	LIM	7		P1= 0.0000 P2= 999.980E+03
9	GAI	8		P1= 20.0000
10	INT	14		P1= 10.0000
11	SUM	-15	10	
12	LIM	11		P1= 0.0000 P2= 999.980E+03
13	GAI	12		P1= 10.0000
14	GAI	-13	9	P1= 0.0450000
15	INT	19		P1= 9.0000
16	SUM	-21	15	
17	LIM	16		P1= 0.0000 P2= 999.980E+03
18	GAI	17		P1= 25.0000
19	GAI	-18	13	P1= 0.0020000
20	INT	25		P1= 8.0000
21	MJL	20	38	
22	SUM	-26	21	
23	LIM	22		

			P1-	0.0000
			P2-	999.980E+03
24	GAI	23		
			P1-	25.0000
25	GAI	-24	18	
			P1-	1.0000
26	INT	30		
			P1-	100.0000
27	SUM	-42	26	
28	LIM	27		
			P1-	0.0000
			P2-	999.980E+03
29	GAI	28		
			P1-	17.1820
30	GAI	-29	24	
			P1-	5.0000
31	GAI	1		
			P1-	1.2500
32	FIX	31		
33	GAI	-32	31	
			P1-	0.8000000
34	GAI	1		
			P1-	1.0000
35	FNC	34		
X,Y-	1	0.0000	0.0800000	
X,Y-	2	0.0200000	0.1620000	
X,Y-	3	0.0400000	0.2170000	
X,Y-	4	0.0600000	0.2550000	
X,Y-	5	0.0800000	0.3000000	
X,Y-	6	0.1000000	0.3240000	
X,Y-	7	0.1200000	0.3490000	
X,Y-	8	0.1400000	0.3450000	
X,Y-	9	0.1600000	0.3410000	
X,Y-	10	0.1800000	0.3380000	
X,Y-	11	0.2000000	0.3080000	
X,Y-	12	0.2200000	0.2860000	
X,Y-	13	0.2400000	0.2500000	
X,Y-	14	0.2600000	0.1600000	
X,Y-	15	0.2800000	0.1070000	
X,Y-	16	0.3000000	0.0400000	
X,Y-	17	0.3200000	0.0133333	
X,Y-	18	0.3400000	0.0132000	
X,Y-	19	0.3600000	0.0102000	
X,Y-	20	0.3800000	0.0084700	
X,Y-	21	0.4000000	0.0123000	
X,Y-	22	0.4200000	0.0117000	
X,Y-	23	0.4400000	0.0152000	
X,Y-	24	0.4600000	0.0149000	
X,Y-	25	0.4800000	0.0184000	
X,Y-	26	0.5000000	0.0183000	
X,Y-	27	0.5200000	0.0217000	
X,Y-	28	0.5400000	0.0216000	
X,Y-	29	0.5600000	0.0214000	
X,Y-	30	0.5800000	0.0213000	
X,Y-	31	0.6000000	0.0211000	
X,Y-	32	0.6200000	0.0210000	
X,Y-	33	0.6400000	0.0208000	
X,Y-	34	0.6600000	0.0207000	
X,Y-	35	0.6800000	0.0205000	
X,Y-	36	0.7000000	0.0204000	

X,Y-	37	0.7200000	0.0202000
X,Y-	38	0.7400000	0.0201000
X,Y-	39	0.7600000	0.0233330
X,Y-	40	0.7800000	0.0600000
X,Y-	41	0.8000000	0.0800000
36 FND	33		P1= 35.0000
37 FNC	34		
X,Y-	1	0.0000	0.5333330
X,Y-	2	0.0200000	0.7100000
X,Y-	3	0.0400000	0.7970000
X,Y-	4	0.0600000	1.0090
X,Y-	5	0.0800000	1.2740
X,Y-	6	0.1000000	1.4090
X,Y-	7	0.1200000	1.5370
X,Y-	8	0.1400000	1.6000
X,Y-	9	0.1600000	1.5950
X,Y-	10	0.1800000	1.5900
X,Y-	11	0.2000000	1.5840
X,Y-	12	0.2200000	1.5260
X,Y-	13	0.2400000	1.3333
X,Y-	14	0.2600000	0.8133300
X,Y-	15	0.2800000	0.4000000
X,Y-	16	0.3000000	0.1600000
X,Y-	17	0.3200000	0.0533000
X,Y-	18	0.3400000	0.0395000
X,Y-	19	0.3600000	0.0204000
X,Y-	20	0.3800000	0.0254000
X,Y-	21	0.4000000	0.0246000
X,Y-	22	0.4200000	0.0312500
X,Y-	23	0.4400000	0.0341000
X,Y-	24	0.4600000	0.0373000
X,Y-	25	0.4800000	0.0404000
X,Y-	26	0.5000000	0.0438000
X,Y-	27	0.5200000	0.0435000
X,Y-	28	0.5400000	0.0432000
X,Y-	29	0.5600000	0.0429000
X,Y-	30	0.5800000	0.0426000
X,Y-	31	0.6000000	0.0423000
X,Y-	32	0.6200000	0.0420000
X,Y-	33	0.6400000	0.0451000
X,Y-	34	0.6600000	0.0483000
X,Y-	35	0.6800000	0.0445000
X,Y-	36	0.7000000	0.0408000
X,Y-	37	0.7200000	0.0405000
X,Y-	38	0.7400000	0.0403000
X,Y-	39	0.7600000	0.0400000
X,Y-	40	0.7800000	0.4000000
X,Y-	41	0.8000000	0.5333300
38 FND	33		P1= 37.0000
39 SUM	-76	26	
40 LIM	39		P1= 0.0000
			P2= 999.980E+03
41 GAI	40		P1= 0.0427350
42 INT	46		P1= 60.0000
43 SUM	-47	42	

-44 LIM	43				P1= 0.0000
					P2= 999.980E+03
45 GAI	44				P1= 2.0953
46 GAI	-41	-45	29		P1= 1.0000
47 INT	58				P1= 30.0000
48 SUM	-54	47			P1= 0.0000
49 LIM	48				P2= 999.980E+03
50 GAI	49				P1= 3.1818
51 SUM	-71	42			P1= 0.0000
52 LIM	51				P2= 999.980E+03
53 GAI	52				P1= 0.3836200
54 INT	62				P1= 20.0000
55 SUM	-63	54			P1= 0.0000
56 LIM	55				P2= 999.980E+03
57 GAI	56				P1= 21.4770
58 GAI	-66	-50	-53	45	P1= 1.1500
59 SUM	-63	47			P1= 0.0000
60 LIM	59				P2= 999.980E+03
61 GAI	60				P1= 0.1275500
62 GAI	-61	-57	50		P1= 0.0700000
63 INT	70				P1= 15.0000
64 SUM	-63	42			P1= 0.0000
65 LIM	64				P2= 999.980E+03
66 GAI	65				P1= 0.1923070
67 SUM	-71	63			P1= 0.0000
68 LIM	67				P2= 999.980E+03
69 GAI	68				P1= 433.6800
70 GAI	-69	61	57		P1= 0.0500000
71 INT	75				P1= 8.0000
72 SUM	-76	71			P1= 0.0000
73 LIM	72				

74 GAI	73			P2-	999.980E+03
75 GAI	-74	69	66	P1-	11.4800
76 INT	80			P1-	0.0030000
77 SUM	-82	76		P1-	6.0000
78 LIM	77			P1-	0.0000
				P2-	999.980E+03
79 GAI	78			P1-	78.0000
80 GAI	-79	74	41	P1-	0.0040000
81 INT	83			P1-	4.0000
82 MUL	81	36			
83 GAI	-5	79		P1-	1.0000
84 LIM	35			P1-	0.0000
				P2-	999.980E+03
85 GAI	2			P1-	30.7692
86 GAI	10			P1-	11.1111
87 GAI	15			P1-	200.0000
89 GAI	26			P1-	1.0000
90 GAI	42			P1-	4.1666
91 GAI	47			P1-	0.8695650
92 GAI	54			P1-	14.2857
93 GAI	63			P1-	20.0000
94 GAI	71			P1-	166.6670
95 GAI	76			P1-	250.0000
100 SUM	82	-101	102	103	
101 GAI	105			P1-	2.8200
102 GAI	110			P1-	1.7500
103 GAI	107			P1-	0.0660000
104 ATT	100			P1-	0.0341250
105 INT	104			P1-	8.0000
106 GAI	107			P1-	3.0000
107 GAI	115			P1-	1.0000
108 GAI	110			P1-	4.0000

109 SUM	-108	105	106	
110 GAI	113			
111 ATT	105			F1- 1.0000
112 ATT	109			F1- 16.0000
113 INT	112			F1- 0.0540000
114 ATT	113			F1- 5.0000
115 INT	118			F1- 0.2000000
116 GAI	115			F1- 4.0000
117 SUM	111	114	-116	F1- 5.0600
118 ATT	117			F1- 0.0500000
119 GAI	105			F1- 0.0325000
120 GAI	113			F1- 0.0900000
121 GAI	115			F1- 0.0500000
122 GAI	105			F1- 1.0000
123 GAI	113			F1- 0.6000000
124 GAI	115			F1- 0.2000000
200 SUM	2	-205		
201 GAI	200			F1- 0.1330000
202 SUM	201	203		
203 GAI	204			F1- 0.2500000
204 SUM	-205	15		
205 INT	202			F1- 10.0000
206 SUM	2	-211		
207 GAI	206			F1- 0.1390000
208 SUM	207	209		
209 GAI	210			F1- 0.1960000
210 SUM	-211	15		
211 INT	208			F1- 8.0000
212 SUM	2	-217		
213 GAI	212			F1- 0.1180000
214 SUM	213	215		
215 GAI	216			F1- 0.1560000
216 SUM	-217	15		
217 INT	214			F1- 10.0000
218 SUM	204	210	216	
302 CON				F1- 40.0000

303	CON				P1= 104.0000
304	SUM	302	-303		
305	GAI	304			P1= 5.0000
306	SUM	305	307	-308	
307	GAI	316			P1= 96.0000
308	GAI	315			P1= 105.0000
309	ATT	306			P1= 270.0000
310	SUM	-307	308	-311	312
311	GAI	316			P1= 6.000E+03
312	GAI	317			P1= 6.000E+03
313	ATT	310			P1= 544.0000
315	INT	309			P1= 40.0000
316	INT	313			P1= 8.0000
317	CON				P1= 100.0000
318	GAI	304			P1= 1.7500
319	SUM	318	320	-321	
320	GAI	329			P1= 132.0000
321	GAI	328			P1= 125.0000
322	ATT	319			P1= 360.0000
323	SUM	-320	-324	321	325
324	GAI	329			P1= 6.000E+03
325	GAI	317			P1= 6.000E+03
326	ATT	323			P1= 816.0000
328	INT	322			P1= 40.0000
329	INT	326			P1= 8.0000
330	GAI	304			P1= 2.0000
331	SUM	330	332	-333	
332	GAI	341			P1= 150.0000
333	GAI	340			P1= 150.0000
334	ATT	331			P1= 450.0000
335	SUM	-332	-336	333	337
336	GAI	341			P1= 6.000E+03
337	GAI	317			P1= 6.000E+03
338	ATT	335			

340 INT	334			P1=	1.360E+03
341 INT	338			P1=	40.0000
342 GAI	316			P1=	8.0000
343 GAI	329			P1=	0.2000000
344 GAI	341			P1=	0.3000000
345 SUM	342	343	344	P1=	0.5000000
346 GAI	345				-351
347 SUM	-351	358		P1=	800.0000
348 GAI	347				
349 SUM	346	348		P1=	200.0000
350 ATT	349				
351 INT	350			P1=	432.0000
352 SUM	351	-358		P1=	0.0000
353 GAI	352				
354 SUM	359	-358		P1=	150.0000
355 GAI	354				
356 SUM	353	355		P1=	300.0000
357 ATT	356				
358 INT	357			P1=	18.0000
359 CON				P1=	0.0000
360 GAI	315			P1=	159.0000
361 GAI	328			P1=	500.0000
362 GAI	340			P1=	300.0000
363 SUM	360	361	362	P1=	200.0000
364 GAI	367				
365 GAI	372			P1=	2.000E+03
366 ATT	363			P1=	100.0000
367 INT	366			P1=	4.200E+03
368 GAI	372			P1=	0.0000
369 GAI	82			P1=	1.800E+03
370 SUM	-368	369		P1=	1.600E+03
371 ATT	370				
372 INT	371			P1=	840.0000
373 LIM	367			P1=	0.0000

P1- 0.0000
P2- 7.0000

REFERENCES

1. Kety SS, "The theory and applications of the exchange of inert gas at the lungs and tissues", *Pharmacol Rev* 3:1-41, 1951.
2. J.Steven Jenkins, Christian P.Valcke, Denham S.Ward, "An extended soluble gas exchange model for estimating pulmonary perfusion", *IEEE transactions on biomedical engineering*, vol.36, No.11, Nov.1989.
3. Mapleson WW, "An electric analogue for uptake and exchange of inert agents and other agents", *J Appl Physiol* 18:197-205, 1963.
4. Yashuiro Fukui, N.Ty Smith, "Interactions among ventilation, the circulation, and the uptake and distribution of halothane - use of a hybrid computer multiple model", *Anesthesiology*, vol.54, pp.107-118, 1981.
5. Ferdinand Kreuzer, "Oxygen supply to tissues: The krogh model and its assumptions", *Experientia*, vol.38, pp.1415-1425, 1982.
6. Harvey S.Borovetz, Chin-Cheng Chen, Robert L Hardesty, "Numerical simulation of the transient transport of inert gases in lung tissue", *Phys.Med.Biol.*, vol.26, No.3, pp.401-411, 1981.
7. Chi-Sang Poon, Donald M.Wiberg, Susan A.Ward, "Dynamics of gaseous uptake in the lungs: The concentration and second gas effects", *IEEE transactions on biomedical engineering*, vol.BME-28, No.12, Dec.1981.
8. Simon A.Barton, Andrew M.S.Black, Clive E.W.Hahn, "Dynamic models and solutions for evaluating ventilation, perfusion, and mass transfer in the lung-Part I: The Models", *IEEE transactions on biomedical engineering*, vol.35, No.6, June 1988.
9. Peter D.Wagner, John W.Evans, "Conditions for equivalence of gas exchange in series and parallel models of the lung", *Respiration Physiology*, vol 31, pp.117-138, 1977.
10. Puranic B., "An overall cardiovascular model for prediction of left ventricular oxygen supply and demand", M.S. Thesis, New Jersey Institute of Technology, 1992.

11. Ashman, Blesser, Epstein, "Nonlinear model for halothane uptake in man", *Anesthesiology*, Vol.33, No.4, Oct.1970.
12. Joseph Boyle III, "Microcomputer analysis of O₂ transport and tissue PO₂ in shock", *Mathematical Modelling*, vol.7, pp.1635-1649, 1986.
13. Rohit Vishnoi, Rob J.Roy, "Adaptive control of closed-circuit anesthesia", *IEEE transactions on biomedical engineering*, vol.38, No.1, Jan 1991.
14. John B.West, *Respiratory Physiology-The Essentials*, 3rd edition, 1985.
15. Michael G.Levitzky, *Pulmonary Physiology*, McGraw-Hill Book Company, 1982.
16. E.I.Eger,II, "A mathematical model of uptake and distribution", in *uptake and distribution of anesthetic agents*, E.M.Papper and R.J.Kitz, eds. New York:McGraw-Hill, 1963, pp.72-87.
17. A.Zwart, *Modeling of gas transfer in the lung*, Utrecht, The Netherlands:Institute of medical physics TNO, 1983.
18. David O.Cooney, *Biomedical Engineering Principles - An Introduction to Fluid, Heat and Mass Transport Process*, Vol.2, 1976.
19. C. Lentner, *Geigy Scientific Tables- Heart and Circulation*, Vol.5, 1990.
20. *Handbook of physiology-The Respiratory System*, American Physiological Society, Vol III, Part I, Section 3, 1986.
21. *Handbook of physiology-The Respiratory System*, American Physiological Society, Vol III, Part II, Section 2, 1986.
22. *Handbook of physiology-The Respiratory System*, American Physiological Society, Vol IV, Part I, Section 3, 1987.
23. Jerry Franklin Green, *Fundamental Cardiovascular and Pulmonary Physiology- An Integrated Approach for Medicine*, 1982.
24. Arthur Guyton, *Text Book of Medical Physiology*, 4th edition, 1976.
25. Julius H.Comroe, *Physiology of Respiration*, 2nd Edition, 1974.

26. Gordon Ross, *Essentials of Human Physiology*, Year book Medical Publishers, 1972.
27. Mainwood, G.W., and Rakusan, K., "A Model for Intracellular Energy Transport". *Can.J.Physiol.Pharmac.*60, 1982.