

Table 1 Clinical characteristics and microbiological findings of 231 patients with community acquired pneumonia

| | Enterovirus (n = 12)* | Rhinovirus (n = 7) | Influenza A (n = 17)* | Other respiratory viruses (n = 12) | Other or undetermined aetiology (n = 184) |
|---|--------------------------|-----------------------|--------------------------|---|--|
| Age (y) (mean (SD)) | 45.9 (18.5) | 44.6 (19.9) | 64.2 (16.7) | 50.3 (23.4) | 48.8 (17.7) |
| Males (n (%)) | 6 (50) | 6 (86) | 5 (29) | 7 (58) | 103 (56) |
| Underlying disease (n (%)) | 4 (33) | 4 (57) | 9 (53) | 3 (25) | 73 (40) |
| COPD or asthma (n (%)) | 2 (17) | 3 (43) | 4 (24) | 1 (8) | 23 (13) |
| Cardiovascular disease (n (%)) | 2 (17) | 1 (14) | 3 (18) | 2 (17) | 29 (16) |
| Smoker (n (%)) | 4 (33) | 4 (57) | 3 (18) | 1 (8) | 59 (32) |
| PSI class IV–V (n (%)) | 2 (17) | 2 (29) | 8 (47) | 2 (17) | 35 (19) |
| Died (n (%)) | 0 | 1 (14) | 3 (18) | 0 | 1 (5) |
| <i>Streptococcus pneumoniae</i> (n (%)) | 3 (25) | 4 (57) | 6 (35) | 2 (17) | 50 (27) |

COPD, chronic obstructive pulmonary disease; PSI, Pneumonia Severity Index.

*Two patients with enterovirus and influenza A.

important viruses causing this disease. Collectively, our findings corroborate those of Jennings and colleagues¹ and support their conclusion that the importance of both viral pneumonia and mixed viral/bacterial pneumonia may be greater than previously realised.

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Leptin and regulatory T cells in obese patients with asthma

Taylor and colleagues¹ demonstrated a significant association between asthma severity and obesity. However, the mechanisms

underlying this association are not fully understood. We suggest that the increase in asthma severity in obese patients might also be related to a defective function of regulatory T cells (Tregs).

Tregs play an essential role in immune homeostasis and protection against autoimmunity, and it has been suggested that the function of Tregs may be defective in patients with asthma.² On the other hand, leptin, a known hormone marker for obesity, exerts actions on multiple organ systems, including the immune system. Indeed, it has been shown that leptin signalling negatively modulates Treg function.³

Therefore, the increase in asthma severity observed in obese patients might be caused, in part, by a decreased immunological tolerance induced by a decreased function of Tregs mediated by leptin. Moreover, it has been suggested that induction of Treg development might be a useful tool for asthma treatment.² However, Treg increases might also increase cancer risk by impairing host antitumor immune response.⁴ Thus the safest way to improve asthma in obese patients is to lose weight.

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Thunderstorm associated asthma in Atlanta, Georgia

Associations between thunderstorm activity and asthma morbidity have been reported in numerous locations around the world.¹ The most prominent hypotheses explaining the associations are that pollen grains rupture by osmotic shock in rainwater, releasing allergens, and that gusty winds from thunderstorm downdrafts spread particles and/or aeroallergens, which may ultimately increase the risk of asthma attacks. A full understanding of “thunderstorm asthma” is crucial, especially with projections of increases in heavy rainfall, thunderstorm events and aeroallergen concentrations as the climate system warms.^{2,3} Many existing studies of this phenomenon have been limited in power and scope.¹ Our study seeks to conduct the most extensive investigation of thunderstorm occurrence and asthma morbidity to date in a region, the Southeast US, that has not previously been examined but where thunderstorms are highly prevalent.

We capitalised on the availability of an extensive emergency department (ED) visit database, consisting of data on over 10 million ED visits collected from 41 of 42 hospitals in 20 county Atlanta, Georgia, between 1993 and 2004. We selected visits for asthma (identified using the primary International Classification of Disease, 9th revision diagnosis codes 493, 786.07) by patients residing in zip codes located wholly or partially in the study area. Thunderstorm occurrence data were obtained from the automated surface observing system station at the Atlanta Hartsfield–Jackson airport, which recorded 564 thunderstorm days (12.9% of 4383 total study days). In order to test the mechanistic hypotheses of thunderstorm asthma, we also obtained total daily rainfall and maximum 5 s wind gust data. The wind gust data were used as a surrogate for thunderstorm downdrafts and to indicate the maximum wind speed of the storm. We assessed the association between thunderstorms and next day asthma ED visits using Poisson generalised linear models.⁴ We controlled for long term temporal and seasonal trends and meteorological conditions with cubic splines,⁵ which allow for flexible control of temporally varying confounding factors. We examined effect modification by levels of rainfall and wind speed, defined a priori by quartiles of their respective distributions.

We observed 215 832 asthma ED visits during the study period; 24 350 of these visits occurred on days following thunderstorms. In our epidemiological models, we observed an association between daily counts of asthma ED visits and thunderstorm occurrence ($p < 0.001$, fig 1). Overall, asthma visits were 3% higher on days following thunderstorms. When thunderstorms were stratified by rainfall amount, associations with asthma were observed for thunderstorms with rainfall but not for thunderstorms with no recorded rainfall.

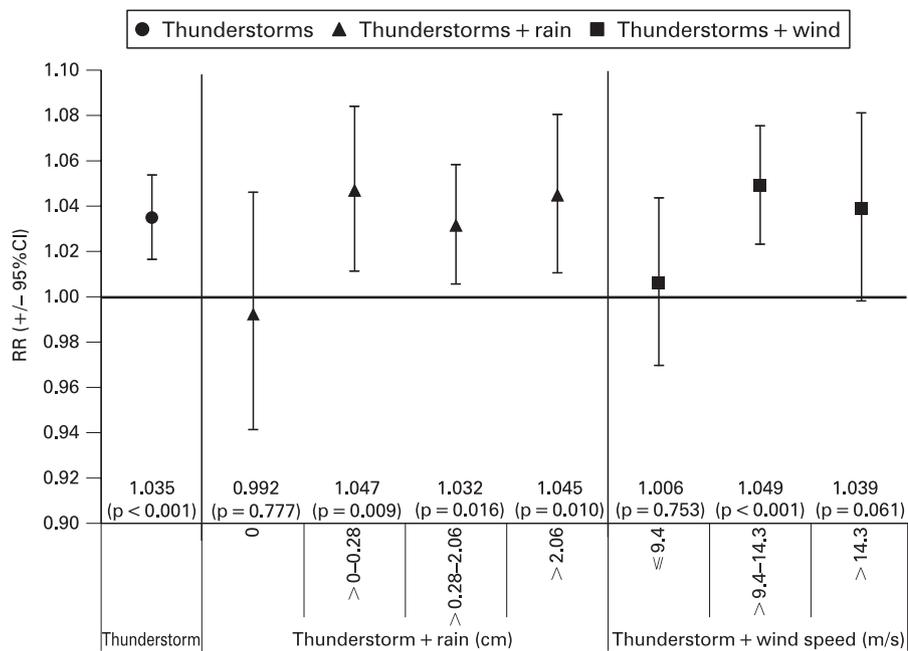


Figure 1 Relative risk of asthma emergency department visits following days with thunderstorms, thunderstorms in combination with rainfall (in four categories) and thunderstorms in combination with wind speed from maximum 5 s wind gusts (in three categories), compared with days with no thunderstorms. Relative risks (RR) and p values are presented for each model result.

When thunderstorms were stratified by wind gust levels, associations with asthma were strongest when wind gusts were intermediate and high.

Our findings corroborate previous reports of an association of thunderstorm activity with asthma exacerbation. Furthermore, our results provide preliminary evidence in support of rainfall and wind gusts playing important roles in this association. While a 3% increase in risk may seem modest, asthma is quite prevalent in Atlanta and a modest relative increase could have a significant public health impact in the population. This analysis used meteorological data from one weather station. However, thunderstorms are small scale phenomena, and these data may only represent events in close proximity to the station. Planned analyses will take advantage of data from other local stations, radar data on thunderstorm characteristics and spatial resolution of the outcome data to conduct a more refined assessment of the mechanistic basis of the observed association.

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Prolonged survival of neutrophils from patients with ΔF508 CFTR mutations

Cystic fibrosis (CF) is an autosomal recessive “channelopathy” characterised by aberrant

CFTR and ENaC function resulting in widespread epithelial cell dysfunction and persistent airway infection. Studies indicating that airway inflammation precedes infection¹ and that patients with CF display exaggerated neutrophilic responses to pathogens have suggested a primary defect in innate immune responses in CF. Given the importance of apoptosis to the resolution of neutrophilic inflammation,² we sought to determine whether circulating CF neutrophils display normal apoptotic capacity.

Peripheral blood neutrophils were isolated from 12 clinically stable *Pseudomonas* colonised ΔF508 homozygote adult patients with CF and 12 age and sex matched healthy controls using discontinuous plasma/Percoll gradients.³ Blood neutrophil counts were in the normal range for all subjects (CF mean 4.1 (range 5.4–8.3), controls 2.5 (3.7–6.6) × 10⁹/l); none of the patients with CF were taking azithromycin. CF and control neutrophils were isolated in parallel and handled identically. Cells were cultured (5 × 10⁶/ml, 5% CO₂, 37°C) in Iscove's Dulbecco's medium with 10% autologous serum for 6 and 20 h, as detailed previously.³ These incubations were conducted with or without tumour necrosis factor α (TNFα 10 ng/ml) or granulocyte macrophage-colony stimulating factor (GM-CSF 10 ng/ml), which have defined proapoptotic and antiapoptotic effects, respectively.³ Apoptosis was assessed by blinded morphological assessment of May–Gründwald–Giemsa stained cytopins, confirmed by quantification of annexin-V–fluorescein isothiocyanate binding and propidium iodide staining.³

Neutrophils from patients with CF had delayed constitutive apoptosis and were resistant to the normal early proapoptotic effects of TNFα,³ yet remained fully sensitive to the antiapoptotic effects of GM-CSF (fig 1A–C). Incubation of control neutrophils with 10% serum from patients with CF mimicked exactly the enhanced survival effect seen in CF cells, suggesting an acquired rather than intrinsic defect (fig 1D). These data indicate that blood neutrophils from clinically well patients with CF display a relative resistance to spontaneous and death ligand induced apoptosis when cultured with autologous serum. Using the Luminex FlowMetrix system to compare protein and cytokine profiles in CF and control sera, only C reactive protein (CRP) differed, with a 3.6-fold increase in CF sera (controls 1.6 (0.3) μg/ml, CF 5.8 (1.3) μg/ml; p < 0.05, n = 4). Although no direct measures of neutrophil activation were performed, there were no differences in proinflammatory cytokines or growth factors present in control and CF sera, including interleukin (IL)8, TNFα, IL6 and GM-CSF. Previous data reporting that migration inhibitory factor can inhibit CF neutrophil apoptosis may reflect lipopolysaccharide contamination of