The effect of a peptide-containing synthetic lung surfactant on gas exchange and lung mechanics in a rabbit model of surfactant depletion

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Background: Currently, a new generation of synthetic pulmonary surfactants is being developed that may eventually replace animal-derived surfactants used in the treatment of respiratory distress syndrome. Enlightened by this, we prepared a synthetic peptide-containing surfactant (Synsurf) consisting of phospholipids and poly-L-lysine electrostatically bonded to poly-L-glutamic acid. Our objective in this study was to investigate if bronchoalveolar lavage (BAL)-induced acute lung injury and surfactant deficiency with accompanying hypoxemia and increased alveolar and physiological dead space is restored to its prelavage condition by surfactant replacement with Synsurf, a generic prepared Exosurf, and a generic Exosurf containing Ca²⁺.

Methods: Twelve adult New Zealand white rabbits receiving conventional mechanical ventilation underwent repeated BAL to create acute lung injury and surfactant-deficient lung disease. Synthetic surfactants were then administered and their effects assessed at specified time points over 5 hours. The variables assessed before and after lavage and surfactant treatment included alveolar and physiological dead space, dead space/tidal volume ratio, arterial end-tidal carbon dioxide tension (PCO₂) difference (mainstream capnography), arterial blood gas analysis, calculated shunt, and oxygen ratios.

Results: BAL led to acute lung injury characterized by an increasing arterial PCO₂ and a simultaneous increase of alveolar and physiological dead space/tidal volume ratio with no intergroup differences. Arterial end-tidal PCO₂ and dead space/tidal volume ratio correlated in the Synsurf, generic Exosurf and generic Exosurf containing Ca²⁺ groups. A significant and sustained improvement in systemic oxygenation occurred from time point 180 minutes onward in animals treated with Synsurf compared to the other two groups (P < 0.001). A statistically significant decrease in pulmonary shunt (P < 0.001) was found for the Synsurf-treated group of animals, as well as radiographic improvement in three out of four animals in that group.

Conclusion: In general, surfactant-replacement therapy in the animals did not fully restore the lung to its prelavage condition. However, our data show that the formulated surfactant Synsurf improves oxygenation by lowering pulmonary shunt.

Keywords: pulmonary surfactant, synthetic peptides, respiratory dead space, capnometry, pulmonary gas exchange, oxygenation

Introduction
Surfactant-replacement therapy with animal-derived surfactant preparations is an established treatment modality for respiratory distress syndrome that revolutionized the care of preterm babies in intensive care units.¹ ² Pulmonary surfactant is a complex mixture of phospholipids and at least four apoproteins that reduces surface tension at the alveolar surface.³ The mixture has unique spreading properties, promotes lung expansion during inspiration, and prevents lung collapse during
expiration. Of all the protein components in the mixture, the hydrophobic surfactant proteins B (SP-B) and C (SP-C) have an essential function in the spreading, adsorption, and stability of surfactant lipids.4,6

Over the past decade, natural and synthetic surfactants have extensively been tested with regard to their in vitro properties and in vivo physiologic effects.1 Unfortunately, synthetic products have lost popularity in favor of natural products that contain low concentrations of SP-B and SP-C, which are essential for adsorption and spreading of the surfactant film at the air–liquid interface. However, commercially the large-scale production and supply of natural surfactants are not only time-consuming and expensive with a limited supply, but there are concerns about the reproducibility and purity and the possibility of transmission of infectious material.7 The development of an effective artificial surfactant mixture, devoid of foreign protein, that can be prepared in large quantities at a reasonable cost remains challenging. Moreover, a common denominator in acute lung diseases is inactivation of surfactant by plasma and other components. Much work is therefore aimed at constructing a new generation of synthetic surfactants that will be more resistant towards inactivation.

Various research groups have chemically prepared peptides with amino acid sequences based on that of SP-B. In two such studies, the treatment of preterm infant rhesus monkeys and human infants with respiratory distress syndrome was demonstrated with a peptide/phospholipid mixture (KL4-surfactant).8,9 In both studies, this synthetic surfactant expanded the pulmonary alveoli and promoted gas exchange. Based on such a design, we prepared a surfactant consisting of the phospholipids dipalmitoylphosphatidylcholine (DPPC), phosphatidylglycerol (PG), and two polymers: poly-L-lysine electrostatically complexed with poly-L-glutamic acid (Synsurf [S]). The polymers were added to the phospholipids, in order to mimic the hydrophobic and hydrophilic nature of SP-B in the mixture.

In this study, we were particularly interested to compare the efficacy of S as a synthetic surfactant in a comparative study with a previously used synthetic protein-free surfactant, Exosurf Neonatal10,11 (we prepared a generic version), hereafter named GE. Although similar in chemical composition, we cannot guarantee that the GE used in our experiments was identical to commercially manufactured Exosurf Neonatal, as it was discontinued at the time of the present study. However, in a previous study12,13 before its discontinuation, we were able to compare the in vivo efficacy of our GE and its physiologic effects and gas-exchange capabilities with the then-available commercial Exosurf Neonatal product. Although we found differences that we could not provide plausible explanations for in the on-site formulations, the overall outcome in performance was similar to Exosurf Neonatal. Moreover, the surface tension-lowering ability of the GE preparations were not significantly different to that of Exosurf Neonatal when we tested them.13 In the present study, we also found that the surface-lowering ability of GE and S is virtually similar. Although surface-tension measurements strongly depend on the technique applied, our data, measured under dynamic conditions, are in agreement with the less effective surface tension-lowering ability reported by others in the absence of SP-B and SP-C.14

Considering reports in literature5,16 that bivalent cations such as Ca2+ can increase the speed of surface adsorption of surfactant molecules and to stabilize films in experimental conditions, we decided to include a GE preparation mixed with Ca2+ (GECa2+) to elucidate the beneficial effect. Hence we tested the efficacy of three surfactant preparations in an adult rabbit model with acute lung injury and surfactant deficiency. We tested the hypothesis that a synthetic peptide-containing surfactant (S) would improve systemic oxygenation and restore the surfactant-deficient lungs to prelavage condition after surfactant depletion was induced by repeated bronchoalveolar lavage (BAL) in comparison to two synthetic surfactants devoid of protein.

**Materials and methods**

DPPC was obtained from Avanti Polar Lipids (Alabaster, AL, USA). PG, cetyl alcohol, tyloxapol, poly-L-lysine (molecular weight 16.1 kDa) and poly-L-glutamic acid (molecular weight 12 kDa) were purchased from Sigma-Aldrich (St Louis, MO, USA). Phospholipid purity was verified by thin-layer chromatography.17 Sterile water for injection was used in the preparation of surfactant. Chloroform used was high-performance liquid chromatography-grade (Merck, Darmstadt, Germany).

**Experimental surfactant preparations**

Synsurf (S) was prepared by mixing DPPC, hexadecanol, and PG in a 10:1:1:1 ratio (w/w) in chloroform. The organic solvent was then removed by rotary evaporation and the mixture was dried under a continuous stream of nitrogen at room temperature. Poly-L-lysine (~100–120 residues) was mixed with poly-L-glutamate (approximately 80 residues) and incubated at 37°C in 0.1 M NaCl to give a complex that was 50% neutralized. The complex was prepared in such a manner as to be positively charged through having an excess
of poly-L-lysine residues. The dried phospholipid film was then hydrated with the polymer mixture (3% by weight of the phospholipid concentration) and gently mixed in the presence of glass beads. A Branson (Danbury, CT, USA) B-15P ultrasonicator fitted with a microtip was then used to sonicate the mixture on ice under a stream of nitrogen (power of 20 watts for 7 × 13 seconds; 60-second intervals). Hereafter, 24 mg of tyloxapol was added to the preparation, and the tube was sealed under nitrogen before use. The GE surfactant was also prepared in a similar fashion as described above and consisted of three components: DPPC/hexadecanol/tyloxapol (13.5:1.5:1) in 0.1 M NaCl. The dose of S, GE, and GE_{ca}^{2+} used was 100 mg/kg. CaCl_2 included in GE_{ca}^{2+} amounted to 5 mM.

Animal preparation
Animal care and experimental procedures were performed under approval from the Faculty of Health Sciences Research Committee of Stellenbosch University. Adult New Zealand white rabbits weighing 2.5–3.75 kg ± 0.39 kg were premedicated with ketamine (25–50 mg/kg). They were positioned on their back and kept in this position throughout the experiment. An auricular intravenous line was inserted, and an infusion (5 mL/kg/hour) with a Ringer’s glucose solution started. Animals then underwent tracheostomy, and an uncuffed endotracheal tube (size 2.5–4.0 mm) was inserted and firmly tied to exclude air leaks. Intravenous pentobarbital (6 mg/kg body weight) and pancuronium bromide (0.1 mg/kg body weight) were administered. Anesthesia was maintained with an infusion of sodium pentobarbital at a dose of 6 mg/kg/hour. The left carotid artery was catheterized for arterial blood gas measurements and hemodynamic monitoring (blood pressure and pulse rate). Lidocaine (1%) was used for local anesthesia at surgical sites. Animals were ventilated using the time-cycled pressure-limited mode (Julian Anaesthetic Workstation; Dräger, Lübeck, Germany) at a peak inspiratory pressure necessary to maintain a tidal volume (V_t) of 10 mL/kg and partial pressure of carbon dioxide in arterial blood (PaCO_2) between 4 and 7.5 kPa (30–56 mmHg). The V_{c} of a spontaneously breathing young adult rabbit (2.775 ± 0.198 kg) varies between 19 and 25 mL, and the mean PaCO_2 for rabbits weighing 2.9–3.5 kg (in the absence of ketamine) is 31.8 ± 1.7 mmHg (4.2 ± 0.22 kPa).^{18,19} Using the same model, V_{c} varying between 8 and 12 mL/kg resulting in partial arterial pressure of CO_2 between 4.5 and 5.3 kPa have been reported.\textsuperscript{20–22} However, since a body of researchers used V_{c} of 10 mL/kg in adult rabbits, we decided to standardize our protocol accordingly.\textsuperscript{23–27} This V_{c} was verified by a combined neonatal CO_2/flow sensor (CO_2SMO plus respiratory profile monitor model 8000; Novametrix Medical Systems, Wallingford, CT, USA). At the moment of the incision of the trachea, continuous intravenous infusion of pentobarbital sodium was commenced (6 mg/kg/hour). Neuromuscular paralysis was achieved by administering intravenous pancuronium bromide (0.1 mg/kg) on an hourly basis. The rectal temperature was monitored, and the aim was to keep it between 38°C and 40°C with an electrical heating pad. The reported normal range of rectal temperatures in the rabbit is 36.8°C–40.1°C.\textsuperscript{19} The blood pressure transducer was intermittently flushed with saline containing heparin 5 IU heparin/mL. The blood pressure of the healthy rabbit varies between 90–130 (systolic) and 60–91 (diastolic) mmHg.\textsuperscript{19} The depth of anesthesia was intermittently checked by pinching the web of a hind-leg paw to create a painful stimulus, and by the flow sensor to check for spontaneous breathing efforts. The study lasted 5 hours before the animals were killed by a lethal intra-arterial injection of 15% potassium chloride.

Bronchoalveolar lavage and surfactant treatment
Animals were subjected to repeated warm saline (37°C) lavage (20 mL/kg) via the endotracheal tube, similar to the technique described by Lachmann et al.\textsuperscript{28} Lavage end points included a decrease in arterial oxygen tension (PaO_2) to below 11 kPa (fraction of inspiratory oxygen [FiO_2] 1.0) and a decrease in dynamic respiratory compliance (C_{D,jaw}) by 40% or more. The total volume of lavage fluid (corrected for body weight) necessary to achieve significant surfactant deficiency/acute lung injury was recorded together with the volume retrieved. The retrieved volume was expressed as a percentage of the instilled volume. A 10-minute period was allowed for stabilization following lavage, and then animals were randomized into three treatment groups. Group A received the GE protein-free surfactant, group B the GE plus Ca^{2+} (5 mM), and group C the peptide-containing surfactant (Synsurf, InnovUS, Stellenbosch University) via the endotracheal tube (DPPC concentration 100 mg/kg).

Measurement of lung mechanics, capnometry, and arterial blood gases
The FiO_2 (1.0), V_t (aim 10 mL/kg), respiratory rate (40 breaths per minute, spontaneous breathing rate of a rabbit varies between 32 and 60/minute), positive end-expiratory pressure (PEEP: 5 cmH_2O after lavage), and the inspiratory time (T_i)-expiratory time (T_e) at 1:1.5 (T_i 0.6 seconds, T_e 0.9 seconds) were kept constant throughout the study. Arterial blood gases (Radiometer ABL 500 blood gas analyzer; Regent...
Medic, London, UK), pulmonary functions (dynamic expiratory airway resistance [Raw], \( V_{T} / C_{aw} \)), ventilator settings, physiological parameters (rectal temperature, blood pressure, pulse rate), oxygenation, capnometry, and other calculations were recorded/measured before and after lavage and at 15, 30, 60, 90, 120, 180, 240, and 300 minutes after surfactant-replacement therapy. Oxygenation variables were calculated. The arterial/alveolar (a/A) ratio = \( \text{PaO}_2 / (\text{P}_a - 47) \text{FiO}_2 - \text{PaCO}_2 / R \) (R assumed respiratory quotient 0.8). Pulmonary function and CO2 measurements were measured with the CO2SMO Plus respiratory profile monitor. The low dead-space measurement chamber with flow sensor was placed inbetween the ventilator circuit wye and endotracheal tube adaptor. The CO2SMO Plus monitor measures and displays respiratory mechanics and carbon dioxide data and calculates flow, CO2, and oximetry-related parameters. Flow-sensor calibration was not necessary, since the device automatically zeroed periodically by internal values. Partial pressure of end-tidal carbon dioxide tension (PetCO2) was measured by mainstream infrared absorption. By using the tension of carbon dioxide (PCO2) and volume measurements, the anatomic dead space, alveolar dead space (V(DL/VT)), physiological dead space, physiological dead space/V(T) ratio, and V(DL)/V(T) ratio were determined. The arterial end-tidal PCO2 difference (P[a-et]CO2) was obtained by subtracting the PetCO2 from PaCO2 of an arterial blood gas sample. The shunt was calculated as follows: Qf/Qt = 88.77 - 2.4 (20.4 log PaO2/FiO2).29

**Chest radiography**

Anteroposterior chest radiographs were taken prior to lavage, immediately prior to randomization, and at the end of the study. The distance between the probe and film was kept at 24 cm. Changes in lung fields were assessed in a blinded manner in regard to whether the radiographic opacification following lavage (atelectasis) resolved (better), remained unchanged (similar), or deteriorated (worse).

**Statistical methods**

One-way analysis of variance and linear mixed-effects modeling were used as described by Pinheiro et al20 and Maritz et al.11 Variables measured for groups at the predetermined time points were also compared using unpaired t-tests. For continuous variables measured over time, a linear regression of the variables over time by least-squares analysis was used to compare groups by differences in the initial responses to surfactant (y-intercepts) and change over time (slopes). Data are expressed as means ± standard deviation. A P-value < 0.05 was taken as significant (Statistica version 10; StatSoft, Tulsa, OK, USA). GraphPad (La Jolla, CA, USA) Prism 5 was used to determine correlations.

**Results**

**Baseline characteristics**

The mean (± standard deviation) values for weight and prelavage mean arterial blood pressure, arterial blood gases, capnometry, and pulmonary functions are shown in Table 1. The total volume of lavage fluid required to induce acute

<table>
<thead>
<tr>
<th>Variable</th>
<th>Exosurf group</th>
<th>Exosurf group</th>
<th>Exosurf + Ca²⁺ group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (kg)</td>
<td>3.13 ± 0.56</td>
<td>2.95 ± 0.19</td>
<td>3.44 ± 0.24</td>
</tr>
<tr>
<td>Pre-Vt (mL/kg)</td>
<td>10.08 ± 0.29</td>
<td>10.20 ± 0.58</td>
<td>10.03 ± 0.35</td>
</tr>
<tr>
<td>180 minutes</td>
<td>10.08 ± 0.17</td>
<td>9.85 ± 0.21</td>
<td>10.13 ± 0.19</td>
</tr>
<tr>
<td>300 minutes</td>
<td>10.05 ± 0.10</td>
<td>9.75 ± 0.24</td>
<td>9.93 ± 0.22</td>
</tr>
<tr>
<td>Pre-MABP (mmHg)</td>
<td>82.60 ± 4.07</td>
<td>92.40 ± 3.83</td>
<td>91.50 ± 7.51</td>
</tr>
<tr>
<td>Post-MABP (mmHg)</td>
<td>89.50 ± 11.21</td>
<td>100.30 ± 6.99</td>
<td>93.25 ± 4.72</td>
</tr>
<tr>
<td>Pre-Va/A ratio</td>
<td>0.76 ± 0.02</td>
<td>0.77 ± 0.04</td>
<td>0.76 ± 0.03</td>
</tr>
<tr>
<td>Pre-PetCO2 (mmHg)</td>
<td>49.70 ± 9.46</td>
<td>511.10 ± 17.38</td>
<td>509.30 ± 24.08</td>
</tr>
<tr>
<td>Post-PetCO2 (mmHg)</td>
<td>57.95 ± 14.90</td>
<td>53.25 ± 15.97</td>
<td>50.81 ± 18.30</td>
</tr>
<tr>
<td>180 minutes</td>
<td>152.30 ± 49.27</td>
<td>85.69 ± 25.85</td>
<td>109.90 ± 46.32</td>
</tr>
<tr>
<td>300 minutes</td>
<td>281.30 ± 47.64</td>
<td>74.25 ± 8.84</td>
<td>85.69 ± 32.56</td>
</tr>
<tr>
<td>Pre-P(a-et)CO2 (mmHg)</td>
<td>0.76 ± 0.02</td>
<td>0.77 ± 0.04</td>
<td>0.76 ± 0.03</td>
</tr>
<tr>
<td>Pre-MABP (mmHg)</td>
<td>0.09 ± 0.02</td>
<td>0.08 ± 0.02</td>
<td>0.08 ± 0.03</td>
</tr>
<tr>
<td>Post-MABP (mmHg)</td>
<td>0.23 ± 0.07</td>
<td>0.13 ± 0.04</td>
<td>0.16 ± 0.07</td>
</tr>
<tr>
<td>Pre-PetCO2 (mmHg)</td>
<td>0.42 ± 0.07</td>
<td>0.11 ± 0.01</td>
<td>0.13 ± 0.05</td>
</tr>
<tr>
<td>Post-PetCO2 (mmHg)</td>
<td>40.69 ± 3.15</td>
<td>39.38 ± 6.26</td>
<td>36.19 ± 8.04</td>
</tr>
<tr>
<td>180 minutes</td>
<td>38.44 ± 4.99</td>
<td>38.63 ± 5.49</td>
<td>36.19 ± 4.99</td>
</tr>
<tr>
<td>300 minutes</td>
<td>36.75 ± 2.12</td>
<td>40.13 ± 4.18</td>
<td>38.81 ± 7.15</td>
</tr>
<tr>
<td>Pre-PetCO2 (mmHg)</td>
<td>14.25 ± 3.06</td>
<td>14.63 ± 3.09</td>
<td>13.88 ± 1.3</td>
</tr>
<tr>
<td>Pre-P(a-et)CO2 (mmHg)</td>
<td>9.56 ± 1.88</td>
<td>10.13 ± 2.17</td>
<td>10.69 ± 0.94</td>
</tr>
<tr>
<td>Post-MABP (mmHg)</td>
<td>9.75 ± 1.50</td>
<td>9.38 ± 1.44</td>
<td>9.75 ± 2.21</td>
</tr>
<tr>
<td>300 minutes</td>
<td>26.44 ± 4.95</td>
<td>24.75 ± 6.15</td>
<td>22.31 ± 7.07</td>
</tr>
<tr>
<td>Post-PetCO2 (mmHg)</td>
<td>43.50 ± 15.16</td>
<td>42.66 ± 8.67</td>
<td>42.88 ± 15.07</td>
</tr>
<tr>
<td>300 minutes</td>
<td>27.00 ± 2.60</td>
<td>30.75 ± 3.06</td>
<td>29.06 ± 8.58</td>
</tr>
</tbody>
</table>

**Note:** Data are shown as the means ± standard deviation.

**Abbreviations:** \( V_t \), tidal volume; MABP, mean arterial blood pressure; \( \text{PaO}_2 \), arterial \( \text{PO}_2 \); \( \text{PaCO}_2 \), arterial \( \text{PCO}_2 \); \( \text{PCO}_2 \), end-tidal \( \text{PCO}_2 \); \( \text{P}(a\text{-et})\text{CO}_2 \), arterial end-tidal \( \text{PCO}_2 \); Raw, expiratory airway resistance; \( C_{aw} \), dynamic respiratory compliance; a/A ratio, arterial/alveolar ratio.
lungs injury and surfactant deficiency (S 74.75 ± 17.04 mL, GE 73.58 ± 21.2 mL, GE_{Ca} 73.58 ± 21.2 mL) and the percentage of fluid retrieved from the airways (lavage %: S 86.5% ± 6.7%; GE 79.38% ± 7.7%; GE_{Ca} 79.25% ± 3.3%) did not differ between the groups. The end points of lavage were similar between the groups. Although the aim was to randomize the individual animals 10 minutes after the final lavage and after the chest X-ray was performed, in reality, the randomization occurred at 9 ± 3.16 minutes. There were no intergroup differences.

Changes in gas exchange and shunt
The changes in PaO₂ and a/A ratio before and after surfactant treatment are given in Table 1. The PaO₂ and a/A ratio decreased significantly (P < 0.05) after lavage. Following treatment with the respective surfactants, the following was noted: oxygenation as reflected by the PaO₂ and a/A ratio improved significantly over time in comparison to the postlavage level (time point 0, P < 0.05; Figure 1, A and B). However, significantly better and sustained improvement in systemic oxygenation occurred from baseline at 60 minutes in the animals treated with S (P = 0.02) compared to the other two groups (global test mixed-effects model \( \chi^2 = 58.81, P < 0.001 \)). Improvement in oxygenation was also recorded for the animals treated with GE_{Ca}, but it was significantly less than that recorded in the S group. A statistically significant decrease in calculated pulmonary shunt (time period 0–300 minutes) was observed in the S-treated group of animals (intergroup differences S 31.49 ± 10.68 vs GE 41.13 ± 1.63, P = 0.01, and S vs GE_{Ca} 37.36 ± 5.29, P = 0.002; Friedman analysis of variance). At 300 minutes, the mean calculated value for S was 12.03% versus 32.17% and 40.33% for GE_{Ca} and GE, respectively (Figure 2).

Changes in pulmonary mechanics
Despite the significant improvement in systemic oxygenation (gas exchange), no real changes in pulmonary mechanics from baseline (time point 0) over time were demonstrated. \( C_{dyn} \) decreased significantly from the prelavage value, and in spite of surfactant treatment decreased nonsignificantly thereafter over time in the three groups (Figure 3). BAL resulted in significant reduction of \( C_{dyn} \) in all of the rabbits and an increase of Raw and an increase of Raw by approximately 52%, 64% and 61%, respectively, from baseline (Table 1). After surfactant instillation, no significant changes for these two parameters were observed over time. Capnometry revealed the effects of lavage on dead spaces and the changes in V_{Dav}/V_T ratio, physiological dead space/V_T ratio, V_{Dphys}/V_T ratio and the arterial-end tidal PCO₂ difference (a-et)CO₂ before lavage and after surfactant treatment (Table 1 and Figure 4A–C). At randomization (baseline), all of these variables had significantly changed in comparison to the prelavage measurements. In all three groups, the V_{Dav}/V_T ratio as well as the V_{Dav}/V_T ratio did not

Figure 1 Time profile for oxygenation in the rabbit groups, as reflected by the arterial PaO₂ and a/A ratio after surfactant administration.
Abbreviations: a/A, arterial/alveolar; PaO₂, arterial PO₂.

Figure 2 Time profile of pulmonary shunt after administration of surfactant in rabbit groups.
change significantly from baseline, despite treatment with surfactant. This finding, together with the increased P(a-et) CO$_2$, indicates a ventilation–perfusion mismatch.

Correlations

We found that the best correlation could be calculated between the physiologic dead space and the a/A PO$_2$ ratio, as well as the physiologic dead space/V$_T$ ratio and a/A PO$_2$ ratio in all three groups of rabbits (Table 2). We also found good correlations between the arterial end-tidal PCO$_2$ and V$_{Dalv}$ as well as V$_{Dalv}$/V$_T$ components in the S- and GE$_{Ca}^{2+}$-treated groups of rabbits (Table 3). There was a significant negative correlation between P(a-et)CO$_2$ and PaO$_2$ in S- and GE$_{Ca}^{2+}$-treated rabbits (S, $r = -0.65$, $P = 0.044$; GE$_{Ca}^{2+}$, $r = -0.74$, $P = 0.014$) and a significant positive correlation between P(a-et)CO$_2$ and Q$/$Q in all three groups for shunt percentage above 30% (S, $r = 0.86$, $P = 0.0014$; GE, $r = 0.92$, $P = 0.0002$; GE$_{Ca}^{2+}$, $r = 0.91$, $P = 0.0003$).

Radiographic changes

Radiographic improvement was found in three out of four animals treated with S, in comparison to one out of four rabbits in the GE$_{Ca}^{2+}$ group and two out of four in the pure GE-treated rabbit group.

Discussion and conclusions

By selecting the well-established saline-lavage methodology introduced by Lachmann et al, we were able to create acute respiratory failure and lung injury with associated surfactant deficiency in adult rabbits. Repeated saline lavage brought about a deterioration in gas exchange, increased dead spaces,

**Table 2** Relation between arterial/alveolar PO$_2$ ratio and dead-space components

<table>
<thead>
<tr>
<th>Surfactant group</th>
<th>Variable</th>
<th>Correlation coefficients</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Synsurf</td>
<td>$V_{Dalv}$</td>
<td>0.37</td>
<td>0.13</td>
</tr>
<tr>
<td></td>
<td>$V_{Dalv}$/V$_T$</td>
<td>0.31</td>
<td>0.10</td>
</tr>
<tr>
<td></td>
<td>$V_{Dphys}$</td>
<td>0.94</td>
<td>0.88</td>
</tr>
<tr>
<td></td>
<td>$V_{Dalv}$/V$_T$</td>
<td>0.90</td>
<td>0.80</td>
</tr>
<tr>
<td></td>
<td>$V_{Dphys}$</td>
<td>0.49</td>
<td>0.24</td>
</tr>
<tr>
<td>Exosurf</td>
<td>$V_{Dalv}$</td>
<td>0.31</td>
<td>0.10</td>
</tr>
<tr>
<td></td>
<td>$V_{Dalv}$/V$_T$</td>
<td>0.93</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>$V_{Dphys}$</td>
<td>0.93</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>$V_{Dphys}$</td>
<td>0.60</td>
<td>0.36</td>
</tr>
<tr>
<td></td>
<td>$V_{Dalv}$/V$_T$</td>
<td>0.58</td>
<td>0.33</td>
</tr>
<tr>
<td></td>
<td>$V_{Dphys}$</td>
<td>0.85</td>
<td>0.72</td>
</tr>
<tr>
<td></td>
<td>$V_{Dphys}$</td>
<td>0.83</td>
<td>0.69</td>
</tr>
</tbody>
</table>

**Abbreviations:** $V_{Dalv}$, alveolar dead space; $V_{Dphys}$, physiologic dead space; $V_{Dalv}$/V$_T$, alveolar dead-space/tidal volume ratio; $V_{Dphys}$/V$_T$, physiologic dead space/tidal volume ratio.
The effect of a peptide-containing synthetic lung surfactant

Table 3 Relation between arterial end-tidal PCO₂ difference and dead-space components

<table>
<thead>
<tr>
<th>Surfactant group</th>
<th>Variable</th>
<th>Correlation coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synsurf</td>
<td>V₄ₐₐ/V₄ₜ</td>
<td>0.88 ± 0.78</td>
</tr>
<tr>
<td></td>
<td>V₄ₐₐ/V₄ₜ</td>
<td>0.87 ± 0.75</td>
</tr>
<tr>
<td></td>
<td>V₄ₚₚy/V₄ₜ</td>
<td>0.63 ± 0.40</td>
</tr>
<tr>
<td></td>
<td>V₄ₚₚy/V₄ₜ</td>
<td>0.70 ± 0.49</td>
</tr>
<tr>
<td>Exosurf</td>
<td>V₄ₐₐ/V₄ₜ</td>
<td>0.74 ± 0.54</td>
</tr>
<tr>
<td></td>
<td>V₄ₚₚy/V₄ₜ</td>
<td>0.19 ± 0.04</td>
</tr>
<tr>
<td></td>
<td>V₄ₚₚy/V₄ₜ</td>
<td>0.51 ± 0.26</td>
</tr>
<tr>
<td></td>
<td>V₄ₚₚy/V₄ₜ</td>
<td>0.35 ± 0.13</td>
</tr>
<tr>
<td>Exosurf + Ca²⁺</td>
<td>V₄ₐₐ/V₄ₜ</td>
<td>0.90 ± 0.81</td>
</tr>
<tr>
<td></td>
<td>V₄ₚₚy/V₄ₜ</td>
<td>0.93 ± 0.87</td>
</tr>
<tr>
<td></td>
<td>V₄ₚₚy/V₄ₜ</td>
<td>0.74 ± 0.55</td>
</tr>
<tr>
<td></td>
<td>V₄ₚₚy/V₄ₜ</td>
<td>0.81 ± 0.66</td>
</tr>
</tbody>
</table>

Abbreviations: V₄ₐₐ, alveolar dead space; V₄ₚₚy/V₄ₜ, alveolar dead space/tidal volume ratio; V₄ₚₚy, physiologic dead space; V₄ₚₚy/V₄ₜ, physiologic dead space/tidal volume ratio.

intrapulmonary right-to-left shunting, venous admixture, and impaired lung mechanics.²⁹,³²,³³

Following lavage, alveoli become unstable and tend to collapse abruptly during expiration when the transalveolar pressure decreases below critical closing pressure.³⁴ In the presence of continuing capillary perfusion of these unstable gas-exchange units, venous admixture (intrapulmonary shunt) increases. Surfactant deficiency induced by BAL elevates alveolar and physiological dead space,²⁵ lowers mean lung volume above residual volume,³⁵ decreases arterial PaO₂, increases arterial PaCO₂, decreases the a/A ratio, elevates pulmonary arterial pressure,²⁶ elevates systolic right ventricular pressure,²³ increases right-to-left shunting/venous admixture,²³,²⁵ and increases perfusion of low ventilation–perfusion regions.³⁷ In the adult rabbit, whole-lung lavage increases V₄ₐₚh almost fivefold and the V₄ₚₚy/V₄ₜ ratio from zero to one-third of V₄ₜ.²⁵ If not treated with surfactant, the majority of lavaged rabbits deteriorate over 1–2 hours in regard to static lung compliance and oxygenation status.³⁸ Like others, we found that lavage increased the alveolar and physiologic dead space/V₄ₜ ratio.²⁵ The increase in physiological dead space would indicate that less of the tidal volume is involved in gas exchange. In addition we found a good correlation between alveolar and physiological dead space/V₄ₜ ratio and arterial end-tidal PCO₂ differences for the S and Gₓ₁₂ groups, but not for the GE group (Table 3). In general, higher arterial end-tidal differences were based on an increase in dead space/V₄ₜ ratio. The alveolar dead space/V₄ₜ ratio has previously been shown to be the best indicator of ventilation disorders and to indicate right-to-left shunt, based mainly on atelectasis.²³ Regions of high ventilation–perfusion ratios contribute to dead space, and the P(a-A)CO₂ value is accepted as an indicator of high ventilation–perfusion lung regions.³⁹ Within 3 hours following surfactant instillation, we found a significant and sustained improvement in oxygenation in S-treated animals compared to the other groups. Concurrent with the improved oxygenation status, we observed a significant decrease in the P(a-et)CO₂ in the S and Gₓ₁₂² groups, which led us to conclude that S clearly improved (decreased) high ventilation–perfusion regions, more so than was the case in the other two groups.³⁹

An increase in oxygenation following instillation of surfactant is largely due to an increase in lung volume, more specifically the functional residual capacity (FRC),³⁰,³¹ and it is reasoned that the increase in FRC is due to stabilization of already open but underventilated air spaces and recruitment of atelectatic gas-exchange units. In the presence of surfactant, the relative contribution of these two mechanisms may depend on ventilator settings, ie, employment of PEEP, mean airway pressure, and other recruitment maneuvers. In the present study, PEEP and mean airway pressures did not differ between groups. We did not measure FRC and could not standardize dynamic compliance for changes in FRC. Did we overventilate open lung units? In that regard, we checked and reviewed the quantitative change in compliance during the last 20% of inspiration (C₀₂₀₀) and compared this value to the total compliance value for the entire breath (C) using the ratio C₀₂₀₀/C.⁴² In patients with overdistention, the C₀₂₀₀/C values decrease below 0.8. Reviewing the same in our groups showed that no rabbits were overventilated for any significant period of time. However, the 300-minute values were significantly lower than the 15-minute values, correlating with higher and lower compliance values at the corresponding time points, respectively. This correlation suggests that some degree of overventilation was taking place that influenced dynamic compliance values towards the end of the study. Another factor that has to be considered in regard to changes observed in oxygenation and shunt over time is lavage-induced pulmonary vascular constriction. In addition to surfactant deficiency, large-volume saline lavage (>20 mL/kg) has previously been shown to increase intrapulmonary right-to-left shunt, with a simultaneous increase in systolic right ventricular pressure.²³ We speculate that a raised systolic right ventricular pressure reflects a raised pulmonary vascular resistance, which could have adversely affected cardiac output, with lowered saturation of mixed venous blood. We substituted the true calculation of shunt (which requires measuring of mixed venous blood) with the calculated shunt²⁹ whilst
animals were receiving 100% oxygen. Several variables may affect this calculation. In this regard, the effect of 
FiO₂ was taken out of the equation, since FiO₂ remained
at 1.0. In regard to possible hypoventilation, we measured
serial PaCO₂ levels and attempted to deliver a constant tidal
volume and minute ventilation throughout the study period.
Furthermore, PEEP was kept constant, with intermittent
checks for inadvertent PEEP, and blood pressure and pulse
rates and rectal temperature did not vary between groups.
We were able to show that the intrapulmonary right-to-left
shunt increased from baseline to approximately 45% after
lavage, thereafter significantly decreasing over time following
surfactant instillation. The initial postlavage value
was very similar to values obtained by Boynton et al who
determined venous admixture and found that the percentage
venous admixture varied between 35% and 55% at a mean
airway pressure between 10 and 15 cmH₂O, respectively.
We therefore conclude that in the S-treated group, mean
airway pressure changes possibly altered lung volumes and/
or redistributed ventilation within alveoli already ventilated,
which affected shunt values.

Since we did not measure pulmonary vascular resistance,
mixed venous oxygen content, or assessed lung volume,
we speculate that the decrease in shunt fraction after sur-
factant instillation could be related to one or more of the
following: shunting of blood from poorly to better-ventilated
lung regions (improved ventilation–perfusion matching), a
decrease in pulmonary vascular resistance (relief of hypoxic
vasoconstriction) in the open but not hypoventilated com-
partment, or lung-volume recruitment. Similar to our study,
Wenzel et al found that protein-containing bovine surfactant
replacement after BAL improved gas exchange but failed
to restore the lung to its prelavage condition, which they
concluded indicates that exogenous surfactant affects only
partly the recruitment of the atelectatic areas.

A criticism of the present study is the lack of lung his-
tology, and this would have to be addressed in future stud-
ies involving animal models treated with newer synthetic
surfactants. A paucity of studies in this regard, especially
following surfactant treatment after saline lavage of adult
rabbits, was noted. Repetitive total lung lavage in adult rab-
bits leads to a reproducible severe surfactant-deficient lung
injury. The most prominent light-microscopy findings include
varying degrees of atelectasis, edema, intra-alveolar protein
leak, hyaline membrane formation, congestion, patchy intra-
alveolar hemorrhage, lymphatic dilatation, and infiltration
of neutrophils associated with peripheral neutropenia. After
 treatment with surfactant, these changes are still evident,
although more marked in placebo controls. In addition,
some authors have described better aeration of alveoli, mea-
sured by volume density, in surfactant-treated groups.

Poly-L-lysine can exist in a variety of conformations,
depending on the degree of ionization of the amino groups
in the side chains, temperature, and salt concentration.
When we examined the circular dichroism spectrum of the
poly-L-lysine–poly-L-glutamic acid complex, it showed a
maxima at 218 nm, indicative that the mixture exists in the
native random-coil conformation (JM van Zyl, unpublished
results, 2000). This is in accordance with the findings of
Chittchang et al who found that the random coil is the native
secondary structure of polylysine. Although hydrophobicity
of poly-L-lysine significantly increases in the order: random
coil < α-helix < β-sheet conformers, we know from our
previous experience that complexes of poly-L-lysine and
poly-L-glutamic acid have a degree of hydrophobicity, as we
have shown that conjugates of polylysine electrostatically
bind to DNA and make good cell-transfecting agents.47 More-
ever, poly-L-lysine adopts a β-sheet conformation from the
random coil during interaction with phospholipids.48 On the
other hand, the random coil (disordered state) of a polymer
mixture will favor the exposure of the basic charged surface
groups on the lysine side chains whereby the peptide could
interact flexibly with other molecules to perform a functional
role in cell membranes. The overall effect could then pos-
sibly be electrostatic binding to phospholipid monolayers.
With regards to SP-B, the α-helical and β-sheet secondary
structure is proposed to penetrate into the lipid acyl chains
of the phospholipid membrane lining in alveolar walls, thus
providing stability and preventing atelectatic collapse.49 We
therefore make the assumption that the charged amino groups
of poly-L-lysine in our S preparation could also possibly
interact with the phospholipid bilayer and thus could mimic
some structural and/or functional properties of SP-B. On the
other hand, as positive charges are important for maintaining
the structure and function of SP-C, it can alternatively be
argued that the overall positive character of poly-L-lysine
residues in S could then rather contribute to the mimicking
of SP-C structural and/or functional properties.

To conclude, in keeping with the finding of similar
experimental and human studies, the best indicator of the
efficacy of the surfactant was the changes observed in
systemic oxygenation over time. In addition to this, the
statistically significant decrease in pulmonary shunt found
for the S-treated group of animals suggests that the present
phospholipid mixture formulated with poly-L-lysine–poly-
L-glutamic acid as a complex (cationic and hydrophobic)
improves oxygenation in the rabbit model of acute lung injury/surfactant depletion.

**Disclosure**

Johan Smith, Johann van Zyl and Arthur Hawtrey are code-signers and developers of the peptide-containing synthetic surfactant. The surfactant has been patented by InnovUS (Stellenbosch University).

**References**


