Adenosine monophosphate and histamine induced bronchoconstriction: repeatability and protection by terbutaline

E Egbagbe, I D Pavord, P Wilding, J Thompson-Coon, A E Tattersfield

Abstract

**Background** – Inhaled adenosine monophosphate (AMP) is thought to cause bronchoconstriction in asthmatic patients indirectly through mast cell mediator release. It may therefore be a more sensitive marker of airway inflammation in asthma and hence more specific for epidemiological surveys of asthma than challenges that act directly on airway smooth muscle such as histamine. There is some uncertainty as to how repeatable the measurement is and this is important if it is to be used for epidemiological studies.

**Methods** – The response to histamine and AMP challenges and the protection afforded by terbutaline (500 μg) against these two challenges was measured on two occasions two weeks apart in 20 subjects with asthma (19 completed the study). The response to histamine and AMP was measured as the provocative dose of AMP or histamine causing a 20% fall in forced expiratory volume in one second (PD20) and the protection afforded by terbutaline in doubling doses (DD). Repeatability was assessed as the limits of agreement.

**Results** – Although terbutaline had a slightly greater protective effect against AMP than histamine on both the first (APD20 = 2.66 versus 2.11 DD) and second occasion (2.56 and 2.15 DD), the differences were not statistically significant. The limits of agreement for the two histamine and two AMP challenges after placebo were from 3.06 to −3.5 and from 3.78 to −4.54 DD respectively, and these values did not differ significantly. The agreement limits between the first PD20 histamine and PD20 AMP values after placebo were similar, being from 3.73 to −3.72 DD after allowing for the 17.8-fold higher PD20 AMP values for AMP compared with histamine.

**Conclusions** – Terbutaline caused a slightly greater inhibition of the bronchoconstrictor response to AMP than histamine but the differences were small and non-significant. Any differences in repeatability between AMP and histamine challenges are small and in this study were not significant. The fact that the agreement between histamine and AMP PD20 values was similar to the agreement between repeat histamine or repeat AMP PD20 values suggests that, within an asthmatic population, PD20 AMP may not be providing different information from that provided by PD20 histamine.

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Keywords: adenosine monophosphate, histamine, bronchial responsiveness.

Bronchial hyperresponsiveness, an exaggerated airway response to constrictor stimuli, is a key component of asthma. Constrictor stimuli can be divided into those that act predominantly through a direct effect on airway smooth muscle such as histamine and methacholine and those that act indirectly by stimulating neural pathways or release of inflammatory mediators. Adenosine monophosphate (AMP) is thought to cause bronchoconstriction by increasing the release of mediators from mast cells. It may therefore be a more sensitive marker of airway inflammation and hence more specific for asthma. In keeping with this, three studies have shown that β agonists cause greater bronchoprotection against AMP than histamine or methacholine challenge in patients with asthma. The specificity for asthma could be useful for epidemiological studies if the test was repeatable.

In a recent study the response to AMP appeared to be slightly less repeatable than that to histamine. We have therefore compared the repeatability of histamine and AMP challenge and their protection by terbutaline after a two week interval in patients with asthma.

We measured the response to histamine and AMP as the provocative dose of AMP or histamine causing a 20% fall in forced expiratory volume in one second (PD20).

**Methods**

**SUBJECTS**

Twenty subjects aged 22–56 years with stable asthma and no other significant illness were studied. All were current non-smokers and had mild asthma with a forced expiratory volume in one second (FEV1) at least 60% predicted and requiring less than four puffs per day of a short acting inhaled β agonist and/or an inhaled corticosteroid. Twelve subjects were taking an inhaled corticosteroid and all were taking an inhaled β agonist. Nineteen subjects were atopic. Subjects gave written consent to the study which was approved by the Nottingham City Hospital ethics committee.
MEASUREMENTS
FEV₁ was measured with a dry bellows spirometer (Vitalograph, Buckingham, UK) as the higher of two successive readings within 100 ml. The PD₂₀ AMP and histamine were determined using a breath activated dosimeter (MEFAR, Brescia, Italy). The nebuliser was set to nebulise for one second with a pause of six seconds at a pressure of 22 lb/in (152 kPa). Histamine and AMP (Sigma, Poole, Dorset, UK) were dissolved freshly in saline to produce a doubling concentration range of 0.115–118 μM for AMP and 0.021–21 μM for histamine. FEV₁ was measured one minute after each dose. Inhalation was stopped when the FEV₁ had fallen by 20% or more, when subjects had inhaled the highest dose of constrictor agent, or if side effects occurred. The PD₂₀ value was determined by interpolation of histamine and AMP PD₂₀ measurements between the two points on the log dose–response plot. Extrapolation was allowed for one further dose.

PROTOCOL
The study had a placebo controlled crossover design. Subjects taking an inhaled steroid kept the dose constant throughout the study. All studies were carried out at the same time of day and after subjects had withheld β₂ agonist treatment for at least eight hours.

Subjects attended the laboratory on four occasions within a week and after a two week interval on a further four occasions within a week. After resting for 15 minutes they inhaled placebo or terbutaline (500 μg) by dry powder inhaler (Turbohaler) followed 15 minutes later by an inhaled histamine or AMP challenge. All four combinations of placebo and terbutaline with the two challenges were given in random order on the four days before and on the four days after the two week interval. Treatment with placebo and terbutaline was double blind; the nature of the histamine and AMP challenge was known to the investigator but not to the subjects.

The number of subjects studied was based on the study by O’Connor et al in which a difference of 1.1 doubling doses between the two groups was considered significant. Protection afforded by terbutaline on AMP and methacholine in 12 subjects was statistically significant.

ANALYSIS OF DATA
PD₂₀ values for histamine and AMP were log transformed for analysis and geometric mean values are given. Differences in PD₂₀ were measured in doubling doses (DD). The protective effect of terbutaline on histamine and AMP was measured in doubling doses for each subject by calculating

\[
\log \text{PD}_{20} \text{ (terbutaline)} - \log \text{PD}_{20} \text{ (placebo)} / \log 2
\]

and compared by paired t test. The repeatability of histamine and AMP PD₂₀ measurements was assessed as the limits of agreement according to Chinn as the mean (SD) difference in PD₂₀ difference × 1.96 and converted to doubling doses. The limits of agreement for histamine and AMP PD₂₀ were then compared by unpaired t test.

The limits of agreement for the first histamine and first AMP measurement were also computed as above after dividing PD₂₀ AMP values by 17.8 since the mean PD₂₀ AMP was 17.8 times higher on average than the mean PD₂₀ histamine value.

RESULTS
Twenty subjects (nine men) aged 22–56 years were recruited. Nineteen completed all eight studies and one failed to return for the second set of four measurements. The mean initial FEV₁ was 2.62 litres (82% predicted). Details of the patients are presented in table 1.

<table>
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<th>Patient no.</th>
<th>Age</th>
<th>Sex</th>
<th>Atopic status</th>
<th>FEV₁(l)</th>
<th>FEV₁ (% predicted)</th>
<th>Treatment</th>
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<td>6</td>
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<td>F</td>
<td>H</td>
<td>4.50</td>
<td>105</td>
<td>Sb</td>
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</tbody>
</table>

FEV₁ = forced expiratory volume in one second; BDP = beclomethasone dipropionate; Bud = budesonide (dose is total daily dose); Sb = salbutamol as required; Tb = terbutaline as required.

Atopic status describes positive skin prick tests to H = house dust mite, C = cat, G = grass.
Adenosine monophosphate and histamine induced bronchoconstriction

**Figure 1** Difference between the first and second measurements of (A) log PD$_{20}$ AMP and (B) log PD$_{20}$ histamine plotted against the mean PD$_{20}$ measurements in 19 subjects with asthma. The relation between the first PD$_{20}$ AMP and PD$_{20}$ histamine values after placebo are also shown in (C) after the AMP values* have been divided by 17.8 (see text).

**Discussion**

The mechanism underlying the bronchoconstriction caused by inhalation of AMP in patients with asthma is not certain but increased release of mast cell mediators is probably involved. Adenosine and its synthetic analogues such as AMP potentiate IgE dependent release of the preformed mediators histamine and hexosaminidase from rodent and human mast cells in vitro, and drugs that inhibit mast cell activation (sodium cromoglycate and nedocromil sodium) or inhibit the effect of mast cell products (the selective H$_1$ receptor antagonists, terfenadine and astemizole) have been shown to protect against AMP induced bronchoconstriction in both atopic and non-atopic subjects with asthma. Bronchoconstrictor prostanoids such as prostaglandins D$_2$, F$_2\alpha$, and thromboxane A$_2$ may also be involved since indomethacin and lysine acetylsalicylate inhibit adenosine and AMP induced bronchoconstriction in asthmatic subjects. The action of adenosine may also involve neural reflexes since adenosine potentiates the constrictor response to nerve stimulation via an A$_2$-receptor mechanism.
and antimuscarinic drugs have a minor protective effect against adenosine-induced bronchoconstriction in asthma.\(^2\,^3\)

The bronchoconstrictor response to adenosine therefore involves one, or possibly two, pathways which may be abnormally activated in asthma, suggesting that it may be a more specific marker of asthma than bronchoconstrictor challenges such as histamine and methacholine. This could be of value for epidemiological studies where the lack of specificity of histamine and methacholine in distinguishing asthma from other lung diseases limits their value. Using AMP to measure bronchial responsiveness would only be of value if the test was repeatable and this was questioned in a previous study.\(^1\,^0\) The present study shows no significant difference in the repeatability of the response to AMP when compared with that of histamine challenge.

Previous studies have shown that a single dose of terbutaline (500 \(\mu\)g) for chronic treatment with budesonide\(^5\) provides greater protection against bronchoconstriction induced by AMP than that induced by methacholine. This difference has aroused interest since it may reflect drug effects other than airway smooth muscle relaxation such as inhibition of mast cell mediator release by \(\beta\) agonists and an anti-inflammatory effect of inhaled corticosteroids. The protection against histamine induced bronchoconstriction in our study was similar to that seen with the same dose of terbutaline against methacholine challenge by O'Connor et al.,\(^6\) whereas the effect of terbutaline against AMP was less and the difference in protection against the two challenges was not statistically significant. The effect of terbutaline against AMP induced bronchoconstriction may have been underestimated in our study since several subjects had censored PD\(_{20}\) AMP values following terbutaline, although the fact that the difference in the protective effect of terbutaline was not significant in the 10 subjects without a censored value argues against this.

The differences between our findings and those in previous studies could reflect differences in asthma severity, or in the contribution of mast cell mediator release to bronchoconstriction, or in previous treatment. The asthma severity appears to be similar to that in two of the previous studies\(^7\,^9\) since patients had identical mean FEV\(_1\), percentage predicted values (92%) and similar consumption of \(\beta\) agonists (average two puffs per day) before the study. In the third study\(^8\) subjects had a higher FEV\(_1\) and \(\beta\) agonists were replaced with ipratropium for one week before the study. Corticosteroid treatment differed between the studies with 13 patients taking an inhaled corticosteroid in a constant dose in our study compared with none in the studies by O'Connor et al.\(^1\) and five of nine subjects in the study by Phillips et al.\(^2\) We found no difference, however, in the relative protection of terbutaline against AMP and histamine between those taking and those not taking an inhaled corticosteroid. Finally, we have considered whether tachyphylaxis to histamine or AMP may be relevant since this has been seen over several hours following AMP\(^2\) and histamine,\(^2\) though usually in normal subjects or patients with mild asthma. To our knowledge, it has not been seen after 24 hours in patients with asthma. Our studies were carried out at least a day apart as were the studies by O'Connor et al.\(^6\) and as their patients had, if anything, milder asthma, tachyphylaxis would have been more likely. Since we have also been unable to confirm that regular inhaled budesonide results in greater protection against AMP than histamine induced bronchoconstriction,\(^1\) we conclude that any difference in the ability of terbutaline or regular budesonide to provide greater protection against AMP is small in subjects with relatively mild asthma.

The agreement between a single PD\(_{20}\) AMP and PD\(_{20}\) histamine measurement after placebo was similar to the repeatability of AMP and histamine after allowing for the 17.8 times higher mean values for AMP. This suggests that PD\(_{20}\) AMP might not be adding anything further to the information provided by PD\(_{20}\) histamine in patients with asthma and that both are reflecting the same pathophysiological process in the airways. A study in children suggested that PD\(_{20}\) AMP was better able to distinguish asthma from COPD than methacholine.\(^4\) Further studies that include non-asthmatic patients are needed to determine whether PD\(_{20}\) AMP provides greater specificity for asthma in adults in an epidemiological setting.

In conclusion, we have shown reasonable agreement between PD\(_{20}\) AMP and PD\(_{20}\) histamine in 20 patients with asthma and similar repeatability between AMP and histamine PD\(_{20}\) values in these patients. We have been unable to confirm the previous finding of a greater protective effect of terbutaline against AMP compared with a challenge that is not mast cell dependent. These findings suggest that AMP PD\(_{20}\) gives similar information to histamine PD\(_{20}\) in an asthmatic population; further field studies are needed to determine whether it is more specific for asthma in a population of adults containing non-asthmatic patients.

We thank Ms H Tattersall for help with the randomisation of the study and Ms S Lewis for help with the analysis.

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