Acute heart failure (AHF) has been defined as new-onset or worsening heart failure (HF) signs and symptoms requiring urgent therapy.1 AHF is a leading cause of morbidity and mortality.2 Despite the considerable variation of clinical profiles and the substantial heterogeneity of underlying causes, the vast majority of patients with AHF present with symptoms and signs of pulmonary and systemic congestion rather than low cardiac output. Accordingly, dyspnea is the cardinal presenting symptom among patients hospitalized for AHF.3

Although many patients respond to initial therapy,1 a significant percentage do not experience early dyspnea relief.1 Additionally, there is dissociation between pulmonary capillary wedge pressure (PCWP) and dyspnea severity, such that patients with a high PCWP may be minimally dyspneic, while patients with a relatively lower PCWP may experience severe dyspnea.4 Moreover, the short-term mortality and readmission rate is up to 50%.5 These observations highlight the incomplete understanding of pulmonary congestion pathogenesis in AHF.

**PATHOPHYSIOLOGY OF PULMONARY CONGESTION**

Pulmonary congestion is defined as accumulation of fluid in the lungs, resulting in impaired gas exchange and arterial hypoxemia. It occurs sequentially, first developing in the hilar region of the lungs, followed by filling of the interstitial space and finally, in its most severe form, by alveolar flooding. High left ventricular (LV) filling pressure leading to pulmonary venous hypertension (increased PCWP) is the main underlying mechanism of pulmonary congestion. Elevation of LV diastolic pressure (LVDP) results from fluid overload caused either by fluid retention or by fluid redistribution.6 On the other hand, a rapid increase in blood pressure (afterload), particularly in patients with diastolic dysfunction, may precipitate severe pulmonary congestion.7 Often, elevation of LVDP (hemodynamic congestion) precedes clinical congestion by days or even weeks.8

**OLD AND NEW CONCEPTS IN THE PATHOGENESIS OF PULMONARY EDEMA**

Pulmonary edema is the result of an imbalance between the forces that drive fluid into the alveoli and the mechanisms for its removal. Filtration of fluid across the pulmonary capillary wall is described by the Starling equation.9

\[ Jv = LpS[(Pc – Pi) – \sigma(iC – \pii)] \]

where \( Jv \) is the net transcapillary filtration rate, \( Lp \) is the hydraulic conductivity of the barrier, \( S \) is the surface area of the barrier, \( Pc \) is the pulmonary capillary hydrostatic pressure, \( Pi \) is the interstitial hydrostatic pressure, \( \piC \) is the capillary plasma colloid oncotic pressure, \( \pii \) is the interstitial fluid oncotic pressure, and \( \sigma \) is the average osmotic reflection coefficient of the barrier. \( LpS \) has been defined as the capillary filtration coefficient (Kfc).

According to the Starling equation, the equilibrium between the hydrostatic pressures (\( Pc – Pi \)) and the oncotic pressures (\( \piC – \pii \)) constitutes the driving force for fluid filtration. Based on this simplistic model, pulmonary edema has been traditionally classified into cardiogenic and noncardiogenic categories. Cardiogenic or hydrostatic pulmonary edema results from high pulmonary capillary hydrostatic pressures which disturb Starling’s equilibrium while the alveolar-capillary barrier remains intact. On the contrary, noncardiogenic or high permeability edema is characterized by injury to the alveolar-capillary barrier with leakage of protein-rich fluid into the interstitium and air spaces.10 However, this pathophysiologic model of passive fluid movement, which depends on the oncotic and hydrostatic gradients across the blood-gas barrier, seems to be an oversimplification. Studies based on the ratio of edema fluid protein to serum protein in patients with cardiogenic and noncardiogenic pulmonary edema have shown that frequently there is a combination of high hydrostatic pulmonary capillary pressure and high permeability of the alveolar-capillary barrier, leading to a significant overlap between the two groups. If increased hydrostatic pulmonary capillary pressure per se were responsible for pulmonary edema formation, protein concentration of the alveolar lining fluid would be expected to decrease due to the influx of plasma ultrafiltrate. Paradoxically, it nearly doubles.11,12 Therefore, hydrostatic and high permeability pulmonary edema may represent the extremes...
in the spectrum of pulmonary edema.\textsuperscript{11,12} Two fundamental processes may lead to alveolar-capillary barrier dysfunction in AHF: \textit{a)} mechanical injury of the barrier due to increased hydrostatic pulmonary capillary pressures, and \textit{b)} inflammatory and oxidative lung injury (Fig. 1).

**PHYSIOLOGICAL PROPERTIES OF THE ALVEOLAR CAPILLARY BARRIER**

In its thinnest parts, the blood-gas barrier consists of the capillary endothelial layer, the alveolar epithelial layer, and the extracellular matrix, which is made up of the fused basement membranes of the two cell layers.\textsuperscript{13,14} The blood-gas barrier of the human lung has to play 2 conflicting roles. On the one hand, it has to be extremely thin in order to promote efficient exchange of oxygen and carbon dioxide through passive diffusion. On the other hand, it needs to be strong enough to overcome the stress imposed by high capillary hydrostatic pressure. Loss of its structural integrity can result in alveolar edema or hemorrhage. The strength of the blood-gas barrier can be attributed to the type of collagen in the basement membranes.\textsuperscript{15}

**ACUTE AND CHRONIC BLOOD-GAS BARRIER DYSFUNCTION IN HEART FAILURE**

The term “stress failure” has been introduced to describe mechanical injury to the alveolar-capillary barrier resulting from an abrupt rise in the pulmonary capillary hydrostatic pressure.\textsuperscript{16} Several experimental models have shown that pressure-induced trauma leads to ultrastructural changes of the blood-gas barrier involving disruption of the pulmonary capillary endothelial layer as well as the alveolar epithelial layer.\textsuperscript{16} The result is a progressive transition from a low permeability form to a high permeability form of pulmonary edema.\textsuperscript{17} There is experimental evidence to suggest the reversibility of ultrastructural changes of the blood-gas barrier observed during acute mechanical injury.\textsuperscript{18} On the other
Inflammatory and oxidative lung injury may play a significant pathophysiological role in HF decompensation by further damaging the alveolar-capillary barrier and increasing its permeability. As a consequence, the pulmonary capillary hydrostatic pressure threshold for pulmonary fluid accumulation decreases. This parameter could account for the vulnerability of AHF patients to recurrences.

ASSESSING LUNG INJURY IN ACUTE HEART FAILURE

Investigation of the epithelial lining fluid may give useful information about the alveolar-capillary barrier damage in patients with HF, particularly with regard to important pathophysiologic processes such as inflammation and redox disturbance. So far, access to this fluid has been based on bronchoalveolar lavage, which is an invasive technique requiring bronchoscopy and may influence the levels of airway inflammation. Consequently, there is limited information from a small number of patients with cardiogenic pulmonary edema requiring mechanical ventilation. Recently, there has been increasing interest in lower respiratory tract sampling by noninvasive means including sputum induction, measurement of exhaled nitric oxide and collection and analysis of exhaled breath condensate (EBC).

EBC has emerged as a potential tool in the study of the alveolar epithelial lining fluid. It consists primarily of water with trapped aerosolized droplets from the airway lining fluid, as well as water-soluble volatile and nonvolatile compounds. Principal component is condensed water vapor, which represents nearly all of the volume (~99%) of fluid collected in EBC. Collection of EBC is simple, completely noninvasive, safe, and reproducible. It is accomplished by exhaling tidally into a cooled condensing apparatus. A wide range of biomarkers have been investigated in EBC, including pH, cytokines, isoprostanes, leukotrienes, nitrogen oxides, peptides, adenosine, arachidonic acid metabolites, ammonia, hydrogen peroxide, and DNA. Consequently, EBC has been increasingly used as a research and clinical tool in the study of airway inflammation, oxidative stress, and acid-base balance in many lung diseases, including asthma, chronic obstructive pulmonary disease, ARDS, cystic fibrosis, bronchiectasis, and lung cancer. With the aim of providing new insights into the role of lung injury and blood-gas barrier dysfunction in AHF we have demonstrated that during episodes of HF decompensation EBC shows an increase in EBC markers of inflammatory activity and oxidative stress (unpublished data).

In conclusion, pulmonary congestion in AHF is a complex pathophysiologic process, beyond fluid overload and hemodynamics. Inflammatory and oxidative lung injury leading to blood-gas barrier dysfunction seems to play a pivotal role in the pathogenesis of pulmonary edema and may be a novel therapeutic target. Further research is needed to clarify whether preventing barrier injury instead of merely controlling hydrostatic pulmonary capillary pressures will improve the treatment and prognosis of AHF.

CONFLICTS OF INTEREST

None declared.

REFERENCES


