Abstract

Background: Chronic Obstructive Pulmonary Disease (COPD) is characterized by a complex range of pathological changes including both pulmonary and systemic effects. Several mechanisms contribute to the variable intermediate and clinically relevant disease phenotypes, such as chronic bronchitis and emphysema, and systemic disease. The molecular mechanisms associated to the pathogenesis of COPD are not yet clearly understood.

Objective: The aim of this study was to evaluate oxidant/antioxidant balance and the systemic inflammation in chronic bronchitis and pulmonary emphysema COPD patients.

Methods: We analyzed COPD patients divided in 2 groups: chronic bronchitis and emphysema. Healthy volunteers without lung disease were used as control group.

Results: We observed a significant (P<0,05) increase in the levels of plasma malondialdehyde (MDA), a marker of oxidative stress, an increase in the circulating C-reactive protein (CRP), used as a biomarker of systemic inflammation, and a decrease in antioxidant defense in COPD patients with emphysema when compared with COPD patients with chronic bronchitis.

Conclusion: Although our results should be regarded as preliminary they indicate a disturbance in oxidant/antioxidant status and systemic inflammatory response associated to COPD patients. The differences observed were more evident in emphysematous phenotype.

Introduction

Chronic obstructive pulmonary disease (COPD) is characterized by an airflow limitation that is not fully reversible and is usually progressive and associated with an abnormal inflammatory response to noxious particles and gases [1,2]. Although COPD affects the lungs, it also produces significant systemic consequences [2]. The systemic effects associated to COPD are clinically relevant and may contribute to better understanding and management of the disease [3,4]. Several studies demonstrated that an oxidant/antioxidant imbalance play an important role in the pathogenesis of COPD [5-10]. The oxidative stress in patients with COPD derives from the increased of oxidants present in cigarette smoke and/or from the increased amounts of reactive oxygen species released from leucocytes, both in air spaces and in blood [8]. Although there is strong evidence of oxidative stress in the pathogenesis of COPD, the mechanisms associated to the heterogeneity of the disease are not understood. The typical clinical manifestations of the COPD syndrome include chronic bronchitis, a condition of large-airway inflammation and remodeling, and emphysema, disease of the distal airways and lung parenchyma that manifests as loss of surface area for gas exchange [11]. The majority of the information associated to the pathogenesis of COPD is related to the emphysema. It has been reported that the pathogenesis of COPD, particularly of emphysema, which involves the destruction of small airway structures and alveolar units, is potentiated by interactions between apoptosis, oxidative stress, and protease/antiprotease imbalance [12-14]. It has been suggested that the factors that initiate inflammation and the effects of proteolytic and oxidant-induced damage may be also important in the other COPD conditions, namely chronic bronchitis [6]. There is growing evidence that new markers are needed to provide further insights into the pathogenesis of COPD [15].

The aim of this study was to evaluate oxidant/antioxidant balance and systemic inflammation in chronic bronchitis and pulmonary emphysema.
**Methods**

**Study subjects**

The present study assessed the involvement of oxidants/antioxidants balance and systemic inflammation in two groups of subjects with clinically stable COPD and with different phenotypes—chronic bronchitis and emphysema.

Fifty healthy subjects (mean age 41.60±12.31 years; 12 female, 38 male and body mass index, BMI 27.32±1.31 kg/m²) having no history of respiratory or atopic disease and free of any medication were used as control group. Twelve of them were current smokers and thirty eight had never smoked.

Patients with stable COPD were study. COPD was defined according to the criteria of the Global Initiative for Chronic Obstructive Lung Disease (GOLD). Lung function was assessed with body plethysmography. COPD patients were recruited from the respiratory outpatient consultation. Data from medical history were collected, with focus in smoking history, respiratory symptoms and signs. Lung function were evaluated for diagnosis and classification of severity of COPD, according to the GOLD criteria. Carbon monoxide gas diffusion were also performed. The characteristics of COPD group are shown in Table 1. The patients were grouped in chronic bronchitis and emphysema. The patients were included in Emphysema group if they had emphysema by high resolution computed tomography and dyspnea on exertion. Were exclusion criteria the presence of others respiratory diseases or malignancy and acute exacerbation. The COPD patients were grouped as follows: patients with chronic bronchitis (n=11) and patients with emphysema (n=9). The clinical and physiological characteristics of COPD phenotypes are shown in Table 2.

The study was conducted according to the rules of the declaration of Helsinki. The ethical conduct was ensure in this investigation and informed written consent was obtained from all subjects participating in the study.

<table>
<thead>
<tr>
<th>Clinical and physiological parameters</th>
<th>Values</th>
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<tbody>
<tr>
<td>Age, years</td>
<td>71.30±7.68</td>
</tr>
<tr>
<td>Male/Female, n</td>
<td>11/9</td>
</tr>
<tr>
<td>Body mass index, Kg/m²</td>
<td>27.91±1.724</td>
</tr>
<tr>
<td>Smoking status: ex-smokers/non-smokers, n</td>
<td>15/5</td>
</tr>
<tr>
<td>Packs-years in ex-smokers</td>
<td>68.8±10.754</td>
</tr>
<tr>
<td>GOLD stage: I/II/IV, n</td>
<td>2/4/14</td>
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<tr>
<td>FVC, % predicted</td>
<td>77.10±5.190</td>
</tr>
<tr>
<td>FEV1, % predicted</td>
<td>58.13±5.332</td>
</tr>
<tr>
<td>FEV1/FVC, %</td>
<td>59.45±3.805</td>
</tr>
<tr>
<td>TLC, % predicted</td>
<td>113.70±5.709</td>
</tr>
<tr>
<td>RV, % predicted</td>
<td>169.22±15.514</td>
</tr>
<tr>
<td>DLCO, % predicted</td>
<td>68.98±7.55</td>
</tr>
<tr>
<td>DLCO/VA, % predicted</td>
<td>74.08±4.459</td>
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BMI= body mass index; FVC-forced vital capacity; FEV1-forced expiratory volume in the first second; TLC-total lung capacity; RV-residual volume; DLCO-carbon monoxide diffusing capacity; VA-alveolar volume. Values are expressed as (mean±SEM).
Circulating inflammatory mediator was assessed by the measurement of the acute phase protein C-reactive protein (CRP) levels, a marker of systemic inflammation. CRP levels were measured by chemiluminescent immunoassay. The levels of CRP were expressed in mg/L.

**Statistical analysis**

The results are expressed as mean ± SEM of the concentrations of plasma parameters evaluated. The appropriate nonparametric test was chosen for data not normally distributed. Comparisons between two groups were tested using unpaired t-test or Mann-Whitney U test. A difference with P<0,05 was considered statistically significant.

**Results**

The plasma concentrations of MDA, vitamin C and GSH of COPD patients with chronic bronchitis and COPD patients with emphysema are shown in Table 3.

The plasma MDA levels found to be significantly (P<0,001) higher in COPD patients with chronic bronchitis and emphysema when compared with control group (3,830±0,310 nmol/mL). Additionally, our results have shown a significant (P<0,05) increase in the marker of oxidative stress associated to emphysematous COPD patients when compared to bronchitis Figure 1.

The two sub-groups of COPD patients had a significant (P<0,001) decrease in antioxidant status in chronic bronchitis and emphysema when compared with control group (vitamin C 6,230±0,220 μg/mL; GSH 0,275±0,011 μmol/mL). However, no significant difference was observed when compared chronic bronchitis and emphysema. The emphysematous patients have a decrease in the antioxidant status Figure 1.

In our study, we observed a significant (P<0,001) decrease in Body Mass index (BMI) and a significant (p<0,05) increase in plasma MDA levels in COPD patients with predominant emphysema when compared with COPD patients with predominant chronic bronchitis Figure 2.

There was no significant difference in CRP levels between COPD patients with emphysema and chronic bronchitis. But we observed a tendency toward an increase associated to emphysematous patients Figure 2.

Although our results should be regarded as preliminary, we observed that low BMI (<21 kg/m²) could be related with higher levels of CRP and higher MDA levels in COPD patients with emphysema. In addition, our results indicated that this increase in oxidative biomarker and systemic inflammation is more evident in group of emphysema with low BMI and with very severe COPD.

**Discussion**

We observed differences in plasmatic markers in the 2 typical clinical phenotypes studied. There was an increase in MDA and CRP levels and a decrease in antioxidant status (vitamin C and GSH) associated to emphysematous patients when compared with chronic bronchitis. Additionally, an increase in MDA and CRP levels were associated to patients with emphysematous phenotype with low BMI.

Our results agree with recent studies that have shown that COPD is associated not only with an abnormal inflammatory response of the lung parenchyma but also with a systemic inflammation and a systemic oxidative stress [3]. There is evidence of an increase in circulating CRP levels associated to stable COPD patients and this acute-phase protein has been regarded as a valid biomarker of systemic inflammation in these patients [23-26]. Some authors investigate the relationship between systemic inflammation, oxidative stress, body mass index and lung function. Karadag et al. [23], reported that CRP levels are higher in COPD patients with low BMI. Other authors suggest that low BMI is associated with higher degrees of bronchial obstruction and pulmonary hyperinflation, in association to circulating CRP levels during acute exacerbations of COPD [27]. However, other studies found increases in CRP levels with increasing BMI in stable patients with moderate to severe COPD [28]. In another study there was no correlation between BMI and MDA in patients with COPD [29]. Most studies of markers of inflammation and oxidative stress in COPD have analyzed the results for all types of patients together and the results are inconclusive. In our study, we observed a significant (P<0,001) decrease in Body Mass index (BMI) and a significant (P<0,05) increase in plasma MDA levels in COPD patients with predominant emphysema when compared with COPD patients with predominant chronic bronchitis. Although our results should be regarded as preliminary, we observed that low BMI (<21 kg/m²) could be related with higher levels of CRP and higher MDA levels in more severe COPD patients with emphysema. Some recent studies demonstrate differences in pulmonary and systemic markers associated to emphysema and chronic bronchitis. In contrast with our results, other authors suggest that in COPD patients with emphysematous phenotype the inflammatory response and oxidative stress were reduced when compared with chronic bronchitis [30]. More studies are needed to clarify the mechanisms involved in inflammatory response and oxidant/antioxidant balance in different clinical phenotypes of COPD patients. In this study, we only evaluate systemic markers and we don’t use EBC samples. Another limitation

**Table 3: MDA, vitamin C, GSH and CRP concentrations in COPD patients with mainly chronic bronchitis or with mainly emphysema.**

<table>
<thead>
<tr>
<th>Marker of oxidative stress</th>
<th>Chronic bronchitis</th>
<th>Emphysema</th>
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<tbody>
<tr>
<td>MDA (nmol/mL)</td>
<td>7.729±1.208</td>
<td>9.552±2.343</td>
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<tr>
<td>Antioxidant status</td>
<td></td>
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<tr>
<td>Vitamin C (μg/mL)</td>
<td>1.899±0.431</td>
<td>1.827±0.609</td>
</tr>
<tr>
<td>GSH (μmol/mL)</td>
<td>0.143±0.034</td>
<td>0.126±0.028</td>
</tr>
<tr>
<td>Marker systemic in</td>
<td></td>
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<tr>
<td>flammation CRP (mg/L)</td>
<td>3.830±0.666</td>
<td>3.996±1.049</td>
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</table>

Results are expressed as (mean±SEM).
of our study was the classification of patients by phenotype. Indeed, no well-established cutoffs are currently available. We use the computed tomography images of the thorax and the clinical characteristics to confirm the classification of patients by phenotypes. Additionally, our results should be regarded as preliminary because of the sample size. But the consistency of our results, showing differences in systemic markers between the 2 COPD phenotypes suggests that different clinical phenotypes have different systemic responses and many mechanisms may be involved in the pathogenesis of COPD. Our results, could contribute to consolidate the association between oxidative stress and COPD phenotypes. Most of the recent research has been directed to validated biomarkers to a more complete and clinically characterization of COPD [24,31-33]. The concept of an oxidant/antioxidant imbalance (oxidative stress) in the lung tissue of patients with COPD may be at the center of the pathobiology of these diseases. Oxidative stress may be one mechanism that enhances the inflammatory response [34]. It has been proposed that inflammation is related to oxidative stress, protease-antiprotease imbalance and apoptosis as destructive processes in emphysema [14,34]. In this study, we observed a statistically (P<0.05) significant increase in the biomarker of oxidative stress in patients with emphysema when compared with patients with chronic bronchitis. We didn’t find a difference in the antioxidants status (vitamin C and GSH) between the 2 phenotypes but we observe a tendency toward a decrease in antioxidant status associated COPD patients with mainly emphysema. Other authors found a significant increase in MDA levels and a decrease in vitamin C associated COPD patients and in emphysema but an increase in GSH levels was observed in patients with emphysema [35]. There are a limited number of studies about oxidants/antioxidants in COPD phenotypes. Strong evidence for the role of oxidative stress in the protease/antiprotease imbalance and apoptosis associated to the pathogenesis of emphysema has been provided by studies in animal models of emphysema [13,36]. Other authors reported an association of emphysema with genetic variations in antioxidant genes and a decrease in
the antioxidant capacity [37]. Our results show an association between COPD and insufficiency antioxidant capacity to prevent oxidative damage. More evidence of a disturbance in oxidant/antioxidant status was found in pulmonary emphysema. In addition, our results suggested that an increase in oxidative biomarker and systemic inflammation is more evident in the group of emphysema with low BMI and with very severe COPD. However, since our study population was limited size, these findings should be confirmed in further studies.

Conclusions

Although our results should be regarded as preliminary they indicate a disturbance in oxidant/antioxidant status and systemic inflammatory response associated to COPD patients. The differences observed were more evident in emphysematous phenotype. These results could lead to better understanding of the variability associated to COPD patients and may contribute to the development of novel therapeutic interventions. Further studies are needed to analyze pathophysiologic mechanisms involved in the phenotypes of COPD associated to oxidant/antioxidant imbalance.

References


