Effect of bradykinin on allergen induced increase in exhaled nitric oxide in asthma

F L M Ricciardolo, M C Timmers, J K Sont, G Folkerts, P J Sterk

Background: Exposure of patients with atopic asthma to allergens produces a long term increase in exhaled nitric oxide (FE\(_{\text{NO}}\)), probably reflecting inducible NO synthase (NOS) expression. In contrast, bradykinin (BK) rapidly reduces FE\(_{\text{NO}}\). It is unknown whether BK suppresses increased FE\(_{\text{NO}}\) production after allergen exposure in asthma, and whether it modulates FE\(_{\text{NO}}\) via NOS inhibition.

Methods: Levels of FE\(_{\text{NO}}\) in response to aerosolised BK were studied before (day 3) and 48 hours after (day 10) randomised diluent (diluent/placebo/BK (Dil/P/BK)), allergen (allergen/placebo/BK (All/P/BK)), and allergen/l-NMMA/BK (All/L/BK)) challenges (day 8) in 10 atopic, steroid naive, mild asthmatic patients with dual responses to inhaled house dust mite extract. To determine whether BK modulates FE\(_{\text{NO}}\) via NOS inhibition, subjects performed pre- and post-allergen BK challenges after pretreatment with the NOS inhibitor l-NMMA in the All/L/BK period.

Results: Allergen induced a fall in FE\(_{\text{NO}}\) during the early asthmatic reaction (EAR) expressed as AUC\(_{0-1}\) (ANOVA, p = 0.04), which was followed by a rise in FE\(_{\text{NO}}\) during the late asthmatic reaction (LAR) expressed as AUC\(_{1-48}\) (ANOVA, p = 0.008). In the Dil/P/BK period, FE\(_{\text{NO}}\) levels after BK on pre- and post-diluent days were lower than FE\(_{\text{NO}}\) levels after placebo (difference 23.5 ppb (95% CI 6.2 to 40.9) and 22.5 ppb (95% CI 7.3 to 37.7), respectively; p<0.05). Despite the long lasting increase in FE\(_{\text{NO}}\) following allergen challenge in the LAR, BK suppressed FE\(_{\text{NO}}\) levels at 48 hours after allergen challenge in the All/L/BK period, lowering the increased FE\(_{\text{NO}}\) (difference from placebo 54.3 ppb (95% CI 23.8 to 84.8); p<0.003) to the baseline level on the pre-allergen day (p<0.51). FE\(_{\text{NO}}\) levels were lower after l-NMMA than after placebo on pre-allergen (difference 10.85 ppb (95% CI 1.3 to 20.4); p=0.03) and post-allergen (difference 36.2 ppb (95% CI 5.5 to 66.9); p=0.03) days in the All/L/BK and All/P/BK periods, respectively. l-NMMA did not significantly potentiate the pre- and post-allergen reduction in BK induced FE\(_{\text{NO}}\).

Conclusions: Bradykinin suppresses the allergen induced increase in exhaled NO in asthma; this is not potentiated by l-NMMA. Bradykinin and l-NMMA may follow a common pathway in reducing increased NO production before and after experimental allergen exposure. Reinforcement of this endogenous protective mechanism should be considered as a therapeutic target in asthma.
METHODS

Subjects

Ten non-smoking patients (five men) with mild intermittent asthma and house dust mite atopy,19 as described elsewhere,16 participated in the study (table 1). All subjects were symptom free at the time of the study and were not on regular medication. They had normal lung function and were hyperresponsive to inhaled histamine.20 Inhaled short acting β2 agonists were allowed on demand until 12 hours before testing. The subjects had documented EAR and LAR to inhaled house dust mite extract in the screening period.20 The study was approved by the ethics committee of the Leiden University Medical Centre and all participants gave written informed consent.

Study design

The screening period for the selection criteria has been described previously.16 The study had a randomised, placebo controlled, crossover design and consisted of three periods (diluent/placebo/bradykinin (Dil/P/BK), allergen/placebo/bradykinin (All/P/BK), and allergen/L-NMMA/bradykinin (All/L/BK)) of five study days each, separated by a washout interval of 2–4 weeks. During each study period the participants pretreated with placebo (Dil/P/BK and All/P/BK periods) or L-NMMA (All/L/BK period) underwent a bradykinin challenge before (day 3) and 48 hours after (day 10) the diluent (Dil/P/BK period) or allergen challenge (All/P/BK and All/L/BK periods, day 8; fig 1). On day 9 the participants underwent spirometric tests and FE NO monitoring (fig 1). On day 1 of each study period a control PC20 histamine measurement was performed.

FE NO was measured (2 minutes after spirometry) at baseline, after placebo or L-NMMA, and at the end of bradykinin (after 5 minutes and every 10 minutes up to 1 hour) and allergen/diluent challenge (every 10 minutes in the first hour, every 30 minutes in the second hour, every 60 minutes up to 10 hours, and at 24 hours), when a fall in forced expiratory volume in 1 second (FEV1) of >20% was achieved or after three consecutive diluent inhalations.

Inhalation challenges

Freshly prepared N\textsuperscript{G}-monomethyl-L-arginine (L-NMMA; Clinalfa AG, Läufelfingen, Switzerland: 10 mg in 3 ml 0.9% saline) or placebo (3 ml 0.9% saline), bradykinin (Clinalfa AG, Läufelfingen, Switzerland: 0.0024–5.0 mg/ml), diluent, and allergen extract of Dermatophagoides pteronyssinus (SQ 503; Vivodiagnost, ALK, Benelux) were inhaled as described previously.16 FEV1 measurements for bradykinin and allergen or diluent challenges were performed as previously reported.16

Measurements of exhaled NO

FE NO measurements were performed, according to the present recommendation,21 using a Sievers NOA 270B chemiluminescence analyser (Sievers, Boulder, CO, USA) as previously described.21 Subjects performed a slow vital capacity manoeuvre with a constant expiratory flow of 100 ml/s using online visual monitoring. An expiratory

Table 1 Characteristics of participants

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Atopic status*</th>
<th>FENO (ppb)†</th>
<th>FEV1 (% predicted)‡</th>
<th>PC20FEV1 histamine (mg/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>22.1</td>
<td>4.2</td>
<td>33.5</td>
<td>94.4</td>
</tr>
<tr>
<td>SD</td>
<td>2.6</td>
<td>0.9</td>
<td>23.7</td>
<td>7.2</td>
</tr>
<tr>
<td>Range</td>
<td>19–26</td>
<td>3–6</td>
<td>14–95</td>
<td>81–104</td>
</tr>
</tbody>
</table>

SD = standard deviation; FENO = fractional exhaled concentration of nitric oxide; FEV1 = forced expiratory volume in 1 s; PC20FEV1 histamine = provocative concentrations of histamine causing a 20% fall in FEV1 in the screening period.

*Atopic status as determined by the number of wheal responses to 10 common allergen extracts (Vivodiagnost, ALK, Benelux).

†Values obtained at the first randomised visit.

‡Baseline values as percentage of predicted values in the screening period. Patients have also been described elsewhere.16

Figure 1 Study design. Dil = diluent; All = allergen; P = placebo; BK = bradykinin; L = N\textsuperscript{G}-monomethyl-L-arginine.
resistance of 5 cm H$_2$O was applied to prevent bias of the measurement with nasal NO. Plateau levels of NO were determined and expressed as parts per billion (ppb). Subjects inspired “NO free” air (<1 ppb) during measurements. Three successive recordings were made at 1 minute intervals and the mean was used in the analysis.

**Statistical analysis**

The difference in FENO after allergen challenge was expressed in absolute terms as the area under the time-response curve (AUC) from 0 to 48 hours (total AUC$_{0-48}$/48 = mean FENO), from 0 to 1 hour (AUC$_{0-1}$) in the EAR, and from 1 to 24 hours (AUC$_{1-24}$) in the LAR. The effect of bradykinin on FENO in the ALL/L/BK period was calculated in terms of the difference between treatments or the difference from placebo with 95% confidence intervals for these differences.

Values in the text and figures are expressed as mean (SE) or 95% confidence intervals (95% CI). In order to measure the effect of allergen and diluent on FENO we compared AUC$_{0-1}$, AUC$_{1-48}$, and total AUC$_{0-48}$ using one way analysis of variance (ANOVA). Repeated measures ANOVA was applied to test whether there were any differences in baseline FENO on different days and in FENO between treatments. Two tailed Student’s $t$ tests were applied to explore the differences. Repeated measures ANOVA of PC$_20$ histamine and FEV$_1$ values not described in the previous report were performed. In all cases a p value of <0.05 was considered significant.

Statistical analyses were performed using Statistica for Windows (StatSoft Inc; Tulsa, OK, USA). A power calculation was based on the standard deviation (SD) of the differences between the bradykinin induced reduction in FENO during placebo pretreatment in the Dil/P/BK (day 3) and All/P/BK (day 3) periods. Based on this SD (13.6% change in FENO), the current sample size allows us to detect a difference of 13.6% in FENO (1 SD) between repeated bradykinin challenges (power 0.8, $\alpha$ 0.05).

**RESULTS**

**Airway responses**

PC$_20$ histamine was similar in each study phase ($p=0.28$). Airway responses to placebo of challenge with L-NMMA (0.9% saline) or 1-NMMA (10 mg in 3 ml) plus diluent or allergen challenge have been reported previously. At 24 and 48 hours after allergen challenge FEV$_1$ was similar to baseline in both the All/P/BK ($p=0.57$) and All/L/BK periods ($p=0.23$). Bradykinin challenge before and after diluent or allergen provoked a similar percentage reduction in FEV$_1$ in the Dil/P/BK period (26 (2)% and 25 (2)%), All/P/BK period (27 (2)% and 28 (2)%), and All/L/BK period (26 (2)% and 28 (2)%), respectively ($p=0.44$).

**Exhaled NO**

NO was detectable in the exhaled air of all asthmatic subjects. Baseline FENO values in the Dil/P/BK period (day 3: 37 (11) ppb; day 8: 38 (12) ppb), All/P/BK period (day 3: 35 (9) ppb; day 8: 33 (8) ppb), and All/L/BK period (day 3: 37 (10) ppb; day 8: 31 (8) ppb) were not different (MANOVA, $p=0.48$).

There was no change in FENO up to 48 hours after diluent challenge (day 8), whereas allergen challenge on day 8 reduced FENO in the first hour after the end of the challenge in the All/P/BK and All/L/BK periods (fig 2), as shown by the significant differences between AUC$_{0-1}$ for FENO in the All/P/BK period (19.9 ppb/h (95% CI 9.2 to 30.7)), the All/L/BK period (17.9 ppb/h (95% CI 8.5 to 27.4)), and the Dil/P/BK period (38.1 ppb/h (95% CI 9.6 to 66.6); $p=0.04$). FENO was increased in the LAR after allergen challenge in the All/P/BK and All/L/BK periods (fig 2). AUC$_{1-48}$ for FENO on day 8 was significantly different in the All/P/BK (3282 ppb/h (95% CI 1693 to 4870)), All/L/BK (2579 ppb/h (95% CI 1467 to 3690)), and Dil/P/BK periods (1781 ppb/h (95% CI 471 to 3091); $p=0.008$). The differences in total AUC$_{0-48}$ for FENO, interpreted as the mean FENO, on day 8 in the All/P/BK (68.8 ppb (95% CI 35 to 102)), All/L/BK (54.1 ppb (95% CI 31 to 77)), and Dil/P/BK periods (37.8 ppb (95% CI 10 to 65)) were significant ($p=0.009$). The differences in all the AUCs for FENO between diluent and the two allergen challenges are shown in table 2.

In the Dil/P/BK period FENO values were significantly lower after bradykinin than after placebo (fig 3) on day 3 (difference 23.5 ppb (95% CI 6.2 to 40.9); $p=0.01$) and day 10 (difference 22.5 ppb (95% CI 7.3 to 37.7); $p=0.008$). Both FENO values after bradykinin in the Dil/P/BK period were not significantly different from the corresponding FENO value on the pre-allergen day in the All/P/BK period (13.6% change in FENO). Forty eight hours after allergen challenge in the All/P/BK period bradykinin completely suppressed the increased FENO levels (fig 3), as shown by the reduction in the allergen induced increase in FENO (difference from placebo: 54.3 ppb (95% CI 23.8 to 84.8); $p=0.003$) to the baseline level of the pre-allergen day ($p=0.51$). The difference between the reductions in FENO induced by bradykinin from the respective placebo 48 hours after allergen in the All/P/BK period and after diluent in the Dil/P/BK period was statistically significant (31.8 ppb (95% CI 7.1 to 56.5); $p=0.017$).

In the Dil/P/BK and All/P/BK periods, neither placebo nor 1-NMMA (0.9% saline) changed baseline FENO on any study days (fig 3). In the All/L/BK period the differences between the level of FENO after 1-NMMA and placebo before and after allergen were significant (All/L/BK: 10.85 ppb (95% CI 1.3 to 20.4); $p=0.029$; All/P/BK: 36.2 ppb (95% CI 5.5 to 66.9), $p=0.026$).

After pretreatment with 1-NMMA, bradykinin significantly reduced FENO on pre-allergen (difference from 1-NMMA: 14.1 ppb (95% CI 6.8 to 21.4); $p=0.002$) and post-allergen (difference from 1-NMMA: 29.7 ppb (95% CI 16 to 43.5); $p=0.0008$) days (fig 3). The differences between the level of FENO after placebo plus bradykinin in the All/P/BK period and after 1-NMMA plus bradykinin in the All/L/BK period on pre- and post-allergen days (1.96 ppb (95% CI −2.1 to 6), $p=0.3$; and 9.4 ppb (95% CI −0.5 to 19.5), $p=0.06$, respectively) were not statistically significant. The difference between the baseline values of FENO (48 hours after allergen) on the post-allergen day (day 10) in the All/P/BK and All/L/BK periods was 15.8 ppb (95% CI −5 to 36.4); $p=0.11$,
which explains the slight difference between FENO after placebo plus bradykinin in the All/P/BK period and after i-NMMA plus bradykinin in the All/L/BK period on the post-allergen day.

On all bradykinin treatment days the recovery time (up to 60 minutes) was characterised by a complete spontaneous recovery in FEV₁ values to baseline levels, whereas FENO levels remained significantly lower than baseline (p<0.05, fig 4).

**DISCUSSION**

This study shows, for the first time, that the allergen induced increase in FENO in atopic asthma is suppressed by bradykinin, and that the NOS inhibitor i-NMMA significantly reduces pre- and post-allergen FENO levels and does not potentiate the bradykinin induced reduction in FENO. Taken together, our results indicate that bradykinin, via NOS inhibition, modulates the prolonged increase in FENO induced by allergen exposure. Our findings suggest that bradykinin inhibits excessive NO production resulting from an overexpression of the NOS pathway in asthmatic airways during an exacerbation.

The bradykinin induced fall in FENO levels in stable asthmatics has recently been reported by Kharitonov et al. 17 We have shown that bradykinin suppresses increased levels of FENO 48 hours after allergen challenge, which suggests that it has a role in modulating exacerbations of allergic inflammation. Furthermore, the finding that FENO levels were still significantly reduced 60 minutes after the end of the pre-allergen and post-allergen bradykinin challenge, when FEV₁ had completely recovered, suggests that the rapid suppression of FENO by bradykinin has a relatively long duration and is not dependent on airway calibre. One possible explanation for the action of bradykinin is vasodilation 18 with potentially enhanced NO trapping by haemoglobin 19 and/or altered diffusion of NO to the airway lumen due to mucosal swelling and gland secretion 20 with subsequent airway obstruction; however, the short term effect of vasodilation and the reduction in FENO even after recovery of the obstruction limit the validity of this hypothesis.

In this study we also examined whether bradykinin negatively modulates FENO through inhibition of NOS. i-NMMA has previously been found to reduce FENO levels significantly in stable asthma, 21 so we studied the effect of i-NMMA on the bradykinin induced reduction in FENO. The lack of significant potentiation by i-NMMA on the bradykinin induced reduction in FENO suggests that bradykinin and i-NMMA share a common pathway in inhibiting FENO production in the airways of patients with asthma. It has recently been found that prostaglandins also reduce FENO in asthmatic subjects. 22 Bradykinin stimulates PG₂E release from airway epithelial cells, either by the constitutive isoform of cyclo-oxygenase enzyme (COX-1) or by the inducible isoform (COX-2), 23 and PG₂E negatively modulates the induction of iNOS expression at the transcriptional level. 24 It is therefore possible that the reduction in FENO induced by bradykinin is a result of the inhibition of iNOS expression through the release of PGE₂. However, the rapid reduction in FENO observed after bradykinin inhalation does not favour such a delayed mechanism, but suggests a possible direct or indirect influence of bradykinin on NOS at the post-transcriptional level. It has previously been shown that high levels of NO can downregulate NOS pathways by negative feedback, 25 and also that augmented production of FENO in the lower respiratory tract of eNOS deficient mice is associated with pulmonary iNOS overexpression, indicating a counter-regulation between the two NOS isoforms. 26

Furthermore, a recent study in human mesangial cells showed a negative post-transcriptional regulation of iNOS by the NO/cGMP pathway. 27 On the basis of the present results we believe that bradykinin is not only an activator of the Ca²⁺ dependent cNOS/cGMP pathway which modulates airway hyperresponsiveness, 28 but also may downregulate excessive NO release, probably derived by iNOS, through negative feedback in allergic asthma.

In line with this hypothesis, we have previously shown that iNOS (but not eNOS or nNOS) immunostaining is higher after allergen exposure in the epithelium of bronchial biopsy sections of subjects with asthma, 29 which suggests two major findings on the basis of the present data: (1) iNOS may be responsible for the increase in FENO after allergen; (2) bradykinin should affect iNOS activity by reducing FENO in asthmatic patients and, in particular, by suppressing the increase in FENO after exposure to allergen.

In the present study, allergen inhalation led to two opposing changes in FENO levels in atopic mild asthmatics. Exhaled NO tended to decrease during the EAR and exhibited a prolonged increase during and after the LAR. These findings are consistent with previous data showing the effect of allergen on FENO levels in atopic asthmatic patients with LAR. 30 In the early phase we found a reduction in FENO levels compared with baseline, which confirms previous observations. 31 In previous studies acute airways obstruction has been found to have a partial effect on FENO levels. 32 It is therefore possible that bronchoconstriction could, at least partially, lead to a fall in FENO levels during the early phase of the bronchial allergic reaction, possibly as a result of limiting NO diffusion or increased airflow velocity in constricted airways. We also postulate an indirect effect of allergen on FENO levels during the early phase reaction via the release of proinflammatory mediators such as kinins or prostanoids. 15 16

Exhaled NO appeared to increase 9–48 hours after allergen inhalation, confirming a previous report. 33 In the latter study the authors observed a decline in FENO by 27 hours. The longer duration of increased FENO in our study could be a reflection of a possibly higher level of allergic inflammation induced by allergen exposure. Several lines of evidence suggest that FENO reflects iNOS expression in asthma, 34 which recognises that FENO is a non-invasive marker of

### Table 2

<table>
<thead>
<tr>
<th>Condition</th>
<th>Difference in AUC&lt;sub&gt;0–1&lt;/sub&gt; (ppb/h)</th>
<th>Difference in AUC&lt;sub&gt;1–48&lt;/sub&gt; (ppb/h)</th>
<th>Difference in total AUC/48 (ppb)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diluent (Dil/P/BK period) v</td>
<td>18.1 (1.3 to 37.5); p = 0.06</td>
<td>-1500 (-2469 to -31) (p = 0.007);</td>
<td>-31 (-51 to -11); p = 0.007</td>
</tr>
<tr>
<td>allergen (All/P/BK period) v</td>
<td>20.2 (-4.8 to 45); p = 0.10</td>
<td>-798 (-1908 to 312); p = 0.13</td>
<td>-16.2 (-40 to 7); p = 0.15</td>
</tr>
<tr>
<td>allergen (All/L/BK period) v</td>
<td>2.05 (-5 to 9.1); p = 0.53</td>
<td>702 (-55 to 1460); p = 0.07</td>
<td>14.7 (-1 to 30); p = 0.07</td>
</tr>
<tr>
<td>allergen (All/L/BK period) v</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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airway inflammation in asthma. The delayed and long term increase in \( \text{FE}_{\text{NO}} \) during the LAR could be explained by the action of proinflammatory cytokines released from inflammatory cells recruited to the airways after allergen exposure, and of reactive oxygen species with subsequent upregulation of iNOS expression. Furthermore, an additional explanation could be derived from the recent evidence that airway acidification converts nitrite (\( \text{NO}_2^- \)) to NO gas in quantities consistent with those observed in expired air during an asthma exacerbation, or after the LAR to allergen.

To avoid differences in \( \text{FE}_{\text{NO}} \) as a result of smoking or medication use, we selected a homogeneous group of non-smoking, atopic, mild intermittent asthmatic subjects who were not using any steroid medication before or during the experiments. It has recently been shown that repeated forced vital capacity (FVC) manoeuvres significantly reduce \( \text{FE}_{\text{NO}} \) levels in healthy and asthmatic subjects by 13% and 10%, respectively. Even though our \( \text{FE}_{\text{NO}} \) measurements were performed 2 minutes after an FVC manoeuvre, we do not consider that it had any effect because no effect on the \( \text{FE}_{\text{NO}} \) measurement was seen following diluent.

\[ \text{NO released by iNOS is likely to exert proinflammatory activities such as induction of eosinophil chemotaxis and activation of the Th2 driven immune response, as observed during the late phase response to inhaled allergen. The bradykinin induced suppression of raised } \text{FE}_{\text{NO}} \text{ levels during the late phase suggests that bradykinin can modulate allergic inflammation exacerbations in the airways by the inhibition of proinflammatory NOS. On the basis of our study, a clinically relevant scenario could be outlined in patients with asthma where an acute inflammatory mediator (bradykinin) could have a modulatory role in limiting the effect of a detrimental long lasting inflammatory pathway (iNOS). The} \]
reinforcement of such endogenous protective mechanisms should be considered as a potential therapeutic target in asthma.

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