CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Supplementary oxygen in healthy subjects and those with COPD increases oxidative stress and airway inflammation

G E Carpagnano, S A Kharitonov, M P Foschino-Barbaro, O Resta, E Gramiccioni, P J Barnes


Background: Hyperoxia increases oxidative stress through the generation of reactive oxygen species and may therefore enhance inflammation in the lungs. The aim of this study was to investigate whether short term supplementary oxygen (28%) increases oxidative stress and inflammation in the airways by measuring 8-isoprostane and interleukin 6 (IL-6) concentrations in exhaled breath condensate.

Methods: Twenty three healthy subjects (12 men, mean (SD) age 48 (7) years) and 23 patients with chronic obstructive pulmonary disease (COPD; 15 men, mean (SD) age 56 (5) years) were studied.

Results: Increased concentrations of 8-isoprostane and IL-6 were found in all subjects after breathing 28% oxygen for 1 hour. In healthy subjects the concentrations of 8-isoprostane and IL-6 were 10.9 (2.9) pg/ml and 4.9 (0.8) pg/ml, respectively, compared with baseline concentrations of 6.1 (1.3) pg/ml and 2.9 (0.6) pg/ml and in patients with COPD the concentrations were 27.9 (3.1) pg/ml and 8.3 (1.2) pg/ml, respectively, compared with baseline concentrations of 18.9 (3.6) pg/ml and 6.3 (0.6) pg/ml. By contrast, breathing air through the same face mask for 1 hour had no significant effects on 8-isoprostane or IL-6 concentrations in normal subjects or those with COPD.

Conclusions: These findings suggest that short term supplementary oxygen may enhance oxidative stress and inflammation in the airways. Whether this happens with long term oxygen therapy needs to be determined.

METHODS

Study population

Twenty three non-smoking healthy subjects and 23 COPD patients who were all confirmed ex-smokers (cigarette consumption 32 (5) pack-years) were studied (table 1). All subjects were recruited from the Respiratory Disease Institute, University of Bari and written informed consent was obtained from all subjects. The study was approved by the Institutional Ethics Committee. The diagnosis of COPD was based on GOLD guidelines. Sixteen patients had mild disease (7 men, mean (SD) age 54 (4) years, forced expiratory volume in 1 second (FEV1) 74 (5)% predicted) and seven were very severe (4 men, mean (SD) age 55 (2) years, FEV1 27 (2)% predicted). The patients were clinically stable with no worsening of symptoms within the previous 8 weeks. The FEV1/FVC ratio was unchanged over a period of at least 8 weeks before the study. All COPD patients were ex-smokers, had stopped smoking for at least 6 months, and were being treated with inhaled corticosteroids (fluticasone propionate 500–1000 μg daily or budesonide 400–800 μg daily) and inhaled β-adrenergic agonists. Those with very severe disease (PaO2 <8 kPa) were treated with domiciliary oxygen for 2–5 hours daily but none were receiving long term oxygen therapy. Healthy subjects were non-smokers who had no respiratory symptoms or respiratory tract infection for >3 months before the study.

All subjects underwent a clinical examination and lung function 1 day before the collection of EBC. Patients with COPD treated with domiciliary oxygen suspended their

Abbreviations: COPD, chronic obstructive pulmonary disease; EBC, exhaled breath condensate; FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; IL-6, interleukin 6
oxygen treatment for 2 days before enrolment. Eighteen COPD patients (11 untreated and seven treated with domiciliary oxygen) and 18 healthy subjects breathed 28% oxygen continuously at tidal volume and normal breathing frequency through a face mask for 1 hour. The remaining subjects (five COPD and five healthy subjects) breathed ambient air through a face mask connected to a cylinder that was turned off for 1 hour (placebo). The selection of patients was random and the intervention blinded to the subject and the EBC analysis. Spirometric tests and EBC collection were performed before and after breathing oxygen or ambient air.

**Pulmonary function testing**

Pulmonary function tests were performed before the measurement of EBC using a dry spirometer (PK Morgan Ltd, Gillingham, Kent, UK).

**Exhaled breath condensate**

EBC was collected using a condenser (EcoScreen, Jaeger, Wurzburg, Germany) as previously described, with tidal breathing for 10 minutes. Condensate (at least 1 ml) was collected on ice and stored at −70°C.

**Assays**

A specific enzyme immunoassay kit (Cayman Chemical, Ann Arbor, MI, USA) was used to measure 8-isoprostane and IL-6 concentrations in EBC. All values were measured in duplicate. The intra-assay and inter-assay variabilities were ≤10%. The detection limits of the assays were 4 and 1.5 pg/ml, respectively.

**Statistical analysis**

Data are expressed as mean (SD) values. A Mann-Whitney test and a Wilcoxon matched paired test were used to compare the groups and correlations between variables were studied using Spearman’s rank correlation test. A p value of <0.05 was considered statistically significant. 95% confidence intervals for any comparisons of non-parametric data between groups were used.

**RESULTS**

8-isoprostane

The baseline values of exhaled 8-isoprostane were significantly higher in patients with COPD than in normal subjects (p<0.001). Exhaled 8-isoprostane levels were higher in healthy subjects (n = 18) after 1 hour breathing 28% oxygen (10.9 (2.9) pg/ml) than in those breathing ambient air (6.1 (1.3) pg/ml, p<0.0001; fig 1A). A similar increase was observed in untreated COPD patients and in those treated with supplementary oxygen (27.9 (3.1) pg/ml) compared with the measurement after breathing ambient air (18.9 (3.6) pg/ml, p<0.0001; fig 1B). There was no significant difference between the baseline values and those after oxygen in patients with COPD and controls (p = 0.2).

The baseline concentrations of 8-isoprostane in patients with mild COPD and those with severe COPD on supplementary oxygen were 30.2 (1.1) and 27.6 (2.7) pg/ml, respectively. No statistically significant differences were found in the rise in 8-isoprostane concentrations after supplementary oxygen between COPD subjects previously treated with domiciliary oxygen and those untreated.

No statistically significant differences were observed in healthy controls (n = 5) or COPD patients (n = 5) after breathing ambient air through the same face mask for 1 hour (5.9 (2.2) and 19.1 (3.1) pg/ml v 6.3 (1.7) and 18.0 (2.7) pg/ml, p = 0.8 for both). No correlation was found between exhaled 8-isoprostane concentrations and FEV1 or FVC. The reproducibility of exhaled 8-isoprostane measurements was assessed in 10 non-smoking normal subjects and 10 with COPD. For most measurements the differences between the two 8-isoprostane values lay within ±2SD (−0.14 (−0.32) pg/ml and −0.08 (1.09) pg/ml). The coefficient of variation for 8-isoprostane was 4.4% and 3.7%.

**Interleukin-6**

The baseline value of exhaled IL-6 was significantly greater in patients with COPD than in normal subjects (p<0.001). Exhaled IL-6 levels were higher in healthy subjects after 1 hour breathing oxygen at 28% (4.9 (0.8) pg/ml) compared with the measurement when breathing ambient air (2.9 (0.6) pg/ml, p<0.0001; fig 1C). A similar increase was seen in patients with COPD when breathing 28% oxygen (8.3 (1.2) pg/ml) compared with ambient air (6.3 (0.6) pg/ml, p<0.0001; fig 1D). There was no significant difference between the baseline values and those after breathing oxygen in individuals with COPD and controls (p = 0.2). The IL-6 baseline concentrations in the mild COPD group and the severe group on supplemental oxygen were 9.1 (0.7) and 7.6 (0.8) pg/ml, respectively.

No statistically significant differences were found in the rise in IL-6 concentrations after supplementary oxygen between COPD subjects treated with domiciliary oxygen and those who were untreated. No statistically significant differences were observed between healthy controls and COPD patients after 1 hour breathing ambient air (3.1 (0.7) and 6.1 (0.4) pg/ml v 2.7 (1.6) and 5.4 (0.7) pg/ml, p = 0.8 and p = 0.7) There was no correlation between the exhaled IL-6 concentration and either FEV1 or FVC.

The reproducibility of exhaled IL-6 measurements was assessed in 10 non-smoking normal subjects and 10 with COPD. For most measurements the differences between the two IL-6 values were within ±2SD (−0.03 (−0.24) pg/ml and −0.04 (0.89) pg/ml). The coefficient of variation for IL-6 was 5.9% and 6.4%.

**Lung function**

No differences in FEV1 and FVC were observed in healthy controls or in patients with COPD after 1 hour of breathing oxygen or ambient air.

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**Table 1 Characteristics of study subjects**

<table>
<thead>
<tr>
<th></th>
<th>COPD subjects receiving air (n = 5)</th>
<th>COPD subjects receiving oxygen (n = 18)</th>
<th>Healthy subjects receiving air (n = 5)</th>
<th>Healthy subjects receiving oxygen (n = 18)</th>
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<tbody>
<tr>
<td>Age (years)</td>
<td>53 (6)</td>
<td>55 (4)</td>
<td>47 (3)</td>
<td>46 (6)</td>
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<tr>
<td>Sex (M/F)</td>
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<td>11/7</td>
<td>2/3</td>
<td>5/13</td>
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<td>FEV1 (% predicted)</td>
<td>60.9 (2.6)</td>
<td>54.1 (3.1)</td>
<td>101 (18)</td>
<td>103 (15)</td>
</tr>
<tr>
<td>FVC (% predicted)</td>
<td>72.1 (2.2)</td>
<td>75.2 (4.3)</td>
<td>119 (9)</td>
<td>120 (10)</td>
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<tr>
<td>PaO2 (kPa)</td>
<td>9.2 (0.4)</td>
<td>7.2 (0.4)</td>
<td>12.8 (0.4)</td>
<td>13.1 (0.3)</td>
</tr>
<tr>
<td>PaCO2 (kPa)</td>
<td>5.2 (0.2)</td>
<td>5.6 (0.2)</td>
<td>4.8 (0.3)</td>
<td>4.9 (0.2)</td>
</tr>
</tbody>
</table>

COPD, chronic obstructive pulmonary disease; FEV1, forced expiratory volume in 1 s; FVC, forced vital capacity.

Data are expressed as mean (SD).
DISCUSSION

Our data show that the concentrations of both 8-isoprostane and of IL-6 are increased in the EBC of healthy subjects and COPD patients after short term oxygen breathing (28% oxygen by face mask for 1 hour). However, no differences were observed after breathing ambient air for the same period through the same face mask (placebo control). In this study we also confirmed previous data that show increased inflammation and oxidative stress in the airways of patients with COPD, with higher concentrations of 8-isoprostane and IL-6 in the EBC of these patients (especially in those with severe disease and using domiciliary oxygen therapy) than in healthy subjects.

Reactive oxygen species are produced endogenously by inflammatory cells or exogenously by inhalation of cigarette smoke, ozone, and nitrogen dioxide. The increased oxidative burden is counteracted by efficient endogenous antioxidant defence mechanisms. Excessive production of oxidants or reduced endogenous antioxidants results in increased oxidative stress which may further enhance pulmonary inflammation. In this study we measured the effect of supplementary oxygen on the production of reactive oxygen species and on airway inflammation measured by exhaled 8-isoprostane and IL-6, respectively.

Several previous studies have reported that hyperoxia may increase oxidative stress in the lungs. Recently, Phillips et al described an increase in breath methylated alkane concentration (BMAC) in normal healthy volunteers after breathing 28% oxygen for 20 minutes. In agreement with these findings, we now report increased concentrations of 8-isoprostane in the EBC of healthy subjects exposed to 28% oxygen, which suggests that supplementary oxygen may increase oxidative stress in the lungs. To confirm that the exposure to 28% oxygen was itself responsible for this increase in oxidative stress, we administrated ambient air through a face mask in healthy subjects and those with COPD and did not find any increase in 8-isoprostane concentrations.

We also observed higher levels of 8-isoprostane in patients with more severe COPD treated with domiciliary oxygen than in those with mild untreated COPD. These results confirm the existence of a relationship between oxidative stress and disease severity or suggest that supplementary oxygen, even when administrated for a short time, could contribute to increased oxidative stress.

We found a further increase in 8-isoprostane concentrations in EBC in patients with COPD (treated with domiciliary oxygen or untreated) exposed to 28% oxygen for 1 hour, indicating that even a modest increase in inspired oxygen concentration is sufficient to further increase oxidative stress, especially in COPD patients in whom baseline oxidative stress is already increased. This increased burden of oxidative stress may further increase the inflammatory response, as suggested in this study by the increased concentration of IL-6 which mirrors that of 8-isoprostane. This may be mediated through an increase in nuclear factor-κB, a transcription factor that is activated by oxidative stress and switches on the transcription of inflammatory genes such as IL-6.

All the patients with COPD were treated with inhaled corticosteroids, but this is unlikely to have had an influence on our results since our previous studies have found no effect of even high doses of inhaled steroids on exhaled isoprostane levels in patients with asthma or in normal subjects exposed to ozone. We believe that, although corticosteroids prolong
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neutrophil survival, when administered by inhalation they may not influence the concentrations of mediators produced by neutrophils.13 The fact that exhaled 8-isoprostane and IL-6 concentrations increase in patients with COPD on corticosteroids in a similar way to untreated normal subjects also suggests that corticosteroids are unlikely to have had an influence on the increase after supplementary oxygen.

Supplementary oxygen is clearly beneficial in patients with severe COPD and pulmonary hypertension with cor pulmonale. It has been shown to improve survival when given continuously and there are strict guidelines for its use.14 However, the value of domiciliary oxygen in COPD patients with less severe hypoxia or with nocturnal desaturation has been questioned as there is no obvious clinical benefit.15 Our results suggest that supplementary oxygen in the short term could have detrimental effects in patients with mild COPD by increasing the inflammatory response. This, supported by recent observations of Phillips et al, suggests that supplementary oxygen should be used cautiously in patients with COPD unless they have pulmonary hypertension as a result of severe hypoxia,16 although hypoxia itself is sufficient to warrant this intervention.

However, it is possible that there is an adaptive response with long term administration with an increase in endogenous antioxidant mechanisms, so that the increase in oxidative stress and inflammation may not persist. Further studies of the effect of longer exposures to supplementary oxygen and at different oxygen concentrations are planned.

References

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