SHORT REPORT

Two patients with occupational asthma who returned to work with dust respirators

Yasushi Obase, Terufumi Shimoda, Kazuko Mitsuta, Hirotu Matsuse, Shigeru Kohno

Abstract

Objectives—To assess the efficacy of dust respirators in preventing asthma attacks in patients with occupational asthma (asthma induced by buckwheat flour or wheat flour).

Methods—The effect of the work environment was examined in two patients with occupational asthma with and without the use of a commercially available mask or a dust respirator. Pulmonary function tests were performed immediately before and after work and at 1-hourly intervals for 14 hours after returning to the hospital.

Results—In patient 1, environmental exposure resulted in no symptoms during and immediately after work, but coughing, wheezing, and dyspnoea developed after 6 hours. Peak expiratory flow rate (PEFR) decreased by 44% 7 hours after leaving the work environment, showing only a positive late asthmatic reaction (LAR). In patient 2, environmental exposure resulted in coughing and wheezing 10 minutes after initiation during bread making, and PEFR decreased by 39%. After 7 hours, PEFR decreased by 34%.

The environmental provocation tests in both patients were repeated after wearing a commercial respirator. This resulted in a complete suppression of LAR in patient 1 and of immediate asthmatic reaction (IAR) and LAR in patient 2.

Conclusions—Two patients with asthma induced by buckwheat flour or wheat flour in whom asthmatic attacks could be prevented with a dust respirator are reported. Dust respirators are effective in preventing asthma attacks induced by buckwheat flour and wheat flour.

Keywords: asthma; buckwheat flour; wheat flour; environmental provocation test

Among occupational diseases, the incidence of occupational asthma has been steadily increasing in recent years. Early detection and avoidance of antigens can often achieve a complete cure of asthma. As occupational asthma is caused by specific antigenic material present in the work environment, in some cases antigen avoidance is effective in preventing attacks, and a change of job results in overall improvement of symptoms or even remission. However, these methods in most circumstances are impractical as they lead to job loss. We report two patients with occupational asthma (to buckwheat flour and wheat flour) in whom the use of a dust respirator for ultrafine particles prevented attacks of asthma and allowed return to the workplace.

Case reports

PATIENT 1 (ASTHMA INDUCED BY BUCKWHEAT)

The patient was a 54-year-old man working in a food factory for buckwheat noodles. Coughing appeared during the production of buckwheat noodles 2 years before presentation. Dyspnoea persisted during noodle production even with the use of a commercially available mask. Dry rales were heard over the entire lung fields during auscultation of the chest. Recording of peak expiratory flow rate (PEFR) over several days showed that it fluctuated between 230 and 340 l/min, with nocturnal and early morning dipping to 230–260 l/min.

PATIENT 2 (ASTHMA INDUCED BY WHEAT)

A 42-year-old male patient had worked as a baker for 16 years since he was 26 years old. During the past 3 years, the patient required daily inhalation of a bronchodilator and developed mild to moderate attacks of wheezing once a week, and wheezing in the workplace became more frequent. One year before presentation, the patient was transported to a local hospital after developing a severe attack of asthma.

Methods

Skin prick tests, intradermal skin tests, Prausnitz-Küstner reaction, and specific bronchial provocation tests were performed with the method described by Cockcroft et al. These tests were performed after confirming that the percentage of their forced expiratory volume in 1 second (FEV1%) increased after admission to 80% of that predicted. In patient 1, commercially available extracts of buckwheat flour (1:10 weight/volume, Torii, Tokyo, Japan) was used. In patient 2, antigens at a final concentration of 1:10 weight/volume were prepared with six components (components A–F) of the wheat flour which were classified by the product's name usually used by the patient.
**Table 1  Characteristics and laboratory examination of patients**

<table>
<thead>
<tr>
<th>Patient 1</th>
<th>Patient 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, sex</td>
<td>54, man</td>
</tr>
<tr>
<td>Occupation</td>
<td>Factory making buckwheat noodles</td>
</tr>
<tr>
<td>History of the work</td>
<td>36 y, since age 18</td>
</tr>
<tr>
<td>Habit</td>
<td>Non-smoker and social drinker</td>
</tr>
<tr>
<td>Peripheral eosinophilia (%)</td>
<td>23</td>
</tr>
<tr>
<td>Total IgE (IU/ml)</td>
<td>176</td>
</tr>
<tr>
<td>FEV₁, (% predicted)</td>
<td>1.31 (49%)</td>
</tr>
<tr>
<td>PaCO₂, PaO₂ (mm Hg)</td>
<td>42, 60</td>
</tr>
<tr>
<td>PC20⁺ (mg/ml)</td>
<td>0.625</td>
</tr>
<tr>
<td>Chest x ray film</td>
<td>Normal</td>
</tr>
<tr>
<td>Prick test† (mm)</td>
<td>Buckwheat flour extract: 10⁻⁷ g/ml: negative</td>
</tr>
<tr>
<td>Chest prick test† (mm)</td>
<td>10⁻⁷ g/ml: 4 x 4 / 28 x 25</td>
</tr>
<tr>
<td>Skin test (mm)</td>
<td>Buckwheat flour extract: 10⁻⁴ g/ml: negative</td>
</tr>
<tr>
<td>Prick test† (mm)</td>
<td>Buckwheat flour: 10⁻⁴ g/ml: 12 x 10 / 40 x 33</td>
</tr>
<tr>
<td>Skin test (mm)</td>
<td>10⁻⁴ g/ml: negative</td>
</tr>
<tr>
<td>Prussin-Küsten reaction</td>
<td>Not done</td>
</tr>
<tr>
<td>IGE-RAST‡</td>
<td>Buckwheat flour: class 3</td>
</tr>
<tr>
<td>Bronchoprovocation test§</td>
<td>Other 30 antigens: all negative</td>
</tr>
<tr>
<td>Bronchoprovocation test§</td>
<td>Buckwheat flour extract (10⁻⁷ g/ml)</td>
</tr>
<tr>
<td>Environmental provocation test¶</td>
<td>LAR: 32% fall in FEV₁, 7 h later</td>
</tr>
<tr>
<td>Environmental provocation test¶</td>
<td>Work for 30 minutes</td>
</tr>
<tr>
<td>Environmental provocation test¶</td>
<td>IAR: negative</td>
</tr>
<tr>
<td>Environmental provocation test¶</td>
<td>LAR: 44% fall in PEFR 9 h later</td>
</tr>
<tr>
<td>Environmental provocation test¶</td>
<td>LAR: 44% fall in PEFR 9 h later</td>
</tr>
</tbody>
</table>

*Non-specific methacholine bronchial provocation test.
†Results of the skin prick test were expressed as wheal / flare (mm). In Patient 2, antigens were prepared using six components (component A–F) of the wheat flour that were usually used by the patient (see text). In Patient 1, no symptoms were seen during and immediately after work, but coughing, wheezing, and dyspnea developed after 6 hours. Seven hours after leaving the work environment, PEFR decreased by 44%, showing positive results only for LAR. In Patient 2, coughing and wheezing developed 10 minutes after the start of work (bread making), and the PEFR decreased by 39%. After 7 hours, coughing, wheezing, and dyspnea occurred, and the PEFR decreased by 34%. The environmental provocation tests were repeated again with the dust respirators. These resulted in a complete suppression of IAR (patient 2) and LAR (patients 1 and 2). On admission, an obstructive pulmonary pattern was found in both patients with PEFR of 180–350 and 300–450 l/min in patients 1 and 2, respectively. At the time of discharge from the hospital, the values of PEFR had increased to 380–450 and 650–750 l/min without exposure to antigens. The variability in PEFR during the daytime had decreased from 49% ((350–180)/350) to 16% ((450–380)/450) in patient 1, and from 33% ((450–300)/450) to 13% ((750–650)/750) in patient 2, respectively. After discharge from the hospital, both patients returned to work with the dust respirator. We followed up patients 1 and 2 in the outpatient department for 2 and 3 years, respectively. During these periods, both patients kept a diary of daily morning and evening PEFR values and clinical examination indicated at each follow up visit that neither patient had had an attack of asthma.

Discussion

We discuss in this report two patients with occupational asthma who returned to work using dust respirators. The reported incidence of asthma induced by wheat flour is 6%–9% among people engaged in bread production. There are a few cases reported of asthma induced by wheat flour in countries such as Japan and Korea, and France, Sweden, and other European countries. In our study, symptoms developed in patient 1 at 34 years after the first exposure to buckwheat. Patient 2 developed dyspnea about 5 years after starting work in bread production. Valdivieso et al. reported a case of asthma induced by buckwheat, and the patient developed both IAR and LAR in a bronchial provocation test with buckwheat flour extract 1:10 000 g/ml. Choudat et al. also reported a patient with asthma induced by buckwheat, who showed only an immediate response in bronchial provocation test with 10 µg buckwheat flour. In our study, patient 1 showed only
an LAR in bronchial provocation test with buckwheat flour extract at a concentration of 10^{-3} g/ml.

As an attack of buckwheat asthma is often very severe, in this study, we limited the concentration of antigen in the specific inhalation test to 10^{-3} g/ml. This concentration induced only LAR; probably reflecting increased nocturnal symptoms reported by the patient after work. The importance of LAR was further shown by a positive late response in the environment test. We think that the inhalation test with less than 10^{-3} g/ml was useful and safe; the test did not result in the appearance of any abnormal shadows suggestive of pneumonitis, as confirmed clinically and through a series of chest x-ray films before and after the challenge tests. Patient 2 showed both IAR and LAR in the environment test as well as in the laboratory inhalation test. These results also necessitated the use of a limited concentration of the antigen.

Buckwheat and wheat allergens belong botanically to the group of high molecular antigens, and occupational asthma induced by these antigens tends to develop in atopic people. However, the two patients in this report showed no atopy. We think that their asthma was due to type 1 allergy because the intradermal test, immunoglobulin E radio allergosorbent test (IgE-RAST), and specific inhalation test were all positive. Unfortunately, immunological cross reaction tests were not performed with the six wheat flour extracts. However, skin tests with these extracts showed positive results in patient 2.

To avoid an antigen, a change of workplace or job, or wearing appropriate protective clothes are necessary. In practice, a change of job is difficult for economic reasons, and protective clothes are cumbersome and may reduce work efficiency. Taivainen et al. had recently reported the efficacy of powered dust respirator helmets in the prevention of occupational asthma among farmers. They reported that, in particular, dairy farmers with occupational asthma benefited from the use of a powered dust respirator helmet. The dust respirators that prevented worsening of asthma in our patients have a dust capture efficiency of >99.5%. These respirators are light and easy to wear, weighing 25 g and about 17 g, for the 3M and Shigematsu masks, respectively. Each filter can be used continuously for 11–16 hours and costs about 3–8 US $. The efficacy of these respirators may be based on static electric and mechanical filtration, with filters of pore size <0.3 µm. Of course, the efficacy of a filter for particles is much more complex than only mechanical filtration and electric characteristics. They may prevent asthma attacks caused by inhalation of antigenic particles >0.3 µm such as western red cedar. However, in asthma induced by isocyanates, a different mechanical respirator may be more effective, as humidity is known to reduce the efficacy of static electric filtration.

Relief of symptoms related to asthma is occasionally reported in patients with occupational asthma in whom antigen avoidance is possible soon after onset by changing workplace or job—for example, asthma induced at a pulpmill, or by tetrachlorophthalic anhydride and snow crab. However, in such patients, antigen sensitisation and airway hyperresponsiveness do not decrease even several years after avoidance of the antigen.9 10 The two patients reported here were followed up for only 2–3 years. Therefore, it is not clear at this stage whether airway hyperresponsiveness would change with time. Furthermore evaluation after longer periods of follow up is planned. Personal protective equipment can reduce exposure to antigens. However, other measures that improve work practices and ventilation should provide a better working environment.

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