Failure of salmeterol to inhibit circulating white cell responses and bronchoconstriction induced by platelet activating factor

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Abstract

**Background** Platelet activating factor (PAF) is a potent mediator of inflammation. Inhalation of PAF causes acute bronchoconstriction and a transient fall in white blood cell count in humans. Salmeterol inhibits pulmonary inflammation induced by PAF in guinea pigs.

**Methods** The effect of salmeterol on effects induced by PAF was investigated in eight normal subjects who inhaled salmeterol (50 µg) twice daily or a matched placebo for one week before challenge with PAF. Blood samples were taken from a forearm catheter for total white cell and neutrophil counts before and for 30 minutes after administration of PAF (48 µg) through a Mefar dosimeter. Blood films were stained for unsegmented neutrophils before and after treatment with PAF on a placebo day.

**Results** Mean baseline total white cell counts and neutrophil counts did not differ on the two days. Mean baseline sGaw was significantly higher after inhaled salmeterol (1.84 ± 0.52 kPa) than after placebo (1.53 ± 0.24 kPa). After placebo mean total white cell counts, neutrophil counts, and sGaw were reduced to 60 (43–78)% of baseline respectively five minutes after inhaled PAF. After salmeterol treatment mean reductions five minutes after inhaled PAF were 59 (45–73)% of baseline after placebo and to 127 (93–161)% of baseline after salmeterol. There was no significant difference in the percentage of immature neutrophils before and after treatment with PAF (2.0 (0.5–2.6)% compared with 3.9 (2.2–5.6)%).

**Conclusions** Treatment with salmeterol did not inhibit reduction in total white cell count or neutrophil count, rebound neutrophilia, acute bronchoconstriction, or transient flushing after inhalation of PAF. These results conflict with the inhibitory effect of salmeterol on lung inflammation in guinea pigs but are consistent with the lack of effect of salbutamol in humans. Salmeterol does not have an anti-PAF effect in vivo in humans.

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Salmeterol is a long acting selective β₂ agonist with significant anti-inflammatory activity both in vitro and in vivo in animal models. It is a potent inhibitor in vitro of the release of inflammatory mediators such as histamine, leukotrienes C₄ and D₄, and prostaglandin D₂ from sensitised lung fragments challenged with antigen.¹ It also inhibits release of leukotriene B₄ from human neutrophils at a significantly lower concentration than isoprenaline or salbutamol.² In vivo, neutrophil accumulation induced in guinea pig lung by lipopolysaccharide was inhibited by salmeterol.³ Stimulation of influx of inflammatory cells into guinea pig skin by zymosan was prevented by local and oral administration of salmeterol.⁴ Accumulation of eosinophils induced by platelet activating factor (PAF) in guinea pig lung was also inhibited by pretreatment with salmeterol.⁵ In human subjects salmeterol induced inhibition of early and late phase bronchoconstriction and increase in non-specific bronchial responsiveness following allergen challenge has been quoted as evidence of an anti-inflammatory effect.⁶

PAF is a potent mediator of inflammation and has the ability to cause microvascular leakage, neutrophil and eosinophil activation, and bronchoconstriction. This has led to PAF being implicated in the pathogenesis of asthma.⁷ Non-specific bronchial hyperresponsiveness also occurred in some studies but not all human subjects.⁸⁻¹¹ After inhaled PAF. The peripheral neutrophil count was reduced transiently after inhalation of PAF in normal and asthmatic subjects and was followed by rebound neutrophilia.⁷⁻¹² We have recently described pulmonary sequestration of indium-labelled neutrophils after inhalation of PAF, but not after equivalent bronchoconstriction induced by methacholine in normal subjects.⁷ In a recent study in normal subjects salbutamol had a partial inhibitory effect on bronchoconstriction induced by PAF but had no effects on changes in circulating white cell number.⁸

The aim of the present study was to investigate whether salmeterol could modulate the inflammatory effects of inhaled PAF in human subjects as it did in guinea pigs. Our hypothesis
was that changes in circulating white cell numbers reflect changes in white cells in tissues, particularly the lung. We examined changes in circulating peripheral blood cells and also effects on airways in normal subjects.

Methods

Subjects

Two normal female and six normal male volunteers from hospital and laboratory staff were studied. None of the subjects had any history of asthma. None had suffered any recent chest infection and no subjects were taking any medication. None were atopic and one subject was an ex-smoker. Mean age was 32 (range 24–44) years. Each subject gave written informed consent to participate in the study, which was approved by the Hammersmith Hospital ethics committee.

Study Design

Each subject was studied in a randomised, double blind, placebo controlled manner on two separate occasions separated by at least three weeks. Subjects inhaled salmeterol (50 μg) or matched placebo through a diskhaler twice daily for one week before visiting the laboratory. The last dose of salmeterol or placebo was inhaled on the study day two hours before challenge with PAF. Airway calibre was recorded by measurement of specific airways conductance (sGaw), as a mean of six determinations, in a computerised constant volume body plethysmograph. Forced expiratory volume in one second (FEV₁) was measured as the best of three manoeuvres with a wedge spirometer (Vitalograph, Buckingham, UK).

Blood samples were drawn from a cannula placed in a forearm vein for total white blood cell and neutrophil counts before and for 30 minutes after administration of PAF.

PAF Inhalation Challenge

PAF (Bachem Inc, California) was dissolved and stored in aliquots at a concentration of 10 mg/ml in 100% ethanol at −77°C. On the morning of each study PAF was diluted to 2 mg/ml in 0.9% saline containing heat treated human serum albumin at a final concentration of 0.04%. The PAF aerosol was delivered from a Mefar dosimeter (Brescia, Italy) driven by compressed air at a pressure of 1.5 kg/m², with a one second actuation time and five seconds between puffs. Output was measured as 12 μl for each puff. Each subject received two puffs (48 μg PAF). Airways response to PAF was measured as changes in sGaw and in FEV₁. Measurements were made before inhalation of PAF (baseline) and seven, 12, 17, and 32 minutes after inhalation of PAF.

Measurement of Circulating Cells

Duplicate venous blood samples (2 × 2 ml) were collected five minutes before and one, two, three, five, 10, 15, and 30 minutes after inhalation of PAF for determination of total white blood cell and neutrophil counts. Cell counts, including total and differential leucocyte counts and platelet counts, were determined in each of the paired samples by automatic analyser (Sysmex E500) and mean values were recorded. Coefficients of variation were 1.8% for total leucocyte counts and 6% for neutrophil counts.

An independent observer, unaware of the patient protocol, examined blood films prepared and stained by a routine May-Grünwald Giemsa method to look for evidence of newly released immature neutrophils. Films from samples collected at −5 and +30 minutes on a placebo day were coded and examined in random order. A manual differential count was performed on 100 white blood cells on the two films from each subject. Particular care was taken to distinguish between mature segmented neutrophils and less mature unsegmented band forms.

Data Analysis

Results were expressed as means (95% confidence intervals (95% CI)). Analysis of variance (ANOVA) of repeated measures for sGaw and FEV₁, neutrophil, and white blood cell count was used to determine the effect of salmeterol compared with placebo. Wilcoxon’s rank sum test was used to determine significance at specific time points. p values < 0.05 were considered significant.

Results

All subjects noted transient facial flushing, cough, and minor chest tightness. Conjunctival injection was seen in every subject one to two minutes after inhalation of PAF. Previous treatment with salmeterol did not prevent these symptoms.
AIRWAY CHANGES
Mean baseline sGaw was significantly higher (p < 0.01) after treatment with salmeterol (1.8 ± 1.4–2.2) s<sup>2</sup> kPa<sup>−1</sup> compared with placebo (1.5 ± 1.2) s<sup>2</sup> kPa<sup>−1</sup> (figure). Baseline FEV<sub>1</sub>, after treatment with salmeterol was significantly higher than after placebo 10 and 15 minutes after inhaled PAF (p < 0.05 for both), although the percentage baseline values did not differ. After salmeterol, inhalation of PAF caused a maximum reduction in sGaw at five minutes to 82 (74–90)% of the baseline value. A remarkably similar fall in sGaw after inhaled PAF occurred with placebo to 82 (71–93)% of baseline (figure). These values were both significantly different from baseline (p < 0.001 and p < 0.01 respectively). Generally, changes in FEV<sub>1</sub> were smaller than those in sGaw. FEV<sub>1</sub>, five minutes after inhaled PAF fell to 93 (90–96)% of baseline on the day of salmeterol treatment and 91 (87–95)% of baseline on the day of placebo (p = 0.08).

Discussion
We have confirmed previous findings that inhaled PAF causes transient bronchoconstriction and changes in neutrophil count in human subjects. Salmeterol at a standard clinical dose (50 μg) inhaled twice daily for one week did not significantly modify the reduction in neutrophil count after inhaled PAF or the subsequent rebound neutrophilia. Salmeterol caused baseline bronchodilatation, confirmed by sGaw, but did not prevent the bronchoconstrictor response to inhaled PAF compared with placebo.

This study precisely defines the time course of the effect of PAF on neutrophils. The first reduction was seen at three minutes with the maximal effect at five minutes as previously documented. Salmeterol had no effect on the time course, or on the degree of leucopenia, or on subsequent rebound neutrophilia compared with placebo, and this was consistent with a previous study of a single dose of inhaled salbutamol.

The lack of effect on circulating neutrophils shown here suggests that salmeterol is unlikely to modulate pulmonary sequestration of neutrophils although this has not been studied directly. This conflicts with the inhibitory effect of salmeterol on migration of neutrophils into guinea pig lung and skin and pulmonary accumulation of eosinophils induced by PAF. The hypothesis that changes in pulmonary white cell numbers are adequately mirrored by changes in the circulation has not been tested but radiation dose prevented examination in a study of similar design to this. It may be possible to pursue this with prostacyclin, which has been suggested to modify circulating white cell changes after inhalation of PAF.

The mechanism of bronchoconstriction induced by PAF in humans remains unknown. Cholinergic nervous pathways are not involved. The role of histamine is unclear as chlorpheniramine produced partial inhibition whereas other studies with different H<sub>1</sub> blockers had no effect. In animals, secondary mediator release after treatment with PAF involves leukotriene and cyclo-oxygenase products including thromboxane A<sub>2</sub>. In humans, thromboxane has at most a minor role. Major cysteinyl leukotriene release was found, however, after inhaled PAF and selective leukotriene C<sub>4</sub> and D<sub>4</sub> antagonists inhibited bronchoconstriction induced by PAF.

Salmeterol is effective in blocking release of leukotrienes from human lungs in vitro. It is therefore all the more surprising that in this study salmeterol did not inhibit airway narrowing induced by PAF. It is difficult to relate the standard clinical dose of salmeterol used here with that which was effective in vitro and in vivo the bronchodilator concentration of salmeterol (0.1 mM) also inhibited neutrophil accumulation induced by lipopolysaccharide.
and accumulation of eosinophils induced by PAF. 2,3

Minimum sGaw after challenge was significantly higher after treatment with salmeterol than after placebo but the percentage reduction was unaffected (figure). In a previous study a single dose of salbutamol (200 µg) partially inhibited bronchoconstriction induced by PAF, measured as partial flow at 30% of vital capacity.

A standard clinical bronchodilator dose of salmeterol was used that would have been expected to block contraction of bronchial smooth muscle. The lack of protective effect of salmeterol suggests that airway narrowing induced by PAF may be due to airway oedema as PAF is known to be a potent mediator of microvascular leakage. 3 This would also be consistent with the findings that acute protection by salbutamol was much less for PAF than equivalent bronchoconstriction induced by methacholine. 

Salmeterol produced bronchodilatation but did not inhibit PAF-induced airway narrowing, cough, vasodilator effects, or neutrophil changes. These results conflict with the inhibitory effect of salmeterol on lung inflammation in guinea pigs but are consistent with the lack of effect of salbutamol in humans. Any anti-inflammatory effect of salmeterol is therefore unlikely to be mediated through PAF. The only evidence of an anti-inflammatory effect of salmeterol in vivo in humans comes from the inhibition of the late phase reaction to allergen in atopic asthmatic patients. 4 There has been some discussion of the significance of these results 22 in the light of baseline bronchodilatation of the type seen in our study. No effect of salmeterol on inflammatory indicators of allergen response was found. 22 We have no evidence to support an anti-inflammatory effect of salmeterol.