Interpreting pulmonary function tests: Recognize the pattern, and the diagnosis will follow

**ABSTRACT**

When interpreting pulmonary function tests, one should first try to determine the pattern of abnormality: is it obstructive, restrictive, or normal? Pulmonary function tests cannot by themselves distinguish among the potential causes of abnormalities, and must be interpreted in light of the patient’s history, physical examination, and ancillary studies. Once a pattern is recognized, the diagnosis will often follow.

**KEY POINTS**

Every clinician should have an organized approach to interpreting pulmonary function tests that will allow him or her to recognize and quantitate abnormalities.

Before interpreting the results, one should ascertain that the test was acceptable and reproducible and that the patient’s demographic data are correct.

Pattern recognition is key. A low FEV₁/FVC ratio (the forced expiratory volume in 1 second divided by the forced vital capacity) indicates an obstructive pattern, whereas a normal value indicates either a restrictive or a normal pattern.

If the FEV₁/FVC ratio is normal, a low forced vital capacity value indicates a restrictive pattern, whereas a normal value indicates a normal pattern.

Pulmonary function tests are not generally indicated in patients without symptoms, and they may be confusing when nonpulmonary diseases that affect the pulmonary system are active (eg, congestive heart failure).
To monitor for the potentially toxic effects of certain drugs or chemicals (eg, amiodarone, beryllium).

Pulmonary function tests are not otherwise indicated in patients without symptoms, and they may be confusing when non-pulmonary diseases that affect the pulmonary system are active (eg, congestive heart failure).

### COMPONENTS OF PULMONARY FUNCTION TESTS

#### Spirometry

Spirometry is the measurement of the air moving in and out of the lungs during various respiratory maneuvers.\(^2\) It allows one to determine how much air can be inhaled and exhaled, and how fast.

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**Table 1**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>DLCO</td>
<td>Diffusing capacity of the lung; the capacity of the lungs to transfer carbon monoxide (mL/min/mm Hg)</td>
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<tr>
<td>DLCOc</td>
<td>The DLCO adjusted for hemoglobin (mL/min/mm Hg)</td>
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<tr>
<td>DLVA</td>
<td>The DLCO adjusted for volume (mL/min/mm Hg/L)</td>
</tr>
<tr>
<td>DLVC</td>
<td>The DLCO adjusted for both volume and hemoglobin (mL/min/mm Hg/L)</td>
</tr>
<tr>
<td>ERV</td>
<td>Expiratory reserve volume; the maximum volume of air that can be exhaled from the end-expiratory tidal position (L)</td>
</tr>
<tr>
<td>FET</td>
<td>Forced expiratory time; the amount of time the patient exhaled during the FVC maneuver (seconds)</td>
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<tr>
<td>FEV(_1)</td>
<td>Forced expiratory volume in 1 second; volume of air forcibly expired from a maximum inspiratory effort in the first second (L)</td>
</tr>
<tr>
<td>FEV(_1)/FVC</td>
<td>Ratio of FEV(_1) to FVC</td>
</tr>
<tr>
<td>FRC</td>
<td>Functional residual capacity; the volume of air in the lungs following a tidal volume exhalation = ERV + RV (L)</td>
</tr>
<tr>
<td>FVC</td>
<td>Forced vital capacity; the total volume that can be forcefully expired from a maximum inspiratory effort (L)</td>
</tr>
<tr>
<td>IC</td>
<td>Inspiratory capacity; the maximum volume of air that can be inhaled from tidal volume end-inspiratory level; the sum of IRV and VT (L)</td>
</tr>
<tr>
<td>IRV</td>
<td>Inspiratory reserve volume; the maximum volume of air that can be inhaled from the end-inspiratory tidal position (L)</td>
</tr>
<tr>
<td>LLN</td>
<td>Lower limit of normal; the lowest value expected for a person of the same age, gender, and height with normal lung function</td>
</tr>
<tr>
<td>PEF</td>
<td>Peak expiratory flow; the highest forced expiratory flow (L/second)</td>
</tr>
<tr>
<td>RV</td>
<td>Residual volume; the volume of air that remains in the lungs after maximal exhalation (L)</td>
</tr>
<tr>
<td>TLC</td>
<td>Total lung capacity; the total volume of air in the lungs at full inhalation; the sum of all volume compartments (IC + FRC or IRV + VT + ERV + RV) (L)</td>
</tr>
<tr>
<td>TV or VT</td>
<td>Tidal volume; the volume of air that is inhaled or exhaled with each breath when a person is breathing at rest (L)</td>
</tr>
<tr>
<td>VC</td>
<td>Vital capacity; the maximum volume of air that can be exhaled starting from maximum inspiration, TLC (L) can be measured either as slow vital capacity (SVC) or forced vital capacity (FVC)</td>
</tr>
</tbody>
</table>
The components of the respiratory cycle are labeled as lung volumes and lung capacities (a capacity is the sum of one or more volumes; Table 1, Figure 1). We are mainly concerned with three of these measures:

- **The forced vital capacity (FVC).** A spirometric maneuver begins with the patient inhaling as deeply as he or she can. Then the patient exhales as long and as forcefully as possible; the amount exhaled in this manner is the FVC.

- **The forced expiratory volume in 1 second (FEV₁)** is the amount of air exhaled during the first second of the FVC maneuver. It tends to be lower in diseases that obstruct the airway, such as asthma or emphysema.

- **The FEV₁/FVC ratio** is used to determine if the pattern is obstructive, restrictive, or normal.

**Diffusing capacity**

The diffusing capacity is a measure of the ability of the lungs to transfer gas.

Diffusion in the lungs is most efficient when the surface area for gas transfer is high and the blood is readily able to accept the gas being transferred. It is thus decreased in:

- Conditions that minimize the ability of
the blood to accept and bind the gas that is diffusing (eg, anemia)
• Conditions that decrease the surface area of the alveolar-capillary membrane (eg, emphysema, pulmonary embolism)
• To a smaller degree, conditions that alter the membrane’s permeability or increase its thickness (eg, pulmonary fibrosis).

The gas used to test the diffusing capacity must be more soluble in blood than in lung tissue. Ideally, the amount of gas entering the blood should be limited by the lungs’ ability to transfer it and not by lung perfusion (ie, the gas must avidly bind to hemoglobin). Carbon monoxide is the gas used, as it most closely meets these requirements.

Residual volume, total lung capacity
Even after one exhales as long and as hard as possible, some air remains in the lungs; this is called the residual volume. The residual volume plus the FVC equals the total lung capacity.

The residual volume (and hence the total lung capacity) cannot be measured by spirometry. Rather, they must be measured by special tests that require the patient either to breathe an inert gas such as helium (the concentration of which is measured in the expired air, from which the residual volume is calculated) or to sit in an airtight booth in which the pressure is measured as he or she breathes.

These measurements (commonly called “static lung volumes” or simply “volumes”) add to the information gained from spirometry. For obstructive diseases, measurement of the residual volume and total lung capacity can demonstrate air trapping and hyperinflation. For restrictive diseases, the total lung capacity is needed to confirm true restriction and better quantitate the degree of restriction.5

OUR APPROACH TO INTERPRETING PULMONARY FUNCTION TESTS

First, confirm the patient’s demographic data
Test results are given as measured values and as percents of predicted values.

The predicted values and lower limits of normal have been determined in population studies of people without physiologic lung impairment. Regression equations have been developed that include the person’s age, height, and sex as variables (although debate exists as to which regression equations are most accurate).6

Each patient’s predicted values therefore depend on his or her age, height, and sex. For example, the predicted values for an 80-year-old man who is 6 feet tall are lower than those of a 50-year-old man who is 6 feet tall. In practice, the physician or technician who performs the test enters the patient’s demographic data into a computer. Although clerical mistakes are rare, the physician who interprets the test should double-check this information, which should be included in the test report. If the patient’s demographic data are not accurate, the interpretation of the results will be affected.

Next, evaluate the test for acceptability and reproducibility
Criteria for acceptability and reproducibility are established by the American Thoracic Society.7

In general, an FVC maneuver is acceptable if the patient has made a good effort. An effort is considered good when there is a rapid increase in airflow at the start of exhalation. A complete maneuver requires at least 6 seconds of exhalation ending with a plateau in flow (ie, no further air is being blown out).

A flow-time curve and flow-volume loop are usually included with the report to allow one to visualize the rapid rise and the plateau in flow over time and over lung volumes. In a
proper FVC maneuver, flow rates should be at their highest near the start of exhalation and should decline through the end of exhalation. This is graphed in the volume-time curve (FIGURE 2).

Similarly, flow rates are highest near the total lung capacity (where the FVC maneuver begins) and they decline until the residual volume (where the FVC maneuver ends). This is graphed as the flow-volume loop (FIGURE 2).

The test is repeated at least three times. To meet reproducibility criteria, all three

*FEV₁ = forced expiratory volume in 1 second, FVC = forced vital capacity

FIGURE 3. Flow chart for rapid interpretation of pulmonary function tests
FEV₁ measurements must be within 200 mL of each other and all three FVC measurements must be within 200 mL of each other. The test with the greatest sum of the FEV₁ and the FVC is reported.

The results may vary if the subject does not give his or her best effort, cannot understand the instructions (owing to a language barrier or hearing impairment), or has pain that is accentuated with the maneuvers. Results that are not reproducible may not accurately reflect the patient’s true lung physiology.

Use a systematic approach to interpreting the results

**FIGURE 3** is our suggested approach to interpreting the results. The approach involves recognizing the pattern and then classifying the severity of the condition.

**Is the pattern obstructive, restrictive, or normal?** The first step is to assess the FEV₁/FVC ratio. If this ratio is less than the lower limit of normal for the patient (including with the test report), an obstructive defect is present (i.e., the FEV₁ has fallen to a greater degree than the FVC).

If this ratio is greater than the lower limit of normal, then either the spirometry test is normal or a restrictive defect is present. In this situation, if only spirometry is available, the next step is to look at the FVC. If the FVC is less than the lower limit of normal, a restrictive defect is suggested. The total lung capacity (if this was measured) can confirm the presence of restriction if this value is less than the predicted lower limit of normal.

**TABLE 2** compares obstructive and restrictive lung patterns.8

<table>
<thead>
<tr>
<th>MEASUREMENT</th>
<th>OBSTRUCTIVE PATTERN</th>
<th>RESTRICTIVE PATTERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced vital capacity (FVC)</td>
<td>Decreased or normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Forced expiratory volume in 1 second (FEV₁)</td>
<td>Decreased</td>
<td>Decreased or normal</td>
</tr>
<tr>
<td>FEV₁/FVC ratio</td>
<td>Decreased</td>
<td>Normal</td>
</tr>
<tr>
<td>Total lung capacity (TLC)</td>
<td>Normal or increased</td>
<td>Decreased</td>
</tr>
</tbody>
</table>

Spirometry is frequently repeated after giving a bronchodilator. If either the FEV₁ or the FVC increases by at least 12% and by at least 200 mL from the prebronchodilator values, then the patient is said to have a significant bronchodilator response.9

**How severe is the defect?** To quantify the degree of obstruction, the clinician needs to note the patient’s FEV₁ as a percentage of the predicted FEV₁ (**TABLE 3**) Similarly, to quantify the degree of restriction, one should note either the patient’s FVC or the total lung capacity as a percentage of the respective predicted value.

### **CASE 1:**
**DYSPEANEA WITH COUGH AND WHEEZING**

A 51-year-old woman presents for evaluation of shortness of breath, cough, and wheezing, especially in the summer. Her symptoms are relieved with albuterol, salmeterol, and fluticasone inhalers. She does not smoke. **TABLE 4** shows her spirometry values.

1 Which of the following patterns is present?

- Obstructive pattern without response to bronchodilators
- Restrictive pattern
- Obstructive pattern with response to bronchodilators

Using **FIGURE 3** as a guide, the first step is to assess the FEV₁/FVC ratio. The ratio of 58% is clearly low. Therefore, the spirometry data reveal an obstructive pattern.

The pattern is not restrictive, since the
FEV₁/FVC ratio is low and the FVC is normal. In a restrictive pattern, the FEV₁/FVC ratio is typically normal or high and the FVC is typically low.

What is the severity of this patient’s defect?

- Mild
- Moderate
- Severe

TABLE 3 classifies the severity of the defect. Since this patient’s FEV₁ lies between 60% and 69% of the predicted value, the degree of obstruction is classified as moderate. It is an obstructive pattern with a good bronchodilator response, since the absolute change in FEV₁ after bronchodilator administration is greater than 12% and 200 mL.

The clinical presentation and spirometry data strongly suggest asthma.

Pulmonary function testing pearl: Distinguish a mixed pattern vs air trapping

Once you have determined that the spirometry data are compatible with obstruction and you have quantitated the degree of obstruction on the basis of the FEV₁ percent of predicted, you should look at the FVC.

If the FVC is less than the lower limit of normal, then two possibilities exist. The first is that there is a mixed pattern with both an obstructive and a restrictive component. The second is that the obstruction is very severe and has led to significant air trapping.

Table 1: A 51-year-old woman with shortness of breath, coughing, and wheezing

<table>
<thead>
<tr>
<th></th>
<th>LOWER LIMIT OF NORMAL</th>
<th>PRE-BRONCHODILATOR</th>
<th>% OF PREDICTED VALUE</th>
<th>POST-BRONCHODILATOR</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced vital capacity (FVC)</td>
<td>2.24 L</td>
<td>2.42 L</td>
<td>83%</td>
<td>2.72 L</td>
<td>12%</td>
</tr>
<tr>
<td>Forced expiratory volume in 1 second (FEV₁)</td>
<td>1.86 L</td>
<td>1.52 L</td>
<td>63%</td>
<td>2.05 L</td>
<td>34%</td>
</tr>
<tr>
<td>FEV₁/FVC ratio</td>
<td>73.4%</td>
<td>58.2%</td>
<td></td>
<td>75.3%</td>
<td>29%</td>
</tr>
<tr>
<td>Forced expiratory time</td>
<td></td>
<td>11.2 sec</td>
<td></td>
<td>10.7 sec</td>
<td></td>
</tr>
</tbody>
</table>
Air trapping will increase the residual volume so that it takes up a greater percentage of the total lung capacity. If the residual volume increases enough, it will encroach on the air in the lung that can be exhaled and may lower the FVC below the lower limit of normal. This spirometry pattern is known as pseudorestriction (Figure 4).

To distinguish between these two possibilities, measure the residual volume and total lung capacity. If there is a mixed pattern with obstructive and restrictive components, the total lung capacity will be decreased. If air trapping is the cause of the low FVC, then the total lung capacity will be normal or elevated and the residual volume will be significantly increased.

**CASE 2:**
**DYSPNEA WITHOUT COUGH OR WHEEZING**

A 68-year-old woman presents for evaluation of shortness of breath without cough or wheezing. She has systemic lupus rheumatoid (for which she takes prednisone and methotrexate) and hypertension (for which she takes metoprolol and hydrochlorothiazide). Her oxygen saturation is 94% by pulse oximetry while breathing room air. Her hemoglobin concentration is 12.3 g/dL. Table 5 shows the results of her pulmonary function tests.

3 Which of the following best describes the pattern seen on this patient’s pulmonary function tests?
- Obstructive pattern with suspicion of emphysema
- Restrictive pattern
- Obstructive pattern without emphysema

The patient’s FEV₁/FVC ratio (88.6%) is normal. Therefore, the pattern could either be normal or restrictive (Table 2). However, since the patient’s FVC (1.85 L, 60% of predicted) is lower than the lower limit of normal (2.39 L), a restrictive pattern is present. The patient’s diminished total lung capacity confirms the presence of restriction.

4 What is the severity of this patient’s defect?

Based on Table 3, the defect, with an FVC of 60% and a total lung capacity of 53% of predicted, is moderately severe. An obstructive pattern is not present since the FEV₁/FVC ratio is normal. Emphysema has an obstructive pattern on pulmonary function tests; therefore, it is unlikely to be present in this case.

The clinical evaluation, including imaging studies and pulmonary function testing, strongly suggests interstitial lung disease related to her lupus.

**Pulmonary function testing pearl:**
**Distinguish parenchymal vs extraparenchymal causes of restriction**

A restrictive pattern seen on pulmonary function testing may be due to causes inside or outside the lung parenchyma.

Pulmonary parenchymal causes include...
diseases such as pulmonary fibrosis, in which abnormalities of the lungs themselves result in restriction. Extraparenchymal causes of restriction include obesity, neuromuscular diseases, chest wall deformities, and large pleural effusions, which may impair a person’s ability to fully inflate the lungs.

The diffusing capacity of the lung (DLCO) can be used to distinguish between these categories. If the DLCO is still below the lower limit of normal after being adjusted for the lung volume (ie, the DLVA), hemoglobin level (ie, the DLCOc), or both (ie, the DLVC), then parenchymal disease is likely. If normal, it suggests that the cause of restriction is extraparenchymal.

To determine which parenchymal or extraparenchymal cause of restriction is present requires a complete clinical evaluation.

CASE 3: PROGRESSIVE DYSPNEA

A 68-year-old woman presents for evaluation of progressive shortness of breath. She describes 18 months of gradually increasing dyspnea on exertion. She has not noted any prominent cough, wheezing, chest pain, light-headedness, or edema. Her review of systems is positive only for cold fingers and mild joint pains. She has never smoked and has no other medical history. Her only medication is hormone replacement therapy. TABLE 6 shows her pulmonary function test results.

Which of the following are potential causes of this pattern?

- Anemia
- Pulmonary arterial hypertension
- Chronic thromboembolic disease
- All of the above

The FEV₁/FVC ratio is normal, leaving us with either a restrictive or a normal pattern. As both the FVC and total lung capacity are normal, we conclude that the spirometry and lung volumes are normal. This suggests that the airways and lung parenchyma are functioning normally. We notice, however, that the diffusing capacity is significantly reduced, and that the value remains low when corrected for lung volumes (ie, the DLVA).

This pattern may be seen in a few situations. In anemia, the number of hemoglobin molecules to which carbon monoxide can bind is reduced, decreasing the ability of the lungs to transfer carbon monoxide to the blood, thus
lowering the diffusing capacity without affecting any of the lung volumes or capacities. Pulmonary vascular diseases, such as pulmonary arterial hypertension and chronic thromboembolic disease, may also cause an isolated decrease in the diffusing capacity.

The clinical, radiographic, and pulmonary function information suggest pulmonary hypertension. Echocardiography and subsequent right heart catheterization confirm this diagnosis.

**CONCLUSIONS**

These cases underscore one of the chief messages in this article, that when interpreting pulmonary function tests, the first goal is to recognize the pattern of physiologic impairment, not to make a diagnosis. Once the pattern is recognized, the astute physician has important information to make the diagnosis and treat a pulmonary problem.

**REFERENCES**

6. Wanger J. Appendix 4: Selected adult reference popula-

**TABLE 6**

<table>
<thead>
<tr>
<th></th>
<th>LOWER LIMIT OF NORMAL</th>
<th>PATIENT’S VALUE</th>
<th>% OF PREDICTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced vital capacity (FVC)</td>
<td>2.07 L</td>
<td>2.63 L</td>
<td>96%</td>
</tr>
<tr>
<td>Forced expiratory volume in 1 second (FEV₁)</td>
<td>1.56 L</td>
<td>2.15 L</td>
<td>101%</td>
</tr>
<tr>
<td>FEV₁/FVC ratio</td>
<td>68.3%</td>
<td>81.7%</td>
<td></td>
</tr>
<tr>
<td>Forced expiratory time (FET)</td>
<td>8.13 sec</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residual volume (RV)</td>
<td>1.30 L</td>
<td>1.77 L</td>
<td>85%</td>
</tr>
<tr>
<td>Total lung capacity (TLC)</td>
<td>3.77 L</td>
<td>4.01 L</td>
<td>83%</td>
</tr>
<tr>
<td>Diffusing capacity (DLCO)</td>
<td>16.4 mL/min/mm Hg</td>
<td>9.29 mL/min/mm Hg</td>
<td>43%</td>
</tr>
<tr>
<td>Adjusted diffusing capacity (DLVA)</td>
<td>3.34 mL/min/mm Hg/L</td>
<td>2.65 mL/min/mm Hg/L</td>
<td>59%</td>
</tr>
</tbody>
</table>