American Red Cross Scientific Advisory Council

American Red Cross Scientific Advisory Council
Scientific Review
Voluntary Hyperventilation Preceding Underwater Swimming

Questions to be addressed:

Does the evidence available on voluntary hyperventilation preceding underwater swimming support the conclusion that over breathing can lead to a sudden loss of consciousness with or without exercise, and therefore must be prohibited at aquatic facilities?

Introduction/Overview:

Grimaldi J. (1993) notes that over breathing or hyperventilation is breathing at rate and depth higher than necessary to meet the metabolic needs of the body. Despite the incontrovertible neurophysiology findings that hyperventilation prior to underwater swimming can lead to a sudden loss of consciousness and death due to decreased carbon dioxide level, and has been identified as a contributing factor to drowning. This dangerous practice is still used in varying degrees by swimmers at aquatic facilities.

Search Strategy and Literature Search Performed

A National Library of Medicine, MEDLINE, PubMed and PsychInfo database search was conducted for the period of 1905 to 2007. Medline searched using the terms (1) the MeSH headings Search headings included combinations of the terms: exercise and hypercapnia; voluntary overbreathing; hyperventilation and hypercapnia; hyperventilation and breath holding; hyperventilation and decreased cerebral function; hyperventilation and underwater swimming; hyperventilation and loss of consciousness; hyperventilation preceding breath holding and unconsciousness; physiology of breath hold diving; physiology of underwater swimming, cardio-respiratory functions and breath hold diving; hyperventilation, breath holding, exercise, and unconsciousness; hypoxia and loss of consciousness; peripheral vasoconstriction reduced cardiac output and bradycardia; bradycardia and breath holding; oxygen apnea

This search yielded 1,789 citations. Journal references were obtained and articles consistent with the research questions were reviewed. Additional articles were identified from references cited in the selected articles "hyperventilation" AND 'breath holding' AND 'loss of consciousness' (2) MeSH headings 'hyperventilation" AND 'respiration' (3) "overbreathing" as a text word, and then hand searched all articles including review articles was conducted. There were 262 abstracts reviewed and 46 papers obtained and reviewed plus papers identified by the hand searches.

Additional Medline search using "hyperventilation only" (textword); 400 titles were screened and 49 articles reviewed and references hand searched. Cochrane Database of Systematic Reviews searched using terms "hyperventilation," "overbreathing" and "underwater swimming" each separately, yielding 4,370 and 12 results.

2021 Review Process and Literature Search of Evidence Since Last Approval Performed
Describe process (key words, databases, numbers of articles excluded and included, date range search which should be a minimum of current date through one year before last revision was approved) to determine if any new evidence available since last approval.

Dates: 2007-2020
Inclusion: English language
Search headings: voluntary over breathing; hyperventilation and breath holding; hyperventilation and underwater swimming; hyperventilation and loss of consciousness;
hyperventilation preceding breath holding and unconsciousness; bradycardia and breath holding; oxygen apnea; hyperventilation, breath holding, exercise, and unconsciousness; hypoxia and loss of consciousness; breath holding and snorkeling; hyperventilation and snorkeling; shallow water blackout

The literature review yielded **759** unique articles for review of which **29** were examined for relevance. Of these, **8** were eliminated as having no full text available or not in English while **12** were eliminated as not applicable. The final count of articles included in this triennial review were **9** of the **29**.

Exclusion criteria: Full text not available, primary language of article not in English, not applicable to scope of review

Scientific Foundation:
The principal function of the respiratory system is to extract oxygen (O_2) from the air that enters the lungs, transport it to the body tissues, and evacuate excess carbon dioxide (CO_2) and water vapor. Neurophysiological control of breathing originates in the respiratory centers located in the brain stem, the pons, and the medulla oblongata. The limbic system and the pre-frontal cortex also regulate breathing.

The medulla oblongata is responsible for the involuntary autonomic nervous system regulatory processes of heart rate, breathing, and blood pressure. The axons in the medulla oblongata transmit signals based on the information received from the respiratory system. The carbon dioxide level, rather than the oxygen level, is the major stimulus for inspiration. The medulla oblongata sensors make certain that an increase in carbon dioxide level beyond normal limits triggers the urge to breathe before decreased oxygen levels leading to hypoxia occur.

The medulla oblongata activates respiratory reflex loops if the concentration of carbon dioxide exceeds normal limits. The increase of carbon dioxide (CO_2) levels and the acidity (H+) bloodstream levels are the primary stimuli for the inspiratory phase of respirations. The necessary amount of oxygen is then inhaled and the level of CO_2 is monitored during expiration to prevent red blood cell respiratory acidosis. Maintaining the proper level of CO_2 exhalation prevents the excessive buildup of either carbonic acid or hydrogen ions thus maintaining the appropriate acid -- base balance crucial to all metabolic processes.

There are two major physiological sensors for detecting oxygen and carbon dioxide levels. Oxygen sensors detect low arterial oxygen (PO_2) concentration. The oxygen level indicator is a weak signal and is easily suppressed especially during competition. Neurons in the solitary nucleus of the brain stem constantly sample the blood in the brain for CO_2 levels. The CO_2 sensors respond to rising carbon dioxide levels which trigger the urge to breathe. This process insures that arterial blood oxygen is adequate to provide the brain with sufficient oxygen to maintain consciousness and not drop below levels incompatible with higher level cerebral functioning.

During voluntary or involuntary hyperventilation excessive carbon dioxide exhalation occurs. This over breathing results in hypocapnia (low levels of carbon dioxide) and respiratory alkalosis (acid – base imbalance). Woodson (1979) found that insufficient CO_2 changes the pH level towards alkalosis and inhibits the functioning of the breathing centers in the brain. Laffey & Kavavagh (2002) reported hyperventilation induced hypocapnia causes vasoconstriction, increases blood pressure, constricts the cerebral and peripheral arteries, reduces the blood flow to the brain, and the capacity of hemoglobin to bind and release oxygen. Inadequate CO_2 reaction with the red blood cells leads to lower production of carbonic acid/hydrogen ions. Respiratory alkalosis (pH level higher than normal) caused by respiratory over breathing lowers the body's CO_2 level significantly below their normal range causing dizziness and unconsciousness.

Hyperventilation lowers the CO_2 levels without increasing arterial oxygen level (PO_2) above the level necessary to maintain consciousness. Fried and Grimaldi (1993) indicated that low CO_2 pressure causes constriction of the blood vessels that supply the brain, tremors, decreased brain blood flow, and lightheadedness. Ley (1987) noted that double vision, vertigo, epileptic like seizures, EEG and EKG changes, coldness of arms and legs, and irritability can occur during hyperventilation. Siesjo, Berntman & Rehncrona (1979) indicate vasoconstriction of peripheral vessels, and the decreased ability to concentrate may occur during overbreathing. A reduction in alveolar CO_2 pressure reduces the diameter of the small pulmonary arteries thereby further restricting the blood flow to body tissues. The increased blood pH reduces the amount of oxygen in the blood delivered to the body's cells. Concurrently, the heart must pump blood with greater force and frequency to compensate for the decrease in alveolar CO_2 pressure and the increase in the pH level.

2021 Updated Scientific Foundation:

No significant new scientific updates were identified; however, Joulia et al. (2013) and Immink et al. (2014) similarly found that plasma adenosine release is associated with bradycardia and transient loss of consciousness in experimental breath hold diving. In this study, high adenosine plasma concentrations were associated with transient loss of consciousness due to bradycardia and/or vasodilatation. In this study, 11 participants had an episode of transient loss of consciousness (T-LOC) in the preceding two years, while 9 participants did not. Divers in the T-LOC group had higher baseline levels of adenosine and the baseline heart rate was also lower in the T-LOC group and found to have a larger decrease in HR compared to the non-TLOC group. Boyd et al. (2015) reviewed cases of drowning for the prevalence of hyperventilation-caused hypoxic blackout in New York State from 1988-2011 after a double-drowning incident in 2011.

Overview of Recommendation:

Proper breathing regulates body chemistry by providing appropriate levels of carbon dioxide based on the metabolic and other physiological requirements dictated by activities and personal factors.

Voluntary hyperventilation deregulates breathing chemistry and brings about a carbon dioxide deficit in the blood through rapid and deep over breathing. The shift in the CO_2 chemistry associated with over breathing causes physiological changes such as hypoxia, cerebral constriction, coronary constriction, blood and cellular alkalosis, cerebral glucose deficit, ischemia, buffer depletion, bronchial constriction, calcium imbalance, magnesium deficiency, muscle spasms, and fatigue. When a person hyperventilates and then swims underwater, the oxygen level in the blood drops below the point needed to maintain higher cerebral functioning. The person will then become unconscious before the CO_2 level raises to the level that triggers the urge to breathe. Drowning then occurs if the person is not rescued.

2021 Updated Overview of Recommendation:

Breath hold diving can result in peripheral vasoconstriction, bradycardia, decreased cardiac output, increased cerebral blood flow as well as myocardial flow and splenic contraction. In addition to the physiological effects seen, glossopharyngeal insufflation to increase lung volume and oxygen stores can result in decreased venous return and subsequent cardiac effects including blackout.

Specific Recommendations and Strength

Standards: Voluntary hyperventilation prior to underwater swimming and underwater breath holding is a dangerous activity. Swimmers should not engage in hyperventilation prior to either underwater swimming or extended breath-holding. Aquatic managers, lifeguards, and swim instructors should prohibit all persons from hyperventilating prior to underwater swimming and breath holding activities. All aquatic facilities should have a policy of actively prohibiting hyperventilation and underwater swimming and breath-holding contests.

Guidelines: None

Options: None

Summary of Key Articles/Literature Found and Level of Evidence/Bibliography:

Author(s)	Full Citation	Summary of Article (provide a brief summary of what the article adds to	Level of Evidence (Using table below)
Schneeberger J, Murray W.B, Mouton W.L, Stewart R. I. (1986)	Breath holding in divers and non-divers--a reappraisal. *South African Medical Journal. 21;69(13):822-834*	The two phases of breath holding, the voluntary inactive and involuntary active phases, were identified by non-invasive methods using the induction plethysmograph. Eight trained divers and 7 non-diving control subjects familiar with respiratory apparatus were studied. During breath holding from normocapnia and total lung capacity it was not possible to distinguish between the two groups in respect of the pattern or duration of breath holding or alveolar gas tensions at the breakpoint. Divers could, however, hold their breath much longer after hyperventilation (165 +/- 40.0 and 121 +/- 31.4 seconds; P less than 0.01). This was associated with a longer second phase than occurred in non-divers (78.0 +/- 29.7 and 17.6 +/- 13.1 seconds; P less than 0.01) and more severe alveolar hypoxia (percentage oxygen 7.6 +/- 1.8 and 10.9 +/- 1.7%; P less than 0.01). It is concluded that these divers had a hyperventilation-dependent attenuated hypoxic ventilatory response. Subjects could also be identified who have either a very short (less than 10 seconds) or very long (greater than 45 seconds) second phase. They were considered to be at risk of developing underwater hypoxia and unexpected loss of consciousness. It is further suggested that analysis of the phases of breath holding holds promise as a screening test of both novice and experienced divers.	2a
Landsberg P.G. (1975)	Bradycardia during human diving. *South African Medical Journal;49(15):626-30*	The bradycardial response to the diving reflex, which occurs in man and in diving animals, is thought to be a physiologically protective oxygen-conserving mechanism whereby the animal is kept alive during submergence. The physiology and nervous pathways are not yet fully understood, but several investigators have pointed out the potentially fatal outcome of an accentuated diving reflex. The CO_2 content of the peripheral venous blood has been proved variable and unpredictable during the hyperventilation-breath-hold dive cycle in man. A group of 8 male divers (average age 34 years) was investigated during breath hold dives to 3.3 m in a swimming pool. Heart rates were recorded and compared at various stages during breath-hold and SCUBA (self-contained	2a

		underwater breathing apparatus) dives, viz. when resting on the surface, breath holding, hyperventilating and swimming underwater. Two divers performed extreme breath hold endurance tests lasting 135 seconds underwater. All divers had a tachycardia after hyperventilation and a bradycardia after breath hold diving, lasting 80-100 seconds. Extra asystoles were recorded during some of the breath hold dives. Prolonged submergence caused extreme bradycardia (24/min) with central cyanosis. Bradycardia during diving may be a physiological conserving reflex or the start of a pathophysiological asphyxial response.	
Craig, A.B. (1961)	Causes of loss of consciousness during underwater swimming. *Journal of Applied Physiology,16,583-586*	Four types of breath holding were executed; a) at rest, b) after hyperventilation, c) during mild exercise, and d) after hyperventilation and during exercise. At the breaking point the subject made maximal expiration, and the end title air was analyzed for O_2 and CO_2. It was found that when the breaking point was reached, the PCO_2 was higher and the PO_2 lower during exercise than at rest. The lowest PO_2 was observed after the subject had exercised following hyperventilation; the PO_2 was 34 mm or below in four of the 12 subjects, a degree of hypoxia often associated with unconsciousness. Other experiments including underwater swimming support the conclusion that the loss of consciousness after hyperventilation and during exercise is possible and is probably due to hypoxia.	2a
Fink, B. R. (1961)	Influence of cerebral activity in wakefulness on regulation of breathing. *Journal of Applied Physiology 16(1):15-20*	13 healthy men, unaware of the objectives of this study, underwent passive or active over ventilation lowering the end expansion carbon dioxide tension to 25 mm Hg or below. At the end of the period of hyperventilation, rhythmic respiration continued uninterrupted at approximately the control frequency. The volume of ventilation was above control during the first minute of recovery and then stabilized at about two thirds of the control volume; it continued at this level for over two minutes during which time the end expiration PCO_2 gradually rose towards the control level. No incidents of periodic breathing occurred. The absence of over ventilatory apnea in the waking condition contrasts with its easy elicitation during general anesthesia. It is concluded that cerebral activity associated with wakefulness is a component of normal respiratory drive and that carbon dioxide acts by augmenting the effects of this component	2a
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American*	Under certain circumstances a person swimming underwater may lose consciousness. Eight incidents here described indicate that hyperventilation before breath holding and exercise may delay the onset of the urge to breath. Before the partial pressure of CO_2 increases significantly, the O_2 may decrease to	5

	Medical Association, 176 (4), 87 -- 90	a degree incompatible with higher level cerebral functioning. In five cases of drowning also reported, this chain of events is likely to have occurred. Discussion of the details suggest that certain preventive steps can be taken without discouraging swimmers from learning to handle themselves underwater.	
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American Medical Association, 176 (4), 87 -- 90*	<u>Report of Cases: Survivors</u> <u>Case 1</u> An excellent swimmer, age 27, set as his goal an underwater swim of over of 200 feet in distance, two laps of the pool. Before beginning he hyperventilated for about two minutes, took a full inspiration, and dove in. After the first few feet, during which he was dizzy, he felt he could have swam underwater "forever." He negotiated the turn and started back before he noted the urge to breathe. As this sensation became more pronounced, he made continuous swallowing movements, a common trick for relief from the pressure of breath holding. The last thing he remembered was passing a ladder which was later measures as 40 feet from the end, or 160 feet from the beginning of the swim. When he reached the end of the pool, he surfaced, regained consciousness, climbed out of the pool, and lay down to rest. His friends, who were following the progress of the swim, noted nothing amiss, and when informed of what the swimmer had experienced they could recall nothing unusual.	5
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American Medical Association, 176 (4), 87 -- 90*	<u>Report of Cases: Survivors</u> <u>Case 2</u> Another good swimmer, age 18, decided to repeat a previous performance he had achieved by swimming underwater for three laps of a 75 foot pool, i.e. 225 feet. He hyperventilated for one minute at which time he was dizzy. A significant urge to breathe was not apparent until the beginning of the third lap, when he reminded himself that his goal was 225 feet. He did not remember swimming most of the third lap. When he reached the end, a fellow student who was specifically watching the swim reported that the subject surfaced but failed to raise his head. He began to cough and gasp, but regained consciousness in two or three breaths after his head was held above the surface. The subject did not recall any after effects other than being slightly tired.	5
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American*	<u>Report of Cases: Survivors</u> <u>Case 3</u> Another boy, age 18, was practicing underwater swimming with mask, fins, and snorkel a short distance offshore. Before one dive he "hyperventilated hard" for	5

	Medical Association, 176 (4), 87 -- 90	about two minutes. Careful questioning failed to reveal that he had not set any time or distance goal on this particular dive nor was he competing against another diver. He went under "… feeling great. I thought I could hold my breath forever." He estimated that he was 5 feet under the surface propelling himself slowly. He did not remember having any urge to breathe before seeing "spots" before his eyes. This was a transient sensation, and his next memory was being on the surface breathing hard. He started to swim for shore, but felt dizzy and exhausted. When he reached shallow water, he tried to stand but was still dizzy and "shaky." He recovered during the next minute or so and had a slight headache for about an hour. Further questioning revealed that he did not call or gasp when he found himself conscious. There was no hint that he has aspirated water. Most interesting was the observation that he could not remember making any decision to surface.	
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American Medical Association, 176 (4), 87 – 90*	<u>Report of Cases: Survivors</u> <u>Case 4</u> A subject related that at the age of 14 he was a participant in an underwater swimming event at a local club. As he was the first to swim, he wished to make a maximal effort. He hyperventilated for "quite a long time," enough to feel dizziness and tingling in the extremities. At the end of the first lap of a 60 foot pool he felt himself "tired." However, after the first turn he recovered and during the second and third lengths he thought that "this was great." The last event he remembered was making the turn at 180 feet and pushing off the wall. He did not recall swimming another three or four strokes only that he regained consciousness while being pulled to the edge of the pool. No artificial resuscitation was necessary.	5
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American Medical Association, 176 (4), 87 – 90*	<u>Report of Cases: Survivors</u> <u>Case 5</u> Several other swimmers had preceded an 18-year-old boy in an event to see how far they could swim underwater. This subject recalls telling a friend that he was going to make two laps of the 60 foot pool and at least complete the second turn. Before starting he made "four or five" maximal expirations and inspirations but did not feel dizzy. He noted the urge to breathe during the middle of the second lap, but "I bit my lip and pumped my lungs." By the latter statement he meant	5

		that he made inspiratory and expiratory efforts against a closed glottis. Within the next few feet he reminded himself that his goal was 120 feet and a turn. As he saw the end of the pool, "things turned dim" his next memory was lying on the edge of the pool with "someone pushing on my back." The person watching the swim reported that nothing seemed to be amiss until the swimmer pushed off from the second turn. He made no further swimming movements but began to sink feet first. He was immediately pulled from the water and regained consciousness after two or three cycles of artificial resuscitation. Although his color was not noted, it was observed that he was flaccid when taken out of the pool. There was no coughing when spontaneous respirations were resumed.	
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American Medical Association, 176 (4), 87 – 90*	<u>Report of Cases: Survivors</u> <u>Case 6</u> A 17-year-old male swimmer had participated in a water polo game about 20 minutes before entering an underwater swimming contest. Before beginning he took 10 or 12 "very deep breaths" and for the first few feet on the water, he felt "very dizzy". He completed the first lap, 75 feet and about half way back "my mind went blank." Spectators said that he continued to swim, completed the second lap, turned, and appeared to surface (about 160 feet). He then began to sink and was immediately pulled out. Artificial resuscitation was carried out for two or three minutes before spontaneous respirations were adequate.	5
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American Medical Association, 176 (4), 87 – 90*	<u>Report of Cases: Survivors</u> <u>Case 7</u> At the conclusion of the lifesaving class the students were asked to swim one length of a 75 foot pool underwater. Most of these college students swam one length and did get out, but one man in a lane at the edge of the pool made the turn and started back. The instructor reached over the edge of the pool with his foot and pushed the swimmer on the back. The swimmer then climbed up, sat on the edge, but did not seem to know "where he was." A short time later the student told the instructor that he did not remember getting out of the pool but only that he had " a wonderful feeling that he could go, go, go," while swimming the length of the pool.	5
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American*	<u>Report of Cases: Survivors</u> <u>Case 8</u> A medical student recounted that he had worked as a lifeguard at a large outdoor pool. A favorite game of a group of 14 to 16-year-olds was to swim underwater.	5

	Medical Association, 176 (4), 87 – 90	The pool was 75 feet wide. They would each do this repeatedly during a swim, and many of them could make the distance without much apparent effort. They routinely hyperventilated before starting. The victim had attempted to swim several times but on this occasion was pulled from the water at a point indicating that he had gone 120 feet. He was found on the bottom but could not have been there more than 30 seconds. When taken from the water he was flaccid, and "very cyanotic." Manual artificial resuscitation was effective in reducing the degree of cyanosis and was continued for five to seven minutes before spontaneous respirations were noted. The subject reported "I don't know what happened," but no further history was obtained	
Craig, A.B. (1961)	Underwater swimming and the loss of consciousness. *The Journal of the American Medical Association, 176 (4), 87 -- 90*	<u>Case 1 Drowning.</u> A young college sophomore who was a good swimmer and was known to be in good condition borrowed his roommates flippers and went to the pool. It was known that the victim intended to swim laps underwater (150 feet). Those of the pool recall that he swam for some time before he presumably attempted the underwater distance. There were only six or seven other people in the pool during this period. The guards suddenly saw the subject on the bottom of the deep end; the maximal time he could've been there was no more than one minute. The body was recovered and back pressure -- arm lift resuscitation was begun immediately. Bloody froth appeared at the mouth with the first positive pressure. Within a minute another instructor began mouth-to-mouth breathing but reported that despite maximal expiratory effort he was unable to move any air. The victim's cyanosis did not decrease. Other efforts were made with a "machine resuscitator" but this merely "chattered." Autopsy revealed the lungs were full of water but there were no contents of the stomach in the airway	5

Level of Evidence	Definitions (See manuscript for full details)
Level 1a	**<u>Experimental and Population based studies</u> -** population based, randomized prospective studies or meta-analyses of multiple higher evidence studies with substantial effects
Level 1b	**<u>Smaller Experimental and Epidemiological studies</u> -** Large non-population based epidemiological studies or randomized prospective studies with smaller or less significant effects
Level 2a	**<u>Prospective Observational Analytical</u>** - Controlled, non-randomized, cohort studies
Level 2b	**<u>Retrospective/Historical Observational Analytical</u>** - non-randomized, cohort or case-control studies
Level 3a	**<u>Large Descriptive studies</u>** – Cross-section, Ecological, Case series, Case reports
Level 3b	**<u>Small Descriptive studies</u>** – Cross-section, Ecological, Case series, Case reports
Level 4	**<u>Animal studies or mechanical model studies</u>**
Level 5	**<u>Peer-reviewed Articles</u>** - state of the art articles, review articles, organizational statements or guidelines, editorials, or consensus statements
Level 6	**<u>Non-peer reviewed published opinions -</u>** such as textbook statements, official organizational publications, guidelines and policy statements which are not peer reviewed and consensus statements
Level 7	**<u>Rational conjecture</u>** (common sense); common practices accepted before evidence-based guidelines
Level 1-6E	**<u>Extrapolations</u>** from existing data collected for other purposes, theoretical analyses which is on-point with question being asked. Modifier E applied because extrapolated but ranked based on type of study.

REFERENCES

Craig, A.B. (1961) Causes of loss of consciousness during underwater swimming. *Journal of Applied Physiology,16,583-586*

Craig, A.B. (1961). Underwater swimming and the loss of consciousness. *The Journal of the American Medical Association, 176 (4), 87 – 90*

Craig, A.B. (1976). Summary of 58 cases of loss of consciousness during underwater swimming and diving**.** *Medicine and Science in Sports.* 8 (3):171-175.

Fersterheim, H, (1994) *Behavioral and psychological approaches to breathing disorders*. (New York: Plenum).

Fink, B. R. (1961). Influence of cerebral activity in wakefulness on regulation of breathing. *Journal of Applied Physiology 16(1):15-20*

Fried, R. and Grimaldi, J. (1993). *The Psychology and Physiology of Breathing*. New York: Plenum Press

Hong , S.K. 1990. Breath-Hold Diving. In: Bove and Davis (ed), *Diving Medicine, 2 ed.*, Philadelphia: Saunders pp 59-68.

Hlastala, M. P. & Berger, A. J. (2001) *Physiology of respiration*: New York: Oxford University Press

Haines, D. E. (2007) *Neuroanatomy: an atlas of structures, sections, and systems*: New York: Lippincott

Laffey, J.G. & Kavavagh, B.P. (2002). Hypocapnia. *New England Journal of Medicine, vol.347,no.1 pp 43 - 53*

Landsberg P.G. (1975). Bradycardia during human diving. *South African Medical Journal; 49(15):626-30*

Ley, B and Timmons, B.H. (1994) ***Behavioral and psychological approaches to breathing disorders*** New York: Plenum

Ley, R. (1987). Panic disorder: a hyperventilation interpretation. In L. Michelson and L.M. Ascher (ed), *Anxiety and stress disorders: cognitive -- behavioral assessment and treatment.* New York: Guilford

Nunn, J.F. (1993) *Applied Respiratory Physiology*; *(4th ed.)* New York: Butterworth-Heinemann Ltd.

Schneeberger J, Murray W.B, Mouton W.L, Stewart R. I. (1986). Breath holding in divers and non-divers--a reappraisal. *South African Medical Journal; 21; 69(13):822-834*

Siesjo, B. K., Berntman, L. & Rehncrona, S. (1979). The effects of hypoxia on blood flow and metabolic flux in the brain. In S. Fahn (ed) *Advances in neurology* Vol. 26. New York: Raven Press

U.S. Navy Dive Manual Revision 6, April 15, 2008, 3-19 – 3-20. SS521-AG-PRO-010:Commander, Naval Sea Systems Command

Woodson, R. D. (1979). Physiological significance of oxygen dissociation curve shifts. *Critical Care Medicine 7:368-373*