Comparison between various indices of exposure to traffic-related air pollution and their impact on respiratory health in adults

G Cesaroni, C Badaloni, D Porta, F Forastiere, C A Perucci

ABSTRACT

Objective: To evaluate the association of different indices of traffic-related air pollution (self-report of traffic intensity, distance from busy roads from geographical information system (GIS), area-based emissions of particulate matter (PM), and estimated concentrations of nitrogen dioxide (NO₂) from a land-use regression model) with respiratory health in adults.

Methods: A sample of 9488 25–59-year-old Rome residents completed a self-administered questionnaire on respiratory health and various risk factors, including education, occupation, housing conditions, smoking, and traffic intensity in their area of residence. The study used GIS to calculate the distance between their home address and the closest high-traffic road. For each subject, PM emissions in the area of residence as well as estimated NO₂ concentrations as assessed by a land-use regression model (R² value = 0.69), were available. Generalised estimating equations (GEE) were used to analyse the association between air pollution measures and prevalence of “ever” chronic bronchitis, asthma, and rhinitis taking into account the effects of age, gender, education, smoking habits, socioeconomic position, and the correlation of variables for members of the same family.

Results: Three hundred and ninety seven subjects (4% of the study population) reported chronic bronchitis, 472 (5%) asthma, and 1227 (13%) rhinitis. Fifteen per cent of subjects reported living in high traffic areas, 11% lived within 50 m of a high traffic road, and 28% in areas with estimated NO₂ greater than 50 μg/m³. Prevalence of asthma was associated only with self-reported traffic intensity whereas no association was found for the other more objective indices. Rhinitis, on the other hand, was strongly associated with all traffic-related indicators (eg, OR = 1.13, 95% CI: 1.04 to 1.22 for 10 μg/m³ NO₂), especially among non-smokers.

Conclusions: Indices of exposure to traffic-related air pollution are consistently associated with an increased risk of rhinitis in adults, especially among non-smokers. The results for asthma are weak, possibly due to ascertainment problems.

During the last two decades a substantial body of epidemiological research has shown that outdoor air pollution, and in particular traffic-related air pollution, is a contributing cause of premature mortality and morbidity.1–2 Several studies have reported adverse respiratory effects from traffic exposures among children,3–5 but the evidence of an effect among adults in the general population is more limited.6–8 An increased risk of persistent wheeze was associated with living within 50 m of a major roadway in a US veterans study,6 while prevalence of chronic bronchitis, respiratory symptoms and hay fever was increased among adults living at busy roads in Germany.9 Swiss investigators have used data from the Swiss Cohort Study on Air Pollution and Lung Diseases in Adults (SAPALDIA), conducted in 1991 and 2002, to study the association between traffic exposures and prevalence of respiratory symptoms in a 12-month period in a random adult population sample. They found that non-smokers living within 20 m of a main street had an increased risk of regular phlegm and wheezing.7 A positive association with a sensitisation to pollen was also seen in the same study.10 In a very recent investigation in the USA, distance from busy roads has been associated with reduced lung function among adults.11

Exposure assessment in studies addressing long-term effects of air pollution is a critical issue since urban fixed air pollution monitors do not differentiate the geographical variability of the exposure. Some studies in the past, especially among children, relied on subjective measures of traffic air pollution.9 12 However, misclassification of exposure is a common phenomenon and reporting bias could be significant, especially when exposure and outcome are collected from the same individuals. Jacquemin and colleagues have recently indicated that female gender, respiratory symptoms and rhinitis, high education, non-smoking and exposure to environmental tobacco smoke are associated with higher reports of annoyance from air pollution.13 Kuehni and colleagues suggested that reporting biases could explain the association between self-reported traffic exposure and respiratory symptoms in children.14 In recent years, the development of geographical information system (GIS) techniques, intense ambient monitoring of air pollutants, air dispersion modelling and land-use regression modelling has improved the available tools for better exposure assessment and more reliable indicators.5 7 15–17 Still more research is needed to understand the role of traffic air pollution on adult respiratory health, and to clarify the specific exposure indicator most sensitive in detecting a health effect.

The objective of this study was to evaluate the association between long-term exposure to air pollution, estimated by different indices of traffic air pollution (self-reported traffic intensity, GIS-derived proximity measurements to busy roads, emissions data, estimates from a land-use regression model), and prevalence of chronic bronchitis, asthma, and rhinitis in adults.
**MATERIALS AND METHODS**

**Study population**

Data were derived from the Italian Studies on Respiratory Disorders in Childhood and Environment (SIDRIA) study, an extension of the International Study on Asthma and Allergies in Childhood (ISAAC) initiative in Italy. A cross-sectional survey was carried out between October 1994 and March 1995 in eight centres of northern and central Italy using standardised questionnaires (response rate = 94%). Details of the survey have been extensively reported.\(^{16}\) Parents of 7015 subjects (first and second graders from a representative sample of primary schools, and adolescents in the third year of a representative...
Table 2  Cross-comparison of indices of exposure among the study population: self-reported traffic, distance from high traffic roads (HTRs), metres of HTR 5 within 200 m from home, particulate matter (PM) emissions, estimated nitrogen dioxide (NO₂)

<table>
<thead>
<tr>
<th>Self-reported traffic</th>
<th>Distance from HTR, mean (SD)</th>
<th>Metres of HTR within 200 m from home, mean (SD)</th>
<th>PM emissions (kg/m³), mean (SD)</th>
<th>Estimated NO₂ (μg/m³), mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>1846</td>
<td>19.5</td>
<td>521 (491)</td>
<td>0.101 (0.073)</td>
</tr>
<tr>
<td>Low</td>
<td>3094</td>
<td>32.6</td>
<td>521 (491)</td>
<td>0.101 (0.073)</td>
</tr>
<tr>
<td>Intermediate</td>
<td>3063</td>
<td>32.3</td>
<td>349 (388)</td>
<td>0.140 (0.075)</td>
</tr>
<tr>
<td>High</td>
<td>1415</td>
<td>14.9</td>
<td>188 (387)</td>
<td>0.196 (0.074)</td>
</tr>
<tr>
<td><strong>p Value</strong></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Distance from HTRs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;200 m</td>
<td>5898</td>
<td>62.2</td>
<td>684 (566)</td>
<td>0.099 (0.074)</td>
</tr>
<tr>
<td>100–200 m</td>
<td>1684</td>
<td>17.7</td>
<td>809 (529)</td>
<td>0.104 (0.077)</td>
</tr>
<tr>
<td>50–100 m</td>
<td>813</td>
<td>8.6</td>
<td>94 (15)</td>
<td>0.154 (0.080)</td>
</tr>
<tr>
<td>&lt;50 m</td>
<td>1014</td>
<td>10.7</td>
<td>11 (17)</td>
<td>0.167 (0.080)</td>
</tr>
<tr>
<td><strong>p Value</strong></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Metres of HTR within 200 m from home</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>5898</td>
<td>62.2</td>
<td>684 (566)</td>
<td>0.099 (0.074)</td>
</tr>
<tr>
<td>Low (&lt;416 m)</td>
<td>1169</td>
<td>12.3</td>
<td>140 (54)</td>
<td>0.122 (0.077)</td>
</tr>
<tr>
<td>Medium (416–798 m)</td>
<td>1177</td>
<td>12.4</td>
<td>89 (52)</td>
<td>0.148 (0.082)</td>
</tr>
<tr>
<td>High (&gt;798 m)</td>
<td>1165</td>
<td>12.3</td>
<td>47 (46)</td>
<td>0.176 (0.077)</td>
</tr>
<tr>
<td><strong>p Value</strong></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>PM emissions (quartiles)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st</td>
<td>2406</td>
<td>25.4</td>
<td>825 (746)</td>
<td>0.023 (0.014)</td>
</tr>
<tr>
<td>2nd</td>
<td>2357</td>
<td>24.8</td>
<td>457 (456)</td>
<td>0.087 (0.018)</td>
</tr>
<tr>
<td>3rd</td>
<td>2312</td>
<td>24.4</td>
<td>328 (302)</td>
<td>0.143 (0.022)</td>
</tr>
<tr>
<td>4th</td>
<td>2311</td>
<td>24.4</td>
<td>225 (230)</td>
<td>0.232 (0.043)</td>
</tr>
<tr>
<td><strong>p Value</strong></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Estimated NO₂ (quartiles, μg/m³)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st (21.0–37.3)</td>
<td>2346</td>
<td>24.7</td>
<td>840 (770)</td>
<td>0.028 (0.028)</td>
</tr>
<tr>
<td>2nd (37.3–47.3)</td>
<td>2291</td>
<td>24.1</td>
<td>552 (444)</td>
<td>0.098 (0.042)</td>
</tr>
<tr>
<td>3rd (47.3–50.3)</td>
<td>2354</td>
<td>24.8</td>
<td>261 (211)</td>
<td>0.127 (0.032)</td>
</tr>
<tr>
<td>4th (50.3–62.6)</td>
<td>2366</td>
<td>24.9</td>
<td>194 (157)</td>
<td>0.227 (0.047)</td>
</tr>
<tr>
<td><strong>p Value</strong></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Totals may vary because of missing information.

sample of junior high schools) answered a self-administered questionnaire on the child’s health status, as well as their personal respiratory health status and various risk factors, including education, occupation, housing conditions, smoking habits, and traffic intensity in their area of residence. An area-based index of socioeconomic position was assigned to each family. The index was developed using the 2001 Census data on education, occupation, housing tenure, family composition, and immigration by census block (500 average number of residents). A record linkage was performed with the Rome Municipal Registry Office Database to collect the residential history of parents who lived in Rome with their children at the time of the survey. We were able to identify 5104 fathers (76%) and 5668 mothers (83%). For this study we selected 9488 subjects aged 25–59 years who had been residents in the same place for at least 3 years before the interview.

Exposure indices

Self-reported traffic intensity in the area of residence was self-reported (traffic absent, low, moderate, high).

GIS indices were developed for each individual. We geocoded each subject’s residence at the time of the survey. To locate the address on the map we used the Environmental Systems Research Institute, Inc. (ESRI) Italian road network. Eighty subjects (0.8% of the study population) had missing address data. The Municipal Office of Rome gave us the data for all high traffic roads (HTRs) in Rome. We defined two different GIS indicators: the distance from the residence to the nearest HTR, and the total length of HTR segments within a 200 m buffer zone. Similarly to the SAPALDIA study,7 we applied buffers of different radii (50, 100 and 200 m) to the residences and intersected the buffers with the list of HTRs to create a categorical variable indicating the distance to HTRs (HTR more than 200 m, between 100 and 200 m, between 50 and 100 m, less than 50 m away). We calculated a four-category variable in metres from home to HTR as the tertiles of the sum of segments’ lengths within the 200 m buffer (none, low <416 m, medium 416–798 m, high >798 m of HTR within 200 m from home).

We collected and stored all geographical variables using ArcGis 9.1 (ESRI, Redlands, California, USA). We used the Word Geodetic System of 1984 with the Universal Transverse Mercator 35N as the coordinate system and map projection.

Emissions (kg/km) of particulate matter from traffic were estimated by the Mobility Agency of Rome (STA) for 164 geographical areas of the city. The emissions were estimated using the Transport Energy and Environment (TEE) model developed by the National Research Centre for Energy and Environment (ENEA). The estimate is based on Computer Programme to Calculate Emissions from Road Transport (COPERT II) methodology. This methodology takes many parameters into account, which include vehicle park (number of vehicles per vehicle category, age distribution of the vehicle park per vehicle category), driving conditions (hot and cold annual


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Table 3  Association between personal characteristics and respiratory diseases

<table>
<thead>
<tr>
<th>Smoking habit</th>
<th>Asthma (n = 472)</th>
<th>Rhinitis (n = 1227)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>OR 95% CI</td>
</tr>
<tr>
<td>Non-smoker</td>
<td>2.1</td>
<td>1.00</td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>4.5</td>
<td>2.10 (1.53 to 2.89)</td>
</tr>
<tr>
<td>Current smoker</td>
<td>5.5</td>
<td>2.64 (1.96 to 3.56)</td>
</tr>
<tr>
<td>p Value</td>
<td>&lt;0.001</td>
<td>0.199</td>
</tr>
<tr>
<td>Education (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;9</td>
<td>4.8</td>
<td>1.75 (1.22 to 2.50)</td>
</tr>
<tr>
<td>9–13</td>
<td>3.8</td>
<td>1.43 (0.99 to 2.06)</td>
</tr>
<tr>
<td>&gt;13</td>
<td>2.9</td>
<td>1.00</td>
</tr>
<tr>
<td>p Value</td>
<td>0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managerial/professional</td>
<td>4.2</td>
<td>1.00</td>
</tr>
<tr>
<td>Other non-manual</td>
<td>4.0</td>
<td>0.87 (0.61 to 1.26)</td>
</tr>
<tr>
<td>Manual labour</td>
<td>5.1</td>
<td>1.00 (0.65 to 1.54)</td>
</tr>
<tr>
<td>Other or unemployed</td>
<td>6.4</td>
<td>1.39 (0.91 to 2.12)</td>
</tr>
<tr>
<td>Housewife</td>
<td>2.8</td>
<td>0.67 (0.41 to 1.10)</td>
</tr>
<tr>
<td>Area-based SEP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>3.5</td>
<td>1.00</td>
</tr>
<tr>
<td>Medium high</td>
<td>4.2</td>
<td>1.09 (0.75 to 1.59)</td>
</tr>
<tr>
<td>Intermediate</td>
<td>3.3</td>
<td>0.87 (0.58 to 1.31)</td>
</tr>
<tr>
<td>Medium low</td>
<td>4.6</td>
<td>1.29 (0.89 to 1.87)</td>
</tr>
<tr>
<td>Low</td>
<td>5.2</td>
<td>1.44 (1.00 to 2.08)</td>
</tr>
<tr>
<td>p trend</td>
<td>0.027</td>
<td>0.767</td>
</tr>
<tr>
<td>Humidity or moulds at home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>4.0</td>
<td>1.00</td>
</tr>
<tr>
<td>Yes</td>
<td>7.5</td>
<td>1.89 (1.34 to 2.97)</td>
</tr>
</tbody>
</table>

OR, odds ratio adjusted for age, sex, smoking habit and educational level.
and all other covariates, and to calculate \( p \) values for trend while accounting for the dependency of members of the same family.

We used Generalised Estimating Equations (GEE) with a logit link to assess the association between traffic exposures and respiratory diseases, adjusting for sex, age (as a continuous variable), smoking habits, and educational level, and taking account of the correlation of data for members of the same family. We used the Wald test to calculate the \( p \) for trend for categorical variables in the regression models.

**RESULTS**

Table 1 shows the characteristics of the study population according to self-reported traffic, distance from HTRs, metres of HTRs within 200 m of home, area-based PM emissions, and estimated NO\(_2\). Mean participants’ age was 40 years, 45% had less than 9 years of education, 12% had managerial jobs, 31% were never smokers and 40% were current smokers. Four percent of the study population (397 subjects) reported to have chronic bronchitis or emphysema, 5% (472) asthma, and 13% (1227) rhinitis. A total of 15% of the participants reported living in high traffic areas. The study subjects lived, at the time of the survey, at an average distance of 463 m from an HTR reported living in high traffic areas. The study subjects lived, at the time of the survey, at an average distance of 463 m from an HTR.

Table 2 shows the correlation among the different traffic exposure indices. The highest correlation of air-pollution continuous variables was between estimated NO\(_2\) and PM emissions (0.86), followed by estimated NO\(_2\) and distance to HTR (−0.48). The categorical traffic variable had a correlation with the other categorical variables that ranged between 0.52 and 0.49. There was a statistically significant association between self-reported traffic and all continuous measures of air pollution considered (\( p < 0.001 \)): those who reported high traffic at their home address had a mean distance from an HTR of 188 m versus 756 m for those who reported the absence of traffic; they had more mean metres of HTR within 200 m of home (854 m vs 392 m) for those who reported the absence of traffic; they had more mean estimated NO\(_2\) (51 g/m\(^3\) vs 39 g/m\(^3\)) for those with the lowest level of education, low area-based socioeconomic index, and the presence of humidity or moulds at home (OR = 1.98, 95% CI: 1.25 to 2.52 for those with the lowest level of education).

Table 3 reports the association of individual factors with the three health outcome variables. Chronic bronchitis or emphysema was strongly associated with smoking habits (current smokers had OR = 2.68, 95% CI: 2.00 to 3.60 compared to never smokers), older age (\( p < 0.001 \)), low education (OR = 1.78, 95% CI: 1.25 to 2.52 for those with the lowest level of education), low area-based socioeconomic index, and the presence of humidity or moulds at home (OR = 1.98, 95% CI: 1.34 to 2.91). Subjects who suffered from asthma were more likely to be

| Table 4 Association between environmental exposures and respiratory diseases |
|-----------------------------|----------------|----------------|----------------|
|                             | Chronic bronchitis or emphysema | Asthma | Rhinitis |
|                             | (n = 397) | (n = 472) | (n = 1227) |
| %                          | OR (95% CI) | % | OR (95% CI) | % | OR (95% CI) |
| Self-reported traffic       | %          | OR (95% CI) | % | OR (95% CI) | % | OR (95% CI) |
| Absent                      | 4.2 | 1.00 | 4.3 | 1.00 | 11.1 | 1.00 |
| Low                         | 3.7 | 0.88 (0.64 to 1.20) | 4.7 | 1.11 (0.83 to 1.48) | 12.8 | 1.14 (0.95 to 1.38) |
| Intermediate                | 4.3 | 1.04 (0.77 to 1.40) | 5.0 | 1.18 (0.88 to 1.58) | 13.3 | 1.18 (0.98 to 1.42) |
| High                        | 4.9 | 1.19 (0.84 to 1.69) | 6.3 | 1.46 (1.05 to 2.03) | 14.9 | 1.30 (1.05 to 1.62) |
| p trend                     | 0.211 | 0.025 | 0.019 |
| Distance from high traffic roads | % | OR (95% CI) | % | OR (95% CI) | % | OR (95% CI) |
| >200 m                      | 4.4 | 1.00 | 4.9 | 1.00 | 12.3 | 1.00 |
| 100–200 m                   | 4.0 | 0.89 (0.66 to 1.20) | 4.9 | 1.00 (0.77 to 1.29) | 12.8 | 1.01 (0.85 to 1.19) |
| 50–100 m                    | 3.1 | 0.69 (0.45 to 1.05) | 5.3 | 1.07 (0.76 to 1.52) | 15.4 | 1.26 (1.03 to 1.54) |
| <50 m                       | 4.1 | 0.94 (0.67 to 1.31) | 4.9 | 1.01 (0.73 to 1.39) | 14.6 | 1.18 (0.96 to 1.44) |
| p trend                     | 0.278 | 0.851 | 0.030 |
| Metres of HTR within 200 m from home | % | OR (95% CI) | % | OR (95% CI) | % | OR (95% CI) |
| None                        | 4.4 | 1.00 | 4.9 | 1.00 | 12.3 | 1.00 |
| Low (<416 m)                | 3.9 | 0.90 (0.63 to 1.26) | 5.4 | 1.09 (0.81 to 1.46) | 13.9 | 1.09 (0.90 to 1.32) |
| Medium (416–798 m)          | 3.5 | 0.75 (0.52 to 1.07) | 5.7 | 1.16 (0.87 to 1.54) | 14.3 | 1.16 (0.97 to 1.39) |
| High (>798 m)               | 4.1 | 0.94 (0.69 to 1.29) | 4.0 | 0.80 (0.58 to 1.11) | 13.6 | 1.09 (0.90 to 1.32) |
| p trend                     | 0.285 | 0.572 | 0.152 |
| Quartiles of PM emissions   | % | OR (95% CI) | % | OR (95% CI) | % | OR (95% CI) |
| 1st                         | 4.2 | 1.00 | 4.9 | 1.00 | 10.6 | 1.00 |
| 2nd                         | 4.1 | 0.96 (0.71 to 1.30) | 5.4 | 1.10 (0.84 to 1.44) | 14.7 | 1.41 (1.17 to 1.69) |
| 3rd                         | 4.1 | 0.90 (0.66 to 1.23) | 4.7 | 0.94 (0.71 to 1.24) | 12.1 | 1.11 (0.92 to 1.34) |
| 4th                         | 4.5 | 1.05 (0.77 to 1.42) | 5.2 | 1.06 (0.80 to 1.39) | 14.7 | 1.37 (1.14 to 1.64) |
| p trend                     | 0.871 | 0.988 | 0.018 |
| Estimated NO\(_2\) (quartiles, \(\mu g/m^3\)) | % | OR (95% CI) | % | OR (95% CI) | % | OR (95% CI) |
| 1st (21.0–37.3)             | 4.2 | 1.00 | 4.6 | 1.00 | 10.8 | 1.00 |
| 2nd (37.3–47.3)             | 4.6 | 1.03 (0.77 to 1.39) | 5.0 | 1.11 (0.84 to 1.47) | 13.3 | 1.27 (1.06 to 1.53) |
| 3rd (47.3–50.3)             | 3.9 | 0.90 (0.65 to 1.23) | 5.1 | 1.08 (0.81 to 1.44) | 13.2 | 1.15 (0.96 to 1.38) |
| 4th (50.3–62.6)             | 4.2 | 0.97 (0.71 to 1.31) | 5.2 | 1.11 (0.84 to 1.48) | 14.7 | 1.30 (1.08 to 1.56) |
| p trend                     | 0.624 | 0.532 | 0.020 |

**OR**, odds ratio adjusted for age, sex, smoking habit and educational level.
highly educated, and have humidity or moulds in their house (OR = 1.55, 95% CI: 1.04 to 2.31). A high prevalence of rhinitis was associated with higher levels of education. Table 4 shows the association of indices of traffic-related pollution with respiratory diseases adjusted for age, sex, smoking habits and educational level. There was no association between chronic bronchitis or emphysema and indices of traffic air pollution. On the other hand, self-reported intense traffic was associated with asthma prevalence, but there was no evidence of association when other measures of air pollution were examined. Finally, self-reported traffic levels, distance from HTRs, PM emissions, and estimated NO2 were all associated with rhinitis.

Table 5 shows the association between the score indicator of traffic pollution exposure and respiratory diseases, by smoking habit.

**Table 5** Association between score indicator of traffic pollution exposure and respiratory diseases, by smoking habit

<table>
<thead>
<tr>
<th>Smoking habit</th>
<th>Chronic bronchitis or emphysema</th>
<th>Asthma</th>
<th>Rhinitis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n %</td>
<td>OR (95% CI)</td>
<td>n %</td>
</tr>
<tr>
<td>All study population</td>
<td>Very low</td>
<td>2175</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>2131</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>Intermediate</td>
<td>2668</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>2322</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>p trend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-smokers</td>
<td>Very low</td>
<td>1279</td>
<td>3.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1242</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>Intermediate</td>
<td>1621</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>1408</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>p trend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smokers</td>
<td>Very low</td>
<td>896</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>889</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td>Intermediate</td>
<td>1047</td>
<td>5.3</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>914</td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td>p trend</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OR, odds ratio adjusted for age, sex, smoking habit and educational level.

DISCUSSION

This study shows that different indices of exposure to traffic air pollution in the city of Rome were moderately correlated to one another. The exposure indices were consistently associated with prevalence of rhinitis, while only self-reported traffic density was associated with asthma prevalence, and there were no exposure indices associated with chronic bronchitis. Combining the indices into an exposure score gave the best fit to the data and indicated that the association between rhinitis and traffic-related air pollution was limited to non-smokers.

Only a few studies have evaluated the correlation between different types of exposure to traffic-related air pollutants. Heinrich and colleagues analysed subjective measures of traffic intensity and GIS-modelled exposures in the Netherlands and in Munich. They found slightly higher NO2 and PM10 estimated levels with self-reports of high traffic at home in Munich and in urban Dutch areas, while no association between self-report and measured air pollution levels were found for rural Dutch areas. The authors did not find an association between socioeconomic position and estimated air pollution, while in Rome, due to historical urban development, higher levels of air pollution in high socioeconomic areas have been found in this and in a previous study.

The SAPALDIA study used different GIS measures to investigate the association between respiratory symptoms and traffic air pollution. The authors found an increased risk of regular phlegm for those living within 20 m of a main street, and an increased risk of attack of breathlessness per 500 m increase of length of main streets within 200 m from home. In never smokers, they found that attack of breathlessness and wheezing without a cold was related to the length of main streets within 200 m from home, and that wheezing with breathing problems was related to living within 20 m of a main street. In our study we did not find an association between length of HTR within 200 m from home and respiratory problems, while adults were more likely to suffer from rhinitis with decreasing distance from HTRs, increasing levels of PM and NO2 at the home address, as well as increasing self-reported traffic intensity.

The increased risk of asthma with higher self-reported traffic density in our study was not confirmed by more objective air pollution measures. The simplest explanation may be reporting bias, as suggested by Kuehni and colleagues, with a higher probability of reporting a high traffic exposure for asthmatic subjects. However, it is plausible that asthmatics are more sensitive than non-asthmatics to air pollution and to other of the respiratory system’s irritating factors, and have a different perception of the level of traffic than the general population. In
addition, given the available evidence regarding the short-term effects of air pollution on asthmatics, it is also plausible that deceased subjects are directly affected by air pollution peaks, thus severity increases together with an increased perception of the exposure although the overall prevalence remains unchanged. A reason for the inconsistent results for asthma is the lack of specific information about time of onset of the disease and about the presence of current symptoms.

It is well accepted that air pollution from traffic, especially diesel emissions, might influence asthma and rhinitis enhancing immunological responses to allergens, and induce inflammatory reactions in the Airways at relatively low concentrations and even with short exposure durations. Animal studies showed that exposure to diesel exhaust particles in mice enhances airway inflammation, hyper-responsiveness, and IgE antibody responses. In vitro studies on human bronchial epithelial cells, the first line of cellular defence against inhaled irritants, suggested that diesel exhaust particles might modulate airway disease influencing them. Laboratory studies show that increased exposures to NO₂, ozone, and PM may play a role in both allergic and non-allergic respiratory diseases.

Although there is a good support from experimental evidence, the results of epidemiological studies are not so clear. Most of the studies on the effects of air pollution on respiratory health have been conducted on children, and a number of them suggest that air pollution is associated with allergic rhinitis. A time series study reported that air pollution worsens allergic rhinitis symptoms, leading to substantial increases in doctor consultations. In the SAPALDIA study, an association between exposure to traffic and allergic sensitisation was detected. However, no association was found with symptoms of hay fever. Heinrich and colleagues found an association between chronic bronchitis and traffic-related air pollutants, but they did not find any association with hay fever and wheezing in the non-smoker population. Our results on rhinitis are then of particular interest. We found that current smoking is inversely associated with rhinitis, a result that has been observed before and explained on the basis of a “healthy smoker effect” or decreased susceptibility to the effect of seasonal allergens. However, the effect of traffic air pollution on rhinitis in our study was found in non-smoking adults, a result that may suggest that the allergic mechanism may be specifically vulnerable in non-smokers or that the response to irritation from air toxicants may be enhanced.


Comparison between various indices of exposure to traffic-related air pollution and their impact on respiratory health in adults

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