Repeatability of lung function tests during methacholine challenge in wheezy infants

Christophe Delacourt, Marie-Rose Benoist, Serge Waernessyckle, Patrick Rufin, Jean-Jacques Brouard, Jacques de Blic, Pierre Scheinmann

Abstract

Background—The repeatability of lung function tests and methacholine inhalation tests was evaluated in recurrently wheezy infants over a one month period using the rapid thoracic compression technique.

Methods—Eighty one wheezy, symptom free infants had pairs of methacholine challenge tests performed one month apart. Maximal flow at functional residual capacity (V_maxFRC) and transcutaneous oxygen tension (PtcO_2) were measured at baseline and after methacholine inhalation. Provocative doses of methacholine causing a 15% fall in PtcO_2 (PD15PtcO_2) or a 30% fall in V_maxFRC (PD30V_maxFRC) were determined.

Results—Large changes in V_maxFRC were measured at T1 to T2, with a mean difference between (T2 — T1) of 7 (113) ml/s and a 95% range for a single determination for V_maxFRC of 160 ml/s. The mean (SD) difference between pairs of PD30V_maxFRC measurements was 0.33 (1.89) doubling doses with a 95% range for a single determination of 2.7 doubling doses. Repeatability of PD15PtcO_2 was similar. A change of 3.7 doubling doses of methacholine measured on successive occasions represents a significant change.

Conclusions—Baseline V_maxFRC values are highly variable in wheezy, symptom free infants. Using either V_maxFRC or PtcO_2 as the outcome measure for methacholine challenges provided similar repeatability. A change of more than 3.7 doubling doses of methacholine is required for clinical significance.

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Keywords: bronchiolitis; infantile asthma; bronchial hyperresponsiveness

Infants often exhibit wheezing with acute lower respiratory illness. The relationship between wheezing symptoms in infancy and asthma remains unclear, and most wheezing infants will stop wheezing after three years of age.1 Many authors have tried to relate wheezing illnesses in infants to bronchial hyperresponsiveness by analogy with the association between non-specific bronchial hyperresponsiveness and asthma in older children. However, interpretation of these studies is controversial. In particular, some studies measuring the maximal flow at function residual capacity (V_maxFRC) have reported bronchial hyperresponsiveness as being present in all young infants, especially in those younger than one year of age, independent of the presence of wheezing illnesses.2–4 If true, these findings would make the detection of bronchial hyperresponsiveness less useful as a marker of infantile asthma. However, assuming that bronchial hyperresponsiveness might be inversely proportional to age during childhood,5 it may be possible to characterise asthmatic infants by the persistence of increased bronchial hyperresponsiveness with age. Prospective studies of the natural history of bronchial hyperresponsiveness in wheezing infants are therefore needed. However, the repeatability of both baseline measurements and methacholine inhalation tests in infants over a short period of time needs to be established to allow serial studies of airway hyperreactivity in infants.

Such reproducibility over a one month period has been established for children over six years of age,6 but in infants the reproducibility of lung function tests over time has not been established. Prendiville et al7 reported a high variability in V_maxFRC and histamine challenge results measured in wheezy infants on two occasions one day apart. On the other hand, Stick et al8 demonstrated a coefficient of repeatability of 31.1% for V_maxFRC in healthy infants measured after a one week interval, and an even better repeatability of bronchial challenge. However, the small number of patients tested (n = 10) limit the generalisability of the conclusions of the study. The aim of the present study was to evaluate the reproducibility of lung function and methacholine inhalation tests in wheezing infants over a one month period. Two reliable indices were used to detect airway response: V_maxFRC and transcutaneous oxygen tension (PtcO_2).
Two consecutive tests, one month apart, were performed in 81 of the 102 infants initially included. Two consecutive tests, one month apart, were performed in 81 of the 102 infants initially included.

The study was approved by the local ethical committee and informed consent was obtained from all parents.

**LUNG FUNCTION TESTS**

Infants were sedated with chloral hydrate (75 mg/kg) prior to testing. The maximal partial expiratory flow volume (PEFV) was obtained using the squeeze technique by rapid inflation of a thoracoabdominal jacket at the beginning of expiration (Medical Engineering Department, Royal Postgraduate Medical School, Hammersmith Hospital, London). The jacket was wrapped around the infant's chest and abdomen with the arms extended outside the jacket. The neck was extended to minimise airway or glottic obstruction. All measurements and calculations were obtained using a paediatric mobile Measurement Module (SensorMedics Corporation 2600, Yorba Linda, California, USA) containing the pressure transducers, electronics modules, and 14-bit analogue-to-digital signal converter. Flow was measured at the infant’s mouth via a face mask attached to a 0-30 LPM triple screen pneumotachograph with a flow resolution of 0.06 ml/s, a volume resolution of 0.12 ml, and a volume range of 0-255 ml. A rim of silicone putty was applied around the mouth and nose and to the face mask to provide an airtight seal. Forced expiration was measured as the maximum expiratory flow at functional residual capacity (VmaxFRC) as previously described.9 Briefly, partial forced expiratory manoeuvres were performed after at least 10 consecutive regular tidal breaths demonstrated a stable FRC level. This level was defined as the end expiratory level obtained from the respiratory cycle preceding the forced expiratory manoeuvre. Because experience with our equipment showed that the jacket pressure necessary to obtain maximal flow was usually between 60 and 80 cm H2O, these two pressure levels were used successively. The pressure transmitted from the jacket to the infant was assessed for each infant by an occlusion test and was found to be around 50% of the jacket pressure. Three PEFV curves were measured for each pressure and a mean baseline value was determined from the highest three of the six technically acceptable values obtained. Criteria for an acceptable PEFV curve included a rapid rise in forced expiratory flow so that the peak flow occurred before expiring 50% of the tidal volume, a smooth curve without transients in the region of FRC, and forced expiration after FRC.

The shape of the baseline PEFV curves was described qualitatively for each subject as either convex, straight, or concave.10 Convex curves (convex away from the expiratory flow and volume axes) are more common in normal infants, and concave or straight curves are more common in those with airway disease. As shown in fig 1, it is straightforward to provide a qualitative description for each curve, as previously shown by Clarke et al.11

**TRANSCUTANEOUS OXYGEN TENSION**

PtcO2 was measured with a Roche electrode calibrated at room temperature, then heated to 45°C and placed on the volar side of the forearm. Transcutaneous oxygen tension was continuously recorded on a chart paper. The baseline value was determined after PtcO2 had reached a stable maximum level. A 15–20 minute period was necessary to obtain a stable value in sleeping infants. After methacholine inhalation the lowest PtcO2 value was taken into account.

**METHACHOLINE CHALLENGE**

The aerosol was administered with a dosimeter (MFDC 88, Mediprom, Paris, France) attached to a nebuliser (De Vilbiss 5610 D), the size of the particles generated by the nebuliser being 1.9 µm MMAD. The apparatus was programmed to deliver a dose of 50 µg of methacholine in a volume of 40 ml of air in 0.5 seconds. Under these conditions the duration and volume of each aerosol dose could not exceed the inspiratory time and volume of the infants, so each delivered dose was completely inhaled. The dosimeter was triggered by the inspiratory negative buccal pressure via the facial mask applied on the infant’s face. The infants initially inhaled normal saline. Two minutes later PtcO2 and lung function were measured. This sequence was repeated after data collection with an initial methacholine dose of 50 µg and the methacholine dose was then doubled until PtcO2 decreased by at least 15% from baseline12 or a maximal methacholine dose of 1600 µg was inhaled. The change was taken as the maximum deviation from baseline two minutes after each dose, before any lung function tests were performed. Because the duration of sedation varied between infants and the measurement of lung

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**Table 1** Mean (SD) age, anthropometric data, and lung function test values

<table>
<thead>
<tr>
<th>Infants retested (n=81)</th>
<th>Infants not retested (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (months)</td>
<td>15.6 (6.8) (7.2–26.0)</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>78.6 (6.9) (62.3–100.1)</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>10.4 (1.8) (6.1–17.3)</td>
</tr>
<tr>
<td>VmaxFRC (m/s) First test (T1)</td>
<td>233 (108) (208–327)</td>
</tr>
<tr>
<td>CV % for VmaxFRC</td>
<td>8.3 (3.2)</td>
</tr>
<tr>
<td>VmaxFRC (%) pred</td>
<td>66.5 (29.8)</td>
</tr>
<tr>
<td>PD15 PtcO2 (µg)</td>
<td>233</td>
</tr>
<tr>
<td>PD30 PtcO2 VmaxFRC (%)</td>
<td>213</td>
</tr>
</tbody>
</table>

Two consecutive tests, one month apart, were performed in 81 of the 102 infants initially included.

VmaxFRC = maximal flow at functional residual capacity; CV = coefficient of variation; PD15 PtcO2 = mean provocative methacholine dose for PtcO2 (geometric mean); PD30 PtcO2 VmaxFRC = mean provocative methacholine dose for VmaxFRC (geometric mean).

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**Figure 1** Qualitative description of the shapes of forced expiratory flow-volume curves obtained in wheezy infants: convex, straight and concave curves.
Methacholine challenges in wheezy infants

function tests after each dose of methacholine was time consuming, we determined VmaxFRC only after each dose where PtcO2 changed by more than 5%. A positive response was defined as a fall in mean VmaxFRC of 30% or more from baseline.

The provocative dose causing a 15% fall in PtcO2 (PD15PtcO2) or a 30% fall in VmaxFRC (PD30VmaxFRC) was derived from the plot of log dose methacholine versus PtcO2 or VmaxFRC by linear interpolation between the last two points on the semilogarithmic dose-response graph.

**DATA ANALYSIS**

All data are expressed as mean (SD). Individual coefficient of variation at baseline was calculated as SD/mean of the three best measurements (%).

To compare VmaxFRC values in the wheezy infants with those obtained from normal non-wheezy infants, the data published by Hanrahan et al.13 were used as control VmaxFRC values. Indeed, Hanrahan and colleagues are the only group to have reported results from a series of normal infants, over eight months of age and the linear relationship observed between length and VmaxFRC (flow at FRC (ml/s) = 9.67 × body length (cm)—399.8) seems therefore appropriate for use in our study population. Furthermore, the methodology used by Hanrahan and colleagues was consistent with ours and, in particular, they used similar sedation and identical jacket pressure. The VmaxFRC values obtained in our patients were expressed as absolute values and as a percentage of the control value.

The repeatability of baseline parameters and of the methacholine challenge was assessed using methods recommended by Chinn.14 Means of data obtained on the two tests were first compared by a paired t test to ensure that there was no overall bias between the two sets of measurements. The 95% range for a single determination was then converted into units of doubling doses by dividing it by log10(2) (=0.301). As stated by Chinn,14 this range may be interpreted as the limits around a single measurement that should be regarded as possible values for the true measurement.

Agreement between evaluation of methacholine challenge by PD15PtcO2 or PD30VmaxFRC was determined on the first test using the methods of Bland and Altman.15 A paired t test was first performed to compare the means of the two sets of data. The difference between PD15PtcO2 and PD30VmaxFRC log values for each subject were then calculated and plotted against their mean result. The limits of agreement were estimated by Δ ± 2s, where Δ was the mean difference between PD15PtcO2 and PD30VmaxFRC and s was the standard deviation.

**Results**

One hundred and two infants were recruited and underwent a first test (T1). A second test (T2) was performed in 81 of the 102 infants. Twenty one did not have a second lung function test: four vomited chloral hydrate so the lung function test was precluded, four woke during the measurements, three did not sleep function tests after each dose of methacholine was time consuming, we determined VmaxFRC only after each dose where PtcO2 changed by more than 5%. A positive response was defined as a fall in mean VmaxFRC of 30% or more from baseline.

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in spite of 100 mg/kg chloral hydrate, and in 10 cases the parents refused the second test. There were no significant differences between the 81 who remained in the study and the 21 who withdrew in terms of anthropometric data and baseline V_{maxFRC}, as reported table 1. All data are calculated only for the group of infants performing both tests (n = 81).

BASELINE LUNG FUNCTION TESTS

Baseline lung function values obtained at T1 and T2 are reported in table 1. When expressed as a percentage of the control values 59% and 75% of the theoretical values at T1 and T2, respectively. The shape of the PEFV curves was convex in 35 infants and concave or straight in 46 infants. V_{maxFRC} values were clearly related to the shape of the PEFV curves; 88% of infants with V_{maxFRC} values below 75% of theoretical values had straight or concave PEFV curves whereas 90% of infants with V_{maxFRC} values greater than or equal to 75% had convex PEFV curves. The individual coefficient of variation (CV) at baseline calculated for the three best V_{maxFRC} measurements at T1 was 8.3 (3.2)% (range 2.2–13.1). No significant difference was observed between T1 and T2; for PD_{PcO2} (p = 0.944; paired t test) or PD_{V_{maxFRC}} (p = 0.586; paired t test). The mean (SD) difference between the PD_{PcO2} results obtained for each challenge was –0.13 (1.87) doubling doses (fig 3B). The 95% range for a single determination was therefore 2.6 doubling doses for a single determination. The use of PD_{V_{maxFRC}} gave similar repeatability results, the mean (SD) difference between the results obtained for each challenge being 0.33 (1.89) doubling doses (fig 3C), giving a 95% range for a single determination of 2.7 doubling doses.

Discussion

The repeatability of lung function tests during methacholine challenge was evaluated in recurrently wheezy infants over a one month period. Our results showed a high variability in baseline V_{maxFRC} values and both V_{maxFRC} and P_{cO2} showed similar repeatability as parameters for methacholine challenges. Because of the variability in the changes in these parameters, only large concentration changes measured on successive occasions may be considered clinically significant in wheezy infants.

BASELINE LUNG FUNCTION TESTS

A large range of V_{maxFRC} values were obtained in our wheezy infants. Despite the fact that all the infants were clinically asymptomatic when tested, 60% had V_{maxFRC} values below 75% of the expected value for their body length. Baseline V_{maxFRC} values have been reported to be lower in recurrently wheezy but symptom free infants than in healthy infants.13 14 17 It has therefore been proposed that the main predisposing factor for recurrent wheeze in infancy is abnormally small airways.16 Reduced airway function has also been reported to precede wheezing illness.18 However, although the
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Mean \( V_{\text{maxFRC}} \) values in our population were lower than the expected mean, a relationship between this observation and congenitally small airways is not supported by our data. Indeed, a large proportion (40%) of our subjects had normal \( V_{\text{maxFRC}} \) values and these infants were easily identified by the convex shape of their flow-volume curve. This subgroup of wheezy infants did not differ significantly from normal infants reported by Hanrahan et al.\(^7\) Thus, the low mean \( V_{\text{maxFRC}} \) value in our study population was due to wheezy, symptom free infants with straight or concave flow-volume curves. Small airways in these infants may be expected to result in repeatedly low \( V_{\text{maxFRC}} \) values when tests were performed on different days. On the other hand, we found a very high variability in \( V_{\text{maxFRC}} \) with a 95% range for a single determination of 160 ml/s. Theoretically, technical factors may contribute to the variability in \( V_{\text{maxFRC}} \). Indeed, the measurement of \( V_{\text{maxFRC}} \) relies on FRC which is usually dynamically determined in young infants. In particular, FRC shifts with many dynamic events including changes in airway calibre and sleep state.\(^9\) Any modification in airway calibre during methacholine challenge may induce changes in FRC which might influence measurements obtained from partial expiratory flow-volume curves but are not evaluable in routine use. Coefficients of variation for \( V_{\text{maxFRC}} \) during one test were found to be relatively high, ranging from 8% to 16%. However, these values are too low for technical factors to be the sole explanation for the very high variability found between the two tests for \( V_{\text{maxFRC}} \) in our study. Large changes in \( V_{\text{maxFRC}} \) from \( T_1 \) to \( T_2 \) were observed in both directions—improvement and deterioration—arguing for a great lability of airway calibre in infants independent of clinical symptoms rather than for fixed small airways. Such large changes in \( V_{\text{maxFRC}} \) with time have previously been reported for healthy infants with a 31% coefficient of variability.\(^7\) If changes in \( V_{\text{maxFRC}} \) in our study were expressed as a percentage of the change from \( T_1 \), the mean change in the subgroup of wheezy infants with initially normal \( V_{\text{maxFRC}} \) values was \(-14[34]%\) with a 95% range for a single determination of 48% of baseline, very similar to the value previously reported in healthy infants.\(^7\)

METHACHOLINE CHALLENGE: FIRST ANALYSIS OF REPEATABILITY IN A LARGE POPULATION OF WHEEZY INFANTS

In this study we have tried to establish the repeatability of methacholine inhalation tests in wheezy infants. Knowledge of the repeatability is required for the study of the natural history of airway hyperreactivity in wheezy infants. This question has previously been addressed only by Prendiville et al.\(^9\) who gave 10 wheezy infants two challenges at an interval of 1–5 days. The reproducibility was poor with a 95% confidence interval of 4.5 doubling concentrations. With a much larger group of wheezy infants we obtained better repeatability results for methacholine challenges than that previously reported, with a 95% range for a single determination of 2.6 doubling doses. Similar results have also been reported for adults. Trigg et al studied the daily variability in bronchial responsiveness to methacholine in adult asthmatic patients and found a 95% range for repeatability of \( \pm 2.36 \) doubling doses.\(^20\) However, most studies performed in adults and children older than six years of age showed better repeatability results than those we obtained in wheezy infants. In particular, Phagoo et al performed two methacholine challenges with a one day interval in children aged 6–12 years and reported coefficients of repeatability of \( \pm 0.96 \) and \( \pm 0.80 \) doubling doses for \( PD_{15PtcO_2} \) and \( PD_{30V_{\text{maxFRC}}} \), respectively.\(^7\) Furthermore, Stick et al reported a coefficient of repeatability of 1.66 doubling concentrations in healthy infants challenged twice with histamine with a one week interval.\(^8\) Many factors may contribute to the increased variability of methacholine challenges in our population. Firstly, \( PD_{15PtcO_2} \) or \( PD_{30V_{\text{maxFRC}}} \) are influenced by baseline bronchial obstruction. This phenomenon has previously been reported and is confirmed in the present study. We found a high variability in baseline \( V_{\text{maxFRC}} \) values and this may contribute substantially to the increase in the coefficient of repeatability for methacholine provocative doses. Secondly, technical factors may also influence repeatability. In particular, variability in methacholine aerosol deposition pattern, depending on tidal volume, degree of sleep and inspiratory airflow, may contribute to changes in methacholine provocative doses. Tal et al reported a large difference in the deposition of radiolabelled drug in wheezy infants and adults, the mean aerosol deposition in the lungs being only 2% in infants and 19% in adults.\(^21\)

Knowledge of the repeatability of methacholine inhalation tests is particularly important when these tests are to be repeated in the same children to monitor the natural history of respiratory diseases or therapeutic interventions. A clinically significant change for an individual patient can be derived from a single determination of the 95% range provided the square root of 2 is included.\(^7\) Thus, from our data, a change in \( PD_{15PtcO_2} \) of more than 3.7 doubling doses measured on successive occasions may be considered clinically significant in wheezy infants.

Methacholine induced bronchial hyperreactivity was assessed by measuring both \( PD_{30PtcO_2} \) and \( PD_{V_{\text{maxFRC}}} \). \( PD_{V_{\text{maxFRC}}} \) is now widely used as a sensitive index for detecting bronchial responsiveness during methacholine challenge.\(^22\) 23 24 Even in infants.\(^7\) 11 25 \( PD_{V_{\text{maxFRC}}} \) was found to be as sensitive as \( PD_{30PtcO_2} \) and in agreement with \( PD_{15PtcO_2} \) within a twofold concentration difference. Although this difference remains lower than the coefficient of repeatability of both \( PD_{30PtcO_2} \) and \( PD_{V_{\text{maxFRC}}} \), the relatively wide limits of agreement do not allow these two variables to be used interchangeably. Furthermore, advantages and limitations for these two methods are different. \( PtcO_2 \) reflects changes in pulmonary blood flow and ventilation-perfusion mismatch and is not measuring the...
same thing as $V_{\text{maxFRC}}$, which is probably a closer reflection of lung mechanics. $V_{\text{maxFRC}}$ allows a baseline evaluation of bronchial obstruction, which is not possible with PtcO2. However, PtcO2 has the advantage of being easily measured, even for infants who are awake, and thus allows repeated testing without repeated sedation.

In conclusion, our study show that baseline $V_{\text{maxFRC}}$ values are highly variable in wheezy, symptom free infants. The use of either $V_{\text{maxFRC}}$ or PtcO2 as a parameter for methacholine obstruction gave similar repeatability results in wheezy infants. A change of 3.7 doubling doses challenge gives similar repeatability results in FRC or PtcO2 as a parameter for methacholine obstruction, which is not possible with PtcO2. Allows a baseline evaluation of bronchial obstruction, which is not possible with PtcO2. However, PtcO2 has the advantage of being easily measured, even for infants who are awake, and thus allows repeated testing without repeated sedation.

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