Key points

- Commercial aircraft have a hypoxic environment, equivalent to an altitude of 2,438 m (8,000 ft) above sea level.
- Normal subjects and the majority of respiratory patients can tolerate this without symptoms. In practice, medical diversions for respiratory problems are very rare.
- The tendency of individual patients to become hypoxic in these conditions cannot be predicted with accuracy from sea-level oxygen saturation or spirometry.
- Hypoxic challenge may be used to simulate the inflight environment, to predict hypoxaemia and to assess the effectiveness of inflight oxygen.
- Most airlines, with adequate warning, can provide oxygen at 2 or 4 litres per minute for respiratory patients.
- While it may be possible to predict hypoxia during flight, there are no means of predicting symptoms or actual risk of harm during air travel.
Problems of air travel for patients with lung disease: clinical criteria and regulations

Educational aims

- To identify the potential problems that patients with chronic respiratory conditions may encounter during air travel.
- To recognise that guidelines have been developed from a number of sources to assist doctors involved in assessing a patient who is considering air travel.
- To make clinicians aware of the different methods of hypoxic challenge that have been developed to help with the clinical assessment of patients.
- To highlight that many patients with chronic lung disease are capable of air travel without developing significant hypoxia, but to raise awareness about which patients are likely to be at risk.
- To discuss the potential difficulties that may arise for the patient when they are arranging inflight oxygen.

Summary

Doctors are frequently asked by patients with chronic lung disease if they are fit to fly. As commercial flights are not pressurised to sea level, there is a reduction in partial pressure of oxygen ($P_{O_2}$), which may result in significant hypoxia in otherwise asymptomatic patients.

A number of different assessment methods have been developed to assess flight fitness and several professional organisations have developed guidelines to help doctors give informed advice.

Patients who become significantly hypoxic during a flight assessment may still be able to travel with supplemental oxygen. However, the provision of supplemental oxygen is dependent on individual airline policy and considerable variations in policy have been recorded.

This review aims to give a brief overview of air travel for patients with lung disease, including physiology, guidelines, assessing fitness to fly and oxygen supplementation.
Air travel is a rapidly expanding mode of travel worldwide. Within the UK, Government forecasts for the increase in passenger numbers at UK airports between 2005 and 2010 range 16-25% [1], and by that analogy many more passengers with respiratory disease will be flying as a result of this increase. One direct consequence of this growth in travel has been that doctors are frequently asked by respiratory patients: "can I fly safely with my lung problems?"

At normal cruising altitudes (9,000-12,500 metres for commercial traffic), most aircraft are designed to maintain a reduced cabin pressure that is equivalent to an altitude of not greater than 2,438 metres (8,000 ft) above sea level (figure 1) [2]. At this altitude, the $P_{O_2}$ is ~14.4 kPa and the inspired fraction of oxygen ($F_{O_2}$) is the equivalent of 15.1% at sea level. Most passengers can tolerate this reduction in $P_{O_2}$ without experiencing any respiratory distress, but patients with chronic respiratory disease may develop hypoxia with or without an exacerbation of their symptoms.

Although the most significant effect of increasing altitude is a reduction in $P_{O_2}$, the reduction in total atmospheric pressure may also affect lung function. Sudden reductions in pressure (hypobaria) during ascent to cruise can result in a temporary increase in the volume of any gas trapped within body cavities as the pressure slowly equalises with the cabin pressure. This may be of significance in patients with either cystic or bullous disease, where the increase in the volume of the trapped gas may have a detrimental effect on lung mechanics by the compression of adjacent healthy tissue.

The prediction of symptoms at altitude is not currently possible, so most studies have focused on attempts to predict hypoxia at altitude, and a number of different assessment protocols have been developed. These protocols either expose patients to the conditions they are likely to encounter during air travel or use sea-level arterial blood gas analysis to estimate altitude $P_{O_2}$. There are advantages and disadvantages to each method.

Fortunately for patients, airline surveys confirm that actual inflight medical emergencies are rare. For example, Delahaye et al. [3] reported the incidence of inflight medical emergencies for one particular North American airline as one incident per 44,212 passengers carried. Of a total of 2,279 medical incidents reported, 251 (11%) were due to some respiratory condition. Only on nine occasions was a flight diverted as a result of a patient suffering an adverse respiratory event. From these data, it can be seen that commercial air travel is a safe proposition for most patients with chronic respiratory disease.

**High-altitude physiology**

The sigmoid shape of the oxygen dissociation curve (figure 2) allows healthy individuals to ascend to moderate altitude (~2,400 metres or 8,000 feet) without any appreciable hypoxaemia. Beyond this altitude, the fall in alveolar $P_{O_2}$ is steep and significant hypoxia will quickly develop. Patients with respiratory disease may have a rightward shift in the oxygen dissociation curve due to chronic respiratory acidosis, which will result in a decreased affinity of haemoglobin for oxygen, increasing the possibility for the development of desaturation.

The normal response to an increase in altitude is an increase in cardiac output and minute volume, which will compensate for the reduced $P_{O_2}$. Passengers with either cardiac or respiratory limitations may experience difficulty in increasing

**Figure 1**
The relationship between altitude, and atmospheric pressure (orange line) and the relative volume of trapped gas (blue line). At normal commercial cruising altitudes (indicated by the shaded box), atmospheric pressure is ~25% of pressure at sea level, which will cause significant expansion of trapped gas. Within the partially pressurised cabin (indicated by the dotted line), the relative increase in gas volume is reduced.

**Figure 2**
An oxygen dissociation curve. In healthy individuals (orange curve), sea-level arterial oxygen tension ($P_{a,O_2}$) is in the region of 13 kPa (solid black line). At 2,438 metres, $P_{a,O_2}$ is ~9.7 kPa, which still gives an $O_2$ saturation of ~92%. Patients with chronic respiratory disease may have a rightward shift of the dissociation curve (blue curve) due to a reduction in arterial pH, placing them at greater risk of desaturation when exposed to a low-oxygen environment.
either of these parameters sufficiently to compensate for the increased altitude, resulting in alveolar and tissue hypoxia. In respiratory patients, desaturation may occur if there is a blunted ventilatory response to hypoxia, either due to chemoreceptor insensitivity, airway obstruction limiting an increase in ventilation or increased shunting in the lungs.

**Existing guidelines**

The current authors are aware of two comprehensive guides, published by the British Thoracic Society (BTS) and the Aerospace Medical Association (AsMA) [4, 5]. These publications aim to provide guidance for physicians who are involved in assessing patients considering commercial air travel. Both publications stress that they are not intended to provide inflexible rules for air travel, but should be used as a guide for advising each patient on an individual basis. The AsMA guidelines do not focus exclusively on respiratory disease, but include other aspects of travel medicine as it relates to air travel.

Some patient care guidelines for specific conditions (notably chronic obstructive pulmonary disease (COPD)) include some advice on patients considering air travel [6, 7].

**Respiratory contraindications to travelling by air**

Absolute contraindications to flight include infectious tuberculosis and unresolved pneumothorax, the latter because air trapped in the pleural space will expand at altitude. Following thoracic surgery, some airlines will accept patients after 2 weeks of recovery, but individual assessment is required.

**Predicting risk of flight in individuals: not a simple task**

Ideally, it would be possible to predict risk of symptoms and of actual medical harm to lung disease patients if they are planning to fly. However, given the rarity of inflight emergencies, coupled with the diagnostic uncertainty about the cause of reported inflight respiratory incidents, it is not currently possible to predict actual risk. Most studies have therefore focused, not unreasonably, on efforts to predict hypoxia as a surrogate for flight-associated risk.

The link between hypoxia and actual clinical risk remains incompletely understood. However, recent work has highlighted mechanisms whereby hypoxia predisposes to a variety of clinical risks. Hypoxia of the magnitude encountered in flight appears to be thrombogenic in those with other risk factors [8], but not in healthy young subjects with no additional risk factors [9]. Pulmonary hypertension is a well-recognised consequence of hypoxia, and the some of the cellular mechanisms are now being elucidated [10]. Chronic hypoxia (even mild levels) has detectable cognitive effects on children [11] and acute hypoxia at altitude affects the mental functioning of adult aircrew [12], even at altitudes <10,000 feet [13]. Thus it is not unreasonable to use hypoxia as a surrogate for clinical risk even though the individual risk of adverse effects from hypoxia remains uncertain.

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**Hypoxic challenge: a suggested protocol**

The protocol described below has been used by the authors for a number of years and appears to be well tolerated by all patients. An interpretation algorithm of the results of hypoxia inhalation test carried out using this protocol can be found in [20].

1. Prepare the patient’s earlobe by rubbing with a topical vasodilator cream.
2. Attach a pulse oximeter ear probe to the patient, and record resting $S\text{a}O_2$ and heart rate every 30 seconds for 5 minutes with the patient breathing room air.
3. Fit the patient with nasal cannulae, which are connected to a supply of 100% O$_2$. The cannulae are used to deliver supplemental O$_2$, if required.
4. Place a 40% Venturi mask over the patient’s face, ensuring a good fit. The Venturi mask is supplied with 100% nitrogen at a flow of 10 litres per minute, which lowers the patient’s F$I\text{O}_2$ to 15.1%.
5. Record $S\text{a}O_2$ and heart rate every 30 seconds for 20 minutes.
6. Patients on long-term oxygen therapy can be assessed using the same protocol, but with the patient receiving supplemental oxygen by nasal cannulae at a flow of 2 litres per minute during HIT.
Methods of predicting hypoxia

In order to assess a patient's risk of hypoxia, a number of different assessment protocols have been developed.

The easiest method is for the patient to breathe a hypoxic gas mixture (commonly referred to as a hypoxic challenge; see box on page 143), which will replicate the $P_{O_2}$ experienced in a pressurised commercial airliner. Ideally, the sea level $F_{I,O_2}$ should be 15.1%, as this replicates the $P_{O_2}$ at 2,438 metres (8,000 feet). Most planes actually have a simulated cabin altitude lower than this figure (~2,000 metres), but it is prudent to assess a patient for the "worst case" scenario. If cabin altitude rises above 2,438 metres, emergency oxygen delivery systems are designed to deploy automatically.

Hypoxic challenge can be carried out using a specially prepared gas mixture either from a gas cylinder or by utilising a Douglas bag, which acts as a reservoir for the hypoxic gas mixture that a patient breathes from using a non-rebreathing valve [14]. A simplification of the hypoxic inhalation challenge method was described by VOHRA and KLOCKE [15] who used a 40% venturi-type oxygen mask driven by 100% $N_2$, which lowers the $F_{I,O_2}$ to 15.1%. This method has the advantage that very little specialist equipment is required to perform the challenge, and this method is being used in a number of respiratory function laboratories within the UK.

Hypobaric chambers have been used for research purposes [16], but they are not common and the current authors are not aware of any chambers that are used for the routine clinical assessment of patients considering commercial air travel. Hypobaric chambers have a theoretical advantage over a hypoxic inhalation challenge, because they will also reproduce the reduction in atmospheric pressure likely to be experienced during the flight, which may affect distribution of ventilation. Hypobaric chambers have the disadvantage of being bulky and cumbersome, and many patients find being in them a claustrophobic experience.

DILLARD et al. [17] compared the results of hypoxic inhalation challenges with hypobaric chamber exposure and found no significant differences between the methods, both in healthy individuals and in patients with stable COPD.

CRAMER et al. [18] used a modified body plethysmograph as an exposure chamber, a method that has the advantage of eliminating the need for the patient to breathe through a mask, which some patients find uncomfortable or inhibiting. The $F_{I,O_2}$ within the exposure chamber needs to be closely monitored to ensure that it remains within the desired range.

GONG et al. [14] developed a hypoxia-altitude simulation test, which involved the patient breathing a series of hypoxic gas mixtures with arterial blood gas analysis after patients had reached a steady state at each level of hypoxia. From their data, a nomogram was produced, which allowed the estimation of $P_{a,O_2}$ at altitude from sea-level $P_{a,O_2}$.

DILLARD et al. [16] studied patients with stable COPD in a hypobaric chamber and found that including forced expiratory volume in one second (FEV1) as a percentage of the predicted value improved the accuracy of the prediction equation they had developed. The same author also carried out a meta-analysis of available published data in 1993, which confirmed the need to include measurements of FEV1 and ground-level $P_{a,O_2}$ in prediction equations when assessing patients with stable COPD [19].

Most of the studies described above have used arterial blood gas analysis to directly measure $P_{a,O_2}$ and thus directly determine the degree of hypoxia. Although arterial blood gas analysis remains the gold standard against which all other methods must be assessed, it is an invasive procedure, which can be uncomfortable for the patient, and is prone to measurement error unless samples are analysed immediately after collection. Measurement of oxygen saturation using a pulse oximeter is a simple, noninvasive method of assessing a
patient’s oxygenation, which can be used as a surrogate for arterial blood gas measurement. It should be stressed that, in some patients, measurement of arterial blood gas tensions will still need to be carried out when the results of $O_2$ saturation are unclear. Several studies of assessment of fitness to fly have been published, which utilise only measurements of $O_2$ saturation rather than arterial blood gas analysis [15, 17, 20].

Although the prediction equations described above will predict hypoxia in groups of patients, their accuracy in individual patients has been questioned. For example, Christensen et al. [21] found that, despite adequate sea-level $P_02$, significant hypoxia occurred in simulated flight in one out of three patients at rest and two out of three during light exercise. These and other data support the view that the most precise way to predict hypoxia in individuals is by hypoxic challenge of the individual patient.

Are long flights more hazardous? Most hypoxic challenges used for the clinical assessment of a patient’s fitness to fly are of 20–30 minutes’ duration. The assumption has always been made that this is a sufficient time for any physiological changes to have taken place. Aker et al. [22] investigated hypoxia in a group of patients with COPD during a 6-hour commercial flight, and found that there was an initial fall in $P_aO_2$ once the flight had reached cruising altitude, which was maintained throughout the flight. Fischer et al. [23] have studied hypoxia in patients with cystic fibrosis at low altitude (530 metres) and after 7 hours at high altitude (2,650 metres). In this study, patients were hypoxic at altitude, but there was no trend to worsening with time and few reported any additional symptoms. Once again, there were no robust individual predictors of hypoxia.

Most published data have been concerned with investigating the response of patients with COPD. This is perhaps understandable as COPD is probably the most common relevant condition amongst airline passengers, although research in other patient groups has been published as well. Oakes et al. [24] have assessed flight fitness in children with cystic fibrosis and found the hypoxic challenge to be a good predictor of which patients were at risk of significant desaturation during flight. Christensen et al. [25] have studied patients with restrictive lung disease, from a variety of different causes, in a hypobaric chamber and have demonstrated that these patients may become hypoxic when exposed to 2,438 metres of simulated altitude.

### Oxygen supplementation during air travel

Most of the studies described above have not only used hypoxic challenge or hypobaric chamber exposure to investigate the development of hypoxia, but have also explored the use of oxygen supplementation to reverse the hypoxia induced. In most cases, the use of supplemental oxygen at low flow rates (2–4 litres per minute) has proved effective in restoring $P_aO_2$ to ground-level values.

The BTS guidelines suggest that those with a resting sea-level $O_2$ saturation >95% will be able to fly without the risk of developing significant hypoxia. The BTS guidelines also recommend that anybody with a sea-level $O_2$ saturation <92% should not fly without supplemental $O_2$. Patients already receiving supplemental $O_2$ (i.e. patients on long-term oxygen therapy) should have their usual flow rate increased by 2 litres per minute for the duration of the flight to compensate for the reduction in $P_aO_2$.

In the current authors’ experience of 157 patients undergoing assessment for flight fitness, it was found that those with a resting $O_2$ saturation >95% are unlikely to show significant desaturation (<90%) during hypoxic challenge (unpublished data, figure 3). These data come from patients with a number of different chronic respiratory conditions (mainly COPD, but including some with pulmonary fibrosis, cystic fibrosis and bronchiectasis) and reinforce the BTS criteria. For patients with a starting saturation of ≤95%, desaturation during hypoxic challenge cannot be predicted from the starting saturation nor from FEV1 (either as an absolute value or as a percentage).

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**Educational questions**

1. How does the oxygen dissociation curve allow healthy individuals to ascend to a moderate altitude without developing significant hypoxaemia?
2. What $P_aO_2$ should be used for hypoxic challenge?
3. Are patients on long-term oxygen therapy able to travel on commercial flights?

**Figure 3**

The percentage of patients maintaining oxygen saturation >90% during hypoxic challenge, broken down by sea-level oxygen saturation.
### REVIEW

#### Problems of air travel for patients with lung disease

Air travel is a popular mode of transportation for both medical and non-medical reasons. However, for patients with lung disease, the high-altitude environment of aircraft can pose unique challenges. This review will discuss the issues related to air travel and the measures taken by airlines to accommodate passengers with special needs.

### Suggested further reading

- A good review of the problems associated with air travel.

#### Travel for technology-dependent patients

Patients with a need for either intermittent or permanent ventilation may also consult doctors about the possibility of air travel. The easiest group to manage are patients with obstructive sleep apnoea requiring treatment with continuous positive airway pressure (CPAP). No problems are anticipated on short-haul flights during the daytime, but difficulties may be encountered on long-haul flights where the patient may need to use CPAP. Patients will need to contact their chosen airline in advance to confirm that they will be able to use their device whilst on the plane, and may require a letter from their doctor outlining the need for the equipment in order to pass through airport security points.

For patients requiring other forms of non-invasive ventilation, a doctor’s letter is normally required outlining the need for the equipment and should include a brief medical history and a note of the correct ventilator settings. Patients will need to contact their airline in advance to ensure that an electrical supply for the ventilator will be available and some form of battery backup should also be taken in case of a failure in the electrical supply. Batteries should be sealed and of dry or gel cell type, as wet lead acid batteries are not permitted. They should be small enough to fit under the seat.

### Conclusion

In response to the wishes of patients with lung disease undertaking air travel, doctors are faced with the complex challenge of assessing risk and the need for the provision of supplemental oxygen. Some progress has been made in the methods used to predict hypoxia, but the harder question of how to predict which patients will need assistance is still being addressed.
develop symptoms or come to actual harm through hypoxia during flight requires further study. Fortunately for patients, it is clear from recent experience that air travel is safe for the great majority of passengers and, with adequate planning for the provision of inflight oxygen, even more can now safely enjoy the benefits of air travel.

References