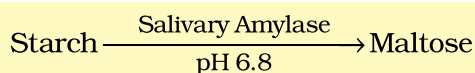


saliva masticate and mix up the food thoroughly. Mucus in saliva helps in lubricating and adhering the masticated food particles into a **bolus**. The bolus is then conveyed into the pharynx and then into the oesophagus by swallowing or **deglutition**. The bolus further passes down through the oesophagus by successive waves of muscular contractions called peristalsis. The gastro-oesophageal sphincter controls the passage of food into the stomach. The saliva secreted into the oral cavity contains electrolytes (Na^+ , K^+ , Cl^- , HCO_3^-) and enzymes, salivary amylase and lysozyme. The chemical process of digestion is initiated in the oral cavity by the hydrolytic action of the carbohydrate splitting enzyme, the salivary amylase. About 30 per cent of starch is hydrolysed here by this enzyme (optimum pH 6.8) into a disaccharide – maltose. Lysozyme present in saliva acts as an antibacterial agent that prevents infections.



The mucosa of stomach has gastric glands. Gastric glands have three major types of cells namely -

- (i) mucus neck cells which secrete mucus;
- (ii) peptic or chief cells which secrete the proenzyme pepsinogen; and
- (iii) parietal or oxyntic cells which secrete HCl and intrinsic factor (factor essential for absorption of vitamin B_{12}).

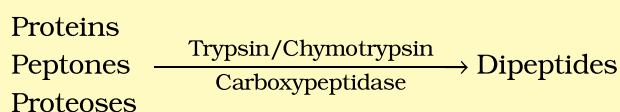
The stomach stores the food for 4-5 hours. The food mixes thoroughly with the acidic gastric juice of the stomach by the churning movements of its muscular wall and is called the **chyme**. The proenzyme pepsinogen, on exposure to hydrochloric acid gets converted into the active enzyme pepsin, the proteolytic enzyme of the stomach. Pepsin converts proteins into proteoses and peptones (peptides). The mucus and bicarbonates present in the gastric juice play an important role in lubrication and protection of the mucosal epithelium from excoriation by the highly concentrated hydrochloric acid. HCl provides the acidic pH (pH 1.8) optimal for pepsins. Rennin is a proteolytic enzyme found in gastric juice of infants which helps in the digestion of milk proteins. Small amounts of lipases are also secreted by gastric glands.

Various types of movements are generated by the muscularis layer of the small intestine. These movements help in a thorough mixing up of the food with various secretions in the intestine and thereby facilitate digestion. The bile, pancreatic juice and the intestinal juice are the secretions released into the small intestine. Pancreatic juice and bile are released through the hepato-pancreatic duct. The pancreatic juice contains inactive enzymes – trypsinogen, chymotrypsinogen, procarboxypeptidases, amylases, lipases and nucleases. Trypsinogen is activated by an enzyme, enterokinase, secreted by the intestinal mucosa

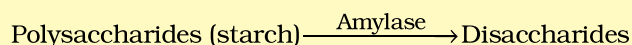
into active trypsin, which in turn activates the other enzymes in the pancreatic juice. The bile released into the duodenum contains bile pigments (bilirubin and bili-verdin), bile salts, cholesterol and phospholipids but no enzymes. Bile helps in emulsification of fats, i.e., breaking down of the fats into very small micelles. Bile also activates lipases.

The intestinal mucosal epithelium has **goblet cells** which secrete mucus. The secretions of the brush border cells of the mucosa alongwith the secretions of the goblet cells constitute the intestinal juice or **succus entericus**. This juice contains a variety of enzymes like disaccharidases (e.g., maltase), dipeptidases, lipases, nucleosidases, etc. The mucus alongwith the bicarbonates from the pancreas protects the intestinal mucosa from acid as well as provide an alkaline medium (pH 7.8) for enzymatic activities. Sub-mucosal glands (Brunner's glands) also help in this.

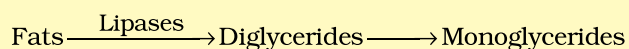
Proteins, proteoses and peptones (partially hydrolysed proteins) in the chyme reaching the intestine are acted upon by the proteolytic enzymes of pancreatic juice as given below:



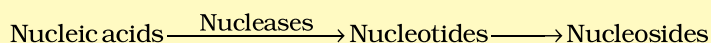
Carbohydrates in the chyme are hydrolysed by pancreatic amylase into disaccharides.



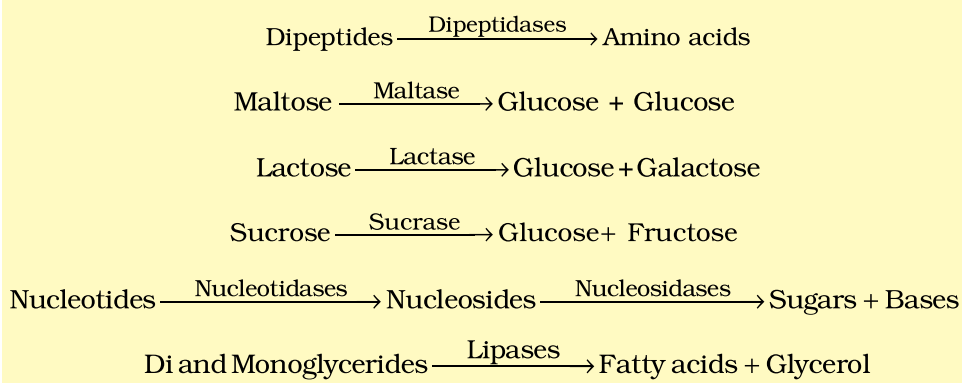
Fats are broken down by lipases with the help of bile into di-and monoglycerides.



Nucleases in the pancreatic juice acts on nucleic acids to form nucleotides and nucleosides



The enzymes in the succus entericus act on the end products of the above reactions to form the respective simple absorbable forms. These final steps in digestion occur very close to the mucosal epithelial cells of the intestine.



The breakdown of biomacromolecules mentioned above occurs in the duodenum region of the small intestine. The simple substances thus formed are absorbed in the jejunum and ileum regions of the small intestine. The undigested and unabsorbed substances are passed on to the large intestine.

No significant digestive activity occurs in the large intestine. The functions of large intestine are:

- (i) absorption of some water, minerals and certain drugs;
- (ii) secretion of mucus which helps in adhering the waste (undigested) particles together and lubricating it for an easy passage.

The undigested, unabsorbed substances called faeces enters into the caecum of the large intestine through ileo-caecal valve, which prevents the back flow of the faecal matter. It is temporarily stored in the rectum till defaecation.

The activities of the gastro-intestinal tract are under neural and hormonal control for proper coordination of different parts. The sight, smell and/or the presence of food in the oral cavity can stimulate the secretion of saliva. Gastric and intestinal secretions are also, similarly, stimulated by neural signals. The muscular activities of different parts of the alimentary canal can also be moderated by neural mechanisms, both local and through CNS. Hormonal control of the secretion of digestive juices is carried out by local hormones produced by the gastric and intestinal mucosa.

16.3 ABSORPTION OF DIGESTED PRODUCTS

Absorption is the process by which the end products of digestion pass through the intestinal mucosa into the blood or lymph. It is carried out by passive, active or facilitated transport mechanisms. Small amounts of monosaccharides like glucose, amino acids and some electrolytes like chloride ions are generally absorbed by simple diffusion. The passage of these substances into the blood depends upon the concentration gradients. However, some of the substances like fructose and some amino acids are absorbed with the help of the carrier ions like Na^+ . This mechanism is called the facilitated transport.

Transport of water depends upon the osmotic gradient. Active transport occurs against the concentration gradient and hence requires energy. Various nutrients like amino acids, monosaccharides like glucose, electrolytes like Na^+ are absorbed into the blood by this mechanism.

Fatty acids and glycerol being insoluble, cannot be absorbed into the blood. They are first incorporated into small droplets called micelles which move into the intestinal mucosa. They are re-formed into very small protein coated fat globules called the chylomicrons which are transported into the lymph vessels (lacteals) in the villi. These lymph vessels ultimately release the absorbed substances into the blood stream.

Absorption of substances takes place in different parts of the alimentary canal, like mouth, stomach, small intestine and large intestine. However, maximum absorption occurs in the small intestine. A summary of absorption (sites of absorption and substances absorbed) is given in Table 16.1.

TABLE 16.1 The Summary of Absorption in Different Parts of Digestive System

Mouth	Stomach	Small Intestine	Large Intestine
Certain drugs coming in contact with the mucosa of mouth and lower side of the tongue are absorbed into the blood capillaries lining them.	Absorption of water, simple sugars, and alcohol etc. takes place.	Principal organ for absorption of nutrients. The digestion is completed here and the final products of digestion such as glucose, fructose, fatty acids, glycerol and amino acids are absorbed through the mucosa into the blood stream and lymph.	Absorption of water, some minerals and drugs takes place.

The absorbed substances finally reach the tissues which utilise them for their activities. This process is called assimilation.

The digestive wastes, solidified into coherent faeces in the rectum initiate a neural reflex causing an urge or desire for its removal. The egestion of faeces to the outside through the anal opening (defaecation) is a voluntary process and is carried out by a mass peristaltic movement.

16.4 DISORDERS OF DIGESTIVE SYSTEM

The inflammation of the intestinal tract is the most common ailment due to bacterial or viral infections. The infections are also caused by the parasites of the intestine like tapeworm, roundworm, threadworm, hookworm, pin worm, etc.

Jaundice: The liver is affected, skin and eyes turn yellow due to the deposit of bile pigments.

Vomiting: It is the ejection of stomach contents through the mouth. This reflex action is controlled by the vomit centre in the medulla. A feeling of nausea precedes vomiting.

Diarrhoea: The abnormal frequency of bowel movement and increased liquidity of the faecal discharge is known as diarrhoea. It reduces the absorption of food.

Constipation: In constipation, the faeces are retained within the rectum as the bowel movements occur irregularly.

Indigestion: In this condition, the food is not properly digested leading to a feeling of fullness. The causes of indigestion are inadequate enzyme secretion, anxiety, food poisoning, over eating, and spicy food.

SUMMARY

The digestive system of humans consists of an alimentary canal and associated digestive glands. The alimentary canal consists of the mouth, buccal cavity, pharynx, oesophagus, stomach, small intestine, large intestine, rectum and the anus. The accessory digestive glands include the salivary glands, the liver (with gall bladder) and the pancreas. Inside the mouth the teeth masticates the food, the tongue tastes the food and manipulates it for proper mastication by mixing with the saliva. Saliva contains a starch digestive enzyme, salivary amylase that digests the starch and converts it into maltose (disaccharide). The food then passes into the pharynx and enters the oesophagus in the form of bolus, which is further carried down through the oesophagus by peristalsis into the stomach. In stomach mainly protein digestion takes place. Absorption of simple sugars, alcohol and medicines also takes place in the stomach.

The chyme (food) enters into the duodenum portion of the small intestine and is acted on by the pancreatic juice, bile and finally by the enzymes in the succus entericus, so that the digestion of carbohydrates, proteins and fats is completed. The food then enters into the jejunum and ileum portions of the small intestine. Carbohydrates are digested and converted into monosaccharides like glucose. Proteins are finally broken down into amino acids. The fats are converted to fatty acids and glycerol. The digested end products are absorbed into the body through the epithelial lining of the intestinal villi. The undigested food (faeces) enters into the caecum of the large intestine through ileo-caecal valve, which prevents the back flow of the faecal matter. Most of the water is absorbed in the large intestine. The undigested food becomes semi-solid in nature and then enters into the rectum, anal canal and is finally egested out through the anus.

EXERCISES

1. Choose the correct answer among the following :

- (a) Gastric juice contains
- (i) pepsin, lipase and rennin
 - (ii) trypsin, lipase and rennin
 - (iii) trypsin, pepsin and lipase
 - (iv) trypsin, pepsin and renin
- (b) Succus entericus is the name given to
- (i) a junction between ileum and large intestine
 - (ii) intestinal juice
 - (iii) swelling in the gut
 - (iv) appendix

2. Match column I with column II

Column I

- (a) Bilirubin and biliverdin
- (b) Hydrolysis of starch
- (c) Digestion of fat
- (d) Salivary gland

Column II

- (i) Parotid
- (ii) Bile
- (iii) Lipases
- (iv) Amylases

3. Answer briefly:

- (a) Why are villi present in the intestine and not in the stomach?
- (b) How does pepsinogen change into its active form?
- (c) What are the basic layers of the wall of alimentary canal?
- (d) How does bile help in the digestion of fats?

- 4. State the role of pancreatic juice in digestion of proteins.
- 5. Describe the process of digestion of protein in stomach.
- 6. Give the dental formula of human beings.
- 7. Bile juice contains no digestive enzymes, yet it is important for digestion. Why?
- 8. Describe the digestive role of chymotrypsin. Which two other digestive enzymes of the same category are secreted by its source gland?
- 9. How are polysaccharides and disaccharides digested?
- 10. What would happen if HCl were not secreted in the stomach?
- 11. How does butter in your food get digested and absorbed in the body?
- 12. Discuss the main steps in the digestion of proteins as the food passes through different parts of the alimentary canal.
- 13. Explain the term thecodont and diphyodont.
- 14. Name different types of teeth and their number in an adult human.
- 15. What are the functions of liver?

CHAPTER 17

BREATHING AND EXCHANGE OF GASES

- 17.1 Respiratory Organs
- 17.2 Mechanism of Breathing
- 17.3 Exchange of Gases
- 17.4 Transport of Gases
- 17.5 Regulation of Respiration
- 17.6 Disorders of Respiratory System

As you have read earlier, oxygen (O_2) is utilised by the organisms to indirectly break down nutrient molecules like glucose and to derive energy for performing various activities. Carbon dioxide (CO_2) which is harmful is also released during the above catabolic reactions. It is, therefore, evident that O_2 has to be continuously provided to the cells and CO_2 produced by the cells have to be released out. This process of exchange of O_2 from the atmosphere with CO_2 produced by the cells is called **breathing**, commonly known as **respiration**. Place your hands on your chest; you can feel the chest moving up and down. You know that it is due to breathing. How do we breathe? The respiratory organs and the mechanism of breathing are described in the following sections of this chapter.

17.1 RESPIRATORY ORGANS

Mechanisms of breathing vary among different groups of animals depending mainly on their habitats and levels of organisation. Lower invertebrates like sponges, coelenterates, flatworms, etc., exchange O_2 with CO_2 by simple diffusion over their entire body surface. Earthworms use their moist cuticle and insects have a network of tubes (tracheal tubes) to transport atmospheric air within the body. Special vascularised structures called **gills** are used by most of the aquatic arthropods and molluscs whereas vascularised bags called **lungs** are used by the terrestrial forms for the exchange of gases. Among vertebrates, fishes use gills whereas reptiles, birds and mammals respire through lungs. Amphibians like frogs can respire through their moist skin also. Mammals have a well developed respiratory system.

17.1.1 Human Respiratory System

We have a pair of external nostrils opening out above the upper lips. It leads to a nasal chamber through the nasal passage. The nasal chamber opens into **nasopharynx**, which is a portion of pharynx, the common passage for food and air. Nasopharynx opens through glottis of the larynx region into the **trachea**. Larynx is a cartilaginous box which helps in sound production and hence called the **sound box**. During swallowing glottis can be covered by a thin elastic cartilaginous flap called epiglottis to prevent the entry of food into the larynx. Trachea is a straight tube extending up to the mid-thoracic cavity, which divides at the level of 5th thoracic vertebra into a right and left primary **bronchi**. Each bronchi undergoes repeated divisions to form the secondary and tertiary bronchi and bronchioles ending up in very thin terminal **bronchioles**. The tracheae, primary, secondary and tertiary bronchi, and initial bronchioles are supported by incomplete cartilaginous rings. Each terminal bronchiole gives rise to a number of very thin, irregular-walled and vascularised bag-like structures called **alveoli**. The branching network of bronchi, bronchioles and alveoli comprise the lungs (Figure 17.1). We have two lungs which are covered by a double layered pleura, with pleural fluid between them. It reduces friction on the lung-surface. The outer pleural membrane is in close contact with the thoracic

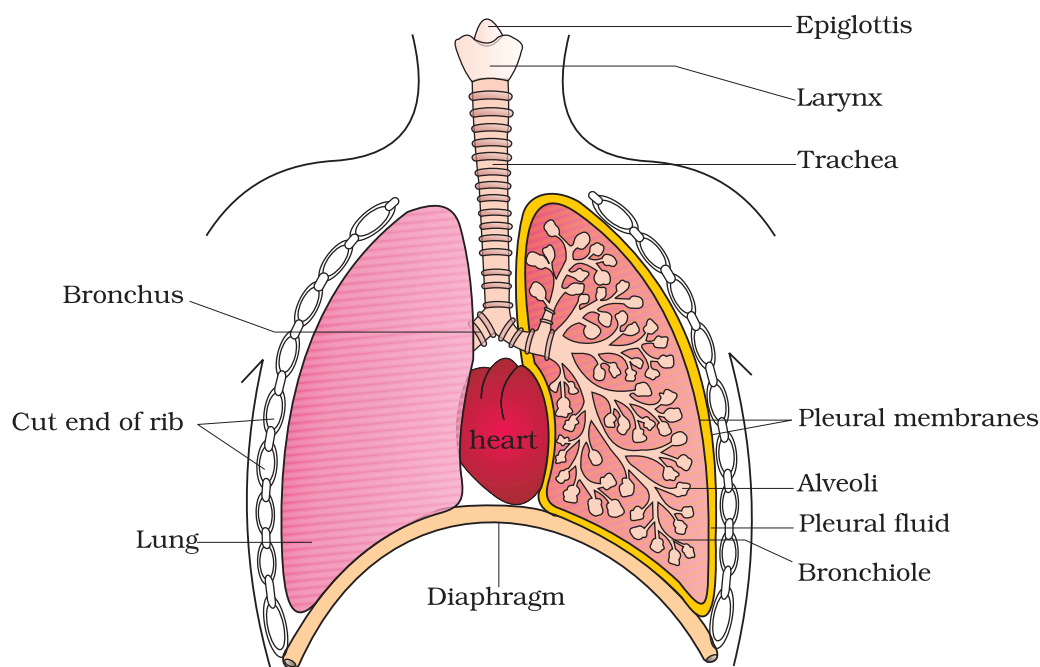


Figure 17.1 Diagrammatic view of human respiratory system (Sectional view of the left lung is also shown)

lining whereas the inner pleural membrane is in contact with the lung surface. The part starting with the external nostrils up to the terminal bronchioles constitute the conducting part whereas the alveoli and their ducts form the respiratory or exchange part of the respiratory system. The conducting part transports the atmospheric air to the alveoli, clears it from foreign particles, humidifies and also brings the air to body temperature. Exchange part is the site of actual diffusion of O_2 and CO_2 between blood and atmospheric air.

The lungs are situated in the thoracic chamber which is anatomically an air-tight chamber. The thoracic chamber is formed dorsally by the vertebral column, ventrally by the sternum, laterally by the ribs and on the lower side by the dome-shaped diaphragm. The anatomical setup of lungs in thorax is such that any change in the volume of the thoracic cavity will be reflected in the lung (pulmonary) cavity. Such an arrangement is essential for breathing, as we cannot directly alter the pulmonary volume.

Respiration involves the following steps:

- (i) Breathing or pulmonary ventilation by which atmospheric air is drawn in and CO_2 rich alveolar air is released out.
- (ii) Diffusion of gases (O_2 and CO_2) across alveolar membrane.
- (iii) Transport of gases by the blood.
- (iv) Diffusion of O_2 and CO_2 between blood and tissues.
- (v) Utilisation of O_2 by the cells for catabolic reactions and resultant release of CO_2 (cellular respiration as dealt in the Chapter 14).

17.2 MECHANISM OF BREATHING

Breathing involves two stages : **inspiration** during which atmospheric air is drawn in and **expiration** by which the alveolar air is released out. The movement of air into and out of the lungs is carried out by creating a pressure gradient between the lungs and the atmosphere. Inspiration can occur if the pressure within the lungs (intra-pulmonary pressure) is less than the atmospheric pressure, i.e., there is a negative pressure in the lungs with respect to atmospheric pressure. Similarly, expiration takes place when the intra-pulmonary pressure is higher than the atmospheric pressure. The diaphragm and a specialised set of muscles – external and internal intercostals between the ribs, help in generation of such gradients. Inspiration is initiated by the contraction of diaphragm which increases the volume of thoracic chamber in the antero-posterior axis. The contraction of external inter-costal muscles lifts up the ribs and the

sternum causing an increase in the volume of the thoracic chamber in the dorso-ventral axis. The overall increase in the thoracic volume causes a similar increase in pulmonary volume. An increase in pulmonary volume decreases the intra-pulmonary pressure to less than the atmospheric pressure which forces the air from outside to move into the lungs, i.e., inspiration (Figure 17.2a). Relaxation of the diaphragm and the inter-costal muscles returns the diaphragm and sternum to their normal positions and reduce the thoracic volume and thereby the pulmonary volume. This leads to an increase in intra-pulmonary pressure causing the expulsion of air from the lungs, i.e., expiration (Figure 17.2b). We have the ability to increase the strength of inspiration and expiration with the help of additional muscles in the abdomen. On an average, a healthy human breathes 12-16 times/minute. The volume of air involved in breathing movements can be estimated by using a spirometer which helps in clinical assessment of pulmonary functions.

17.2.1 Respiratory Volumes and Capacities

Tidal Volume (TV): Volume of air inspired or expired during a normal respiration. It is approx. 500 mL, i.e., a healthy man can inspire or expire approximately 6000 to 8000 mL of air per minute.

Inspiratory Reserve Volume (IRV): Additional volume of air, a person can inspire by a forcible inspiration. This averages 2500 mL to 3000 mL.

Expiratory Reserve Volume (ERV): Additional volume of air, a person can expire by a forcible expiration. This averages 1000 mL to 1100 mL.

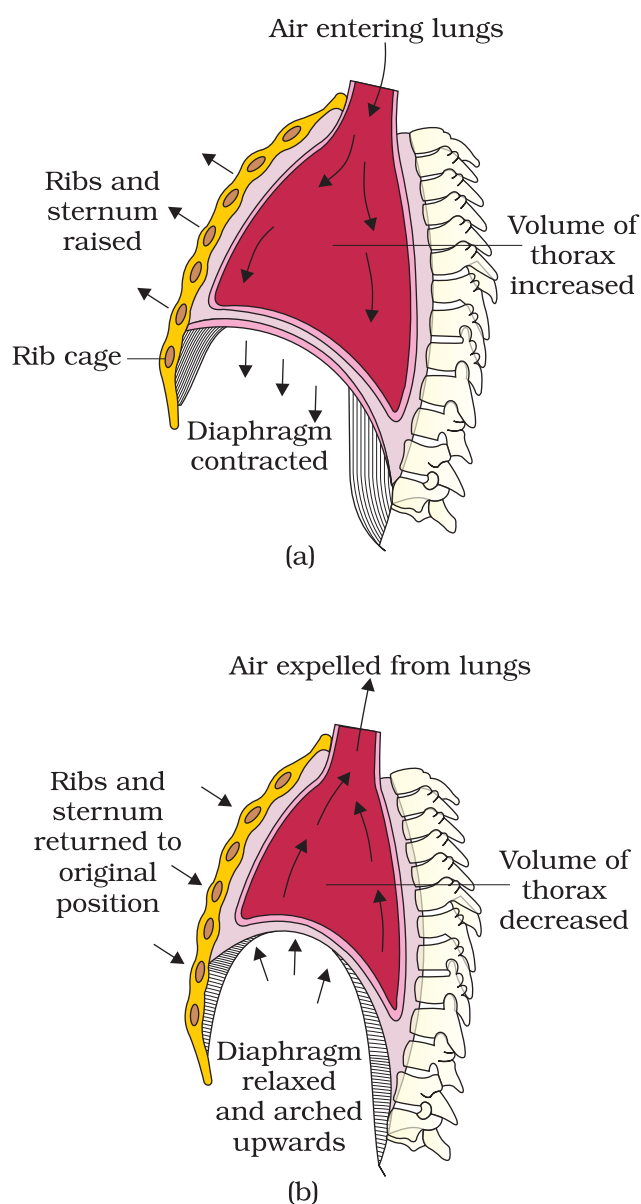


Figure 17.2 Mechanism of breathing showing :
(a) inspiration (b) expiration

Residual Volume (RV): Volume of air remaining in the lungs even after a forcible expiration. This averages 1100 mL to 1200 mL.

By adding up a few respiratory volumes described above, one can derive various pulmonary capacities, which can be used in clinical diagnosis.

Inspiratory Capacity (IC): Total volume of air a person can inspire after a normal expiration. This includes tidal volume and inspiratory reserve volume (TV+IRV).

Expiratory Capacity (EC): Total volume of air a person can expire after a normal inspiration. This includes tidal volume and expiratory reserve volume (TV+ERV).

Functional Residual Capacity (FRC): Volume of air that will remain in the lungs after a normal expiration. This includes ERV+RV.

Vital Capacity (VC): The maximum volume of air a person can breathe in after a forced expiration. This includes ERV, TV and IRV or the maximum volume of air a person can breathe out after a forced inspiration.

Total Lung Capacity: Total volume of air accommodated in the lungs at the end of a forced inspiration. This includes RV, ERV, TV and IRV or vital capacity + residual volume.

17.3 EXCHANGE OF GASES

Alveoli are the primary sites of exchange of gases. Exchange of gases also occur between blood and tissues. O_2 and CO_2 are exchanged in these sites by simple diffusion mainly based on pressure/concentration gradient. Solubility of the gases as well as the thickness of the membranes involved in diffusion are also some important factors that can affect the rate of diffusion.

Pressure contributed by an individual gas in a mixture of gases is called partial pressure and is represented as pO_2 for oxygen and pCO_2 for carbon dioxide. Partial pressures of these two gases in the atmospheric air and the two sites of diffusion are given in Table 17.1 and in Figure 17.3. The data given in the table clearly indicates a concentration gradient for oxygen from alveoli to blood and blood to tissues. Similarly,

TABLE 17.1 Partial Pressures (in mm Hg) of Oxygen and Carbon dioxide at Different Parts Involved in Diffusion in Comparison to those in Atmosphere

Respiratory Gas	Atmospheric Air	Alveoli	Blood (Deoxygenated)	Blood (Oxygenated)	Tissues
O_2	159	104	40	95	40
CO_2	0.3	40	45	40	45

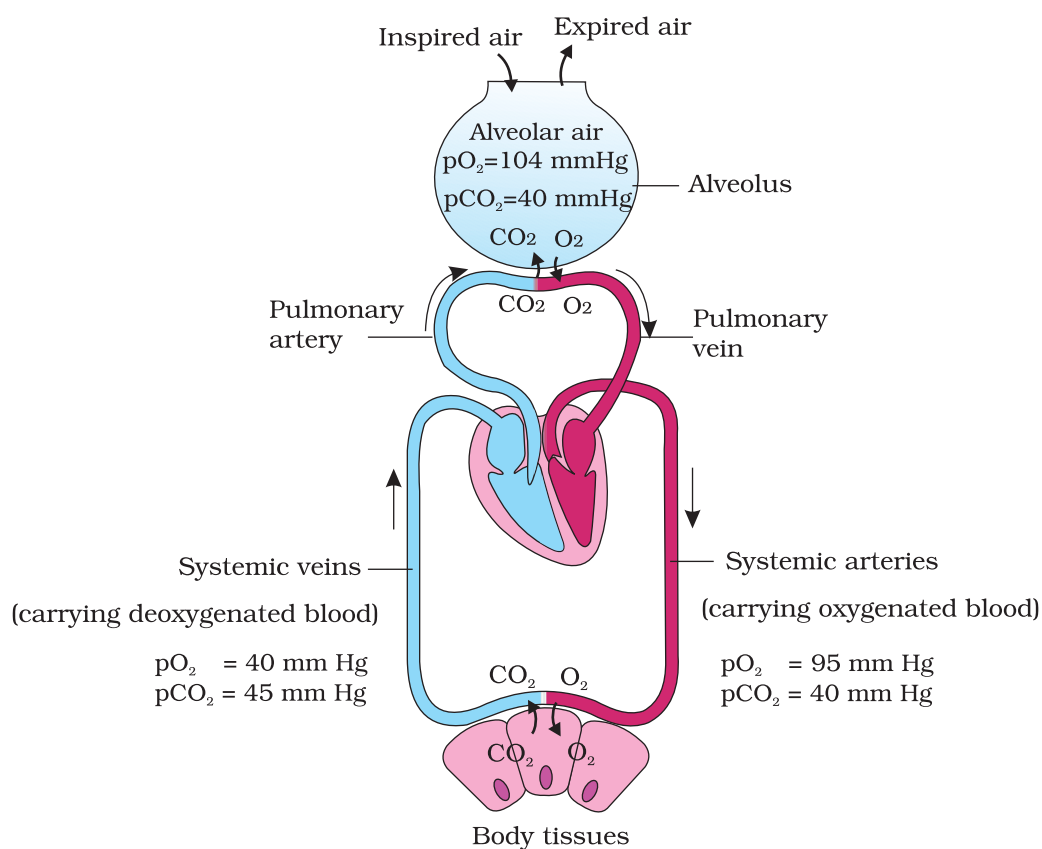


Figure 17.3 Diagrammatic representation of exchange of gases at the alveolus and the body tissues with blood and transport of oxygen and carbon dioxide

a gradient is present for CO_2 in the opposite direction, i.e., from tissues to blood and blood to alveoli. As the solubility of CO_2 is 20-25 times higher than that of O_2 , the amount of CO_2 that can diffuse through the diffusion membrane per unit difference in partial pressure is much higher compared to that of O_2 . The diffusion membrane is made up of three major layers (Figure 17.4) namely, the thin squamous epithelium of alveoli, the endothelium of alveolar capillaries and the basement substance in between them. However, its total thickness is much less than a millimetre. Therefore, all the factors in our body are favourable for diffusion of O_2 from alveoli to tissues and that of CO_2 from tissues to alveoli.

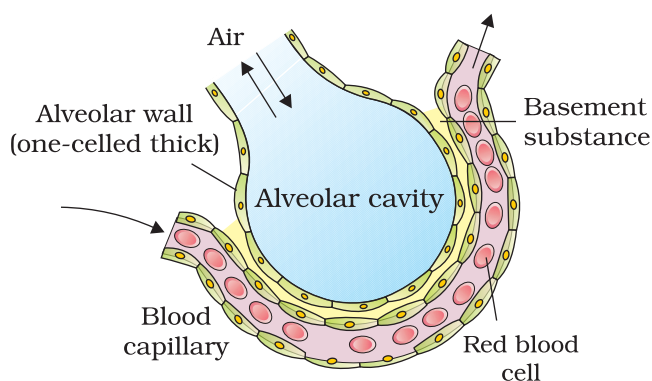


Figure 17.4 A Diagram of a section of an alveolus with a pulmonary capillary.

17.4 TRANSPORT OF GASES

Blood is the medium of transport for O_2 and CO_2 . About 97 per cent of O_2 is transported by RBCs in the blood. The remaining 3 per cent of O_2 is carried in a dissolved state through the plasma. Nearly 20-25 per cent of CO_2 is transported by RBCs whereas 70 per cent of it is carried as bicarbonate. About 7 per cent of CO_2 is carried in a dissolved state through plasma.

17.4.1 Transport of Oxygen

Haemoglobin is a red coloured iron containing pigment present in the RBCs. O_2 can bind with haemoglobin in a reversible manner to form **oxyhaemoglobin**. Each haemoglobin molecule can carry a maximum of four molecules of O_2 . Binding of oxygen with haemoglobin is primarily related to partial pressure of O_2 . Partial pressure of CO_2 , hydrogen ion concentration and temperature are the other factors which can interfere with this binding. A sigmoid curve is obtained when percentage saturation of haemoglobin with O_2 is plotted against the pO_2 . This curve is called the Oxygen dissociation curve (Figure 17.5) and is highly useful in studying the effect of factors like pCO_2 , H^+ concentration, etc., on binding of O_2 with haemoglobin. In the alveoli, where there is high pO_2 , low pCO_2 , lesser H^+ concentration and lower temperature, the factors are all favourable for the formation of oxyhaemoglobin, whereas in the tissues, where low pO_2 , high pCO_2 , high H^+ concentration and higher temperature exist, the conditions are favourable for dissociation of oxygen from the oxyhaemoglobin. This clearly indicates that O_2 gets bound to haemoglobin in the lung surface and gets dissociated at the tissues. Every 100 ml of oxygenated blood can deliver around 5 ml of O_2 to the tissues under normal physiological conditions.

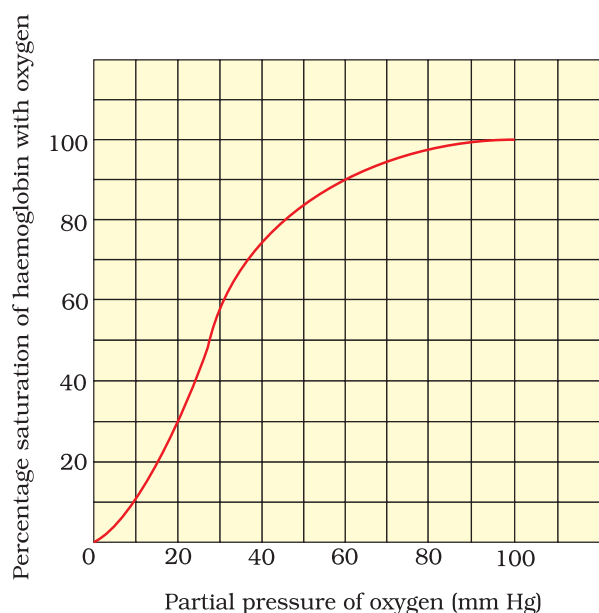
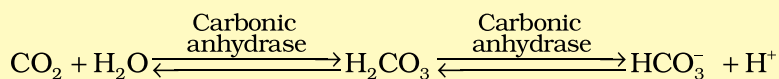


Figure 17.5 Oxygen dissociation curve

17.4.2 Transport of Carbon dioxide

CO_2 is carried by haemoglobin as **carbamino-haemoglobin** (about 20-25 per cent). This binding is related to the partial pressure of CO_2 . pO_2 is a major factor which could affect this binding. When pCO_2 is high and pO_2 is low as in the tissues, more binding of carbon dioxide occurs whereas, when the pCO_2 is low and pO_2 is high as in the alveoli, dissociation

of CO_2 from carbamino-haemoglobin takes place, i.e., CO_2 which is bound to haemoglobin from the tissues is delivered at the alveoli. RBCs contain a very high concentration of the enzyme, carbonic anhydrase and minute quantities of the same is present in the plasma too. This enzyme facilitates the following reaction in both directions.



At the tissue site where partial pressure of CO_2 is high due to catabolism, CO_2 diffuses into blood (RBCs and plasma) and forms HCO_3^- and H^+ . At the alveolar site where pCO_2 is low, the reaction proceeds in the opposite direction leading to the formation of CO_2 and H_2O . Thus, CO_2 trapped as bicarbonate at the tissue level and transported to the alveoli is released out as CO_2 (Figure 17.4). Every 100 ml of deoxygenated blood delivers approximately 4 ml of CO_2 to the alveoli.

17.5 REGULATION OF RESPIRATION

Human beings have a significant ability to maintain and moderate the respiratory rhythm to suit the demands of the body tissues. This is done by the neural system. A specialised centre present in the medulla region of the brain called respiratory rhythm centre is primarily responsible for this regulation. Another centre present in the pons region of the brain called pneumotaxic centre can moderate the functions of the respiratory rhythm centre. Neural signal from this centre can reduce the duration of inspiration and thereby alter the respiratory rate. A chemosensitive area is situated adjacent to the rhythm centre which is highly sensitive to CO_2 and hydrogen ions. Increase in these substances can activate this centre, which in turn can signal the rhythm centre to make necessary adjustments in the respiratory process by which these substances can be eliminated. Receptors associated with aortic arch and carotid artery also can recognise changes in CO_2 and H^+ concentration and send necessary signals to the rhythm centre for remedial actions. The role of oxygen in the regulation of respiratory rhythm is quite insignificant.

17.6 DISORDERS OF RESPIRATORY SYSTEM

Asthma is a difficulty in breathing causing wheezing due to inflammation of bronchi and bronchioles.

Emphysema is a chronic disorder in which alveolar walls are damaged due to which respiratory surface is decreased. One of the major causes of this is cigarette smoking.

Occupational Respiratory Disorders: In certain industries, especially those involving grinding or stone-breaking, so much dust is produced that the defense mechanism of the body cannot fully cope with the situation. Long exposure can give rise to inflammation leading to fibrosis (proliferation of fibrous tissues) and thus causing serious lung damage. Workers in such industries should wear protective masks.

SUMMARY

Cells utilise oxygen for metabolism and produce energy along with substances like carbon dioxide which is harmful. Animals have evolved different mechanisms for the transport of oxygen to the cells and for the removal of carbon dioxide from there. We have a well developed respiratory system comprising two lungs and associated air passages to perform this function.

The first step in respiration is breathing by which atmospheric air is taken in (inspiration) and the alveolar air is released out (expiration). Exchange of O_2 and CO_2 between deoxygenated blood and alveoli, transport of these gases throughout the body by blood, exchange of O_2 and CO_2 between the oxygenated blood and tissues and utilisation of O_2 by the cells (cellular respiration) are the other steps involved.

Inspiration and expiration are carried out by creating pressure gradients between the atmosphere and the alveoli with the help of specialised muscles – intercostals and diaphragm. Volumes of air involved in these activities can be estimated with the help of spirometer and are of clinical significance.

Exchange of O_2 and CO_2 at the alveoli and tissues occur by diffusion. Rate of diffusion is dependent on the partial pressure gradients of O_2 (pO_2) and CO_2 (pCO_2), their solubility as well as the thickness of the diffusion surface. These factors in our body facilitate diffusion of O_2 from the alveoli to the deoxygenated blood as well as from the oxygenated blood to the tissues. The factors are favourable for the diffusion of CO_2 in the opposite direction, i.e., from tissues to alveoli.

Oxygen is transported mainly as oxyhaemoglobin. In the alveoli where pO_2 is higher, O_2 gets bound to haemoglobin which is easily dissociated at the tissues where pO_2 is low and pCO_2 and H^+ concentration are high. Nearly 70 per cent of carbon dioxide is transported as bicarbonate (HCO_3^-) with the help of the enzyme carbonic anhydrase. 20-25 per cent of carbon dioxide is carried by haemoglobin as carbamino-haemoglobin. In the tissues where pCO_2 is high, it gets bound to blood whereas in the alveoli where pCO_2 is low and pO_2 is high, it gets removed from the blood.

Respiratory rhythm is maintained by the respiratory centre in the medulla region of brain. A pneumotaxic centre in the pons region of the brain and a chemosensitive area in the medulla can alter respiratory mechanism.

EXERCISES

1. Define vital capacity. What is its significance?
2. State the volume of air remaining in the lungs after a normal breathing.
3. Diffusion of gases occurs in the alveolar region only and not in the other parts of respiratory system. Why?
4. What are the major transport mechanisms for CO_2 ? Explain.
5. What will be the pO_2 and pCO_2 in the atmospheric air compared to those in the alveolar air ?
 - (i) pO_2 lesser, pCO_2 higher
 - (ii) pO_2 higher, pCO_2 lesser
 - (iii) pO_2 higher, pCO_2 higher
 - (iv) pO_2 lesser, pCO_2 lesser
6. Explain the process of inspiration under normal conditions.
7. How is respiration regulated?
8. What is the effect of pCO_2 on oxygen transport?
9. What happens to the respiratory process in a man going up a hill?
10. What is the site of gaseous exchange in an insect?
11. Define oxygen dissociation curve. Can you suggest any reason for its sigmoidal pattern?
12. Have you heard about hypoxia? Try to gather information about it, and discuss with your friends.
13. Distinguish between
 - (a) IRV and ERV
 - (b) Inspiratory capacity and Expiratory capacity.
 - (c) Vital capacity and Total lung capacity.
14. What is Tidal volume? Find out the Tidal volume (approximate value) for a healthy human in an hour.

CHAPTER 18

BODY FLUIDS AND CIRCULATION

18.1 Blood

18.2 Lymph (Tissue Fluid)

18.3 Circulatory Pathways

18.4 Double Circulation

18.5 Regulation of Cardiac Activity

18.6 Disorders of Circulatory System

You have learnt that all living cells have to be provided with nutrients, O₂ and other essential substances. Also, the waste or harmful substances produced, have to be removed continuously for healthy functioning of tissues. It is therefore, essential to have efficient mechanisms for the movement of these substances to the cells and from the cells. Different groups of animals have evolved different methods for this transport. Simple organisms like sponges and coelenterates circulate water from their surroundings through their body cavities to facilitate the cells to exchange these substances. More complex organisms use special fluids within their bodies to transport such materials. **Blood** is the most commonly used body fluid by most of the higher organisms including humans for this purpose. Another body fluid, **lymph**, also helps in the transport of certain substances. In this chapter, you will learn about the composition and properties of blood and lymph (tissue fluid) and the mechanism of circulation of blood is also explained herein.

18.1 BLOOD

Blood is a special connective tissue consisting of a fluid matrix, plasma, and formed elements.

18.1.1 Plasma

Plasma is a straw coloured, viscous fluid constituting nearly 55 per cent of the blood. 90-92 per cent of plasma is water and proteins contribute 6-8 per cent of it. Fibrinogen, globulins and albumins are the major proteins.

Fibrinogens are needed for clotting or coagulation of blood. Globulins primarily are involved in defense mechanisms of the body and the albumins help in osmotic balance. Plasma also contains small amounts of minerals like Na^+ , Ca^{++} , Mg^{++} , HCO_3^- , Cl^- , etc. Glucose, amino acids, lipids, etc., are also present in the plasma as they are always in transit in the body. Factors for coagulation or clotting of blood are also present in the plasma in an inactive form. Plasma without the clotting factors is called serum.

18.1.2 Formed Elements

Erythrocytes, leucocytes and platelets are collectively called formed elements (Figure 18.1) and they constitute nearly 45 per cent of the blood.

Erythrocytes or red blood cells (RBC) are the most abundant of all the cells in blood. A healthy adult man has, on an average, 5 millions to 5.5 millions of RBCs mm^{-3} of blood. RBCs are formed in the red bone marrow in the adults. RBCs are devoid of nucleus in most of the mammals and are biconcave in shape. They have a red coloured, iron containing complex protein called haemoglobin, hence the colour and name of these cells. A healthy individual has 12-16 gms of haemoglobin in every 100 ml of blood. These molecules play a significant role in transport of respiratory gases. RBCs have an average life span of 120 days after which they are destroyed in the spleen (graveyard of RBCs).

Leucocytes are also known as white blood cells (WBC) as they are colourless due to the lack of haemoglobin. They are nucleated and are relatively lesser in number which averages 6000-8000 mm^{-3} of blood. Leucocytes are generally short lived. We have two main categories of WBCs – granulocytes and agranulocytes. Neutrophils, eosinophils and basophils are different types of granulocytes, while lymphocytes and monocytes are the agranulocytes. Neutrophils are the most abundant cells (60-65 per cent) of the total WBCs and basophils are the least (0.5-1 per cent) among them. Neutrophils and monocytes (6-8 per cent) are phagocytic cells which destroy foreign organisms entering the body. Basophils secrete histamine, serotonin, heparin, etc., and are involved in inflammatory reactions. Eosinophils (2-3 per cent) resist infections and are also

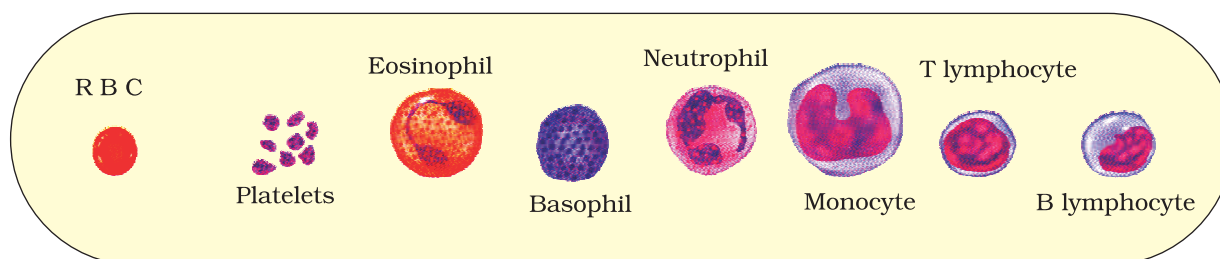


Figure 18.1 Diagrammatic representation of formed elements in blood

associated with allergic reactions. Lymphocytes (20-25 per cent) are of two major types – ‘B’ and ‘T’ forms. Both B and T lymphocytes are responsible for immune responses of the body.

Platelets also called **thrombocytes**, are cell fragments produced from megakaryocytes (special cells in the bone marrow). Blood normally contains 1,50,00-3,50,00 platelets mm^{-3} . Platelets can release a variety of substances most of which are involved in the coagulation or clotting of blood. A reduction in their number can lead to clotting disorders which will lead to excessive loss of blood from the body.

18.1.3 Blood Groups

As you know, blood of human beings differ in certain aspects though it appears to be similar. Various types of grouping of blood has been done. Two such groupings – the ABO and Rh – are widely used all over the world.

18.1.3.1 ABO grouping

ABO grouping is based on the presence or absence of two surface antigens (chemicals that can induce immune response) on the RBCs namely A and B. Similarly, the plasma of different individuals contain two natural antibodies (proteins produced in response to antigens). The distribution of antigens and antibodies in the four groups of blood, **A**, **B**, **AB** and **O** are given in Table 18.1. You probably know that during blood transfusion, any blood cannot be used; the blood of a donor has to be carefully matched with the blood of a recipient before any blood transfusion to avoid severe problems of clumping (destruction of RBC). The donor’s compatibility is also shown in the Table 18.1.

TABLE 18.1 Blood Groups and Donor Compatibility

Blood Group	Antigens on RBCs	Antibodies in Plasma	Donor's Group
A	A	anti-B	A, O
B	B	anti-A	B, O
AB	A, B	nil	AB, A, B, O
O	nil	anti-A, B	O

From the above mentioned table it is evident that group ‘O’ blood can be donated to persons with any other blood group and hence ‘O’ group individuals are called ‘universal donors’. Persons with ‘AB’ group can accept blood from persons with AB as well as the other groups of blood. Therefore, such persons are called ‘universal recipients’.

18.1.3.2 Rh grouping

Another antigen, the Rh antigen similar to one present in Rhesus monkeys (hence Rh), is also observed on the surface of RBCs of majority (nearly 80 per cent) of humans. Such individuals are called **Rh positive** (Rh+ve) and those in whom this antigen is absent are called **Rh negative** (Rh-ve). An Rh-ve person, if exposed to Rh+ve blood, will form specific antibodies against the Rh antigens. Therefore, Rh group should also be matched before transfusions. A special case of Rh incompatibility (mismatching) has been observed between the Rh-ve blood of a pregnant mother with Rh+ve blood of the foetus. Rh antigens of the foetus do not get exposed to the Rh-ve blood of the mother in the first pregnancy as the two bloods are well separated by the placenta. However, during the delivery of the first child, there is a possibility of exposure of the maternal blood to small amounts of the Rh+ve blood from the foetus. In such cases, the mother starts preparing antibodies against Rh antigen in her blood. In case of her subsequent pregnancies, the Rh antibodies from the mother (Rh-ve) can leak into the blood of the foetus (Rh+ve) and destroy the foetal RBCs. This could be fatal to the foetus or could cause severe anaemia and jaundice to the baby. This condition is called *erythroblastosis foetalis*. This can be avoided by administering anti-Rh antibodies to the mother immediately after the delivery of the first child.

18.1.4 Coagulation of Blood

You know that when you cut your finger or hurt yourself, your wound does not continue to bleed for a long time; usually the blood stops flowing after sometime. *Do you know why?* Blood exhibits coagulation or clotting in response to an injury or trauma. This is a mechanism to prevent excessive loss of blood from the body. You would have observed a dark reddish brown scum formed at the site of a cut or an injury over a period of time. It is a clot or coagulam formed mainly of a network of threads called fibrins in which dead and damaged formed elements of blood are trapped. Fibrins are formed by the conversion of inactive fibrinogens in the plasma by the enzyme thrombin. Thrombins, in turn are formed from another inactive substance present in the plasma called prothrombin. An enzyme complex, thrombokinase, is required for the above reaction. This complex is formed by a series of linked enzymic reactions (cascade process) involving a number of factors present in the plasma in an inactive state. An injury or a trauma stimulates the platelets in the blood to release certain factors which activate the mechanism of coagulation. Certain factors released by the tissues at the site of injury also can initiate coagulation. Calcium ions play a very important role in clotting.

18.2 LYMPH (TISSUE FLUID)

As the blood passes through the capillaries in tissues, some water along with many small water soluble substances move out into the spaces between the cells of tissues leaving the larger proteins and most of the formed elements in the blood vessels. This fluid released out is called the interstitial fluid or tissue fluid. It has the same mineral distribution as that in plasma. Exchange of nutrients, gases, etc., between the blood and the cells always occur through this fluid. An elaborate network of vessels called the lymphatic system collects this fluid and drains it back to the major veins. The fluid present in the lymphatic system is called the lymph. Lymph is a colourless fluid containing specialised lymphocytes which are responsible for the immune responses of the body. Lymph is also an important carrier for nutrients, hormones, etc. Fats are absorbed through lymph in the lacteals present in the intestinal villi.

18.3 CIRCULATORY PATHWAYS

The circulatory patterns are of two types – open or closed. **Open circulatory system** is present in arthropods and molluscs in which blood pumped by the heart passes through large vessels into open spaces or body cavities called sinuses. Annelids and chordates have a **closed circulatory system** in which the blood pumped by the heart is always circulated through a closed network of blood vessels. This pattern is considered to be more advantageous as the flow of fluid can be more precisely regulated.

All vertebrates possess a muscular chambered heart. Fishes have a 2-chambered heart with an atrium and a ventricle. Amphibians and the reptiles (except crocodiles) have a 3-chambered heart with two atria and a single ventricle, whereas crocodiles, birds and mammals possess a 4-chambered heart with two atria and two ventricles. In fishes the heart pumps out deoxygenated blood which is oxygenated by the gills and supplied to the body parts from where deoxygenated blood is returned to the heart (single circulation). In amphibians and reptiles, the left atrium receives oxygenated blood from the gills/lungs/skin and the right atrium gets the deoxygenated blood from other body parts. However, they get mixed up in the single ventricle which pumps out mixed blood (incomplete double circulation). In birds and mammals, oxygenated and deoxygenated blood received by the left and right atria respectively passes on to the ventricles of the same sides. The ventricles pump it out without any mixing up, i.e., two separate circulatory pathways are present in these organisms, hence, these animals have double circulation. Let us study the human circulatory system.

18.3.1 Human Circulatory System

Human circulatory system, also called the blood vascular system consists of a muscular chambered heart, a network of closed branching blood vessels and blood, the fluid which is circulated.

Heart, the mesodermally derived organ, is situated in the thoracic cavity, in between the two lungs, slightly tilted to the left. It has the size of a clenched fist. It is protected by a double walled membranous bag, **pericardium**, enclosing the pericardial fluid. Our heart has four chambers, two relatively small upper chambers called **atria** and two larger lower chambers called **ventricles**. A thin, muscular wall called the inter-atrial septum separates the right and the left atria, whereas a thick-walled, the inter-ventricular septum, separates the left and the right ventricles (Figure 18.2). The atrium and the ventricle of the same side are also separated by a thick fibrous tissue called the atrio-ventricular septum. However, each of these septa are provided with an opening through which the two chambers of the same side are connected. The opening between the right atrium and the right ventricle is guarded by a valve formed of three muscular flaps or cusps, the tricuspid valve, whereas a bicuspid or mitral valve guards the opening between the left atrium and the left ventricle. The openings of the right and the left ventricles into the

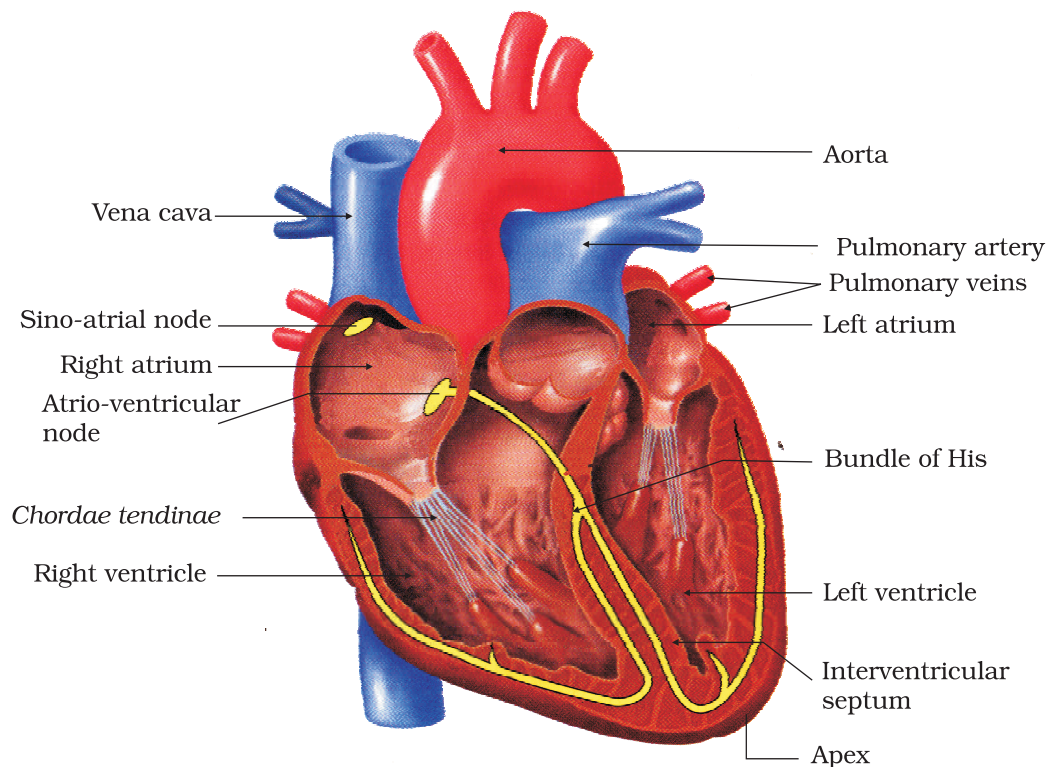


Figure 18.2 Section of a human heart

pulmonary artery and the aorta respectively are provided with the semilunar valves. The valves in the heart allows the flow of blood only in one direction, i.e., from the atria to the ventricles and from the ventricles to the pulmonary artery or aorta. These valves prevent any backward flow.

The entire heart is made of cardiac muscles. The walls of ventricles are much thicker than that of the atria. A specialised cardiac musculature called the nodal tissue is also distributed in the heart (Figure 18.2). A patch of this tissue is present in the right upper corner of the right atrium called the **sino-atrial node** (SAN). Another mass of this tissue is seen in the lower left corner of the right atrium close to the atrio-ventricular septum called the **atrio-ventricular node** (AVN). A bundle of nodal fibres, atrio-ventricular bundle (AV bundle) continues from the AVN which passes through the atrio-ventricular septa to emerge on the top of the inter-ventricular septum and immediately divides into a right and left bundle. These branches give rise to minute fibres throughout the ventricular musculature of the respective sides and are called purkinje fibres. These fibres alongwith right and left bundles are known as bundle of His. The nodal musculature has the ability to generate action potentials without any external stimuli, i.e., it is autoexcitable. However, the number of action potentials that could be generated in a minute vary at different parts of the nodal system. The SAN can generate the maximum number of action potentials, i.e., $70\text{--}75\text{ min}^{-1}$, and is responsible for initiating and maintaining the rhythmic contractile activity of the heart. Therefore, it is called the pacemaker. Our heart normally beats $70\text{--}75$ times in a minute (average 72 beats min^{-1}).

18.3.2 Cardiac Cycle

How does the heart function? Let us take a look. To begin with, all the four chambers of heart are in a relaxed state, i.e., they are in joint diastole. As the tricuspid and bicuspid valves are open, blood from the pulmonary veins and vena cava flows into the left and the right ventricle respectively through the left and right atria. The semilunar valves are closed at this stage. The SAN now generates an action potential which stimulates both the atria to undergo a simultaneous contraction – the atrial systole. This increases the flow of blood into the ventricles by about 30 per cent. The action potential is conducted to the ventricular side by the AVN and AV bundle from where the bundle of His transmits it through the entire ventricular musculature. This causes the ventricular muscles to contract, (ventricular systole), the atria undergoes relaxation (diastole), coinciding with the ventricular systole. Ventricular systole increases the ventricular

pressure causing the closure of tricuspid and bicuspid valves due to attempted backflow of blood into the atria. As the ventricular pressure increases further, the semilunar valves guarding the pulmonary artery (right side) and the aorta (left side) are forced open, allowing the blood in the ventricles to flow through these vessels into the circulatory pathways. The ventricles now relax (ventricular diastole) and the ventricular pressure falls causing the closure of semilunar valves which prevents the backflow of blood into the ventricles. As the ventricular pressure declines further, the tricuspid and bicuspid valves are pushed open by the pressure in the atria exerted by the blood which was being emptied into them by the veins. The blood now once again moves freely to the ventricles. The ventricles and atria are now again in a relaxed (joint diastole) state, as earlier. Soon the SAN generates a new action potential and the events described above are repeated in that sequence and the process continues.

This sequential event in the heart which is cyclically repeated is called the cardiac cycle and it consists of systole and diastole of both the atria and ventricles. As mentioned earlier, the heart beats 72 times per minute, i.e., that many cardiac cycles are performed per minute. From this it could be deduced that the duration of a cardiac cycle is 0.8 seconds. During a cardiac cycle, each ventricle pumps out approximately 70 mL of blood which is called the stroke volume. The stroke volume multiplied by the heart rate (no. of beats per min.) gives the cardiac output. Therefore, the cardiac output can be defined as the volume of blood pumped out by each ventricle per minute and averages 5000 mL or 5 litres in a healthy individual. The body has the ability to alter the stroke volume as well as the heart rate and thereby the cardiac output. For example, the cardiac output of an athlete will be much higher than that of an ordinary man.

During each cardiac cycle two prominent sounds are produced which can be easily heard through a stethoscope. The first heart sound (lub) is associated with the closure of the tricuspid and bicuspid valves whereas the second heart sound (dub) is associated with the closure of the semilunar valves. These sounds are of clinical diagnostic significance.

18.3.3 Electrocardiograph (ECG)

You are probably familiar with this scene from a typical hospital television show: A patient is hooked up to a monitoring machine that shows voltage traces on a screen and makes the sound "... pip... pip... pip..... peeeeeeeeeeeeeeeeeeeee" as the patient goes into cardiac arrest. This type of machine (electro-cardiograph) is used to obtain an electrocardiogram (ECG). ECG is a graphical representation of the electrical activity of the heart during a cardiac cycle. To obtain a standard ECG (as shown in the

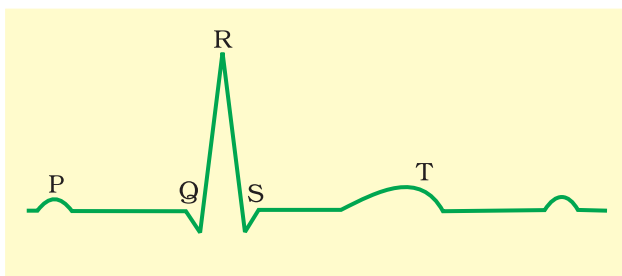


Figure 18.3 Diagrammatic presentation of a standard ECG

Figure 18.3), a patient is connected to the machine with three electrical leads (one to each wrist and to the left ankle) that continuously monitor the heart activity. For a detailed evaluation of the heart's function, multiple leads are attached to the chest region. Here, we will talk only about a standard ECG.

Each peak in the ECG is identified with a letter from P to T that corresponds to a specific electrical activity of the heart.

The P-wave represents the electrical **excitation (or depolarisation) of the atria**, which leads to the contraction of both the atria.

The QRS complex represents the **depolarisation of the ventricles**, which initiates the ventricular contraction. The contraction starts shortly after Q and marks the beginning of the systole.

The T-wave represents the return of the ventricles from excited to normal state (**repolarisation**). The end of the T-wave marks the end of systole.

Obviously, by counting the number of QRS complexes that occur in a given time period, one can determine the heart beat rate of an individual. Since the ECGs obtained from different individuals have roughly the same shape for a given lead configuration, any deviation from this shape indicates a possible abnormality or disease. Hence, it is of a great clinical significance.

18.4 DOUBLE CIRCULATION

As mentioned earlier, the blood pumped by the right ventricle enters the pulmonary artery, whereas the left ventricle pumps blood into the aorta. The deoxygenated blood pumped into the pulmonary artery is passed on to the lungs from where the oxygenated blood is carried by the pulmonary veins into the left atrium. This pathway constitutes the pulmonary circulation. The oxygenated blood entering the aorta is carried by a network of arteries, arterioles and capillaries to the tissues from where the deoxygenated blood is collected by a system of venules, veins and vena cava and emptied into the right atrium. This is the systemic circulation (Figure 18.4). The systemic circulation provides nutrients, O_2 and other essential substances to the tissues and takes CO_2 and other harmful substances away for elimination. A unique vascular connection exists between the digestive tract and liver called hepatic portal system. The hepatic portal vein carries blood from intestine to the liver before it is delivered to the systemic circulation. A special coronary system of blood vessels is present in our body exclusively for the circulation of blood to and from the cardiac musculature.