Exhaled nitric oxide in the diagnosis of asthma: comparison with bronchial provocation tests

N Berkman, A Avital, R Breuer, E Bardach, C Springer, S Godfrey

Background: Bronchial provocation tests such as exercise, methacholine (MCH), and adenosine 5'-monophosphate (AMP) challenges are used extensively in the diagnosis of asthma. A study was undertaken to determine whether exhaled nitric oxide (eNO) can be used to diagnose asthma in patients with non-specific respiratory symptoms and to compare this test with conventional provocation tests.

Methods: Patients with non-specific respiratory symptoms and normal spirometric parameters were included in the study. eNO was measured and exercise, MCH and AMP challenges performed in all subjects. Patients were defined as asthmatic based on clinical follow up 24 months after testing.

Results: Forty patients were considered asthmatic and 45 were not. The area under receiver operating characteristic curves gave values of 0.896 for eNO, 0.781 for exercise, 0.924 for MCH, and 0.939 for AMP (p = 0.033, 0.575 and 0.085 for eNO vs exercise, MCH and AMP respectively). From our data, a cut off value of NO ≥7 ppb at a flow rate of 250 ml/s best differentiates between asthmatics and non-asthmatics (sensitivity 82.5%, specificity 88.9%). Optimal cut off values for other tests were exercise: ΔFEV₁ ≥10% (sensitivity 57.9%, specificity 100%); PC₂₀-MCH: ≤3 mg/ml (sensitivity 87.5%, specificity 86.7%); and PC₂₀-AMP: ≤150 mg/ml (sensitivity 89.5%, specificity 95.6%).

Conclusions: Measurement of eNO can be used as a safe, simple and rapid test for the diagnosis of asthma and is as good as bronchial provocation tests.

METHODS

Subjects
Patients with non-specific respiratory symptoms of at least 3 months' duration referred to the outpatient pulmonary clinic of Hadassah University Hospital for diagnostic evaluation and in whom the consulting respiratory physician considered the possibility of a diagnosis of asthma were included in the study. Patients with a clear alternative diagnosis, a previous diagnosis of asthma, or evidence of airway obstruction on baseline spirometry (forced expiratory volume in 1 second (FEV₁) <75% predicted or FEV₁/forced vital capacity (FVC) <70%) or reversibility of FEV₁ ≥12% and patients on asthma medication of any type were excluded from the study. Chest and sinus radiographs were performed at the discretion of the physician.

Patients with acute upper respiratory tract infection were asked to return for testing 4 weeks after resolution of symptoms.

Subjects underwent initial measurement of eNO followed by bronchial challenges using MCH, exercise, and AMP. Provocation tests were performed in random order and in a blinded fashion (results of previous challenges and eNO were unknown to the technician performing the study). A minimum of 4 hours washout time was observed between each challenge. This complies with published recommendations.

Local ethics committee approval and informed consent from all participants was obtained for performance of the study.

Abbreviations: AMP, adenosine 5'-monophosphate; eNO, exhaled nitric oxide; FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity; MCH, methacholine; NO, nitric oxide
Follow up
All patients were assessed by the investigating physicians 24 months after performing provocation studies. A final diagnosis of doctor diagnosed asthma was made by a pulmonary physician (one of the authors) in a blinded fashion—that is, without knowledge of the results of the provocation tests. Patients with documented variability in FEV₁ of ≥12% at any time over the follow-up period, whether in response to bronchodilators given on a single test day (“reversibility”) or as determined over time (with or without inhaled corticosteroids or other asthma medication; “variability”), were considered asthmatics. Alternatively, a final diagnosis of asthma was based on patient history only (three or more episodes of doctor recorded wheezing, dyspnoea or cough relieved by bronchodilators) even in the absence of spirometric documentation of reversible airway obstruction. Patients in whom asthma did not manifest within 2 years were considered non-asthmatics. Patients lost to follow up were excluded from further analysis.

Performance of spirometric tests/challenges
Spirometric tests were performed using a pneumotachograph based system (Vitalograph Compact, Buckingham, UK). Bronchial challenges for MCH (Spectrum Chemical Corp, Gardena, CA, USA), AMP (Sigma-Aldridge, Rehovot, Israel), and exercise were performed according to recommended guidelines and as previously described.5–7

Measurement of exhaled NO
Exhaled nitric oxide was measured using a chemiluminescence analyser (LR 2000, Logan Research, Rochester, UK). Patients performed a slow vital capacity exhalation manoeuvre according to recommended guidelines.12–14 Resistance, mouth pressure (5 cm H₂O), and flow rate (250 ml/s) were kept constant for the duration of the manoeuvre using a visual aid for patient guidance. eNO levels were recorded during the plateau phase and coinciding with the plateau phase for exhaled CO₂. Three successive recordings were made and the mean value was recorded.

Calibration was performed using 0 and 110 parts per billion (ppb) calibration gas cylinders. Ambient NO levels were measured daily and were always found to be <3 ppb.

Reference values for eNO in known non-asthmatic non-asthmatic and steroid naive asthmatics measured in our laboratory were as follows (median, 95% confidence intervals): normal subjects 5.3 ppb (4.90 to 6.97); asthmatics 19.2 ppb (15.15 to 28.82), (p<0.0001).

Data analysis
Comparison between tests was performed by constructing receiver operating characteristic (ROC) curves and measurement of area under the curve.24 In the ROC plot, the sensitivity (percentage true positive results) is plotted against the percentage false positive results (1 – specificity). The nearer the curve approaches the top left of the ROC plot, the greater the sum of sensitivity and specificity. ROC plots provide a pure index of accuracy of a test by demonstrating the limits of the test’s ability to discriminate between health and disease over the complete spectrum of operating conditions.29 Quantification of the overall diagnostic accuracy of a test can be expressed by calculating the area under the curve of the ROC plot and provides a value between 0.5 (no separation of test values in healthy and disease groups) and 1.0 (perfect separation). Comparison of AUC is performed according to the method of Hanley and McNeil.26

Using clinical follow up to define asthma, the sensitivity and specificity of increasing cut off values of eNO for the diagnosis of asthma were determined. Similar determinations were obtained for exercise, MCH, and AMP challenges. Optimal cut off values to differentiate asthmatics from non-asthmatics were determined from the highest value obtained by adding sensitivity and specificity.5

The diagnostic value of eNO was also determined using positive bronchial provocation tests to define asthma. The optimal cut off value of eNO for the diagnosis of asthma was calculated as above and, using this value, sensitivity, specificity, positive and negative predictive values were determined.

Values for provocation tests and eNO are expressed as medians and interquartile ranges (25–75%). Correlations between NO and other provocation tests were determined in the entire cohort and in the asthmatic group of patients using linear regression analysis. In the asthmatic group, subjects with PC₂₀ values higher than the maximal concentration tested were excluded from analysis of correlations only but included for all other analyses.

Comparison between asthmatic and non-asthmatic groups was performed using the Mann-Whitney test. A p value of <0.05 was considered significant.

RESULTS
Symptoms for which patients were referred were as follows: cough (n = 39), dyspnoea (n = 32), cough and dyspnoea (n = 14), wheeze (n = 2), cough and wheeze (n = 1), dyspnoea and wheeze (n = 1), and chest tightness (n = 2).

Ninety patients completed the initial evaluation including bronchial provocation and eNO determinations. Of these patients, adequate follow up could not be obtained in five. We were left with 85 patients of whom 40 could clearly be classified as asthmatic. The 45 patients in whom a definitive diagnosis of asthma could not be made after 2 years of follow up were considered “non-asthmatic”. Because follow up was biased, final diagnosis in the non-asthma group was determined retrospectively at the end of the 2 year period. Of the non-asthmatics, symptoms resolved over the 2 years in 16 (35.5%), were attributed to chronic sinusitis, postnasal drip or allergic rhinitis in 10 (22%), to reflux in four (9%), to anxiety attacks in two (4.5%), to cardiac failure in two (4.5%), and to poor physical condition in six (13.4%). No definitive diagnosis was made in five (11.1%) of the remaining cases.

Demographic data and values for lung function, bronchial provocation tests, and eNO levels in asthmatics and non-asthmatics are shown in table 1 and fig 1. The median (interquartile range) eNO level in asthmatics was 12.7 ppb (8.25–17.1) compared with 3.8 ppb (3.05–5.25) in non-asthmatics (p<0.0001).

Comparison between tests for the diagnosis of asthma
Areas under the curve (AUCs) obtained from ROC curves for eNO, exercise, MCH, and AMP were 0.896, 0.781, 0.924, and 0.966, respectively.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Demographic data, spirometric parameters, and values for exhaled nitric oxide and bronchial provocation tests in asthmatic and non-asthmatic patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma (n = 40)</td>
<td>Non-asthma (n = 45)</td>
</tr>
<tr>
<td>Age (years)*</td>
<td>24 (1.6)</td>
</tr>
<tr>
<td>Sex (M:F)</td>
<td>24:16</td>
</tr>
<tr>
<td>FEV₁ (% predicted)†</td>
<td>94 (1.6)</td>
</tr>
<tr>
<td>FEV₁/FVC (%)</td>
<td>82 (0.8)</td>
</tr>
<tr>
<td>eNO (ppb)†</td>
<td>127 (8.25–17.1)</td>
</tr>
<tr>
<td>MCH (mg/ml)†</td>
<td>0.60 (0.25–1.5)</td>
</tr>
<tr>
<td>AMP (mg/ml)†</td>
<td>23.5 (5.25–50)</td>
</tr>
</tbody>
</table>

*Median (interquartile range).
†Mean (SE) values.

FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity; MCH, methacholine; AMP, adenosine 5’-monophosphate.
Exhaled nitric oxide for diagnosing asthma

Correlations between eNO and exercise (percentage change in FEV₁), log PC₂₀ for MCH and AMP were performed in the whole study cohort and repeated in asthmatics only. A significant linear correlation with eNO was found for exercise, MCH, and AMP when all subjects were included, with log-AMP giving the best correlation followed by exercise. Values were $r^2 = 0.41$, $p<0.0001$ for log-AMP; $r^2 = 0.31$, $p<0.0001$ for exercise; and $r^2 = 0.21$, $p<0.0001$ for log-MCH. When only asthmatics were included and those with assumed values for AMP ($>400$ mg/ml) and MCH ($>8$ mg/ml) were excluded, a significant correlation was observed for exercise only but not for log-AMP or log-MCH ($r^2 = 0.21$, $p = 0.003$ for exercise; $r^2 = 0.06$, $p = 0.0001$ for log-AMP).

### Table 2

<table>
<thead>
<tr>
<th>Test</th>
<th>Best cut off value</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>% (95% CI)</td>
<td>% (95% CI)</td>
</tr>
<tr>
<td>eNO</td>
<td>$&gt;7$ ppb</td>
<td>82.5 (67.2 to 92.7)</td>
<td>88.9 (76.0 to 96.3)</td>
</tr>
<tr>
<td>Exercise</td>
<td>$&gt;10%$ fall</td>
<td>57.9 (38.3 to 70.7)</td>
<td>100 (91.8 to 100)</td>
</tr>
<tr>
<td>MCH</td>
<td>$&lt;3$ mg/ml</td>
<td>87.5 (73.2 to 95.8)</td>
<td>86.7 (73.2 to 95.0)</td>
</tr>
<tr>
<td>AMP</td>
<td>$&lt;150$ mg/ml</td>
<td>89.5 (75.2 to 97.1)</td>
<td>95.6 (84.9 to 99.5)</td>
</tr>
</tbody>
</table>

eNO, exhaled nitric oxide; MCH, methacholine; AMP, adenosine 5'-monophosphate.
amp in asthmatic and non-asthmatic patients. Area under the curve (AUC) was 0.896, 0.781, 0.924, and 0.939, respectively.

This sensitivity and specificity was similar to that obtained with MCH (PC₂₀ > 100 mg/ml) and superior to exercise (ΔFEV₁ ≥ 10%), although AMP (PC₂₀ ≤ 15 mg/ml) was superior to other tests including eNO.

For our study we chose to define asthma by clinical follow up. This approach has several advantages. Provocation tests have a significant false positive and negative yield and are therefore in themselves somewhat problematic when used as a gold standard for the diagnosis of asthma. Furthermore, the primary aim of our study was to compare the diagnostic value of eNO with these tests. This necessarily excluded them from inclusion in the “gold standard” for the definition of asthma in our study. Rather, we chose a clinical “gold standard” which also included reference to changes in lung function with either bronchodilator or corticosteroids. Irrespective of the “gold standard” chosen, there is always a degree of uncertainty at a single point in time regarding the diagnosis of asthma in some patients. We attempted to overcome this problem by using a prolonged (24 month) follow up time, at which point patients were classified as having “doctor diagnosed asthma” or as “non-asthmatic”.

Although several studies have shown that eNO is raised in steroid naive asthmatics and that levels correlate with airway inflammation, only a few studies have evaluated this test as a tool for the diagnosis of asthma. Chatkin et al showed that eNO may be used for diagnosing asthma in patients with chronic cough. Dupont et al found that measurement of eNO (using a cut off value of 16 ppb) yielded a specificity of 90% and a positive predictive value of >90% for the diagnosis of asthma. Deykin et al showed that measurement of eNO allows differentiation between asthmatic patients and healthy subjects, and Smith et al recently found that eNO is superior to spirometry and peak flow variation and comparable to sputum eosinophilia for the diagnosis of asthma. In contrast to our study, all of these studies used a positive initial response to bronchodilators or a positive challenge test to define the presence of asthma.

Like the studies of Dupont and Smith, we felt that performing diagnostic tests including eNO in patients in whom a definitive diagnosis has not yet been established—rather than testing known asthmatics and non-asthmatic controls—gives more meaningful information because it reflects the real clinical scenario in which we propose that eNO be used.

Physicians may be reluctant to dispense with bronchial provocation tests in favor of eNO for diagnosing asthma. Guidelines define asthma by the presence of reversible

Figure 2  ROC curves obtained for (A) exhaled nitric oxide, (B) percentage fall in FEV₁ after exercise, (C) PC₂₀ for methacholine, and (D) PC₂₀ for AMP in asthmatic and non-asthmatic patients. Area under the curve (AUC) was 0.896, 0.781, 0.924, and 0.939, respectively.

Figure 3  Sensitivity and specificity of increasing cut off values for exhaled nitric oxide in the diagnosis of asthma. An optimal value to differentiate between asthmatics and non-asthmatics was obtained from the highest sum obtained from adding sensitivity and specificity and corresponded to 7 ppb.
Exhaled nitric oxide for diagnosing asthma

Table 3  Sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) of eNO >7 ppb for the diagnosis of asthma using different parameters to define asthma

<table>
<thead>
<tr>
<th>Parameter defining asthma</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>PPV (%)</th>
<th>NPV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>82.5 (33/40)</td>
<td>88.9 (41/48)</td>
<td>89.1 (33/37)</td>
<td>85.4 (41/48)</td>
</tr>
<tr>
<td>MCH ≤ 3 mg/ml</td>
<td>66.7 (28/42)</td>
<td>72.9 (35/48)</td>
<td>68.3 (28/41)</td>
<td>71.4 (35/49)</td>
</tr>
<tr>
<td>AMP ≤ 150 mg/ml</td>
<td>86.6 (32/37)</td>
<td>81.5 (44/54)</td>
<td>76.2 (32/42)</td>
<td>89.8 (44/49)</td>
</tr>
<tr>
<td>Exhaled (ΔFEV1 &gt;10%)</td>
<td>91.3 (21/23)</td>
<td>70.1 (47/67)</td>
<td>51.2 (21/41)</td>
<td>95.9 (47/49)</td>
</tr>
</tbody>
</table>

Numbers in brackets are absolute numbers of patients.

airways obstruction which therefore requires performance of spirometric tests and, if normal, bronchial provocation tests. Nevertheless, airway inflammation is also considered a key element in the diagnosis and pathogenesis of asthma and, while eNO is widely considered to reflect airway inflammation, spirometric testing is at best a poor and inconsistent indicator of inflammation. There is also controversy as to whether airway hyperresponsiveness as measured by bronchial provocation studies reflects airway inflammation. Measurement of eNO is extremely easy, quick, and safe to perform, while performance of bronchial provocation tests is time-consuming, expensive and associated with some risk, albeit small, of inducing severe bronchospasm. It is therefore not unreasonable to suggest that eNO may be preferable at least of comparable value to bronchial provocation studies for diagnosing asthma.

We found that an eNO level of >7 ppb is the optimal single cut off point for differentiating asthmatics from non-asthmatics. We obtained the same optimal cut off value for eNO irrespective of whether asthma was defined by clinical parameters, positive MCH challenge, positive AMP challenge, or by positive exercise test. This consistency adds considerable strength to the validity of the findings in our study. Using a higher or lower cut off value alters the specificity or sensitivity of this test and may be preferable in certain patients depending on pretest probability of asthma. eNO values of 4 ppb yield sensitivity and specificity similar to that of PC20 <8 mg/ml for MCH (sensitivity 95.0%, specificity 57.8% for eNO, 92.5% and 66.7% for MCH), while an eNO value of 12 ppb is analogous to a positive exercise test (ΔFEV1 >10%) (sensitivity 55%, specificity 95.6% for eNO, 57.9% and 100% for exercise). Clearly, the optimal cut off for eNO for a diagnosis of asthma will depend on the population studied. Our study was performed in a select group with a high prevalence of asthma (40/85, 47%) and different considerations would apply for diagnosing asthma in a less select group of subjects.

Considerable differences in absolute eNO values have been found in different centres. These are related to differences in technique used to measure eNO, the analyser used, and possibly ambient NO levels. For this study we used an expiratory flow rate of 250 ml/s. ATS guidelines recommend a flow rate of 50 ml/s, although the statement makes it clear that other flow rates can be used. Our study started before publication of the ATS guidelines and was performed in accordance with ERS guidelines which recommend flow rates of 10–15 l/min. eNO has been shown to discriminate between known asthmatics and healthy subjects over a wide range of flow rates (50–250 ml/s for online measurements). Although attempts have been made to standardise eNO measurements, caution should be used in extrapolating absolute values obtained in one centre to those obtained elsewhere.

In conclusion, we found that eNO can be used as a diagnostic test for asthma in patients presenting with non-specific respiratory symptoms. This test has high sensitivity and specificity for the diagnosis of asthma, is safe and easy to perform, and has a diagnostic value comparable to that of conventional bronchial provocation tests.

Figure 4  Correlation between eNO and (A) log PC20 for MCH, (B) log PC20 for AMP, and (C) change in FEV1 following exercise in asthmatic subjects. A significant correlation was observed for exercise but not for log-MCH or for log-AMP (r² = 0.21, p = 0.003 for exercise; r² = 0.06, p = 0.17 for log-AMP, and r² = 0.002, p = 0.8 for log-MCH). Assumed values (PC20 >8 mg/ml for MCH and >400 mg/ml for AMP) were excluded from this analysis.
Published: October 19, 2003

Authors' affiliations
N Berkman, A Avital, R Breuer, E Bardach, C Springer, S Godfrey, Institute of Pulmonology, Hadassah-Hebrew University Medical Center, Jerusalem, Israel

Sponsors: none
The contributing authors have no competing interests related to this publication.

REFERENCES