Comparison of measured exhaled nitric oxide at varying flow rates

Altered levels of exhaled nitric oxide (FeNO) have been well documented in a number of conditions, although it is in asthma that this phenomenon has been most extensively investigated. Raised FeNO levels in patients with asthma have been correlated not only with other markers of airway inflammation (including induced sputum eosinophil count), but also with airway hyperresponsiveness and response to inhaled corticosteroids. Furthermore, the detection of a raised FeNO level has been shown to have a positive predictive value of up to 95% for the diagnosis of asthma.

A number of factors can influence the production and measurement of FeNO including airway calibre, caffeine, smoking and, in particular, respiratory flow rate. A standardized flow rate of 50 ml/s has recently been adopted by both the European Respiratory Society and the American Thoracic Society; however, to date, there has been a discrepancy in the rates used by clinicians and researchers worldwide. The Logan LR 2000 chemiluminescence analyser (Logan Research Ltd, UK) uses a mouth flow rate of 250 ml/s to measure FeNO while the Niox Nitric Oxide Analyzer (Aerocrine AB, Sweden) uses a flow rate of 50 ml/s. Both analysers use online measurements to calculate FeNO, express the results in parts per billion (ppb), and have similar accuracies. Few data are available to allow direct comparison between the two analysers and hence flow rates. This can make comparison of studies using the different methods difficult. We have prospectively analysed the FeNO from asthmatic (n = 63) and non-asthmatic (n = 29) adult patients with both devices in a head to head fashion. We have prospectively analysed the FeNO level has been shown to have a positive predictive value of up to 95% for the diagnosis of asthma. One another (r² = 0.62, p<0.001). Altman-Bland plots of the data obtained support the suggestion that there is a high level of agreement between the two methods (fig 1). This agreement is retained when subgroup analysis of asthmatics and non-asthmatics is performed. The slightly better discrimination between asthmatics and non-asthmatics at lower flow rates (shown by the well separated confidence intervals) may be partly because of the improved FeNO plateau at this rate.

These results suggest that data obtained using either flow rate are valid, and the methods demonstrate a strong degree of correlation. This is an important confirmatory analysis as it facilitates comparison of results obtained by the two techniques, both previously and in ongoing clinical trials using flow rates which differ from that recently recommended.

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References

Local IFN-γ responses in TB

Globally, the tuberculin skin test (TST), smear microscopy, and culture remain central to the diagnosis of tuberculosis (TB) because of the cost and ease of performance. However, TST has poor sensitivity and reduced sensitivity in settings including HIV and advanced TB, smear microscopy lacks sensitivity, and TB culture (the diagnostic gold standard) takes weeks and is positive in only two thirds of treated cases. TB pleuritis and peritonitis can be particularly difficult to diagnose due to paucity of bacilli and often need invasive or open procedures. In this setting, assays measuring interferon-γ (IFN-γ) production by lymphocytes in response to TB antigens may be useful. While most studies have used blood based assays, more clinically relevant information may exist in local fluids such as bronchoalveolar lavage (BAL) fluid and pleural fluid in which much higher responses have been achieved.

We investigated a 32 year old Somali man, resident in Britain for 2 years, who presented with a 3 week history of vomiting, diarrhoea, anorexia, and abdominal pain. On examination he was febrile (38.5°C), tachycardic, and tachypnoeic. No lymph nodes were palpable. A BCG scar was noted. He had signs of a right pleural effusion and ascites. BAL and pleural fluid cultures were negative.

A full blood count showed lymphopenia (0.26 × 10⁹/l), normal neutrophils (3.6 × 10⁹/l), hypochromic microcytic anaemia (Hb 10.7 g/dl), and a normal platelet count.

Hyponatraemia (129 mmol/l (normal range 135–145)), hypocalcaemia (28 g/l (normal range 35–50)), and mild hepatitis (aspartate transaminase 121 U/l (normal range 3–50)) were noted. Inflammatory markers were increased as follows: C reactive protein 280 mg/l; erythrocyte sedimentation rate 75 mmh. An HIV antibody test was negative. A tuberculin skin test was not performed. The CT scan showed a moderate right pleural effusion and small left pleural effusion, small bowel dilatation, and mesenteric induration. A right pleural effusion and ascites were noted on ultrasound. The ascitic fluid was a transudate, and the pleural fluid was a transudate. The ascites fluid was non-inflamed (171 cells/ml (75% lymphocytes)) with 55 g/l protein and 3.8 mmol/l glucose was found but no organism was identified. The pleural fluid had a protein level of 36 g/l and a glucose level of 6.4 mmol/l.

Bronchoalveolar lavage was performed. Auramine staining of sputum and ascitic fluid, pleural, and BAL fluids was negative. Molecular assays (TB strand displacement assay) were negative from all sites. TB cultures were negative at 8 weeks. The pleural fluid, ascitic fluid, BAL fluid, and peripheral blood were examined for absolute leucocyte and lymphocyte numbers by flow cytometry, as well as lymphocyte phenotypes. The frequency of lymphocytes synthesising IFN-γ in response to purified protein derivative of Mycobacterium tuberculosis (PPD) was then measured as described previously. The percentage of lymphocytes in BAL fluid, ascitic fluid, and pleural fluid was 10.5%, 79.2%, and 91.1%, respectively. In CD3+ T cells the CD4/CD8 lymphocyte ratios in BAL fluid, ascitic fluid, pleural fluid, and blood were 1.5, 7.7, 2.7, and 2.1, respectively, in the CD4+ T cell population. The frequency of PPD specific IFN-γ positive lymphocytes in BAL fluid, ascites, pleural fluid, and...
A presumptive diagnosis of tuberculous peritonitis was made. The patient was too unwell for exploratory surgery. Empirical antituberculosis treatment with rifampicin, isoniazid, ethambutol, and pyrazinamide was commenced with adjunctive corticosteroids which resulted in rapid resolution of his symptoms and signs. Corticosteroids were tailed off over a few weeks. He continues on rifampicin and isoniazid and remains well.

Although we were unable to obtain histological or microbiological confirmation of the diagnosis in this case, clinical and radiological evidence combined with the treatment response were highly suggestive of TB. The patient had marked lymphopenia which, in HIV negative TB patients, has been associated with extrapulmonary disease, and an attenuation of skin test reactivity.

Hence, in a setting where traditional diagnostic tools are least indicated, may contribute to airway constriction. Here we present experimental evidence that TA causes airway obstruction by non-competitive inhibition of the constitutive endothelial isoform of nitric oxide synthase (eNOS) in the tracheobronchial epithelium, which is reported to provoke airway hyperresponsiveness and bronchoconstriction.

Organ bath experiments were performed using the trachea and main bronchi of non-sensitised guinea pigs. The tracheobronchial tree was dissected out of CO₂ sacrificed guinea pigs of either sex weighing 300–450 g and cut into rings of 3–4 cartilage segments wide. Isometric contractions were recorded as described previously. Briefly, individual rings were mounted in organ baths containing 10 ml carbogen aerated Tyrode solution (pH 7.4, 37°C), kept at a preload of 25 mN, left to equilibrate for 60 minutes, and precontracted by addition of 25 μmol/l prostaglandin F₂α to 30–40% of their individual isometric maximum (100%).

NO release was determined in real time by an amperometric microsensor as described elsewhere. Briefly, the tracheal and bronchial rings were opened longitudinally and kept in Heps-Krebs solution (10 ml; pH 7.4, 25°C). The sensor was placed onto the luminal surface at a distance of 200 μm. After 30 minutes of equilibration, individual NO reactivity was assessed by addition of 15 nmol/l substance P.

Tannic acid (penta-digalloyl-β-D-glucose; Fluka, Seelze, Germany) produced an immediate concentration dependent contraction of the tracheobronchial rings (lasting 30–60 minutes) with a mean EC₅₀ of 0.19 μmol/l (95% CI 0.10 to 0.35) and a maximal response (p = 0.05) was 0.7 nmol/l (corresponding to 1.2 mg/m³). The contraction was completely abolished in epithelium denuded rings and by pretreatment with an unspecific NOS inhibitor. It was not affected by the presence of an inhibitor of the neuronal and inducible isoforms of NOS (fig 1A), indicating that the contraction in non-sensitised guinea pig was entirely due to inhibition of eNOS in the airway epithelium and that TA does not elicit direct effects on tracheobronchial muscle. The contractions were not blunted by addition of the substrate L-arginine, which suggests a non-competitive eNOS blockade by TA (fig 1B).

This finding also agrees with a biochemical
Contraction following treatment with cumulatively increasing concentrations of TA after pre-incubation (15 min) with 0.2 µmol/l TA. (D) Contraction in response to 1 µmol/l bradykinin, 100 µmol/l L-arginine, or 10 µmol/l calcium ionophore A23187 in the absence and after pretreatment (15 min) with 0.2 µmol/l TA, and after removal of the epithelium. (E) Contraction following treatment with cumulatively increasing concentrations of aqueous barley flour extract (20 g/l) and after pre-incubation (15 min) with L-NMMA. Values represent mean (SE) of five independent experiments each. A p value, NOS isoform specific inhibitor 1400 W. Contraction in response to a single 10 mol/l dose of TA compared with subsequent treatment with 100 µmol/l L-arginine. (C) NO release in response to 1 µmol/l bradykinin, 100 µmol/l L-arginine, or 10 µmol/l calcium ionophore A23187 in the absence and after pretreatment (15 min) with 0.2 µmol/l TA. (D) Contraction in response to 1 µmol/l bradykinin, after pre-incubation (15 min) with 0.2 µmol/l TA, and after removal of the epithelium. (E) Contraction following treatment with cumulatively increasing concentrations of aqueous barley flour extract (20 g/l) and after pre-incubation (15 min) with L-NMMA. Values represent mean (SE) of five independent experiments each. A p value <0.05 (two tailed test with Holm correction for multiple comparisons) was considered statistically significant. p values in (A) and (E) indicate the nominal significance levels of TA and barley flour extract induced contractions compared with the respective contractions in the presence of L-NMMA.

In conclusion, hydrolysable tannins may be aetiologically involved in the development of plant dust induced acute and chronic obstructive airway diseases by impairing the endogenous release of bronchoprotective NO.

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