Airway inflammation in aluminium potroom asthma

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Aims: To examine whether asthma induced by exposure to aluminium potroom emissions (potroom asthma) is associated with inflammatory changes in the airways.

Methods: Bronchial biopsy specimens from 20 asthmatic workers (8 non-smokers and 12 smokers), 15 healthy workers (8 non-smokers and 7 smokers), and 10 non-exposed controls (all non-smokers) were analysed. Immunohistochemical staining was performed to identify mucosal total leucocytes (CD45+ leucocytes), neutrophils, and mast cells.

Results: Median RBM thickness was significantly increased in both asthmatic workers (8.2 μm) and healthy workers (7.4 μm) compared to non-exposed controls (6.7 μm). Non-smoking asthmatic workers had significantly increased median density of lamina propria CD45+ leucocytes (1519 cells/mm² v 660 and 887 cells/mm²) and eosinophils (27 cells/mm² v 10 and 3 cells/mm²) and significantly increased concentrations of exhaled NO (18.1 ppb v 6.5 and 5.1 ppb) compared to non-smoking healthy workers and non-exposed controls. Leucocyte counts and exhaled NO concentrations varied with smoking habits and fewer leucocytes were observed in asthmatic smokers than in non-smokers. Asthmatic smokers had significantly increased numbers of eosinophils in lamina propria compared to non-exposed controls (10 v 3 cells/mm²). Both eosinophilic and non-eosinophilic phenotypes of asthma were recognised in the potroom workers and signs of airway inflammation were also observed in healthy workers.

Conclusions: Airway inflammation is a central feature of potroom asthma and exposure to potroom emissions induces pathological alterations similar to those described in other types of asthma. Cigarette smoking seems to affect the underlying mechanisms involved in asthma, as the cellular composition of airway mucosa appears different in asthmatic smokers and non-smokers.
Main messages

- Workers with potroom asthma develop chronic bronchial inflammation.
- Non-smoking potroom asthmatics have similar inflammatory changes in airway mucosa as conventional asthma, shown by thickened RBM, increased leucocyte and eosinophil influx, and increased exhaled NO.
- Smoking potroom asthmatics have thickened RBM but lower leucocyte density than asthmatic non-smokers, suggesting an immunomodulating effect of tobacco smoking.

Policy implications

- Early diagnosis of potroom asthma and relocation is essential to prevent irreversible histopathological changes.

and recording of medical and occupational history was performed by a physician (TS); the subjects underwent spirometry, chest radiography, electrocardiography, blood tests, and measurement of exhaled NO the day before bronchoscopy with bronchial biopsy.

Exposure

In the Norwegian aluminium industry measurements of total airborne fluorides and dust are regularly performed from personal samplers. The mean levels of exposure are mostly far below the Norwegian threshold limit value (total fluorides 0.6 mg/m² and total particulates 5 mg/m³), but peak exposures frequently occur. About 40% of the measurements for fluorides and 10% of the measurements for particulates are reported to exceed the hygienic limit values. In the present study, levels of exposure are not estimated for the individual worker, and only duration of exposure is recorded.

Measurement of lung function and exhaled NO

Spirometry was performed with a pneumotachograph (Vitalograph, Birmingham, UK) in accordance with the guidelines recommended by European Respiratory Society; the reference values of European Coal and Steel Community were used. Exhaled NO was measured by a chemiluminescence analyser (LR 2000, Logan Research, UK) at a sampling rate of 250 ml/min as previously described.

Bronchoscopic and processing of bronchial biopsy specimens

Fibreoptic bronchoscopy and biopsy sampling was performed following the guidelines from the European Society of Pneumology. All subjects were premedicated with atropine 0.6 mg subcutaneously, 5 mg diazepam orally, and alfentanil intravenously as needed (0–2 mg) for mild sedation and analgesic. Under local anaesthesia with lidocaine, a bronchoscope with working channel 2.8 mm (Pentax FB-19H or Olympus 20D IT) was used to obtain a maximum of six bronchial biopsy specimens from the second and third generation carinae of the right lung by a single use forceps (Microvasive L267, Radial Jaw, Boston Scientific). The biopsy specimens were immediately embedded in Tissue-Tek Optimal Cutting Temperature Compound (Miles Laboratories, IN), snap frozen in isopentane precooled in liquid nitrogen, and stored at −70°C. Cryo sections were cut serially at 4 μm, dried overnight, and stored at −20°C until use.

Immunohistochemistry

From a lower lobe biopsy, two sections of 100 μm interval were prepared for immunohistochemistry examination using antibodies (all Dako A/S, Denmark) against total common leucocytes CD45 (catalogue number M701), mast cell tryptase (M7052), and neutrophil elastase (M752). The primary antibodies were applied at optimal dilutions and incubated one hour at room temperature. The sections were prefixed for 10 minutes at 4°C in 2% paraformaldehyde for CD45 staining and in 4% paraformaldehyde for mast cell and neutrophil staining. Goat serum 5% was then applied for 15 minutes to block unspecified binding sites. The secondary layer was biotinylated goat anti-mouse.
immunoglobulin (Dako A/S) incubated for 1.5 hours followed by 0.5 hour incubation with Streptavidin Alexa 594 conjugate (Molecular Probes, Nederlands) mixed with DNA staining to visualise the nucleus (4,6-diamino-2-phenylinodole (DAPI) Molecular Probes). Figure 1 shows an example of immunohistofluorescent staining of CD45 + leucocytes. Methodological controls included sections stained without primary antibody and sections incubated with non-immune mouse immunoglobulin. The adjacent slides were stained with haematoxylin and eosin for examination of eosinophils.

Quantitation of leucocytes

All slides were analysed blind by one observer (TS) using a Zeiss Axioplane2 microscope at 630× magnification. Eosinophils were identified on haematoxylin and eosin stained slides examined by light microscopy in combination with differential interference contrast (DIC) microscopy. This method for identification of eosinophils has been shown to be more reliable in cryo sections than immunohistochemical labelling of eosinophil granule proteins.20 In cases of doubt, we additionally used the eosin fluorescence to localise the cell. Positively stained cells were counted in intact epithelium (defined as the presence of both basal and columnar cells) and in a tissue zone 114 μm beneath the RBM, referred to as lamina propria. All available area was analysed. The final result, expressed as number of intraepithelial cells per millimetre of intact epithelium or number of cells per square millimetre of lamina propria, was calculated as the average of all the measurements performed of each section. The median length of intact epithelium examined in a subject was 5 mm (range 2–16 mm) and the median area of lamina propria examined was 0.87 mm 2 (range 0.36–2.24 mm 2), corresponding to a basement membrane length of 6.2 mm (2.4–16.0 mm), as recommended.21

Measurements of RBM

By use of DIC microscopy combined with light microscopy, a digital captured high power image was used to measure the distance from the base of the bronchial epithelium to the outer limit of the RBM by AnalySIS Soft Imaging System, as illustrated in fig 2. Only perpendicular cut sections were examined and a median of 68 measurements (range 37–161) were performed on each section at approximately 20 μm intervals, as recommended.21

Epithelial integrity

The degree of epithelial damage was expressed as epithelial integrity, defined as the length of basal membrane covered with intact epithelium divided by the total length of the membrane. By light microscopy examination (haematoxylin and eosin stained slides and 630× magnification), a test grid (eyepiece reticule) was superimposed on the section, and the length of basal membrane with and without intact epithelium was recorded. A median of 31 grids were analysed for each subject, corresponding to a median length of basement membrane of 6.2 mm.

Statistics

Results are presented as median (range) values. Differences between two groups were compared by the Mann-Whitney U test and correlation coefficients were calculated using Spearman’s rank method. To control for potential confounders
(age and smoking habits), analysis of variance was performed for all results. A p value <0.05 was regarded as significant.

RESULTS

Leucocyte density in lamina propria, RBM thickness, epithelial integrity, and exhaled NO concentrations are shown in table 2 and the variables are shown as individual scatter plots in fig 3. The results varied with smoking habits and are presented for non-smokers and smokers separately. The non-exposed control group was younger than the other two groups, and the results were controlled for age. The only outcome parameter that varied with age was neutrophils, and the results were controlled for age. The only present for non-smokers and smokers separately. The non-smoking asthmatic workers.

In fig 3. The results varied with smoking habits and are presented for non-smokers and smokers separately. Table 2 and the variables are shown as individual scatter plots in fig 3. The results varied with smoking habits and are presented for non-smokers and smokers separately. The non-smoking asthmatic workers.

Leucocyte density in lamina propria

Asthmatic non-smokers had significantly higher density of CD45+ leucocytes (fig 3A) and eosinophils (fig 3B) compared to both non-smoking healthy workers and non-exposed controls (table 2). In contrast, a rather low density of leucocytes was observed in asthmatic smokers, in whom the densities of CD45+ leucocytes, eosinophils, and neutrophils were significantly reduced compared to asthmatic non-smokers (p < 0.001, p = 0.05, and p = 0.04 respectively). The difference in mast cells did not reach the level of significance. Healthy workers (both non-smoking and smoking subgroup) had a significantly increased density of eosinophils compared to non-exposed controls (p = 0.04 and p = 0.01).

Classifying subjects with eosinophil density above the upper range seen in non-exposed controls (0–15 cells/mm²) as eosinophil(+), 50% of the asthmatics and 40% of the healthy workers were eosinophil(+) subjects. This cut-off value coincides with two standard deviations of the mean value in non-exposed controls.

Intraepithelial cell counts

The number of intraepithelial CD45+ leucocytes was significantly increased in both asthmatic (22 cells/mm epithelium) and healthy smokers (35 cells/mm epithelium) compared to the non-smoking groups. Within the non-smoking groups there were no difference (varying from 8 to 11 cells/mm epithelium). Intraepithelial mast cells were significantly increased in asthmatic non-smokers compared to non-exposed controls (0.9 vs 0.2 cells/mm epithelium, p = 0.05).

Epithelial integrity

In non-smokers, we found no significant difference in epithelial integrity between asthmatics and controls (table 2). Epithelial integrity was significantly increased in asthmatic smokers compared to asthmatic non-smokers (p = 0.03), but no difference was found between asthmatic

Table 2 Leucocyte density in lamina propria, reticular basement membrane thickness, epithelial integrity, and exhaled nitric oxide

<table>
<thead>
<tr>
<th>CD45+ leucocytes</th>
<th>Asthmatic workers (n = 20)</th>
<th>Healthy workers (n = 15)</th>
<th>Non-exposed controls (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-smokers (n = 8)</td>
<td>Smokers (n = 12)</td>
<td>Non-smokers (n = 8)</td>
<td>Smokers (n = 7)</td>
</tr>
<tr>
<td>1519 (720–1917)</td>
<td>675 (452–914)</td>
<td>660 (415–1289)</td>
<td>687 (566–1595)</td>
</tr>
<tr>
<td>27 (6–164)</td>
<td>10 (0–41)</td>
<td>10 (2–193)</td>
<td>10 (0–15)</td>
</tr>
<tr>
<td>116 (66–161)</td>
<td>78 (29–141)</td>
<td>93 (43–169)</td>
<td>89 (30–118)</td>
</tr>
<tr>
<td>83 (46–162)</td>
<td>42 (13–93)</td>
<td>45 (18–110)</td>
<td>84 (29–175)</td>
</tr>
<tr>
<td>8 (3–10.2)</td>
<td>6 (1–8.7)</td>
<td>7 (2–8.7)</td>
<td>6.7 (6–10)</td>
</tr>
<tr>
<td>52 (10–99)</td>
<td>70 (51–94)</td>
<td>67 (36–97)</td>
<td>42 (13–70)</td>
</tr>
<tr>
<td>18.1 (6.3–91.1)</td>
<td>4.4 (1.2–80.0)</td>
<td>4.1 (1.6–20.3)</td>
<td>5.1 (3.5–8.4)</td>
</tr>
</tbody>
</table>

RBM, reticular basement membrane; ppb, parts per billion.

Cell counts are expressed as cells/mm².

*p < 0.05 vs non-smoking healthy workers and non-exposed controls.

+t p < 0.05 vs non-smoking subjects.

+tt p < 0.05 vs smoking asthmatic workers.

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smokers and the smoking healthy workers. In the damaged area, the ciliated epithelial cells were often absent while the layer of cuboidal basal cells was intact.

Exhaled NO

In non-smoking subjects, the concentrations of exhaled NO were significantly higher in asthmatic workers than in both healthy workers and non-exposed controls (fig 3D). Exhaled NO was, as expected, low in smokers, and NO values in asthmatic smokers did not differ from those in control smokers. In non-smoking asthmatic workers, exhaled NO correlated to the density of lamina propria CD45+ leucocytes ($r = 0.81, p = 0.02$) and eosinophils ($r = 0.79, p = 0.02$).

Exposure and outcome variables

We found no association between number of years employed in the potrooms and any of the outcome parameters. There was no difference between asthmatic workers who were still exposed in the potrooms and those who were relocated to non-polluted working environments.
DISCUSSION
This study reveals the presence of airway inflammation in subjects with potroom asthma, shown by significantly increased density of lamina propria CD45+ leucocytes and eosinophils, significantly increased numbers of intraepithelial mast cells, thickening of RBM, and increased exhaled NO in asthmatic non-smokers. In addition, a subclinical inflammation, shown by significantly increased lamina propria eosinophils and RBM thickening, was observed in healthy potroom workers when compared to non-exposed controls.

Similar results have been reported in earlier studies of non-smokers with occupational asthma induced by low-molecular weight compounds such as isocyanates and plicatic acid in western red cedar as well as non-occupational asthma. Early studies in aluminium smelters indicate that eosinophils contribute to the pathophysiology of potroom asthma and we could confirm the presence of airway mucosal eosinophilia. However, about half of the asthmatic workers had eosinophil counts in the range observed for non-exposed controls. These findings are in line with the increasing recognition of non-eosinophilic forms of asthma. Similar results have been reported in earlier studies of non-eosinophilic asthmatics (90% vs 91% of predicted value). Two of the asthmatic workers and three of the healthy workers were ex-smokers. (The asthmatics had smoked respectively 8 and 20 pack-years and had stopped smoking 3 and 13 years ago. The healthy workers had smoked 2, 5, and 11 pack-years and had stopped respectively 14, 15, and 6 years ago.) No studies are available to clarify a potential effect of cigarette smoking on inflammatory parameters in the airways of previous smokers. Excluding the five ex-smokers from the analyses did not change the main results, but the sample size might be too small to show a hangover effect of smoking.

Studies of asthmatic inflammation in humans have been limited to non-smokers, and to our knowledge there is no published biopsy study including asthmatic smokers. Hence, an immunomodulating effect of smoking on airway mucosa in asthmatics has not previously been shown, but recent publications from peripheral blood and induced sputum of smoking asthmatics support our data. In agreement with other studies showing smoking to induce an inflammatory airway reaction in non-asthmatics, the smoking healthy workers tended to have higher leucocyte density compared to non-smoking healthy workers.

Smoking in itself may be immunomodulating rather than proinflammatory. This is supported by several human and animal studies. Nicotine was recently shown to have a direct inhibitory effect on the production of proinflammatory mediators by stimulating the nicotinic acetylcholine receptor. Moreover, in a recent study a smoke induced reduction in the number of dendritic cells in the murine lung was reported. The finding that smoke exposure influences the antigen presenting cells may have profound effects on immune responsiveness.

According to this, it is likely that the relatively low number of leucocytes in the airway wall found in our asthmatic smokers was induced by smoking and not by occupational exposure or interaction effects. However, at present we have no explanation for why smoking seems to have a
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pro-inflammatory effect in non-asthmatics but an anti-inflammatory effect in asthmatics.

In conclusion, in non-smoking workers with potroom asthma characteristic immunopathological features of asthma such as inflammatory cell infiltrate, thickening of RBM, and increased levels of exhaled NO were shown. In asthmatic smokers, only thickening of RBM was observed, suggesting a different pathophysiological process for potroom asthma in smokers than in non-smokers. In healthy workers, exposure to pot fume emissions may induce a subclinical airway inflammation.

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