PostScript

Relationship between asthma severity and progression of Alzheimer’s disease

Severity of asthma is occasionally modulated by neuropsychiatric conditions.1 However, little is known about the impact of cognitive decline on asthma severity. Cognitive decline is a core symptom in patients with Alzheimer’s disease (AD).2 AD is a disease characterised by progressive cholinergic failure3 that could possibly reduce airway hypersensitivity to cholinergic stimulation and thus symptoms of asthma. Furthermore, the functions of T lymphocytes—which play a crucial role in the development of chronic asthma—are partially impaired in patients with AD related diseases.4 We hypothesised that declining cognitive function might result in an improvement in asthma, and prospectively studied the contribution of the progression of AD to the clinical course of asthma.

Eight patients with asthma of mean (SE) duration 15.3 (0.9) years from 1995 to 2000. All subjects were identified and prospectively followed for 5 years (table 1). Induced sputum eosinophil counts—which play a crucial role in the development of chronic asthma—are partially impaired in patients with AD related diseases.5 It has been reported that the nervous system may modulate immunological responses including eosinophilic inflammation in the airway.6

Table 1 Assessment of asthma severity and change in cognitive function at study entry (baseline) and 5 year follow up (endpoint) in asthma patients with Alzheimer’s disease

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (y)</th>
<th>Sex</th>
<th>MMSE score</th>
<th>Asthma symptom score</th>
<th>Daily inhaler puffs</th>
<th>Number of hospital admissions for asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baseline</td>
<td>End point</td>
<td>Baseline</td>
<td>End point</td>
</tr>
<tr>
<td>1</td>
<td>67</td>
<td>M</td>
<td>23</td>
<td>18</td>
<td>6.4</td>
<td>1.2</td>
</tr>
<tr>
<td>2</td>
<td>66</td>
<td>M</td>
<td>21</td>
<td>16</td>
<td>8.6</td>
<td>2.2</td>
</tr>
<tr>
<td>3</td>
<td>70</td>
<td>F</td>
<td>23</td>
<td>17</td>
<td>10.2</td>
<td>1.6</td>
</tr>
<tr>
<td>4</td>
<td>65</td>
<td>M</td>
<td>22</td>
<td>15</td>
<td>7.8</td>
<td>1.2</td>
</tr>
<tr>
<td>5</td>
<td>65</td>
<td>M</td>
<td>21</td>
<td>16</td>
<td>7.5</td>
<td>0.4</td>
</tr>
<tr>
<td>6</td>
<td>69</td>
<td>F</td>
<td>23</td>
<td>17</td>
<td>9.4</td>
<td>3.6</td>
</tr>
<tr>
<td>7</td>
<td>66</td>
<td>F</td>
<td>22</td>
<td>16</td>
<td>9.2</td>
<td>2.4</td>
</tr>
<tr>
<td>8</td>
<td>68</td>
<td>M</td>
<td>23</td>
<td>21</td>
<td>7.6</td>
<td>7.4</td>
</tr>
<tr>
<td>Mean</td>
<td>67 (0.7)</td>
<td></td>
<td>22.3 (0.3)</td>
<td>17.0 (0.7)*</td>
<td>8.4 (0.5)</td>
<td>1.8 (0.4)†</td>
</tr>
</tbody>
</table>

MMSE=Mini-Mental State Examination; SE=standard error.

If you have a burning desire to respond to a paper published in Thorax, why not make use of our “rapid response” option? Log on to our website (www.thoraxjnl.com), find the paper that interests you, and send your response via email by clicking on the “eletters” option in the box at the top right hand corner. Providing it isn’t libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on “read eletters” on our homepage.

The editors will decide as before whether to also publish it in a future paper issue.

IL-1 haplotypes and lung function decline

We read with interest the paper by Joos et al7 on the association of IL-1 gene haplotypes with decline in lung function in smokers and share their view on a possible role of IL-1 genetics in inflammatory respiratory diseases. We have analysed the same polymorphism by


www.thoraxjnl.com
the same methods in adult incident non-smoking asthmatic patients and non-smoking controls. Our results indicate that the association of IL-1 genetics with rate of decline in lung function is not limited to smokers.

New adult asthma cases and controls were selected from a cohort of the Mini-Finland Health Survey (MFHS) and later re-evaluated. A more detailed description of the methods used in MFHS has been published elsewhere.¹ The accuracy of the method of asthma case ascertainment has also recently been described.¹ IL-1 haplotypes were found to be significantly associated with the rate of decline of lung function in non-smoking incident cases of asthma (new asthma during follow-up) but not in controls (table 1), the individual haplotypes. Joos et al found that IL1RN A2/IL1B –511T was associated with a rapid decline of lung function in smokers and IL1RN A1/IL1B –511T with a slow decline. In our control group the observed differences were not significant. Surprisingly, in the asthma group the haplotypes had the opposite effects from those in smokers: IL1RN A1/IL1B –511T was associated with a slower decline in lung function and IL1RN A2/IL1B –511T with a more rapid decline. IL1RN A2/IL1B –511T has previously been found to be associated with many inflammatory diseases.² The function of these haplotypes would therefore appear to be disease specific.

J Karjalainen
Tampere University Hospital, Department of Respiratory Medicine and Medical School, FIN-33014 University of Tampere, Finland; jussi.karjalainen@uta.fi

J Hulkkonen, M Hurme
Tampere University Hospital, Centre for Laboratory Medicine and Department of Microbiology and Immunology

The accuracy of the method of asthma case ascertainment has also recently been described.¹ IL-1 haplotypes were found to be significantly associated with the rate of decline of lung function in non-smoking incident cases of asthma (new asthma during follow-up) but not in controls (table 1), the individual haplotypes. Joos et al found that IL1RN A2/IL1B –511T was associated with a rapid decline of lung function in smokers and IL1RN A1/IL1B –511T with a slow decline. In our control group the observed differences were not significant. Surprisingly, in the asthma group the haplotypes had the opposite effects from those in smokers: IL1RN A1/IL1B –511T was associated with a slower decline in lung function and IL1RN A2/IL1B –511T with a more rapid decline. IL1RN A2/IL1B –511T has previously been found to be associated with many inflammatory diseases.² The function of these haplotypes would therefore appear to be disease specific.

Molecular analysis of drug resistant TB

Since the mid 1980s the number of notified cases of TB in the UK has continued to rise with the largest increases noted in London and inner city areas.³ King George Hospital in Goodmayes, Essex provides clinical services to a population of approximately 230 000: 17% are non-white subjects including immigrants from countries with high rates of M tuberculosis infection and drug resistance. From September 1996 to July 1997 47 adult cases of culture proven TB were identified including seven with drug resistant isolates. None was identified by contact tracing. A previous TB audit of African born patients revealed a high rate of drug resistance (6/24 (25%)) and delays in obtaining drug sensitivities which could have been detrimental to patient management.³ Under these circumstances the rapid identification of drug resistance in M tuberculosis isolates would have been helpful. The aim of this study was to determine retrospectively the usefulness of PCR-reverse hybridisation methods for screening for mutations within or adjacent to M tuberculosis genes associated with rifampicin (rif) and isoniazid (inh) resistance. We also determined whether resistance genotyping combined with IS6110 typing could help to identify clusters of drug resistant cases not previously identified by contact tracing.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Demographic data, site, phenotypic and genotypic resistance of the seven resistant study isolates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolate</td>
<td>Age</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
</tr>
<tr>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>6</td>
<td>42</td>
</tr>
<tr>
<td>7</td>
<td>44</td>
</tr>
</tbody>
</table>

INH=isoniazid; Rif=rifampicin; PZ=pyrazinamide. Isolates 3 and 5 had indistinguishable IS6110 types. Isolates 1 and 4 were not typable due to insufficient culture and the banding pattern of isolate 6 was uninterpretable.
assay INNO-LIPA Rif.TB® was used to detect *rpoB* mutations and an in-house PCR-reverse hybridisation line probe was used to detect mutations in or adjacent to the *katG, inhA,* and *ahpC* genes. The isolates were also IS6110 typed.

The single rifampicin and isoniazid resistant isolate had an *rpoB* gene mutation associated with rifampicin resistance (table 1). Four of the five isoniazid resistant isolates had the same single point mutation upstream of the *inhA* gene and the other a single *katG* point mutation. Isolates 3 and 5 had indistinguishable IS6110 types that could represent isolates where recent transmission had occurred. No mutations were detected in the 40 fully susceptible isolates.

PCR-reverse hybridisation methods were highly sensitive and specific at detecting mutations that predict for isoniazid and rifampicin resistance. We also demonstrated that different point mutations can be used to discriminate between isoniazid resistant isolates. We believe that with automation and the addition of oligonucleotide probes designed to detect mutations associated with pyrazinamide (*pncA*) and ethambutol (*embB*) resistance, a system capable of detecting resistance to four front line antituberculous drugs will soon be commercially available. Rapid resistance detection by PCR-reverse hybridisation is likely to have a major impact on patient management and our understanding of the epidemiology of drug resistant TB.

**Acknowledgements**

We would like to thank the Steering Group Members of the “Molecular Epidemiology of Tuberculosis in London” for allowing us access to their samples and to the Mycobacterial Reference Laboratory (Dubuque) for conventional susceptibility testing.

M Melzer, T J Brown, G L French

Department of Infection, St Thomas’ Hospital, London SE1 7EH, UK

A Dickens, T D McHugh

Department of Medical Microbiology, Royal Free and University College Medical School, London NW3 2PF, UK

L R Bogg, R A Storring, S Lacey

King George Hospital, Goodmayes, Essex IG3 8YB, UK

Correspondence to: Dr M Melzer, Department of Infection, St Thomas’ Hospital, London SE1 7EH, UK. markmelzer@hotmail.com

**References**


**Lung bullae and marijuana**

A previous paper from this hospital described apical lung bullae in four young male mari-juana smokers, three West Indian and one Caucasian. Four further cases were recently reported, both in Caucasian men. We describe three further cases (one woman) with large upper lobe bullae. All are Caucasian and had a prolonged history of heavy marijuana smoking with an alpha1-antitrypsin level within the normal range (table 1). These further cases support the view that marijuana may have a causal role in the development of lung bullae.

We suggest that a detailed marijuana smoking history is taken from patients of all ethnic origins with upper lobe bullae.

C S Thompson, R J White

Department of General Medicine, Frenchay Hospital, Bristol BS16 1IE, UK

Correspondence to: Dr C S Thompson, Department of General Medicine, Frenchay Hospital, Bristol BS16 1IE, UK

**Pathophysiology of COPD**

The paper by Dentener et al is interesting and contributes to the understanding of the pathophysiology of chronic obstructive pulmonary disease (COPD). It is becoming clear that COPD is a systemic syndrome, and this paper suggests some potential mechanisms. However, a number of issues merit further comment.

It is noted that, in healthy controls, there is a wide range of C reactive protein (CRP) values extending well beyond what would be considered to be the normal range. The reason for this is unclear, but it does suggest that these individuals are not as healthy as described. In addition, patients with stable COPD have a range of CRP values that also extend beyond this normal range. This is not consistent with previous studies, which suggests that, in patients with stable COPD, the range of CRP values falls within the normal range. Although patients with bronchitis were excluded, it is possible that undiagnosed bronchitis may have been present. Previous work has shown that 29% of patients presenting with what appeared to be stable COPD had CT evidence of at least mild bronchitis. This could conceivably explain a wider range of CRP levels. In addition, it is interesting that after just 5 days of treatment for an acute exacerbation the CRP had returned to a level below that of the stable cohort in the study. Since standard treatment for an exacerbation is able to achieve this in just a few days, it suggests that the stable group may have contained individuals that were in fact not so stable.

The authors allude to the potential confounding effect of systemic corticosteroids in the study. The changes in total leucocyte count during the exacerbation are likely to be due to the effect of prednisolone, making it difficult to interpret the changes in leucocyte count. In stable patients the action of corticosteroids may also confound the results. It is possible that, even in patients using inhaled corticosteroids, leucocyte numbers could be affected since there may be significant bioavailability at higher doses. Leucocyte count should therefore not be used as a marker for systemic inflammation in these patients.

Finally, it would appear that the exacerbations of COPD might have been mild, despite the presence of severe COPD on lung function criteria. Although PaO2 was slightly higher and PaO2 slightly lower than in the stable group, these differences were small in magnitude. The pH was not significantly different and, in fact, the stable group contained individuals with a lower pH range (7.30–7.50) than in the exacerbated group (pH 7.34–7.49). Although the mean CRP level appears higher than in stable patients, the range does not differ significantly. This may therefore have led to a less profound change in inflammatory markers than might have been expected, and a study looking at more severe exacerbations may be more revealing.

M Kelly

Department of Respiratory Medicine, Belfast City Hospital, Belfast BT9 7AB, UK; m.g.kelly@qub.ac.uk

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age on presentation (years)</td>
<td>33</td>
<td>45</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Ethnic origin</td>
<td>Caucasian</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Tobacco smoking history</td>
<td>9 pack years</td>
<td>10 pack years</td>
</tr>
<tr>
<td>Marijuana smoking history</td>
<td>2–3 joints/day</td>
<td>“heavy” 10 years</td>
</tr>
<tr>
<td></td>
<td>“heavy” 10 years</td>
<td>“moderate” 10 years</td>
</tr>
<tr>
<td></td>
<td>“heavy” 24 years</td>
<td></td>
</tr>
<tr>
<td>Alpha, antitrypsin (g/l) (normal range 1.1–2.1)</td>
<td>1.4</td>
<td>2.3</td>
</tr>
<tr>
<td>FEV1 (% predicted)</td>
<td>2.7 (64)</td>
<td>2.4 (96)</td>
</tr>
<tr>
<td>FVC (% predicted)</td>
<td>4.3 (85)</td>
<td>3.3 (112)</td>
</tr>
<tr>
<td>FEV1/FVC (%)</td>
<td>63</td>
<td>73</td>
</tr>
<tr>
<td>Tico (% predicted)</td>
<td>9.44 (81)</td>
<td>4.99 (62)</td>
</tr>
<tr>
<td>Kco (% predicted)</td>
<td>1.44 (88)</td>
<td>1.10 (64)</td>
</tr>
</tbody>
</table>

FEV1 forced expiratory volume in 1 second; FVC forced vital capacity; Tico carbon monoxide transfer factor; Kco carbon monoxide transfer coefficient.
Dr Kelly has some concerns about the levels of C reactive protein (CRP) in the healthy controls and patients with clinically stable COPD in our study. The control group used consisted of randomly selected subjects over 50 years of age and living in the same area as the patients. These subjects had no evidence of COPD based on questionnaires and lung function testing, did not exhibit any acute or chronic disease, and were not taking medication. Based on these selection criteria, this group was considered a healthy population control group. Although two of the 23 control subjects had enhanced CRP levels, the reason for which is unknown, they were not excluded in order to prevent bias. Non-parametric tests were used to compare the CRP levels between controls and COPD patients, and therefore the results are not affected by these two outliers.

Concerning the diagnosis of COPD, all patients in our study underwent high resolution computed tomographic scanning to exclude the presence of bronchiectasis. The control group used to compare the CRP levels between controls and COPD patients, and therefore the results are not affected by these two outliers. Non-parametric tests were used to compare the CRP levels between controls and COPD patients, and therefore the results are not affected by these two outliers.

As discussed in our paper, increased circulating levels of leucocytes were observed in the subgroup of clinically stable COPD patients treated with oral corticosteroids compared with those who did not receive oral corticosteroids. However, comparison of subgroups of patients without corticosteroid treatment (oral or inhaled) with control subjects still revealed significantly increased leucocyte counts (data not shown). This indicates that the enhanced levels of circulating leucocytes are not solely due to corticosteroid use, and could be a marker of the systemic inflammatory process in COPD. In line with this hypothesis, Noguera et al reported enhanced circulating levels of polymorphonuclear cells in patients with stable COPD, none of whom had received steroids before the start of the exacerbation.

As discussed in our paper, administration of prednisolone during treatment of an exacerbation is most probably the cause for the observed rise in leucocyte counts. In order to determine the effect of exacerbation on leucocyte counts, studies are currently being performed in our hospital in which blood from patients with an exacerbation is collected before the start of treatment. COPD comprises a heterogeneous group of conditions characterised by chronic airflow limitation and destruction of lung parenchyma with clinical manifestations of dyspnoea, cough, sputum production, and impaired exercise tolerance. The definition of an acute exacerbation of COPD is still imprecise, and is generally based on varying combinations of symptoms. Rodriguez-Roisin et al suggested staging COPD exacerbations based on use of health care. They defined three levels of severity: mild, moderate and severe. During a mild exacerbation the patient has an increased need for medication which he/she can manage in their own environment; patients with a moderate exacerbation have an increased need for medication and need to seek additional medical assistance; the patient with a severe exacerbation recognises obvious and/or rapid deterioration in his/her condition requiring admission to hospital. Based on this definition, the patients included in our study were suffering from severe exacerbations of disease. Only limited information is so far available concerning (changes of) inflammatory markers during exacerbations.

In our study the kinetics of pro- and anti-inflammatory mediators have been analysed in patients with COPD during the first 7 days in hospital for an exacerbation of the disease. The results showed a significant decline in systemic levels of both CRP (at day 3) and LBP (at day 7) compared with day 1, whereas levels of the anti-inflammatory mediator soluble IL-1 receptor II dramatically increased (until day 5). This change in levels of inflammatory mediators may contribute to the clinical improvement of the patients. Additional studies are required to obtain more insight into the role of the inflammatory processes in the pathogenesis of exacerbations which could contribute to measurable parameters, in order to define the severity or outcome of disease more accurately.

M A Dentener, E C Creutzberg, E F M Wouters

Department of Pulmonology, Maasstricht University, Nutrition and Toxicology Research Institute Maastricht (Nutrim), Maasstricht, The Netherlands; Melle.Dentener@pul.unimaas.nl

References

Molecular analysis of drug resistant TB

M Melzer, T J Brown, G L French, A Dickens, T D McHugh, L R Bagg, R A Storring and S Lacey

Thorax 2002 57: 562-563
doi: 10.1136/thorax.57.6.562

Updated information and services can be found at:
http://thorax.bmj.com/content/57/6/562

These include:

References
This article cites 5 articles, 3 of which you can access for free at:
http://thorax.bmj.com/content/57/6/562#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.

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/