Inflammatory cells and cellular activation in the lower respiratory tract in Churg-Strauss syndrome

Armin Schnabel, Elena Csernok, Jörg Braun, Wolfgang L Gross

Abstract

Background—To obtain insight into the mechanisms of tissue injury in lung disease due to Churg-Strauss syndrome (CSS), the bronchoalveolar lavage (BAL) cell profile and the levels in the BAL fluid of cell products released by activated eosinophils and neutrophils were assessed.

Methods—Thirteen patients with active progressive CSS (n = 7) or CSS in partial remission (n = 6) underwent clinical staging and bronchoalveolar lavage. The levels of eosinophil cationic protein (ECP), myeloperoxidase (MPO), and peroxidase activity in the BAL fluid were determined and the results were compared with those of 19 patients with pulmonary active Wegener’s granulomatosis (WG) and nine control subjects.

Results—In patients with progressive CSS the BAL cell profile was dominated by eosinophils, neutrophil elevation being the exception. The eosinophilia was associated with high ECP levels (4.39 ng/ml and 0.40 ng/ml in the two CSS groups compared with unmeasurable values in the controls). Individual patients with highly active CSS also had raised MPO levels, comparable to the levels in the most active WG patients. Peroxidase activity in the BAL fluid was 1.26 U/ml and 0.10 U/ml in the two groups of patients with CSS and 0.20 U/ml in the controls. Pulmonary disease in patients with WG was characterised by an extensive increase in MPO (0.30 ng/ml versus 0.13 ng/ml in the controls) together with high peroxidase activity in the BAL fluid (4.37 U/ml), but only a small increase in ECP levels was seen. No correlation was found between the ECP and MPO levels in patients with CSS which suggests that eosinophil and neutrophil activation vary independently of each other.

Conclusions—These findings suggest that, in addition to eosinophil activation, neutrophil activation is an important feature in some patients with highly active CSS. The balance of neutrophil and eosinophil involvement appears to be variable and this may be one explanation for the individually variable treatment requirements of patients with CSS.

Keywords: Churg-Strauss syndrome; eosinophils; neutrophils; bronchoalveolar lavage.
criteria and the 1992 Chapel-Hill definition (table 1). All 13 patients had active pulmonary disease which manifested itself as bronchial asthma in eight patients and obstructive bronchitis in association with a history of bronchial asthma in five. Three patients also had parenchymal infiltrates at the time of examination. Staging investigations included lung function testing, chest radiography, bronchoscopy, BAL, echocardiography, otolaryngological, ophthalmological and neuro-logical consultation, cranial magnetic resonance imaging, and laboratory screening for anti-neutrophil cytoplasmic antibodies. Extrapulmonary organ manifestations were chronic rhinitis or sinusitis in all 13 patients, cutaneous leukocytoclastic vasculitis or nodular skin infiltrates in seven, peripheral neuropathy mainly in the form of mononeuritis multiplex in eight, cardiac involvement in the form of dilatory cardiomyopathy, ventricular or supraventricular arrhythmias or pericardial effusion in six, arthritis in seven, intestinal involvement in the form of diarrhoea or abdominal cramping which resolved upon immunosuppression in three, and glomerulonephritis and myositis in one patient each (table 1). The duration of vasculitic disease ranged from one to 111 months with a mean of 28 months. The time span from the onset of asthma to generalised disease was 1–112 months with a median of 23 months. Histological confirmation was obtained in the upper and lower respiratory tract, and from various other sites in the remaining eight. Pulmonary disease manifested itself radiologically in the form of ill defined infiltrates or consolidation in 12 patients and solitary or multiple nodules in five. Two patients had ulcerative and granulomatous bronchitis in association with a lymphocytic BAL profile. Extrapulmonary organ involvement included the upper respiratory tract in all 19 patients, the kidneys in 14 patients, the eyes in 12, the peripheral nervous system in seven, the skin in four, the heart in three, the gastrointestinal tract in two, the central nervous system in two, and the musculoskeletal system in 16 patients. At the time of examination 12 patients were not receiving any immunosuppressive medication; in the others a major relapse occurred while receiving low dose prednisolone (n = 2), low dose methotrexate (n = 2), cotrimoxazole (n = 2), or cyclophosphamide (n = 1).

There were nine patients in the control group (five women) with a mean age of 33 years (interquartile range 29–39). Six of these had been transferred to our department for evaluation of suspected systemic rheumatic disease and turned out to be free of inflammatory systemic or pulmonary disease and three were healthy laboratory personnel. All nine subjects had a normal chest radiograph, normal lung function, and a normal BAL cell profile. All patients and the control subjects were non-smokers and were free of clinical or microbiological evidence of infection.

**BRONCHOSCOPY**

Fibreoptic bronchoscopy was performed after local anaesthesia with lidocaine and premedication with atropine and a morphine antitus-sive. The bronchoscope was wedged into a seg-

### Table 1 Characteristics of patients with progressive Churg-Strauss syndrome (n = 7) and Churg-Strauss syndrome in partial remission (n = 6)

<table>
<thead>
<tr>
<th></th>
<th>Progressive disease</th>
<th>Partial remission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female:male</td>
<td>6:1</td>
<td>3:3</td>
</tr>
<tr>
<td>Age (years)</td>
<td>50 (39–55)</td>
<td>57 (42–60)</td>
</tr>
<tr>
<td>Duration of vasculitis (months)</td>
<td>6 (1–104)</td>
<td>43 (26–67)</td>
</tr>
<tr>
<td>ESR (mm/h)</td>
<td>28 (16–72)</td>
<td>14 (3–16)</td>
</tr>
<tr>
<td>C-reactive protein (mg/dl)</td>
<td>1.7 (0.6–11.7)</td>
<td>0.5 (0.4–0.7)</td>
</tr>
<tr>
<td>Blood eosinophil count (cells/µl)</td>
<td>1470 (550–2560)</td>
<td>170 (100–210)</td>
</tr>
<tr>
<td>Disease extent index (DEI score)</td>
<td>5 (3–9)</td>
<td>4 (3–4)</td>
</tr>
<tr>
<td>Cumulative organ involvement (n)</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Upper respiratory tract</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Arthritis</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Polyneuropathy</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Kidney</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Skin</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Heart</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Myositis</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>VCIN (% predicted)</td>
<td>97 (78–102)</td>
<td>92 (67–100)</td>
</tr>
<tr>
<td>FEV1/VCIN (%)</td>
<td>70 (67–75)</td>
<td>67 (43–70)</td>
</tr>
<tr>
<td>TLCO/VA (% predicted)</td>
<td>88 (71–92)</td>
<td>84 (77–87)</td>
</tr>
</tbody>
</table>

VCIN = inspiratory vital capacity; FEV1 = forced expiratory volume in one second; TLCO = carbon monoxide transfer factor; VA = alveolar volume.

### Table 2 Characteristics of patients with progressive Wegener's granulomatosis (n = 19)

<table>
<thead>
<tr>
<th></th>
<th>8:11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>60 (54–64)</td>
</tr>
<tr>
<td>Duration of disease (months)</td>
<td>39 (11–87)</td>
</tr>
<tr>
<td>ESR (mm/h)</td>
<td>90 (40–105)</td>
</tr>
<tr>
<td>C-reactive protein (mg/dl)</td>
<td>11.3 (2.1–15.8)</td>
</tr>
<tr>
<td>Disease extent index (DEI score)</td>
<td>7 (3–11)</td>
</tr>
<tr>
<td>Cumulative organ involvement (n)</td>
<td>19</td>
</tr>
<tr>
<td>Upper respiratory tract</td>
<td>19</td>
</tr>
<tr>
<td>Kidney</td>
<td>14</td>
</tr>
<tr>
<td>Eye</td>
<td>12</td>
</tr>
<tr>
<td>Arthritis</td>
<td>16</td>
</tr>
<tr>
<td>Polyneuropathy</td>
<td>7</td>
</tr>
<tr>
<td>Central nervous system</td>
<td>2</td>
</tr>
<tr>
<td>Skin</td>
<td>4</td>
</tr>
<tr>
<td>Heart</td>
<td>3</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>2</td>
</tr>
<tr>
<td>VCIN (% predicted)</td>
<td>94 (78–106)</td>
</tr>
<tr>
<td>FEV1/VCIN (%)</td>
<td>71 (62–78)</td>
</tr>
<tr>
<td>TLCO/VA (% predicted)</td>
<td>115 (95–120)</td>
</tr>
</tbody>
</table>

VCIN = inspiratory vital capacity; FEV1 = forced expiratory volume in one second; TLCO = carbon monoxide transfer factor; VA = alveolar volume.

Values are median (interquartile range).
Inflammatory cells and cellular activation in Churg-Strauss syndrome

This laboratory is counting 400 cells. Normal reference values in neutrophils, and <1% eosinophils. The cell differential was assessed microscopically by using the May-Giemsa-Gruenwald stain. The don Products, Cheshire, UK) and stained compared with a Shandon II cytocentrifuge (Shandon Corporation, San Diego, California, USA) according to the recommendations of the manufacturer. The detection threshold in the BAL fluid concentrate was 1.2 ng/ml. Per- 1.5 ng/ml. All assays were run in duplicate.

**RESULTS**

**BAL CELL PROFILE**

An abnormal BAL cell profile was found in 11 of the 13 patients with CSS. The most prominent abnormality was an excess of eosinophils (fig 1A). The median eosinophil count was 34% (interquartile range 8–71%) in the patients with progressive disease and 0.5% (interquartile range 0–5%) in the patients in partial remission, compared with a normal reference value of <1%. The difference in the eosinophil count between the two CSS subgroups was statistically significant (p = 0.015). The eosinophil count in the BAL fluid proved to be more sensitive in reflecting disease activity than the eosinophil count in the blood, with three patients (one in the high activity group and two in the group in partial remission) having increased levels of eosinophils in the BAL fluid in the presence of normal blood eosinophils. Increased lymphocyte levels were found in two patients in the group with highly active disease and in two of those with CSS in partial remission, but only one patient in the former group had raised BAL neutrophils.

Thirteen of the 19 patients with highly active WG had an abnormal BAL cell profile (fig 1B). On the basis of the BAL cell pattern these patients fell into three categories. Seven patients had raised neutrophil levels (range 6–18%, normal reference value ≤5%), six had raised lymphocyte levels (interquartile range 18–42%, normal reference value ≤15%), and the remaining six patients had a normal BAL cell profile. Low grade elevation of the eosinophils in the range of 1–3% was found in four patients.

**CELLULAR ACTIVATION MARKERS IN BAL FLUID**

All CSS patients with highly active disease and five of the six patients in partial remission had measurable ECP levels in the BAL fluid whereas none of the controls had a measurable ECP level (fig 2). The median ECP level was 4.39 ng/ml (interquartile range 4.00–6.50) in the highly active patients and this was significantly higher than the level of 0.40 ng/ml (interquartile range 0–0.56) in the patients in partial remission (p = 0.004). A statistically significant correlation was found between the ECP level in the BAL fluid and the percentage eosinophil count in the BAL fluid of the 13 patients with CSS (R = 0.774, p = 0.002; fig 3),
and the strength of the correlation was very similar when absolute counts of BAL eosinophils were used in this analysis ($R = 0.724$, $p = 0.005$). This suggests that the BAL eosinophils were the dominant source of the ECP in the BAL fluid. MPO levels in the BAL fluid
spanned essentially the same range in the patients with highly active CSS as in the patients with WG (fig 4), resulting in virtually identical median levels in the two groups (0.32 ng/ml and 0.30 ng/ml, respectively). The MPO levels in the patients with WG differed significantly from the controls (p = 0.018), but the number of cases with progressive CSS was too small for the increase in MPO levels to reach statistical significance. No correlation was found between the ECP and MPO levels in the BAL fluid of patients with either CSS or WG.

The patients with highly active WG had moderately increased ECP levels in the BAL fluid which were significantly higher than those in the controls (p = 0.019) but lower than those in the patients with highly active CSS (0.07 ng/ml versus 4.39 ng/ml, p<0.001; fig 2). The median MPO level in the BAL fluid of patients with WG was significantly higher than the median MPO level of the controls (p = 0.018; fig 4). The highest MPO levels were seen in the patients with an increased BAL neutrophil count. The patients with a lymphocytic pattern had somewhat lower levels, while patients with a normal BAL cell profile also had normal MPO levels (1.40 ng/ml, 0.30 ng/ml, and 0.17 ng/ml in the WG patients compared with 0.08 ng/ml in the controls). The coefficient of correlation between the MPO level in the BAL fluid and the percentage of BAL neutrophils in these patients was R = 0.610 (p = 0.005), and the coefficient of correlation between the MPO level and the absolute BAL neutrophil count was R = 0.539 (p = 0.021).

The median peroxidase levels in the BAL fluid of patients with progressive CSS were 1.26 U/ml (interquartile range 0.26–3.14 U/ml) which were significantly higher than those in the patients with CSS in partial remission (median 0.10 U/ml; interquartile range 0–0.29; p = 0.021) and the controls (median 0.20 U/ml; interquartile range 0–0.37; p = 0.030; fig 5). A statistically significant correlation between the peroxidase and ECP levels in the BAL fluid of the 13 patients with CSS (R = 0.674, p = 0.011) suggests that the eosinophils were a major source of the excess peroxidase. In the patients with WG a correlation was found between peroxidase levels and the percentage neutrophil count in the BAL fluid.
Discussion

Previous studies of the pulmonary pathology of the small vessel vasculitides have relied mainly on materials obtained by open or transbronchial lung biopsy or necropsy. Small vessel vasculitides are characterised by a patchy distribution of the tissue lesions and, indeed, biopsy studies in patients with WG and CSS have shown that the small specimens obtained by forceps biopsy are very heterogeneous with respect to the presence of vasculitis, granuloma, necrosis, and non-specific changes. This suggests that, in patients with WG, the neutrophils rather than the eosinophils are an important source of the excess peroxidase activity.

Peroxidase activity in BAL fluid (U/ml)

(\(R = 0.571, p = 0.011\)) and between peroxidase levels and the absolute neutrophil count (\(R = 0.531, p = 0.019\)), but no correlation was found between peroxidase levels and the eosinophil count. This suggests that, in patients with WG, the neutrophils rather than the eosinophils are an important source of the excess peroxidase activity.

Figure 5 Peroxidase activity in BAL fluid in patients with Churg-Strauss syndrome, Wegener’s granulomatosis, and controls.

In agreement with previous studies, extracellular peroxidase activity is a useful index of local degranulation of the eosinophils. The correlation between ECP levels and the eosinophil count in the BAL fluid suggests that the eosinophils on the epithelial surfaces are an important, although not necessarily the exclusive, source of the ECP measured in the BAL fluid. High eosinophil counts were also associated with high peroxidase levels in the BAL fluid, and this activity correlated significantly with ECP levels. Peroxidase is a secretory product of both eosinophils and neutrophils but, given the aforementioned correlation, the main source of the peroxidase in these CSS patients appears to be the eosinophils.

MPO is a secretory product of neutrophils and macrophages but, by all accounts, the amount of macrophage-derived MPO in inflammatory tissues is small. Extracellular MPO and other granule constituents are therefore useful indices of local degranulation of neutrophils. Pulmonary disorders involving a strong neutrophil component are associated with increased MPO levels in the BAL fluid. Prominent examples of this are bacterial infections, chronic bronchitis, idiopathic pulmonary fibrosis, and interstitial lung...
Inflammatory cells and cellular activation in Churg-Strauss syndrome

CSS. Indeed, an increase in the ECP levels in the BAL fluid, which reflects eosinophil degranulation, was the most consistent BAL finding in those patients. Neutrophil degranulation appears to be a further mechanism involved in this disorder, but the present results suggest that this is less consistent than eosinophil degranulation. These findings suggest also that the magnitude of neutrophil and eosinophil degranulation vary independently of each other. Treatment requirements of CSS range from moderate corticosteroid doses in some patients to intense immunosuppression in others. It is tempting to speculate that the different responsiveness of eosinophils and neutrophils to therapeutic agents is one reason for the heterogeneity of the clinical responses, but this needs to be examined in studies designed specifically for this purpose.

Supported by the Bundesminister für Bildung und Forschung, grant no. 01 VM 9306.


Inflammatory cells and cellular activation in the lower respiratory tract in Churg-Strauss syndrome

Armin Schnabel, Elena Csernok, Jörg Braun and Wolfgang L Gross

Thorax 1999 54: 771-778
doi: 10.1136/thx.54.9.771

Updated information and services can be found at:
http://thorax.bmj.com/content/54/9/771

These include:

References
This article cites 29 articles, 5 of which you can access for free at:
http://thorax.bmj.com/content/54/9/771#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections
Vascularitis (53)
Interstitial lung disease (559)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/