Inducible NO synthase expression is low in airway epithelium from young children with cystic fibrosis

A Moeller, F Horak Jr, C Lane, D Knight, A Kicic, S Brennan, P Franklin, J Terpolilli, J H Wildhaber, S M Stick

Background: This is the first study to measure inducible nitric oxide synthase (iNOS) gene and protein expression quantitatively in primary epithelial cells from very young children with cystic fibrosis (CF). Low levels of exhaled nitric oxide (NO) in CF suggest dysregulation of NO production in the airway. Due to the importance of NO in cell homeostasis and innate immunity, any defect in the pathway associated with CF would be a potential target for treatment.

Methods: Cells were obtained by tracheobronchial brushing from 40 children with CF of mean (SD) age 2.1 (1.5) years and from 12 healthy non-atopic children aged 3.4 (1.2) years. Expression of iNOS mRNA was measured using quantitative PCR and iNOS protein by immunofluorescence and Western blot analysis.

Results: Inducible NOS mRNA expression was significantly lower in CF patients with and without bacterial infection than in healthy children (0.22 and 0.23 vs 0.76; p = 0.002 and p = 0.01, respectively). Low levels of iNOS gene expression were accompanied by low levels of iNOS protein expression as detected by Western blot analysis.

Conclusions: These results support the findings of previous studies in adult patients with advanced disease, cell lines, and animal models. Our findings reflect the situation in children with mild lung disease. They indicate that low iNOS expression may be an innate defect in CF with potential consequences for local antimicrobial defence and epithelial cell function and provide evidence for an approach to treatment based on increasing epithelial NO production or the sensitivity of NO dependent cellular processes.

Considerable efforts are currently being made to enable primary treatment of the genetic abnormality responsible for cystic fibrosis (CF) using a genetic based treatment for the disorder. In addition, strategies to ameliorate the effects of the genetic abnormality or of associated disease modifier genes may be helpful in the short to medium term. An example is the potential for abnormally low nitric oxide (NO) levels in the airways of patients with CF to affect critically normal epithelial function, thus contributing to the multifactorial pathogenesis of CF lung disease. Observations that include measurements of exhaled NO suggest an abnormality in the regulation of this important molecule in CF. The fractional concentration of exhaled NO (FeNO) is increased in a number of inflammatory disorders of the lung. However, despite the severity of airway inflammation, several studies have shown reduced orally or nasally exhaled NO levels in patients with CF. Since there is evidence that inducible nitric oxide synthase (iNOS) in the airway epithelium is the major source of NO in exhaled breath, reduced epithelial iNOS activity is a plausible explanation for these observations. However, the data from studies that have examined epithelial iNOS activity are contradictory. Whether downregulation of epithelial iNOS in CF is a fundamental or even innate defect is important, given the crucial signalling, regulatory, and antibacterial activities of NO. Previous studies of epithelial iNOS activity in CF have generally used semi-quantitative techniques, examined immortalised cell lines or, in studies of primary epithelial cells, iNOS activity has mostly been determined in samples from subjects with significant lung disease or older subjects than those included in the present study. Overall, studies to date have not helped to determine whether low iNOS expression is a primary effect or at least present from an early age in CF. In this report we present definitive evidence that iNOS is reduced in airway epithelial cells from young children with CF compared with control children with no evidence of respiratory disease or atopy.

We therefore studied very young children with CF with mild lung disease to determine epithelial iNOS gene and protein expression in early life. Given that newborn screening allows for early intervention to prevent lung disease in CF, the question of whether there is primary dysfunction of iNOS is important to answer if the NO pathway is to be further investigated as a therapeutic target. We present evidence to support the hypothesis that decreased iNOS expression in CF epithelium is a primary phenomenon and thus indicate a clear rationale for investigating the potential therapeutic benefits of manipulating the epithelial NO pathway in CF.

METHODS
Subjects
Forty young children with CF (20 boys, 20 girls) of mean (SD) age 2.1 (1.5) years (range 0.12–5.6) and 12 healthy non-atopic controls free of previous or current respiratory disease
of mean (SD) age 3.3 (1.2) years (range 1.1–5.1) were included in the study (Table 1). Current symptoms of CF patients were scored using the cystic fibrosis clinical score (CFCS).15

### Study design

This study was carried out at a single center (Princess Margaret Hospital for Children (PMH), Perth, Western Australia). Since 1997 all children under 6 years of age are given the opportunity to take part in the clinical bronchoalveolar lavage (BAL) programme to identify respiratory pathogens. BAL is performed in newly diagnosed children with CF and repeated annually as part of the clinical assessment until the children are able to expectorate sputum. The diagnosis of CF was confirmed by a sweat chloride level assessment until the children are able to expectorate sputum. In four of them gastrointestinal endoscopy was performed to investigate the intestinal endoscopy. Five of the healthy controls had celiac disease, this was ruled out by normal findings. One patient was compound heterozygote with one unidentified allele and a positive sweat test. The study was approved by the Princess Margaret Hospital for Children ethics committee and informed written consent was obtained for all subjects.

### Techniques

#### Tracheobronchial brushing

Epithelial cells were obtained from the distal trachea during anaesthesia using a cytology brush (BC 25105, Olympus, Australia) as previously described.7 This brushing procedure was repeated 3–5 times. The brush was then withdrawn and agitated in 5 ml bronchial epithelial basal media (Clonetics, CA, USA) to remove epithelial cells. Cell samples were placed on ice and immediately taken to the laboratory and processed within 15 minutes of sampling. An aliquot (20 μl) of the resulting cell suspension was diluted 1:2 with trypan blue to determine cell number and viability using a Neubauer haemocytometer. The cell samples consisted of 95–98% epithelial cells with 2–5% macrophages. Immunocytochemical staining of the cytopsins was used to confirm the purity of the epithelial sample as described previously.17

#### Expression of iNOS

Macrophages were removed by positive selection using CD-68 antibody as previously described,7 and cytospin slides were then fixed, washed, and blocked in 5% bovine serum albumin (BSA) (w/v), 10% fetal calf serum (FCS) (v/v), and 0.1% Triton X-100 in 1 × Tris buffered saline (TBS) for 1 hour at room temperature. Cells were then incubated with the primary antibody (iNOS; 1:100; Santa Cruz, CA, USA) for 24 hours at 4°C followed by the secondary fluorescently conjugated antibody (rabbit anti-goat IgG FITC conjugated; Sigma, MO, USA) for a similar period, after which the antibody complex was visualised using a fluorescent microscope (Leica Microsystems, Australia). In addition to immunohistochemistry, protein levels were also measured using Western blot analysis. Briefly, epithelial cells (2.5 × 10^6) were harvested by centrifugation at 1000 g for 5 minutes, washed once with ice cold phosphate buffered saline and resuspended in 600 μl ice cold lysis buffer (20 mM Tris, 1 mM EDTA (pH 7.4), 1 mM DTT (dithiothreitol) and 50 μl of a protease cocktail mixture containing 10 μM 4-(2-aminoethyl)benzenesulfonyl fluoride (AESF), 0.08 mM aprotinin, 2 mM leupeptin, 4 mM bestatin, 1.5 mM pepstatin A

### Table 1 Characteristics of children with cystic fibrosis and healthy controls

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>CFA (n = 16)</th>
<th>CFB (n = 24)</th>
<th>Healthy (n = 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)*</td>
<td>1.15 (0.83)</td>
<td>2.7 (1.5)</td>
<td>3.3 (1.2)</td>
</tr>
<tr>
<td>M/F</td>
<td>9/7</td>
<td>11/13</td>
<td>8/4</td>
</tr>
<tr>
<td>Symptom score†</td>
<td>13.5 (2.2)</td>
<td>14.6 (2.7)</td>
<td>NA</td>
</tr>
<tr>
<td>Cells from TB (×10^5)*</td>
<td>1.84 (0.67)</td>
<td>1.9 (1.07)</td>
<td>1.52 (0.7)</td>
</tr>
<tr>
<td>Genotype</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>df508 homozygote</td>
<td>50%</td>
<td>66.7%</td>
<td>NA</td>
</tr>
<tr>
<td>df508 heterozygote†</td>
<td>43.75%</td>
<td>29.2%</td>
<td>NA</td>
</tr>
<tr>
<td>GS42X/GS42X</td>
<td>–</td>
<td>4.2%</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>6.25%</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Cells in BAL fluid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TCC (cells ×10^7/ml)†</td>
<td>345.3 (236 to 506)</td>
<td>443.5 (285 to 690)</td>
<td>NA</td>
</tr>
<tr>
<td>Neutrophils (cells ×10^3/ml)†</td>
<td>55.9 (29.5 to 105.9)</td>
<td>88.4 (43.2 to 181.1)</td>
<td></td>
</tr>
<tr>
<td>Neutrophil (%)*</td>
<td>22.6 (18.9)</td>
<td>28.3 (23.2)</td>
<td></td>
</tr>
<tr>
<td>iNOS expression†</td>
<td>0.23 (0.11 to 0.46)</td>
<td>0.22 (0.14 to 0.34)</td>
<td>0.76 (0.51 to 1.14)</td>
</tr>
</tbody>
</table>

SD, standard deviation; BAL, bronchoalveolar lavage; TB, tracheobronchial brushing; TCC, total cell count per ml BAL fluid; CFA, CF without bacterial infection at actual or previous BAL; CFB, CF with bacterial infection either in present or previous BAL.

*Mean (SD).
†Geometric mean (95% confidence interval).
‡Cystic fibrosis clinical score.15
* Heterozygote mutations included: unknown mutation (n = 5), N310, G551D, R117(H, R553X, P67L, S1235R, dF508 homozygote 50% 66.7% NA
† Others included: unknown mutation (n = 5), N310, G551D, R117(H, R553X, P67L, S1235R, W1282 (n = 1).
‡Heterozygote mutations included: unknown mutation (n = 5), N310, G551D, R117(H, R553X, P67L, S1235R, dF508 heterozygote
‡Heterozygote mutations included: unknown mutation (n = 5), N310, G551D, R117(H, R553X, P67L, S1235R, dF508 heterozygote
‡Heterozygote mutations included: unknown mutation (n = 5), N310, G551D, R117(H, R553X, P67L, S1235R, W1282 (n = 1).
‡This patient was compound heterozygote with one unidentified allele and a positive sweat test.
Bacterial density between $10^2$ and $10^4$ cfu/ml were recorded. In brief, RNA was extracted from epithelial cells using the Qiagen RNeasy mini kit (Qiagen, Victoria, Australia). Total RNA was eluted in 50 μl RNase-free water and cDNA synthesised by reverse transcription using TaqMan Reverse Transcription Reagents (Applied Biosystems, CA, USA). Expression of NOS2 gene was quantified relative to the "housekeeping gene" TCC, and PMN were log normally distributed and expressed as mean (SD). The data for iNOS, and 1.4 mM E-64). On ice, the cells were disrupted by passage through a 27 gauge needle. Protein concentrations were determined using the Bicinchoninic Acid (BCA) protein assay (Pierce, IL, USA). A total of 40 μg of protein was electrophoresed on 8% SDS-PAGE gels, transferred to PVDF membranes, and immunoblotted using a polyclonal iNOS antibody (1:200, Santa Cruz, CA, USA). iNOS was visualised using the enhanced chemiluminescence (ECL-Plus) Western blotting detection system (Amersham Biosciences, IL, USA). The protein content was estimated from Western blots by densitometry using Quantity One software (BIORAD, NSW, Australia).

iNOS expression was quantified using a method previously published. Two aliquots of normal saline (1 ml/kg body weight) were instilled into the right middle lobe or right lower lobe and fluid retrieved), absolute neutrophil numbers (PMN; cells×10⁶/ml), and percentage neutrophils of TCC (%PMN) were calculated.

Microbiology

BAL samples from patients with CF were cultured on blood, CLED, Filides and Sabouraud agar with chloramphenicol. Viruses (RSV, parainfluenza, influenza A/B, adenovirus, CMV) were detected using direct immunofluorescence and/ or rapid viral tissue culture. Significant microbial infection was considered as $>10^5$ colony forming units (cfu)/ml. Bacterial density between $10^2$ and $10^3$ cfu/ml were recorded as isolated colonies. The presence of mixed oral flora was not considered pathogenic but was recorded.

Statistical analysis

Anthropometric data and % PMN in BAL fluid were normally distributed and expressed as mean (SD). The data for iNOS, TCC, and PMN were log normally distributed and are presented as geometric mean (GM) with 95% confidence intervals (95% CI). Statistical analyses were performed using the log (base10) for these variables allowing parametric tests to be performed. A Student’s t test or one-way analysis of variance (ANOVA) was used to test for significant differences between groups. Pearson moment correlation was used to test for associations between NOS expression and inflammatory cell data. All analyses were performed using SigmaStat for Windows 2.03 (SPSS Inc).

RESULTS

The 40 children with CF were divided into two groups based on a history of bacterial colonisation. Infection was defined as $>10^4$ cfu for any of the common pathogens. The two groups were (1) CF without bacterial infection (CFA), consisting of children who had never had significant infection (n = 16), and (2) CF with infection (CFB) which comprised children with bacterial infection either in the most recent or a previous BAL, (n = 24; table 1). The CFB group was significantly younger than the CFB group (mean (SD) 1.15 (0.83) v 1.15 (0.83) years; p < 0.001) but were of similar age to the CFB group (1.3 (1.2) v 1.3 (1.2) years; p = 0.25).

The CFB group comprised 14 children with significant bacterial growths in a previous but not in the most recent BAL and 10 children with bacterial infection in the most recent BAL ($>10^4$ cfu/ml). Nine of the 10 children with recently documented infection had repeatedly positive cultures in their successive BALs, whereas one child showed the first significant colonisation. There was no difference in age between these two CFB subgroups (p = 0.2). Most of the children with infection in the most recent BAL showed cultures of two or more pathogens. Pseudomonas aeruginosa was isolated in six of these children. Other pathogens were Haemophilus influenzae (n = 6), Stenotrophomonas maltophilia (n = 3), Staphylococcus aureus (n = 2), E coli (n = 2) and Enterobacter (n = 1). One child showed a positive culture of cytomegalovirus in addition to P aeruginosa and Enterobacter. The mean (SD) number of epithelial cells obtained per sample by brushing was 1.86 (0.93) million in the CF group and was similar to the 1.52 (0.7) million cells obtained in the control group (p = 0.2). The mean viability of the cells sampled was 17.3% and did not differ between CF and healthy groups.

Initially, endogenous iNOS protein expression was determined in healthy children and young CF patients. Immunohistochemical results indicated that iNOS staining intensity was greater in healthy non-atopic children than in CF children. However, the pattern of staining was similar in both phenotypes with the majority of staining occurring at the apical surface of the cells (fig 1A). Differential iNOS protein expression was further confirmed using Western blot analysis. A higher level of iNOS protein expression was observed in healthy non-atopic children than in children with CF (fig 1B), correlating with the immunohistochemical results obtained initially. Equal loading of samples was confirmed by the expression of β-actin. When the protein was quantified, healthy non-atopic children were found to express a significantly greater amount (>2.5 fold; p = 0.0078) of iNOS than their CF counterparts (fig 1C).

Inducible NOS mRNA was detectable in all samples from patients with CF and healthy controls (fig 2). Geometric mean (95% CI) iNOS expression (mRNA) was 0.23 (0.11 to 0.46) in the CFA group and 0.22 (0.14 to 0.34) in the CFB group. There was no significant difference between the two groups of patients with CF (p = 0.7). Children with positive bacterial cultures in the most recent BAL (CFB group) had a slightly lower geometric mean iNOS expression (0.13 (95% CI 0.07 to 0.24)) than children who had significant bacterial growth in a previous BAL but not in the most recent BAL (0.24 (95% CI 0.14 to 0.41) and those in the CFA group (0.23 (95% CI 0.11 to 0.46), but the difference was not statistically significant (one way ANOVA, p = 0.3; individual t tests, p = 0.26 and 0.12, respectively). There were no differences in iNOS expression between children with or without P
aeruginosa isolates in the most recent BAL. Inducible NOS expression in cells from healthy children was 0.76 (95% CI 0.51 to 1.14) and was significantly higher than both the CFA (p = 0.01) and CFB (p = 0.002) groups. Levels of iNOS expression were independent of sex and weight in all groups, but there was a statistically significant positive correlation for iNOS with age in children with CF (r² = 0.104; p = 0.04). The correlation with age was confined to the CFB group (r² = 0.36; p = 0.002).

Twenty four children with CF (eight CFA) were homozygotes for dF508/dF508, 14 (seven CFA) were heterozygotes (dF508/–), one child with infection G542X/G542X and one compound heterozygote with one unidentified allele and a positive sweat test (without infection). There were no differences in iNOS expression (mRNA) between the dF508 homozygote and compound heterozygote children (p = 0.12).

The geometric mean TCC in BAL fluid samples of patients with CF was 401.2 ± 10³ (95% CI 295.7 to 544.4) which was similar to that reported in healthy children. The absolute PMN number was 74.1 ± 10³ (95% CI 44.8 to 122.4) and mean (SD) %PMN was 26.1 (21.5), both higher than that reported for healthy children but lower than that reported for similarly aged children with CF. However, CF patients with significant pathogens in the most recent BAL had a geometric mean TCC of 554.9 ± 10³ (95% CI 266.6 to 1154.9) compared with 352.1 (95% CI 241.0 to 514.6) in the CFA group and 369.4 (95% CI 273.9 to 498.1) in those with previous infection but sterile current BAL. Although there was a higher geometric mean, the difference was not significant (p = 0.8 and 0.3, respectively). However, %PMN were significantly higher in children with actual infection (mean (SD) 40.3 (27.8)) than in the CFA group (20.75 (17.5); p = 0.037) and in patients with positive BAL cultures only in the past (21.9 (17.1); p = 0.05). No significant differences were found in TCC or %PMN between children with and without growth of P. aeruginosa in the most recent BAL. There were no significant associations between any of the BAL cell count variables and iNOS expression (mRNA) in either the whole CF group or in either of the two CF subgroups separately.
DISCUSSION

This is the first study to measure iNOS quantitatively in primary epithelial cells from very young children with CF. Previous studies have used semi-quantitative methods such as immunohistochemistry. 24 Quantitative studies using real time PCR have previously been carried out either in immortalised cell lines or in epithelial cells from adult patients with CF and, although suggesting low expression of NOS, they could not rule out low expression resulting from processes associated with advanced lung disease. 891–4 We hypothesised that iNOS gene and protein expression would be low in epithelium from young children with CF with mild lung disease due to a primary low iNOS gene expression in CF epithelium. Until now this hypothesis has been difficult to test because of problems obtaining samples of epithelial cells from very young children with CF and having samples from truly healthy controls for comparison. Our newborn CF surveillance programme has provided an opportunity to obtain samples from children with CF soon after birth, and an ongoing programme to study epithelial function during childhood has enabled us to obtain samples from healthy young children.7

We have shown that the expression of iNOS in airway epithelial cells from children with CF is lower than expression in cells from healthy children. Past or present airway colonisation with bacterial pathogens did not influence the expression of iNOS in the epithelial cells. Our observations contrast with those of the only other study to investigate iNOS expression in epithelium from children with CF. Woolridge et al. 24 reported similar iNOS expression in CF and non-CF epithelium. However, there are important differences between our study and that of Woolridge. We used a fully quantitative technique to measure iNOS mRNA expression in contrast to the semi-quantitative immunostaining technique used by Woolridge and colleagues. Furthermore, the latter report included only eight children in the age range that we studied. Finally, our control subjects were free of respiratory disease or symptoms whereas the controls reported by Woolridge included subjects with a variety of respiratory conditions. Our observations regarding iNOS gene expression were supported by quantitative and semi-quantitative assessments of protein expression. To date, studies have not been able to determine whether the low iNOS expression is present from an early age in children with CF—that is, whether this is a primary defect (table 2).

Table 2

<table>
<thead>
<tr>
<th>Study</th>
<th>Cell source</th>
<th>CF:controls (n)</th>
<th>Age (years)</th>
<th>Nature of controls</th>
<th>Outcomes</th>
<th>iNOS expression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wooldridge 25</td>
<td>CFBE41</td>
<td>17:14*</td>
<td>6.5:3.5</td>
<td>Respiratory disease</td>
<td>Semi-quantitative IHC</td>
<td>No difference</td>
</tr>
<tr>
<td>Darling 22</td>
<td>CFBE41</td>
<td>–</td>
<td>–</td>
<td>16HBE</td>
<td>Chemiluminescence</td>
<td>Low NO production</td>
</tr>
<tr>
<td>Meng 9</td>
<td>CFBE41</td>
<td>–</td>
<td>&gt;19</td>
<td>16HBE</td>
<td>PCR, Western</td>
<td>Reduced</td>
</tr>
<tr>
<td>Meng 21</td>
<td>CFBE41 biopsy</td>
<td>13:14</td>
<td>21–42:50–68</td>
<td>Non-CF mice</td>
<td>PCR, Western</td>
<td>Reduced</td>
</tr>
<tr>
<td>Kelley 21</td>
<td>Murine transgenic</td>
<td>–</td>
<td>–</td>
<td>Lung cancer</td>
<td>Semi-quantitative IHC</td>
<td>Reduced</td>
</tr>
<tr>
<td>Morrissey 22</td>
<td>Ex vivo lung sections</td>
<td>5:3</td>
<td>13–18:40–59</td>
<td>Non-CF nasal polyps</td>
<td>PCR, Western</td>
<td>Reduced</td>
</tr>
<tr>
<td>Dotch 19</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>CFTR+/– mice</td>
<td>IHC, PCR, Iso NO-meter</td>
<td>Reduced to absent</td>
</tr>
<tr>
<td>Steagall 23</td>
<td>Murine CFTR knock out</td>
<td>–</td>
<td>–</td>
<td>Healthy + non-CF</td>
<td>PCR, Western IFN-γ</td>
<td>Reduced to iNOS</td>
</tr>
<tr>
<td>Kahn 24</td>
<td>Ex vivo lung sections</td>
<td>7:9†</td>
<td>–</td>
<td>Lung disease</td>
<td>Stimulation</td>
<td>Promoter activity</td>
</tr>
</tbody>
</table>

CFBE41, CF airway epithelial cell line 41; 16HBE, human bronchial epithelial cell line; IHC, immunohistochemistry; PCR, polymerase chain reaction; Western: western blot; NO: nitric oxide.

*11/17 CF and 9/14 non-CF samples allowed IHC analysis of NOS expression.
†Five samples from explanted non-CF lungs and four samples by bronchoscopic brushing of healthy volunteers.

apparent trapping and metabolism of NO within the mucus and by colonising bacteria suggested by others 36–22 are also likely to contribute to low NO in exhaled breath, but are possibly less significant factors early in the course of CF airway disease and before colonisation.

Studies using CFBE410 epithelial cell lines have shown that iNOS expression does not increase in response to cytokine stimulation7 or neutrophil co-culture. 14 These studies suggest a defect at some point in the chain of events leading to transcription, but there are only limited data using primary cells. Zheng and colleagues28 described a defect in autocrine activation of NOS2 in primary cells from CF patients when stimulated; however, whether this is a primary phenomenon has not been clarified since samples were not obtained from young children.

Lung disease is the predominant cause of morbidity and mortality in CF and airway inflammation and bacterial colonisation can be detected early in childhood. 9–13 The chronic colonisation by pathogens such as P aeruginosa is one of the most important factors in the rate of progression of lung disease in children with CF. 32–33 However, bacterial infection did not affect levels of iNOS expression in our study. These results agree with previous observations in CF mice6 and in humans. 14 However, in the colonised group there was a weak but significant positive correlation between age and iNOS expression. The reason for the observed increase in iNOS expression with age is not clear. This observation does not seem to be due to developmental changes in iNOS expression because there was no such relationship in the healthy children. Furthermore, the increase in iNOS expression with age in the colonised group of patients with CF did not appear to be a consequence of airway inflammation because there was no association between iNOS and any marker of inflammation in the BAL fluid that we examined. Although significant, the correlation is very weak. Therefore, since the relationship between age and iNOS expression was not a primary outcome for this study, it is feasible that the observation is a statistical artifact due to small numbers. The observation does not invalidate our argument that iNOS expression is lower in CF epithelium than in epithelium from the healthy group and, indeed, this result would tend to reduce the difference in iNOS expression between the healthy and CF groups.

Overall symptoms in the CF patients were assessed using the CFCS59 with a range from a minimum of 10 to a maximum of 50 points. The mean score of the subgroup of non-colonised children (CFA) in our study was 13.5, which is in the very low range. These mild clinical symptoms were in agreement with missing airway colonisation and only slightly increased neutrophil numbers in BAL fluid. This subgroup is
arginine or overexpression of arginase. A similar mechanism, deriving from explanted lungs, hence peripheral airways, was not seen with explanted epithelium from healthy controls. Staining for iNOS was seen in CF epithelium in infection. Also, in animal models, airway epithelial cells have a role for treatments aimed at increasing NO production by chronic bacterial colonisation and infection and suggests a defect in the iNOS pathway in CF, present from early age, is a worthwhile target for treatment.

In this study we have quantitatively measured, for the first time, iNOS expression in primary epithelial cells in children under the age of 5 years with CF. Inducible NOS gene and protein expression was significantly reduced in CF epithelial cells compared with cells derived from healthy controls. Our findings reflect the situation in young children with CF without advanced disease and therefore indicate that low iNOS expression may be a primary defect. We believe these data differentiate our observations from previously published data and suggest a new therapeutic approach commencing immediately following diagnosis in the newborn period with the aims of raising local NO levels or sensitivity of NO to a functional important defect in the iNOS pathway in CF, present from early age, is a worthwhile target for treatment.

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A Moeller and F Horak have equal first author responsibility for this study.

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