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Imbalance of endogenous prostanoids in moderate-to-severe asthma

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PG Prostaglandin
TX Thromboxane
FEF25–75 Mid-forced expiratory flow

A B S T R A C T

Background: Inhalation studies suggested “protective” roles of exogenous prostaglandin E2, but the clinical relevance of endogenous prostanoids in asthma is poorly known. The objective of this study is to measure sputum levels of prostanoids in asthmatic patients to correlate with clinical indices.

Methods: Mild (n = 41) or moderate-to-severe (19) asthmatics and 27 normal controls were examined for pulmonary function (FEV1 and mid-forced expiratory flow), sputum cell differentials, and sputum prostanoids levels. Levels of prostaglandins D2, E2, F2, and thromboxane B2 measured by sandwich enzyme immunoassay. Results: Each prostanoid level did not differ among the three groups. Sputum number of bronchial epithelial cells was greater in moderate-to-severe asthmatics than in the other two groups, suggesting epithelial desquamation. Levels of prostaglandin F2, D2, and thromboxane B2 positively correlated with the severity of airflow obstruction in the 60 asthmatic patients, whereas prostaglandin E2 levels were unrelated to pulmonary function. The ratio of combined “contractile” prostanoids (prostaglandin D2/prostaglandin F2/thromboxane B2) to prostaglandin E2 was 2.5-fold greater in moderate-to-severe asthmatics than in controls (p = 0.001) or in mild asthmatics (p = 0.0002) but did not differ between the latter two groups. In the two asthmatic groups combined, this ratio positively correlated with the sputum number of epithelial cells. The combined “contractile” prostanoids levels positively correlated with prostaglandin E2 levels in controls and in mild asthmatics but not in moderate-to-severe asthmatics.

Conclusions: An imbalance in production, breakdown, or both between prostaglandin E2 and other prostanoids possibly due to epithelial damage may be involved in the pathogenesis of moderate-to-severe asthma.

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Introduction

Asthma is a chronic inflammatory disease of the airways, which involves inflammatory mediators such as histamine, cysteinyl leukotrienes, platelet-activating factor and prostanoids.1 Prostaglandin (PG) D2, PGF2α, and thromboxane (TX) A2 have contractile effects on airway smooth muscle in vitro,2,3 and cause bronchoconstriction in asthmatic subjects when inhaled.4,5 These prostanoids may thus exert deleterious effects in the pathophysiology of asthma. In contrast, inhaled PGE2 attenuates allergen-induced early and late asthma responses, airway hyperresponsiveness, and inflammation characterized by the increased number of eosinophils.6 Inhaled PGE2 also protects against aspirin-induced exacerbation of asthma through mechanisms unrelated to its bronchodilatory activity.7 PGE2, when exogenously administered, may thus exert bronchoprotective and anti-inflammatory effects. Despite PGE2 is contractile via EP1 and EP3 receptor in mice and human whereas relaxant via EP2 receptor in mice and human and EP4 in human,8,9 the net effect of PGE2 is therefore considered “inhibitory”. Though a variety of cells have the capacity to release prostanoids in the asthmatic airways,10 PGD2, and its metabolite, 9α,11β-PGF2α are primarily mast cell products,11 while PGE2 is primarily a product of epithelial cells.1 Desquamation or damage of epithelial cells may be characteristic of more severe asthma.12–14

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The levels of endogenous prostanoids in the airway surface liquid of asthmatic patients and healthy controls have been examined in samples of bronchoalveolar lavage, sputum, and exhaled breath condensate.20–22 Previous studies have suggested that airway levels of some prostanoids are increased in subsets of asthmatic patients, such as smokers,19 but failed to show a relation to asthma severity or activity.

We measured sputum levels of PGD₂, PGE₂, PGF₂α, and TXB₂ in a large number of nonsmoking, asthmatic patients and healthy controls. These levels were compared among patients with mild asthma, those with moderate-to-severe asthma, and controls, and were examined with respect to pulmonary function in the patients. We then compared the ratio of combined “contractile” prostanoids (PGD₂, PGF₂α, and TXB₂), each of which was associated with airflow obstruction in the patients, to PGE₂ levels among the three groups, on the hypothesis that the ratio of constrictor to dilator prostanoids are increased in asthma dependent on asthma severity.

Methods

Study design

This was a cross-sectional study. To investigate the role of endogenous prostanoids in asthma, we measured sputum levels of PGD₂, PGE₂, PGF₂α, and TXB₂ in steroid-naïve asthmatic patients to correlate with clinical indices.

Subjects

Sixty asthmatic and 27 healthy subjects including members of our hospital staff, from whom adequate sputum samples were obtained, were studied between March 2002 and June 2005. Asthma was diagnosed according to the Global Initiative for Asthma and those with moderate-to-severe asthma. FEV₁ and FEF₂₅₋₇₅% differed significantly among the three groups, and between each pair of the three groups.

Data were expressed as medians (25th–75th percentiles), and analyzed with the StatView 5.0 program (SAS Institute, Cary, NC, USA). The Mann–Whitney U-test or Fisher’s exact probability test was performed to compare two groups. Comparison of three groups was made by the Kruskal–Wallis test followed by Mann–Whitney U-test, ANOVA followed by Fisher’s PLSD test, or chi-square test as appropriate. Spearman’s rank correlation test was used to analyze correlations. P values < 0.05 were considered statistically significant.

Results

Characteristics and outcome of asthmatic patients and control subjects

The characteristics of the control subjects and the two asthmatic groups are shown in Table 1. Age differed among the three groups, and the controls were significantly younger than both asthmatic groups. The distribution of sex, duration of asthma, total IgE levels, and prevalence of atopy did not differ between patients with mild asthma and those with moderate-to-severe asthma. FEV₁ and FEF₂₅₋₇₅% differed significantly among the three groups, and between each pair of the three groups.

Sputum total cell count differed among the three groups but not between any pair of groups. As compared with controls, the number of eosinophils was significantly increased in patients with mild asthma and in those with moderate-to-severe asthma, and the number of macrophages was significantly decreased in patients with...
mild asthma. The number of epithelial cells was significantly greater in patients with moderate-to-severe asthma than in those with mild asthma and in controls and but was similar in the latter two groups.

There was no significant difference in sputum levels of PGE2, PGE2, PGF2α, or TXB2 among the three groups (Table 1).

**Relationship of sputum prostanoid levels with pulmonary function in asthmatic patients**

The relations between sputum levels of prostanoids and pulmonary function in the 60 asthmatic subjects are presented in Table 2. Sputum levels of PGF2α and TXB2 negatively correlated with FEV1 and FEF25–75%. Sputum levels of PGD2 negatively correlated with FEF25–75%. Sputum levels of PGE2 were not related to any index of airflow obstruction.

Sputum epithelial cell number did not correlate with the sputum levels of PGD2 ($r = -0.03$), PGE2 ($r = -0.07$), PGF2α ($r = 0.13$), or TXB2 ($r = 0.08$) ($p > 0.1$ for all).

The sputum eosinophil number did not correlate with the sputum levels of PGD2 ($r = -0.03$), PGE2 ($r = -0.07$), PGF2α ($r = 0.13$), or TXB2 ($r = 0.08$) ($p > 0.1$ for all). The number of macrophages, neutrophils, or epithelial cells was unrelated to any of the prostanoid levels (data not shown). In the healthy controls, the sputum levels of prostanoids did not correlate with pulmonary function or sputum cell differentials (data not shown).

**Balance between PGE2 and other prostanoids**

The levels of combined PGD2, PGF2α, and TXB2, and their ratio to PGE2 levels, were calculated in each group to examine the net effect of these “contractile” and “inhibitory” prostanoids. The absolute levels of PGD2, PGF2α, and TXB2 combined did not differ among controls and two asthmatic groups ($p = 0.13$ by ANOVA). However, the ratio of these levels to PGE2 levels differed among the three groups, and was highly significantly elevated in moderate-to-severe asthmatics as compared with controls or mild asthmatics, but was similar in the latter two groups (Table 1, Fig. 1). When the two asthmatic groups were combined, this ratio significantly correlated with sputum number of epithelial cells ($r = 0.39$, $p = 0.0009$).

**Table 1** Characteristics of asthma patients and healthy controls.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Healthy control (n = 27)</th>
<th>Asthma (n = 41)</th>
<th>Moderate-to-severe (n = 19)</th>
<th>p Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td>30 (25–33.8)</td>
<td>48 (32.8–66.8)</td>
<td>57 (38–63.8)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Sex (M/F)</td>
<td>17/10</td>
<td>19/22</td>
<td>8/11</td>
<td>NS</td>
</tr>
<tr>
<td>Duration of asthma (yr)</td>
<td>–</td>
<td>1.5 (0.23–6.5)</td>
<td>2.5 (0.75–7.0)</td>
<td>NS</td>
</tr>
<tr>
<td>Log IgE (IU/ml)</td>
<td>Not tested</td>
<td>2.2 (1.7–2.7)</td>
<td>2.2 (2.1–2.3)</td>
<td>NS</td>
</tr>
<tr>
<td>Atopy/non-atopy</td>
<td>Not tested</td>
<td>30/11</td>
<td>15/4</td>
<td>NS</td>
</tr>
<tr>
<td>FEV1 (%pred)</td>
<td>98 (92–107)</td>
<td>91 (83–100)</td>
<td>75 (64–84)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>FEF25–75% (%pred)</td>
<td>84 (76–96)</td>
<td>61 (45–84)</td>
<td>43 (34–48)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

**Table 2** Relationship between sputum levels of prostanoids and pulmonary function in 60 asthmatic patients.

<table>
<thead>
<tr>
<th>Prostanoid</th>
<th>FEV1 (%predicted)</th>
<th>r</th>
<th>p</th>
<th>FEF25–75% (%predicted)</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGE2 (ng/g)</td>
<td>–0.15</td>
<td>0.26</td>
<td>0.01</td>
<td>–0.21</td>
<td>0.14</td>
<td>0.0006</td>
</tr>
<tr>
<td>PGF2α (ng/g)</td>
<td>–0.33</td>
<td>0.02</td>
<td>0.40</td>
<td>–0.40</td>
<td>0.004</td>
<td>0.0002</td>
</tr>
<tr>
<td>PGD2 (ng/g)</td>
<td>–0.23</td>
<td>0.096</td>
<td>0.037</td>
<td>–0.36</td>
<td>0.009</td>
<td>0.0002</td>
</tr>
<tr>
<td>TXB2 (ng/g)</td>
<td>–0.27</td>
<td>0.05</td>
<td>0.37</td>
<td>–0.37</td>
<td>0.008</td>
<td>0.0002</td>
</tr>
</tbody>
</table>

FEV1, mid-forced expiratory flow; PG, prostaglandin; TX, thromboxane; NS, not significant.

**Fig. 1.** The ratio of combined “contractile” prostanoids (prostaglandin D2, prostaglandin F2α, and thromboxane B2) to prostaglandin E2 in control subjects, mild asthmatics and moderate-to-severe asthmatics. The ratio differed significantly among the three groups ($p = 0.0006$), and was greater in moderate-to-severe asthmatics than in controls ($p = 0.0009$) and in mild asthmatics ($p = 0.0002$), but did not differ between the latter two groups.
Discussion

There was no significant difference in sputum levels of PGD2, PGE2, PGF2α, or TXB2 among controls, mild asthmatics and moderate-to-severe asthmatics. Sputum levels of PGD2, PGF2α, and TXB2, but not those of PGE2, were related to the degree of airflow obstruction in 60 asthmatics. The levels of combined “contractile” prostanoids (PGD2, PGF2α, and TXB2) did not differ among controls and two asthmatic groups. However, the ratio of these levels to PGE2 levels differed among the three groups and was approximately 2.5-fold greater in moderate-to-severe asthmatics than in other two groups. The combined PGD2/PGF2α/TXB2 levels positively correlated with PGE2 levels in controls and in mild asthmatics but not in moderate-to-severe asthmatics. The sputum epithelial cell number was significantly greater in moderate-to-severe asthmatics than in other two groups, and positively correlated with PGD2/PGF2α/TXB2 to PGE2 ratio in 60 asthmatics. We have also shown that this ratio is increased and correlates with asthma severity, thus indicating the potential increase in constrictor compared to dilator prostanoids in asthma. These results suggest that an imbalance in the production, breakdown, or both between prostaglandin E2 and other prostanoids may be involved in the pathogenesis of moderate-to-severe asthma, and that epithelial damage might be an underlying mechanism for this imbalance.

Potential pathophysiologic roles of prostanoids in asthma have been extensively studied. PGD2, PGF2α, and TXA2 induce smooth muscle cell contraction and hyperplasia, as well as mucous hypersecretion in human airway preparations. In contrast, PGE2 inhibits various inflammatory events, including mast cell degranulation, leukotriene B4 production by macrophages, and eosinophil activation. Mice deficient in prostanoid receptors have also been used for in vivo studies. After ovalbumin sensitization and challenge, PGD2 receptor-deficient mice failed to develop Th2 cytokines production, eosinophil infiltration, and airway hyperresponsiveness. In sharp contrast, mice lacking PGE2 (EP3) developed much more pronounced inflammation after ovalbumin than wild-type mice or mice deficient in other PGE2 receptor subtypes. An EP3-selective agonist suppressed the inflammation in wild-type mice. Other study demonstrated that EP4 receptor knock-out mice had an enhanced cellular inflammation. Furthermore, cell-based assays using human monocytes or eosinophils showed an inhibition of cytokine release or cyclic AMP production via activation of the EP4 receptor, suggesting an endogenous anti-inflammatory role for PGE2 acting on the EP4 receptor. In asthmatic subjects, synthase inhibitors or receptor antagonists of TX attenuate airway eosinophilia and hyperresponsiveness.

Airway levels of endogenous prostanoids have been examined in asthmatic patients. Bronchoalveolar levels of PGD2, 9α,11β-PGF2α, and PGF2α, but not of TXB2, 6-keto-PGF1α, or PGE2 were higher in 15 asymptomatic patients than in 12 normal controls, but were unrelated to either airway obstruction or hyperresponsiveness. Sputum levels of PGD2, PGE2, PGF2α, and TXB2 were similar in 17 asthmatic patients (8 receiving inhaled corticosteroids) and 10 normal controls, and failed to correlate with disease severity or FEV1 values in 10 aspirin-tolerant patients or 13 aspirin-intolerant patients. Exhaled breath condensate levels of PGD2, PGE2, PGF2α, and TXB2 levels were similar between 15 steroid-naive asthmatics and 12 healthy controls. Kostikas et al. have examined PGE2 levels in breath condensate of smoking and nonsmoking mild asthmatics (n = 15 for each) and healthy controls (n = 10 for each). PGE2 levels were higher in asthmatic smokers than in the other two groups, but no difference was found among the latter. The increased PGE2 levels in the asthmatic smokers were
attributed to the activation of airway macrophages by cigarette smoke.

We have demonstrated, for the first time to our knowledge, contrasting characteristics of endogenous prostanoids in asthmatic patients, by correlating their sputum levels and pulmonary function. These are consistent with previous in vitro, animal, and human studies, that showed a contractile property of PGD2, PGE2, and TXA2, but not PGE2, which may even be dilatory.5,28,30,31 Our study showed that airway obstruction was greater in moderate-to-severe asthmatics than in controls and mild asthma, and each sputum contractile prostanoid level correlated with indices of airway obstruction. However, the combined contractile prostanoids levels were not different among the three groups. It is difficult to answer this discrepancy but it may be due to the inhomogeneous distribution of sputum levels of contractile prostanoids irrespective to asthma severity and the factors other than prostanoids such as airway remodeling. Arguably, both “contractile” and “inhibitory” prostanoids may be active in the asthmatic airways and their net effects should be considered. Wenzel et al. measured the bronchoalveolar lavage fluid levels of bronchoconstrictors prostanoids (PGD2, TXB2) and bronchoprotectors (6-keto-PGF1α, PGE2) before and after allergen challenge in asthmatic patients. They demonstrated that the ratio of combined PGD2 and TXB2 to combined PGE2 and 6-keto-PGF1α increased greater than 5-fold in asthmatics after allergen challenge although the underlying mechanism was not referred.33 In the present study, the ratio of combined PGD2/PGE2/ TXB2 levels to PGE2 levels was significantly higher in moderate-to-severe asthmatics than in controls or mild asthmatics, although the levels of each prostanoid were similar in the three groups. The levels of combined PGD2/PGE2/TXB2 positively correlated with PGE2 levels in the controls and in the mild asthmatic group, but not in the moderate-to-severe asthmatic group. The effects of “deleterious” prostanoids may be counterbalanced by the synthesis of “inhibitory” prostanoid PGE2 in mild asthmatics, but such mechanism might be deficient in more severe disease.

Previous studies have shown that the number of epithelial cells in bronchoalveolar lavage or sputum of asthmatic patients is elevated as compared with healthy controls,2,3,14 correlates with the severity of disease14 and airway responsiveness,12 and responds to intervention in parallel with clinical improvement.13 These indicate the presence, and pathophysiological relevance, of epithelial desquamation or damage in asthma. In our study, the sputum epithelial cell number was increased in moderate-to-severe asthmatics as compared with controls and mild asthmatics, and positively correlated with the PGD2+PGE2+TXB2/PGE2 ratio in the two asthmatic subgroups combined. Epithelial damage as suggested in the latter group might be responsible for this imbalance.

The effect of proinflammatory stimuli on PGD2/PGE2 production by bronchial fibroblasts of aspirin-tolerant and -intolerant asthmatic patients has been examined.26 Both prostanoids were increasingly produced, but PGE2/PGD2 concentration ratio elevated significantly less in aspirin-intolerant patients, a severer phenotype of asthma, than in aspirin-tolerant patients.13 This imbalance in the prostanoid production by fibroblasts may also explain our results, but fibroblasts could not be addressed by our sputum study. Other investigator also demonstrated a dysregulation of PGE2 production from alveolar macrophage from severe asthmatics.38 We found no correlation between the sputum PGE2 levels and the number of sputum macrophages in moderate-to-severe asthmatics, but cannot exclude the possibility that PGE2 synthesis of alveolar macrophage is downregulated.

Our asthmatic patients were older than controls. It was very difficult to obtain an age-matching control group. To our knowledge, there is no evidence that prostanoids production or metabolism could be affected by age. Indeed, our patients and controls showed no correlation between age and prostanoid levels (data not shown). Ex vivo production of eicosanoids is unlikely to have influenced our results, because treatment of sputum with agents blocking ex vivo production and breakdown of prostanoids does not affect their concentrations.10

In the decades, evidence has been collected demonstrating the role of prostanoids in asthma. Recent studies have shown each prostanoid receptor has multiple functions resulting in opposing effects, such as deleterious and inhibitory outcomes. Therefore, the current study supports the view that an imbalance of endogenous prostanoids may play an important role in the pathophysiology of asthma. Our findings provide some insight into the mechanisms of development of severe asthma and may suggest consideration of a new therapeutic strategy of asthma.


