LETTERS TO THE EDITOR

Comorbidity in elderly NSCLC patients

We read with interest the report by Janssen-Heijnen and associates on the effect of comorbidity on the treatment and prognosis of elderly patients with non-small cell lung cancer (NSCLC).1 The authors concluded that the number of comorbid conditions had no significant influence on the treatment chosen for patients with non-localised disease. We share the authors’ opinion that “comorbidity had no independent prognostic effect”. In their report, the authors used the Charlson comorbidity index and analysed the number of comorbid conditions. However, they did not examine the scoring system of the index. We would like to know why the authors did not use the scoring of the index, and whether the conclusion would be different if the scoring system was used.

In the original article by Charlson et al and other related studies,2,3 “angina pectoris” was not evaluated as one of the cardiovascular comorbidity diseases. However, Janssen-Heijnen et al4 included “angina pectoris” as a comorbid disease although they did not describe it precisely. We consider this inclusion is reasonable, and we would appreciate hearing from the authors whether “angina pectoris” would be evaluated as one of the cardiovascular comorbidity diseases in future studies to evaluate the effect on mortality, and what score it should be assigned.

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References

Authors’ reply

Miyazaki and colleagues wonder why we did not use the scoring system of Charlson’s comorbidity index and whether the conclusion would be different if the scoring system was used. We did not use the scoring system of Charlson’s index because this was not available in the large population based database from which the data were derived. We were, however, able to analyse the prognostic impact of each condition and each combination of conditions. None of these had a significant prognostic impact.1 The conclusion might have been different if we had used the scoring system. However, in two other recent studies5,6 the hazard ratio for death for comorbidity was much lower for patients with a lethal tumour than for those with a tumour with a good prognosis.

We also included angina pectoris as a comorbid condition. We think it is important to include this condition in future studies. In other studies, hospitalization for angina or treated angina was classified as high severity for mortality, and angina not requiring hospitalisation or untreated angina was classified as moderate severity.2,3 The severity index should be validated in future studies.

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References

Neutrophilic inflammation in childhood bronchial asthma

Although there is increasing evidence that neutrophilic inflammation is involved in enhanced bronchial reactivity and exacerbation of bronchial asthma,7 the definitive role of neutrophil mediated inflammation in the pathophysiology has not been fully established. To investigate this further, we performed a historical cohort study of 64 children with primary autoimmune neutropenia (AIN) and compared the incidence of asthma with a control group. The study was approved by the Human Research Committee of Shinsu University.

Between January 1997 and December 2000, 64 patients (31 boys and 33 girls) of mean (SD) age 6.1 (1.9) years (range 4.8–10.3) were recruited from our hospitals (table 1). They were followed up for at least 3 years. All were diagnosed with AIN by the age of 12 months, and they had no signs of other autoimmune diseases or haematological disorders. Neutropenia is defined as an absolute neutrophil count of less than 1000/μl blood lasting for 6 months. The diagnosis of AIN was determined by the presence of antineutrophil antibodies and bone marrow findings. Neutropenia resolved in 46 patients (71.9%) within 16–60 months after diagnosis. 415 control subjects (218 boys and 197 girls) were recruited from the following: all children who resided in areas of Matsumoto, Toyoshina and Moriguchi. They were matched with each of the index children in terms of age, sex, and indoor family smoking. A diagnosis of bronchial asthma was established by interviewing the parents with the modified ATS-DLD structured questionnaire8 and paediatric pulmonologists reviewed the clinical symptoms and responses to asthma medications under 3 years of age (before school age). The results were analysed using the χ² test (with Yate’s correction) for categorical variables. The frequency of asthma and eczema in first degree relatives was identical for the two groups (8.2% ± 7.1% and 16.1 ± 18.2%, respectively).

In controls, the prevalence of asthma was 9.9%. By contrast, none of the patients with AIN developed asthma (p = 0.0243) during the neutropenic period and/or recurrent wheezing episodes.

Our findings strongly suggest that neutrophilic inflammation contributes to the onset of childhood asthma. It is well known that, in infants, common viral infections of the respiratory tract such as respiratory syncytial virus (RSV) can induce small airway bronchiolitis and persistent infantile wheezing without significant eosinophilia.9 Injurious viral infections are common precipitants of exacerbations of asthma. It has been proposed that interleukin (IL)-8 and neutrophil elastase are key factors in this process. Antineutrophil antibodies in AIN usually recognise HNA-1 and HNA-2 antigens that are not detected on...
Table 1 No (%) of children diagnosed with infantile asthma and their history

<table>
<thead>
<tr>
<th>AIN</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>31</td>
</tr>
<tr>
<td>Girls</td>
<td>33</td>
</tr>
<tr>
<td>Asthma</td>
<td>0.64</td>
</tr>
<tr>
<td>(0.05)</td>
<td>(9.95)*</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>6.1 (1.9)</td>
</tr>
<tr>
<td>age (years)</td>
<td>12</td>
</tr>
<tr>
<td>Smoking in family</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

*Significant difference between groups (p = 0.0243).

References


3. Ferris BG. Epidemiology standardization project.


Protein C in pneumonia

Pneumonia is characterised by a disturbed alveolar fibrin turnover which is the net result of activation of coagulation and attenuation of fibrinolysis.1,2 We have recently shown, in patients developing ventilator associated pneumonia (VAP), that suppression of fibrinolysis precedes the clinical diagnosis while procoagulant effects mainly occur afterwards.3 We have extended these findings by investigating the relationship in time between changes in the anti-coagulant protein C (PC) pathway and VAP. Levels of PC, activated PC (APC), and soluble thrombomodulin (sTIM) were measured in non-directed bronchial lavage fluid collected every other day from critically ill patients during mechanical ventilation. APC was measured with an enzyme capture assay using monoclonal antibody HAPC 1555 and chromogenic substrate Spectrozyme PCa (American Diagnostica, Greenwich, CT, USA); PC activity was measured with an amidolytic assay using chromogenic substrate S2366 (Chromogenix, Milan, Italy); and sTIM was measured with an ELISA (Diagnostica Stago, Asnières-sur-Seine, France). Serial data from patients were evaluated using analysis of repeated measures with a linear mixed model, as described previously.4 Data are presented as medians (interquartile ranges).

The patient population was as previously described.5 In short, specimen collection was initiated in 60 consecutive patients; 28 patients were selected for final analysis, which required at least three sample sets (minimum ventilation duration >5 days). Nine patients developed VAP and 19 showed no signs of pulmonary infection during the clinical course. There were no significant differences between patients who did and did not develop VAP with regard to baseline characteristics, mechanical ventilation settings, and baseline levels of PC, APC, and sTIM. Median (IQR) baseline concentrations (minimum ventilation duration 5 days). In patients who developed VAP the clinical diagnosis was preceded by a fall in pulmonary PC levels, as measured in lavage fluids, from 0.69 (0.45–0.86) U/ml before VAP to 0.47 (0.24–0.56) U/ml on the day of diagnosis of VAP (p < 0.0001; fig 1). In patients who did not develop VAP, pulmonary PC levels remained unchanged (p = 0.07). The decline in PC levels in the infected lungs was accompanied by a decrease in levels of APC, which fell from 0.40 (0.25–0.46) ng/ml before VAP to 0.21 (0.21–0.37) ng/ml on the day of diagnosis of VAP (p < 0.01; fig 1). The suppression of APC occurred before the clinical diagnosis of VAP was made. Furthermore, in patients who developed VAP a significant increase in sTIM levels was observed. Local levels of sTIM increased from 95 (120–151) ng/ml before VAP to 214 (186–312) ng/ml on the day of diagnosis of VAP (p < 0.0001; fig 1). Thereafter, sTIM increased to a lesser extent from 102 (79–123) ng/ml at admission to 130 (102–156) ng/ml on day 10 of mechanical ventilation (p < 0.01; fig 1). In sepsis, low levels of APC contribute, at least in part, to the systemic procoagulant shift of the haemostatic balance, potentially evolving into disseminated intravascular coagulation.6 Correction of the systemic haemostatic balance has been acknowledged as a pivotal goal in the treatment of patients with sepsis. Indeed, treatment with recombinant human APC has been found to reduce mortality in patients with severe sepsis.7 Our results show that, during the pathogenesis of pneumonia, the PC pathway is locally suppressed. We suggest that this is the net result of increased PC consumption, cleavage of PC by neutrophil elastase, as well as inadequate PC activation due to oxidation of TM and shedding of TM from the cell surface (resulting in soluble fragments of TM).7 Presumably, the insufficient anticoagulant PC system contributes to the local procoagulant environment at the site of infection during pneumonia. Correction of the local PC system may be a target in the treatment of pneumonia.

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doi: 10.1136/thx.2005.043075

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Figure 1 Levels of protein C (PC), activated protein C (APC), and soluble thrombomodulin (sTIM) in non-directed bronchial lavage fluid prospectively collected in mechanically ventilated patients. Left panels: patients who did not develop pneumonia; day 0 denotes start of mechanical ventilation. Right panels: patients who developed ventilator associated pneumonia (VAP); day 0 corresponds to the day at which VAP was clinically diagnosed. Data represent medians with interquartile ranges.

Table 1: No (%) of children diagnosed with infantile asthma and their history

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*Significant difference between groups (p = 0.0243).
The study protocol was reviewed and approved by the Central Oxford regional ethics committee. This study was funded in part by the Oxford Health Services Research Committee (research project number 593). doi: 10.1136/thx.2004.037341

References

Surgery for difficult persistent asthma

A 35 year old non-smoking woman was referred to hospital for advice regarding poorly controlled atopic asthma. Despite good compliance with fluticasone 2 mg/day, a long-acting β2 agonist, anticholinergic agent, nebulised bronchodilators plus theophylline, she experienced persistent symptoms necessitating frequent courses of oral corticosteroids. It became apparent that her asthma control deteriorated after menstruation—a pattern which was not influenced by premenstrual or continuous oral corticosteroids. Trials with various combined oral contraceptive pills failed to improve asthma control. Some improvement was observed with 6 months of treatment with a gonadorelin analogue (goserelin); although premenstrual exacerbations of asthma did persist, exacerbations were less marked resulting in a significant reduction in oral corticosteroid use. Gonadorelin analogues produce an initial phase of stimulation followed by downregulation of gonadotrophins, releasing hormone receptors, thereby reducing the release of gonadotrophins and subsequent inhibition of oestrogen production. On discontinuation of goserelin (contraindicated for use longer than 6 months) symptomatic asthma recurred, requiring repeated monthly courses of oral corticosteroids. Following discussion with the patient and her gynaecologist, it was decided that, given the cyclical severity of symptoms, the need to supplement oral corticosteroids, and partial success with a gonadorelin analogue, definitive surgical treatment should be considered.

Four years after initial referral a bilateral oophorectomy and subtotal hysterectomy was performed without complication and an oestrogen-alone hormone replacement was implanted. In the year following surgery the patient had a single exacerbation of asthma that coincided with the end of the effectiveness of her oestrogen implant (with consequent rise in hemoglobin and oestradiol levels due to lack of suppression by oestrogen). She was subsequently commenced on regular oestrogen only hormone replacement therapy to good effect. One year after surgery the patient has discontinued alternative day oral prednisolone, is asymptomatic, and maintained on 250 μg/day fluticasone combined with salmeterol.

This unusual case highlights the importance of enquiring about the possible temporal relationship between worsening asthma control and the menstrual cycle. Premenstrual exacerbations of asthma are well recognised and do not always respond to more aggressive anti-inflammatory treatment. Some success has been achieved with the institution of oral oestrogen and intramuscular progesterone administration.1 We believe this to be one of the first documented cases of difficult asthma where marked improvement in asthma control has been achieved after a beneficial therapeutic trial of a gonadorelin analogue, followed by bilateral oophorectomy and subtotal hysterectomy plus oestrogen replacement. An initial improvement in asthma control was observed when gonadotrophin levels were low (as a result of the gonadorelin analogue) and a deterioration occurred when gonadotrophin levels were likely to have been rising (towards the end of the effectiveness of the oestrogen implant). This, in turn, suggests that high (or rapidly increasing) gonadotrophin levels, rather than oestrogen/progesterone, were implicated in adversely affecting asthma activity.

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Is there a relationship between Mycobacterium tuberculosis strain type and TB paradoxical reaction?

Paradoxical reaction (PR) in tuberculosis (TB) is defined as transient worsening of symptoms and signs or the appearance of new lesions after beginning appropriate anti-tuberculosis chemotherapy. Recent studies suggest that PR is a feature of a subset of patients. It is more common and more severe in HIV co-infected individuals with disseminated disease.1 PR is thought to be an immune mediated phenomenon but the reasons for its occurrence are unknown.2

Infection by Mycobacterium tuberculosis (MTB) results in highly variable outcomes between individuals. The characterisation of MTB strains by molecular typing techniques suggests this may be a reflection of the infecting organism, as well as host response and environmental factors. Indeed, distinct genotypes have been shown to evoke different immunopathological events in mouse models3 and variable clinical manifestations in human population based studies. Further, infection, individual susceptibility and type of HIV infection have been linked to particular clinical outcomes; for example, a significant association was seen between the Beijing MTB lineage and transient fever unrelated to disease severity, toxicity, or drug resistance in early treatment.4

We sought to investigate the hypothesis that the risk of PR may be strain dependent as defined by IS6110 restriction fragment length polymorphism (RFLP) typing. Between January 2002 and December 2003 all adult patients seen at our centre with culture positive MTB had IS6110 RFLP typing performed on one isolate. A case note review was performed retrospectively for clinical evidence of PR.5 IS6110 RFLP typing was undertaken using a modification of the standard international protocol.5 All patterns were entered onto a database using Bionumerics Edition 3.0 package (Applied Maths, Kourtrai, Belgium). Comparison of DNA fingerprints and cluster analysis of profiles was performed by calculation of the Dice coefficient; optimisation was set at 1% and minimum tolerance at 1%. Each cluster was defined as a series of isolates with 100% identity. A putative lineage was identified as a series of isolates with 70% or greater similarity.6,7

143 patients had isolates that were typed. 100 (69%) sets of notes were reviewed. 45 were excluded (24 were unavailable or incomplete; 21 patients were lost to follow up or care was transferred). Of the 100 patients' notes reviewed, 52 were male, age range 16–81 years. 48% were black African, 16% Asian, and 19% from the UK. Table 1 shows the TB site and HIV status of the patients. PR occurred in 20 patients (20%) (HIV positive 10/26 (38%); HIV negative or unknown 10/74 (14%)). All patients with PR had distinct IS6110 RFLP profiles suggesting 20 separate strains.

There was only one identified lineage with a similarity of 70% within the whole patient cohort. This was not associated with increased risk of PR. The group comprised 10 patients who were all black African, only one of whom had a PR. The similarity is likely to represent an original strain of African descent (data not shown).

IS6110 typing is the recognised gold standard for MTB strain typing and has widespread application in epidemiological and outbreak investigations of tuberculosis. Using this method we found one lineage, but no association between strain type and PR. The power of our study is limited by its small size and use of a single laboratory. However, the rate of PR (20% and three times higher in HIV positive subjects: 38% vs 14%) is in line with previous work.1 IS6110 typing is not a definitive phylogenetic marker and other molecular techniques such as single nucleotide polymorphism may demonstrate an association.

The possibility exists that paradoxical TB reactions may be a consequence of specific host response genes. Particular MHC haplotypes have been linked to “immune reconstitution disease” in HIV positive patients starting antiretroviral therapy.1 A larger study
is needed to focus on both strain type and consequent host immune response.

**References**


**Table 1** Site of TB and HIV status of patients with and without clinically evident paradoxical reactions (PR)

<table>
<thead>
<tr>
<th>Pulmonary TB</th>
<th>Lymph node TB</th>
<th>Other primary site</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV+</td>
<td>HIV-</td>
<td>HIV+</td>
</tr>
<tr>
<td>FR</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>No FR</td>
<td>10</td>
<td>46</td>
</tr>
<tr>
<td>NK, not known.</td>
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</tbody>
</table>

**Table 1** Mean (SD) 6MWD and cardiac haemodynamics at baseline and after at least 3 months of treatment with bosentan

<table>
<thead>
<tr>
<th>6MWD (m)</th>
<th>3 months change (m)</th>
<th>Baseline</th>
<th>3 months</th>
<th>Change from baseline</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYHA class II/III/IV</td>
<td>5/14/1</td>
<td>8/11/1</td>
<td>262 (106)</td>
<td>307 (100)</td>
<td>45 (53)</td>
</tr>
<tr>
<td>CI (l/min/m²)</td>
<td>1.9 (0.62)</td>
<td>2.3 (0.59)</td>
<td>918 (275)</td>
<td>247 (322)</td>
<td>0.003</td>
</tr>
<tr>
<td>TRP (dyne.s/cm²)</td>
<td>1165 (392)</td>
<td>918 (275)</td>
<td>247 (322)</td>
<td>0.003</td>
<td></td>
</tr>
<tr>
<td>PVR (dyne.s/cm²)</td>
<td>964 (406)</td>
<td>690 (271)</td>
<td>274 (300)</td>
<td>0.005</td>
<td></td>
</tr>
<tr>
<td>mPAP (mm Hg)</td>
<td>48 (13)</td>
<td>45 (11)</td>
<td>3 (7.6)</td>
<td>0.09</td>
<td></td>
</tr>
<tr>
<td>mRAP (mm Hg)</td>
<td>9.4 (6.5)</td>
<td>7.7 (4.8)</td>
<td>1.6 (6.6)</td>
<td>0.28</td>
<td></td>
</tr>
<tr>
<td>Mixed venous saturations (%)</td>
<td>59 (8.6)</td>
<td>63 (7.8)</td>
<td>3.8 (9.6)</td>
<td>0.15</td>
<td></td>
</tr>
</tbody>
</table>

**References**


**Table 1** Mean (SD) 6MWD and cardiac haemodynamics at baseline and after at least 3 months of treatment with bosentan
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