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Chapter

Who Is Balancing: Is It RBC or Acid-Base Status?

T. Rajini Samuel

Abstract

Hemoglobin is an important intracellular protein buffer present inside the red blood cells (RBC). When the partial pressure of carbon dioxide (pCO₂) is increased, it freely diffuses into the RBC where it reacts with water molecules to form carbonic acid which dissociates to form bicarbonate and hydrogen ions by the enzyme carbonic anhydrase. Hydrogen ions liberated in this reaction are buffered by hemoglobin. Oxyhemoglobin is a stronger acid than deoxyhemoglobin. Oxygenation of hemoglobin causes an increase in net titratable hydrogen ion due to the Haldane effect. As the oxygen saturation of hemoglobin (sO₂) increases, the base excess is changed in the acidic direction, or as the sO₂ decreases, the base excess is changed in alkaline direction. The changes in the level of the enzyme carbonic anhydrase in RBC are related to the changes in pH, pCO₂, and bicarbonate levels in the blood. The understanding of the acid-base balance is a challenging task, but at the same time, it has immense clinical value. The relationship of carbonic anhydrase enzyme present inside the RBC in maintaining the acid-base balance to the commonly employed arterial blood gas (ABG) parameters like pH, pCO₂ bicarbonate, and base excess may help us for better understanding.

Keywords: acid-base balance, carbonic anhydrase enzyme, oxygen saturation, hemoglobin

1. Introduction

Arterial blood gas (ABG) analysis plays a vital role in the management of intensive care unit patients, especially for critically ill patients, but the interpretation is sometimes a challenging task especially if the acid-base disturbances are complex [1–5]. In ABG analysis, the pH and pCO₂ are measured parameters, but bicarbonate concentration is a calculated parameter derived from the modified Henderson equation [2]. Davenport or bicarbonate-pH diagram is a graphical tool representing the relationship between pH, pCO₂, and bicarbonate to depict the respiratory and metabolic acid-base disturbances. This Davenport diagram is rarely used in clinical setting [1].

Simple acid-base disorders are very easy to diagnose, but combined acid-base disorders due to either compensatory mechanisms or mixed disorders are often difficult and sometimes confusing. The four acid-base disorders are metabolic acidosis, metabolic alkalosis, respiratory acidosis, and respiratory alkalosis. Simple acid-base disorder is the presence of any of the four disorders with appropriate compensations. Mixed acid-base disorder denotes the presence of more than one primary disturbances which can be suspected from a lesser or greater than expected
compensations. Respiratory disorders are associated with appropriate renal compensatory mechanisms, and similarly metabolic disorders are compensated by respiratory mechanisms [6, 7].

Base excess is defined as the amount of strong acid that must be added to each liter of fully oxygenated blood to return the pH to 7.40 at a temperature of 37°C and a pCO$_2$ of 40 mmHg. The normal level for base excess is $-2$ to $+2$ mEq/L. A negative base excess indicates the presence of base deficit. Actual base excess is the base excess of the blood, while standard base excess is the base excess of the extracellular fluid (ECF) at hemoglobin concentration of 5 gm/dL [8–10].

Under normal ventilation, bicarbonate parameter is useful, but in patients with abnormal ventilation (respiration), it may not reflect the true status because bicarbonate is a dependent variable and it changes with the concentration of pCO$_2$. As pCO$_2$ increases, it reacts with water molecules to form carbonic acid which dissociates into hydrogen and bicarbonate ions. The hydrogen ions are buffered by non-bicarbonate buffers like albumin, hemoglobin, and phosphate buffer system. So, the concentration of bicarbonate increases as pCO$_2$ also increases. This problem is solved by measuring standard bicarbonate [11, 12].

Standard bicarbonate is the concentration of bicarbonate in the plasma from blood which is equilibrated with a normal pCO$_2$ (40 mmHg) and a normal pO$_2$ (over 100 mmHg) at a normal temperature (37°C). The actual bicarbonate and the standard bicarbonate concentrations are approximately equal under normal ventilation, but in abnormal respiration (either hypoventilation or hyperventilation), the two values alter and deviate from each other depending on the changes in the concentration of pCO$_2$ [1].

The bicarbonate value is increased in respiratory acidosis and decreased in respiratory alkalosis. So, the difference between bicarbonate and standard bicarbonate value is positive for respiratory acidosis and negative for respiratory alkalosis. If the acid-base disorder is purely metabolic without respiratory compensation, then the bicarbonate and standard bicarbonate values are more or less closer. If the metabolic disorder is compensated by respiratory mechanisms, then the two values alter and deviate from each other.

The most commonly used approach for arterial blood gas (ABG) analysis interpretation is a physiological approach based on the bicarbonate-carbon dioxide buffer system. The major buffer system in the ECF is the carbon dioxide-bicarbonate buffer system, and other buffer systems that play a role in buffering are protein and phosphate buffer systems. The buffers are substances that resist changes in pH. All buffers in a common solution are in equilibrium with the same hydrogen ion concentration. Therefore, whenever there is a change in hydrogen ion concentration in the extracellular fluid, the balance of all the buffer systems changes at the same time. This phenomenon is called the isohydric principle. Henderson-Hasselbalch equation concentrating on the bicarbonate-pCO$_2$ buffer is based on this principle. This approach is very simple and easier, but a major drawback of this is it is unable to quantify the metabolic (non-respiratory) component and does not explain the causative mechanism of metabolic acid-base disturbances [8].

2. Base excess

Base excess approach was developed to quantify the metabolic component, but it was criticized because it represents the whole blood and did not accurately represent the whole body behavior. Blood volume diluted with interstitial fluid represents the effective extracellular fluid hemoglobin concentration of 5 g/dL. Standard base excess
or extracellular base excess is the base excess at hemoglobin concentration of 5 g/dl [8–12].

Oxyhemoglobin is a stronger acid than deoxyhemoglobin. Oxygenation of hemoglobin causes an increase in net titratable hydrogen ion because hydrogen ions are liberated from the oxygen-linked buffer groups due to the Haldane effect. So, the variation of oxygen saturation of hemoglobin (sO\textsubscript{2}) influences the base excess result. The formula for calculating this is

\[
c\text{Base}(B, \text{oxygenated}) = c\text{Base}(B, \text{actual}) - 0.2 \times c\text{Hb} \times (1 - sO_2)
\]

or

\[
c\text{Base}(B, \text{actual}) = c\text{Base}(B, \text{oxygenated}) + 0.2 \times c\text{Hb} \times (1 - sO_2)
\]

As the sO\textsubscript{2} increases, the term \(0.2 \times c\text{Hb} \times (1 - sO_2)\) decreases, so the base excess is changed in the acidic direction because it is slightly decreased, or as the sO\textsubscript{2} decreases, the term \(0.2 \times c\text{Hb} \times (1 - sO_2)\) increases, so the base excess is changed in alkaline direction because it is slightly increased [8–10].

The correlation between pCO\textsubscript{2} and \((\text{HCO}_3 - \text{standard HCO}_3)/\text{H}_2\text{CO}_3\) and ratio of \(\text{HCO}_3/\text{standard HCO}_3\) is clearly shown in Figures 1 and 2, respectively. From that, it is very clear that as the pCO\textsubscript{2} decreases, the ratio of \((\text{HCO}_3 - \text{standard HCO}_3)/\text{H}_2\text{CO}_3\) also decreases and, as the pCO\textsubscript{2} increases, the ratio of \((\text{HCO}_3 - \text{standard HCO}_3)/\text{H}_2\text{CO}_3\) also increases and, thereafter, the curve flattens. At pCO\textsubscript{2} of 40 mmHg, the ratio of \((\text{HCO}_3 - \text{standard HCO}_3)/\text{H}_2\text{CO}_3\) is zero because the difference between bicarbonate and standard bicarbonate value is zero (HCO\textsubscript{3} - standard HCO\textsubscript{3} is zero). In respiratory acidosis (due to hypoventilation), pCO\textsubscript{2} retention occurs, and in respiratory alkalosis (due to hyperventilation), the pCO\textsubscript{2} value is decreased. The ratio of \((\text{HCO}_3 - \text{standard HCO}_3)/\text{H}_2\text{CO}_3\) changes in respiratory disorders and also in metabolic acid-base disturbances associated with respiratory compensations. The ratio of \((\text{HCO}_3 - \text{standard HCO}_3)/\text{H}_2\text{CO}_3\) is greater positive for respiratory acidosis and greater negative for respiratory alkalosis [1].

The normal range for standard base excess is \(\pm 2\) mmol/L. If the value is >2 mmol/L, then it denotes metabolic alkalosis, and if the value is <−2 mmol/L, then it denotes metabolic acidosis (base deficit). Using this concept a four-quadrant graphical tool can be constructed for ABG interpretation using standard base excess.

\[x: \text{axis } pCO_2 \quad \text{vs} \quad y: \text{axis } (\text{HCO}_3 - \text{Standard HCO}_3)/\text{H}_2\text{CO}_3\]

Figure 1.
Relation between pCO\textsubscript{2} and \((\text{HCO}_3 - \text{standard HCO}_3)/\text{H}_2\text{CO}_3\).
and the ratio of \((\text{HCO}_3^- - \text{standard HCO}_3^-)/\text{H}_2\text{CO}_3\) in the two axes that demarcate the various acid-base disturbances which are shown in Figure 3 [1].

The aim of the manuscript is to increase in depth the understanding of the acid-base balance which is a challenging and at times an arduous task, yet it has immense

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**Figure 2.**
Relation between pCO$_2$ and HCO$_3$/Std HCO$_3$.

**Figure 3.**
Analysis of various acid-base disturbances using standard base excess (x-axis) and the ratio of \((\text{HCO}_3^- - \text{standard HCO}_3^-)/\text{H}_2\text{CO}_3\) (y-axis) in the four-quadrant graph.
clinical value. The relationship of the formation of bicarbonate from pCO$_2$ with the help of carbonic anhydrase enzyme present inside the RBC plays a significant role in maintaining the acid-base balance. The application of standard bicarbonate in the calculation of non-respiratory hydrogen ion concentration and development of a novel four quadrant graphical method for arterial blood gas interpretation may help us for better understanding.

3. Materials and methods

About 188 arterial blood gas sample data were utilized. Strict precautions were taken to avoid pre-analytical errors, and the consistency of the ABG report was checked by using the modified Henderson equation [2].

The main parameters like measured pH, pCO$_2$, HCO$_3$, standard HCO$_3$, and standard base excess values were noted. Carbonic acid concentration was calculated from pCO$_2$. The difference between bicarbonate and standard bicarbonate was calculated. The ratio of (HCO$_3$ – standard HCO$_3$)/H$_2$CO$_3$ was calculated [1].

Calculation of $H^+$: $H^+$—hydrogen ion concentration at actual pH

\[
pH = -\log[H^+ \text{ nanomoles/L}] = -\log [H^+ \times 10^{-9} \text{ moles/L}] = -\log [H^+] - \log [10^{-9}] \text{ (nanomoles/L = 10}^{-9} \text{ moles/L)}
\]

Calculation of NRH$^+$ (non-respiratory hydrogen ion concentration):

NRH$^+$—hydrogen ion concentration at non-respiratory pH

(At pCO$_2$ of 40 mmHg)

This calculated hydrogen ion concentration equivalent of standard bicarbonate has thus been called the “non-respiratory” hydrogen ion concentration or NRH$^+$ [13, 14]. It has a unique value for a given standard bicarbonate concentration, and the relationship is clearly shown in Figure 4:

![Figure 4](http://dx.doi.org/10.5772/intechopen.84768)

*Figure 4. Relation between NRH$^+$ and Std HCO$_3$.*
NRH⁺ = (24 × pCO₂)/Std HCO₃
= (24 × 40)/Std HCO₃ (pCO₂ is 40 mmHg)
NRH⁺ = 960/Std HCO₃
NRpH = 9 − log [NRH⁺]

Calculation of ΔRpH:

\[ pH = 9 − \log [H^+] \]
\[ NRpH = 9 − log [NRH⁺] \]
\[ p[H] = 40 + \log (HCO₃⁻/Std HCO₃) − \log(pCO₂) \]
\[ [pH − NRpH] = 1.6 + \log{(HCO₃⁻/Std HCO₃)/pCO₂} \]

At pCO₂ of 40 mmHg, pH − NRpH is zero (because bicarbonate and standard bicarbonate values are equal, log 1 is zero, and log 40 is 1.6). At higher pCO₂ levels (>40 mmHg), the value of [pH − NRpH] is negative which denotes the acidic influence of increased pCO₂. At lower pCO₂ levels (<40 mmHg), the value of [pH − NRpH] is positive which denotes the alkaline influence of decreased pCO₂:

\[ [pH − NRpH] = 1.6 + \log{(HCO₃⁻/Std HCO₃)/pCO₂} \]
\[ where \ NRpH \ denotes \ the \ non-respiratory \ pH. \]
\[ pH = 9 − \log [H^+] \]
\[ NRH⁺ = 9 − log [NRH⁺] \]
\[ p[H] = 40 + \log (HCO₃⁻/Std HCO₃) − \log(pCO₂) \]
\[ [pH − NRpH] = 1.6 + \log{(HCO₃⁻/Std HCO₃)/pCO₂} \]

The magnitude and direction (positive or negative) of the changes in the parameter ΔRpH (pH − NRpH) denote the respiratory influence in causing changes in pH. The value is negative for acidic effect and positive for alkaline effect. At pCO₂ of 40 mmHg, pH − NRpH is zero [14].

3.1 Net changes in total pH

The net changes in total pH (actual pH) include both the changes in respiratory and non-respiratory (metabolic) components affecting the pH [14]:

\[ \Delta pH = \Delta RpH + \Delta NRpH \]
\[ pH − 7.4 = \Delta RpH + NRpH − 7.4 \]

where ΔNRpH (NRpH − 7.4) denotes the changes in pH due to metabolic component.

3.2 Predicted respiratory pH

\[ pH = 7.4 + \Delta RpH + \Delta NRpH \]
\[ 7.4 + \Delta RpH − pH = −\Delta NRpH \]
\[ Pr RpH − pH = −\Delta NRpH \{Pr RpH (predicted respiratory pH) = 7.4 + \Delta RpH\} \]
The predicted respiratory pH is the pH at which the changes in pH due to metabolic component are zero ($\Delta NRpH$ is zero).

The difference between the predicted respiratory pH and actual pH denotes the changes in pH due to metabolic component. The magnitude and direction (positive or negative) of the changes in the parameter $\Delta NRpH$ ($NRpH - 7.4$) are due to the accumulation of acids other than carbonic acid or bases. The value is negative for acidic effect and positive for alkaline effect. This is one of the postulates of the acid-base balance theory recently published. If the actual pH is less than the predicted respiratory pH, $\Delta NRpH$ is negative. If the actual pH is greater than the predicted respiratory pH, $\Delta NRpH$ is positive [15–18].

$$NRpH-7.4 = 9 - \log [NRH^+] - [9 - \log [40]$$

$$= 9 - \log [NRH^+] - 9 + \log [40]$$

$$= \log ([40]/[NRH^+]) \text{ or } -\log ([NRH^+]/[40])$$

$$7.4 + \Delta RpH:$$

$$7.4 + \Delta RpH = [9 - \log [40] + 9 - \log [H^+] - 9 + \log [NRH^+])$$

$$= 9 + \log([NRH^+] - [H^+] \times [40])$$

$$\{\Delta RpH (pH - NRpH) = 9 - \log [H^+] - 9 + \log [NRH^+])$$

$$= \log ([NRH^+] - [H^+] \text{ or } -\log ([H^+]/[NRH^+])$$

$Pr \text{ Resp Ph related to } [NRH^+]/([H^+] \times [40])$

### 3.3 Net changes in total hydrogen ion concentration

The sum total changes in the hydrogen ion concentration ($\Delta H^+ = [H^+] - [40]$) in the blood include both the changes due to respiratory ($\Delta RH^+ = [H^+] - [NRH^+]$) and non-respiratory (metabolic) components ($\Delta NRH^+ = [NRH^+] - [40]$):

$$[\Delta RH^+/H^+] = [H^+ - NRH^+]/H^+] = 1 - \{[NRH^+] + [H^+]$$

$$[\Delta NRH^+/40] = (NRH^+ - 40)/40 \text{ or }$$

$$-[\Delta NRH^+/40] = (40 - NRH^+)/40$$

$$= 1 - ((NRH^+/40)) \text{.}$$

The hydrogen ion concentration is 40 at pH 7.4 which denotes the homeostatic set point of acid-base balance [14, 18].

### 4. New graphical tool

This new graphical tool developed for ABG interpretation contains four quadrants. In the x-axis, standard base excess values were taken, and in the y-axis, the ratio of $(\text{HCO}_3^- \text{ standard HCO}_3)/\text{H}_2\text{CO}_3$ values was taken to analyze the various acid-base disturbances which are clearly shown in the four-quadrant graph (Figure 3).

In the first quadrant (both x- and y-axes are positive), if the plotted area is toward the x-axis, then it represents metabolic alkalosis, and if the area is toward the y-axis, then it represents respiratory acidosis. The plotted area in between and higher may represent combined acid-base disturbances (metabolic alkalosis and respiratory acidosis). The combined acid-base disturbances may be due to compensatory mechanism or mixed acid-base disorders.

In the second quadrant (the x-axis is positive, and the y-axis negative), if the plotted area is toward the y-axis, then it represents respiratory alkalosis, and if the
area is in between and lower, then it may represent combined acid-base disturbances (metabolic alkalosis and respiratory alkalosis).

In the third quadrant (both x- and y-axes are negative), if the plotted area is toward the x-axis, then it represents metabolic acidosis, and if the area is in between and lower, then it represents both metabolic acidosis and respiratory alkalosis. In the fourth quadrant (the x-axis is negative and the y-axis is positive), if the area is toward the y-axis, then it represents respiratory acidosis, and if the area is in between and higher, then it may represent both metabolic acidosis and respiratory acidosis [1].

The acid-base disorders can be classified and plotted in the four-quadrant graph by using the values of standard base excess and the ratio of $(\text{HCO}_3^- - \text{standard HCO}_3)/H_2\text{CO}_3$. Each acid-base disorder will occupy any of the four quadrants, and the normal ABG analysis reports will be seen around the center of the graph. ABG interpretation is very essential for critically ill patients. Immediate analysis, interpretation, and prompt treatment may reduce the morbidity and mortality of the patients. [1] This newer graphical tool may provide a rough guide and help in easier and quicker interpretation of ABG reports. A minor drawback of this graphical tool is that, as the pCO$_2$ increases, the ratio of $(\text{HCO}_3^- - \text{standard HCO}_3)/H_2\text{CO}_3$ also increases and afterward the curve flattens. This may not clearly demarcate the different higher levels of pCO$_2$ values. Although the ratio of $(\text{HCO}_3^- - \text{standard HCO}_3)/H_2\text{CO}_3$ differentiates the respiratory acidosis and respiratory alkalosis, it may not clearly differentiate the different pCO$_2$ levels. But this can be corrected (rectified) in a three-dimensional graph if pCO$_2$ values are included in the third axis (z-axis). The parameter (pCO$_2$ = 40 mmHg) should be taken in the third axis, because the ratio $(\text{HCO}_3^- - \text{standard HCO}_3)/H_2\text{CO}_3$ is zero at pCO$_2$ of 40 mmHg, so that the zero central point is common to all the three parameters of the three axes [18].

Arterial blood gas reports should be interpreted with clinical correlation. This newer graphical tool clearly demonstrates that the different acid-base disorders in a four-quadrant graph method may provide a rough guide to interpret the results quickly and easily. The current research study tries to emphasize the clinical significance of this newer diagnostic tool, which, used along with other ABG parameters and proper clinical correlation, may help in better interpretation of ABG reports.

The concept of non-respiratory hydrogen ion concentration plays a key role in understanding of ABG interpretation, yet often it is not discussed in detail during

Figure 5.
Relation between NRH$^+$ and Std base excess.
Who Is Balancing: Is It RBC or Acid-Base Status?
DOI: http://dx.doi.org/10.5772/intechopen.84768

Figure 6.
Relation between $[40 - NRH^+]$ and Std base excess.

Figure 7.
X-axis pCO$_2$ vs. y-axis $[NRH]/[H]$.

Figure 8.
X-axis $\Delta$pH vs. y-axis $[NRH]/[H]$. 
Erythrocyte

Figure 9.
X-axis $\Delta RpH$ vs. y-axis $1 - \{[NRH]/[H]\}$.

Figure 10.
X-axis $(pCO_2 - 40 \text{ mmHg})$ vs. y-axis $1 - \{[NRH]/[H]\}$.

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Comment: changes in net pH (acidic) are mainly due to metabolic component, partly opposed by respiratory component (alkaline effect)

Comment: changes in net pH (alkaline) are mainly due to metabolic component

Comment: changes in net pH are normal

Comment: changes in net pH (acidic) are mainly due to metabolic component and partly due to respiratory component
ABG interpretation because it is not routinely applied at the clinical practice due to the lack of simple formulae to calculate the same and nonavailability of its interrelationship with the other acid-base parameters. In the recently published research study, calculation of non-respiratory hydrogen ion concentration from standard bicarbonate and its relationship with other commonly utilized ABG parameters were discussed with the postulates of the acid-base balance theory and shown in Figures 5–10 and tabulated in Table 1 [14, 18].

5. Predicted respiratory pH

The predicted respiratory pH is usually calculated by pCO$_2$ variance. This calculation is slightly different for higher (>40 mmHg) and lower (<40 mmHg) pCO$_2$

Table 1.
Examples of ABG data showing metabolic and respiratory components involved in net changes in total pH.

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<td>7.17</td>
<td>76</td>
<td>27.7</td>
<td>23.3</td>
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<td>-0.21</td>
<td>-0.02</td>
<td>7.19</td>
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<td>14</td>
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Comment: changes in net pH (alkaline) are mainly due to metabolic component, partly opposed by respiratory component (acidic effect)

Comment: changes in net pH (acidic) are mainly due to respiratory component

Comment: changes in net pH are zero. The changes in pH due to metabolic and respiratory component are equal and opposite. So, they cancelled each other and the net change is zero

Comment: changes in net pH (acidic) are mainly due to metabolic component, partly opposed by respiratory component (alkaline effect)

Comment: changes in net pH (alkaline) are mainly due to respiratory component

Comment: changes in net pH (acidic) are mainly due to metabolic component, partly opposed by respiratory component (alkaline effect)
Figure 12.
X-axis predicted respiratory pH vs. y-axis pCO₂.

Figure 13.
X-axis predicted respiratory pH(Pr RpH) calculated by newer formulae vs. y-axis Pr RpH calculated using pCO₂ variance.

Predicted respiratory pH calculation using pCO₂ variance (previous method)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>pCO₂ &gt; 40 mmHg</th>
<th>pCO₂ &lt; 40 mmHg</th>
</tr>
</thead>
<tbody>
<tr>
<td>pCO₂ variance</td>
<td>(pCO₂ - 40)/100</td>
<td>(40 - pCO₂)/100</td>
</tr>
<tr>
<td>Predicted respiratory pH</td>
<td>7.4 - (pCO₂ variance)/2</td>
<td>7.4 + (pCO₂ variance)</td>
</tr>
</tbody>
</table>

Predicted respiratory pH calculation using newly derived formulae

Formulae is the same for all the values of pCO₂

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>∆RpH</td>
<td>[pH - NRpH] + 1.6 * \log (\text{HCO}_3/\text{Std HCO}_3)/\text{pCO}_2</td>
</tr>
<tr>
<td>Predicted respiratory pH</td>
<td>7.4 + ∆RpH</td>
</tr>
</tbody>
</table>

Table 2.
Comparison of predicted respiratory pH calculation (one by previous method using pCO₂ variance and the other by newly derived formulae).
levels. The difference between the predicted respiratory pH and the measured pH reflects the metabolic pH change. [15] The predicted respiratory pH is calculated by using a newly derived formula which is common for all pCO$_2$ values [18]. The graphical relationship is shown in Figures 11–13 and tabulated in Table 2.

6. Postulates of the acid-base balance theory

The postulates of the acid-base balance theory are listed below [14]:

1. The net changes in pH of the blood reflect the sum total changes in the hydrogen ion concentration in the blood. The net changes in total or actual pH [$\Delta pH (pH - 7.4)$] are due to both the changes in respiratory [$\Delta RpH (pH - NRpH)$] and non-respiratory (metabolic) components [$\Delta NRpH (NRpH - 7.4)$] affecting the pH.

2. The sum total changes in the hydrogen ion concentration ($\Delta H = [H^+] - [40]$) in the blood include both the changes due to respiratory ($\Delta RH^+ = [H^+] - [NRH^+]$) and non-respiratory (metabolic) components ($\Delta NRH^+ = [NRH^+] - [40]$).

3. The non-respiratory hydrogen ion concentration [$NRH^+$] has a unique value for a given standard bicarbonate concentration represented by the relation $NRH^+ = 960/\text{Std bicarbonate}$.

4. The concentration of hydrogen ion excess given by [$NRH^+ - 40$] is directly proportional to the base deficit. This quantity with opposite sign [$40 - NRH^+] is directly proportional to the base excess. Standard base excess is the base excess at hemoglobin concentration of 5 g/dl.

5. The changes in the dependent variable non-respiratory hydrogen ion concentration [$NRH^+$] representing the non-respiratory (metabolic) component are due to the changes by the independent variables, namely, strong ion difference (SID) and the total concentration of weak nonvolatile acids, namely, albumin and phosphate [ATOT].

6. The changes in the dependent variable [HCO$_3$] are a marker of metabolic acid-base disturbances and not its causative mechanism.

7. The magnitude and direction (positive or negative) of the changes in the parameter $\Delta NRpH(NRpH - 7.4)$ are due to the accumulation of acids other than carbonic acid or bases. The value is negative for acidic effect and positive for alkaline effect.

8. The magnitude and direction (positive or negative) of the changes in the parameter $\Delta RpH(pH - NRpH)$ denote the respiratory influence in causing changes in pH represented by the relation $pH - NRpH = 1.6 + \log((\text{HCO}_3/\text{Std HCO}_3)/\text{pCO}_2)$. The value is negative for acidic effect and positive for alkaline effect.

9. The ratio [$NRH^+/H^+$] is directly proportional to the parameter $\Delta RpH (pH - NRpH)$ which denotes the respiratory influence of pCO$_2$. 

Who Is Balancing: Is It RBC or Acid-Base Status?
DOI: http://dx.doi.org/10.5772/intechopen.84768
10. The respiratory influence of pCO$_2$ in changing pH through bicarbonate is a variable one (ratio of HCO$_3^-$/Std HCO$_3^-$) depending on the acute or chronic conditions or compensations and through carbonic acid is a constant one given by \((H_2CO_3 - 1.2)/H_2CO_3\).

7. Conclusion

Arterial blood gas analysis test is one of the most commonly employed point-of-care testings in intensive care units, yet the understanding of acid-base disturbances and interpretation of ABG reports are sometimes a challenging task especially for critically ill patients with multiorgan failure. The graphical relationship between the metabolic and respiratory components of the net changes in pH and the total changes in hydrogen ion concentration with other ABG parameters like standard base excess, bicarbonate, standard bicarbonate, and pCO$_2$ will help in better understanding of the arterial blood gas interpretation which results in proper, quicker, and better management of the patient’s critical conditions. A newer graphical tool developed using standard base excess and the ratio of \((HCO_3^- - \text{standard HCO}_3^-)/H_2CO_3\) may help in easier and quicker interpretation of ABG reports. This simple four-quadrant graph method may provide a rough guide for ABG interpretation, which, when applied at the appropriate time, results in timely management.

Although, standard bicarbonate value is not routinely utilized for ABG interpretation, the parameters derived from standard bicarbonate plays a vital role in the understanding of acid-base disturbances. The application of these newly derived parameters and the four-quadrant graphical tool may serve as a supporting tool for teaching and diagnostic purposes, which when properly correlated with clinical conditions and other ABG parameters results in better understanding and quicker interpretation of ABG reports.

Conflict of interest

Nil.

Author details

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References


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