

pulse oximetry first since it is a noninvasive office procedure. If resting or, more likely, exercise hypoxemia occurs ($SAO_2 < 90\%$), further evaluation is indicated. If the results of oximetry are equivocal (*i.e.*, O_2 saturation 90% to 94%, or $<3\%$ decline in SAO_2 from rest or previous baseline measurements) or felt to be inconsistent with clinical assessment, arterial blood gas values and DLCO could then be determined to confirm or clarify the oximetry results.

If the results of spirometry, DLCO, and oximetry all fail to show any significant changes from baseline, focal or extrapulmonary disease may still be present and additional studies, particularly chest radiography, may also be indicated. The frequency of repeat studies is dictated by the severity of the disease.

The value of spirometry, DLCO, and exercise oximetry done at regular intervals in the severely immunosuppressed patient, even without changes in respiratory symptoms, in order to detect disease before symptoms develop is a question currently under prospective study in the AIDS and other immunosuppressed populations.

Glossary

A-a O_2	Alveolar-arterial oxygen difference
DLCO	Diffusing capacity
Dm	Alveolocapillary membrane
FEV ₁	Forced expiratory volume in one second
F O_2	Fraction of inspired oxygen (%)
FVC	Forced vital capacity
PA-a O_2	Partial pressure of alveolar arterial oxygen difference
PACO ₂	Partial pressure of alveolar carbon dioxide (mmHg)
Paco ₂	Partial pressure of arterial carbon dioxide (mmHg)
PaO ₂	Partial pressure of arterial oxygen (mmHg)
PFT	Pulmonary function tests
RQ	Respiratory quotient
RV	Residual volume
SaO ₂	Oxygen saturation
SVC	Slow vital capacity
TLC	Total lung capacity
V _A	Alveolar volume
VC	Vital capacity
V _c	Capillary bed
VCO ₂	CO ₂ production
V _D	Wasted ventilation
V _{O₂}	Oxygen consumption

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