

### Small Airways Disease and Pneumoconiosis among California Farmworkers

M.B. Schenker<sup>1</sup>, K.E. Pinkerton<sup>1</sup>, B. Elvine-Kreis<sup>1</sup>, V. Vallyathan<sup>2</sup>, M. Lugo<sup>1</sup>, F. Green<sup>1</sup>. <sup>1</sup>University of California at Davis, Davis, CA; <sup>2</sup>NIOSH, Morgantown, WV; University of Calgary, Calgary, AB, Canada. Email: mbschenker@ucdavis.edu

**Introduction & Methods:** Lung autopsy specimens were obtained on consecutive farmer's cases of Hispanic males in Fresno County, California (n=86) to determine the prevalence of lung disease. Specimens were fixed by standardized protocol. Airway pathology and dust content were scored. Histological changes in lung tissue samples of farmworkers were compared to non-farmworkers.

**Results:** Of the first 86 cases, farmworkers comprised 51% (51% smokers) and non-farmworkers 49% (49% smokers). Microscopic exam to the sixth airway generation demonstrated little mineral dust accumulation, but respiratory bronchioles showed evidence of wall thickening and remodeling associated with heavy carbonaceous and mineral dust accumulation. Increased collagen and interstitial cells including dust-laden macrophages were also present with the wall changes. These changes were associated with agricultural work history, and were independent of cigarette smoking. Independently-rated mineral dust small airways disease, pneumoconiosis, and lymph node fibrosis predominated in the farmworkers compared to the non-farmworkers; 71% vs. 29%, 19% vs. 5%, and 69% vs. 31%, respectively. There was also an association between increasing age and dust concentration present in the lungs.

**Conclusions:** Hispanic males in Central California show early, subclinical histopathological changes consistent with silicosis and mixed-dust pneumoconiosis. Agricultural dust exposure is associated with mineral dust airways disease independent of age and cigarette smoking. The natural history and clinical significance of these changes remains to be determined.

This Abstract is Funded by: NIOSH

### Single and Repeated Zinc-Oxide Exposure in Asthma: Effect on Airway Inflammation

K. Reintjes<sup>1</sup>, A. Witten<sup>1</sup>, J. Balmes<sup>1</sup>, P. Blanc<sup>1</sup>, C. Solomon<sup>1</sup>. <sup>1</sup>University of California, San Francisco, San Francisco, CA.

Single and repeated exposure to zinc-oxide (ZnO) results in an increase in inflammatory cells and cytokines in healthy individuals. The chronic airway inflammation in asthma could increase ZnO-induced inflammation, however this is unknown. This experiment was designed to test the hypothesis that exposure to ZnO on two consecutive days would decrease both the cellular and cytokine responses, compared to one exposure, in individuals with asthma. Utilizing a repeated measure, counter-balanced, single-blind design, 10 subjects with asthma (8 females; age range 22-47 yr; methacholine PC<sub>20</sub> < 5 mg ml) were exposed for 30 min, at rest, to: 1) filtered-air (FA); 2) ZnO; one exposure (ZnO-1: 10 mg m<sup>3</sup>); 3) ZnO; two exposures (ZnO-2: 10 mg m<sup>3</sup>). Sputum induction (3% saline, t = 20 min) was performed 65 h pre- and 6 h post-exposure. Comparisons were made with (pre- vs post-exposure), and between-conditions (post- minus pre-exposure delta). Within ZnO-1, there was a significant (P<0.05) increase in the neutrophil percent (median; 25-75% range: 67.3; 58.9-74.6 vs 38.1; 26.7-68.5%), the delta of which, compared to FA, was increased (18.6; 5.7-26.7 vs -1.8; -7.7-7.7%). In ZnO-2, compared to FA, there was a significant increase in the total leukocyte concentration (175; 125-240 vs 89; 61-133 x 10<sup>4</sup> cells ml), and TNFα (5.9; 3.6-25.0 vs 0.; 0.0-1.4 pg ml). There were no significant differences in any variables between ZnO-1 and ZnO-2. These results indicate that in individuals with asthma, both single and repeated exposure to ZnO causes an increase in indices of inflammation, but that the specific cell and protein changes could be different as a function of the exposure format.

This Abstract is Funded by: COEH/NIOSH: T421/CCT910427

### Documentation of Occupational History in Adults with Recently Diagnosed Asthma: A Structured Retrospective Analysis

S.L. Shofer<sup>1</sup>, B.M. Haus<sup>2</sup>, W.G. Kuschner<sup>3,4</sup>. <sup>1</sup>Department of Medicine; <sup>2</sup>Stanford University School of Medicine; <sup>3</sup>Division of Pulmonary and Critical Care Medicine. All at Stanford University School of Medicine, Stanford, CA; <sup>4</sup>Veteran Affairs Palo Alto Healthcare System, Palo Alto, CA. Email: sshofer@earthlink.net

**Objective:** The most effective instrument for detecting occupational asthma (OA) is the health care provider (HCP) derived history. The purpose of this investigation was to assess the quality of the occupational history (OH) obtained by HCP's who manage adults with recently diagnosed asthma. **Methods:** We identified by computer search, patients age 18-55 with asthma newly reported between 1999-2002. We conducted structured chart abstraction to assess the OH elements documented by HCP's. We also reviewed self-administered patient pulmonary function test (PFT) questionnaires that were not available to HCP's as well as PFT data to assess respirable agent exposure history and pulmonary physiology. **Results:** Occupational status was documented in 94 of 119 (79%) charts. Occupational duties, presence or absence of exposures at work or home, and status of protective equipment use at work were identified in only 3%, 27%, and 3% of the group, respectively. HCP's made a diagnosis of OA in 3 (3%) patients. 71 (60%) patients documented a history of exposure to gas, dusts, or fumes at work in their PFT questionnaire. Bronchodilator response was present in 26%, 77% used short acting bronchodilators. **Conclusion:** In this population of working-age adults with newly diagnosed asthma, patient self-reports of occupational respirable exposure were common. Occupational status was the only OH element frequently documented by HCP's. Fewer than expected cases of OA were diagnosed by HCP's based on prior prevalence studies. OH is likely underdiagnosed by HCP's

This Abstract is Funded by: None

### Adaptation of an International Job Exposure Matrix To Assess Exposure to Occupational Asthmagens in the United States

J.M. Villaveja<sup>1</sup>, V.R. Breen<sup>2</sup>, D.M. DeBruckere<sup>3</sup>, E.A. O'Connor<sup>1</sup>, M.A. Heumann<sup>3</sup>, W.M. Vollmer<sup>1</sup>. <sup>1</sup>Center for Health Research, Kaiser Permanente Northwest, Portland, OR; <sup>2</sup>Northwest Permanente Associates, PC, Kaiser Permanente Northwest, Portland, OR; <sup>3</sup>Department of Human Services, Oregon Public Health Services, Portland, OR. Email: jacqueline.villaveja@kpchr.org

**Rationale:** We adapted a previously described (Kennedy et al., *Occup Environ Med* 2000;57:635-641) asthma-specific job exposure matrix (AJEM) so that it could be used reliably in the United States. The AJEM and limited expert judgment can estimate asthma exposure risk in occupational epidemiology studies. **Methods:** The Kennedy et al. AJEM uses the International Standard Classification of Occupations, 1988 edition (ISOC-88) coding system. A coder trained in the U.S. Bureau of Census (BOC) system mapped each ISOC-88 code to a corresponding BOC-2000 code(s). An industrial hygienist and an occupational health physician then created exposure ratings for those BOC-2000 jobs that did not get mapped or that had multiple, inconsistently rated mappings. **Results:** The mapping from ISOC-88 to BOC-2000 was surprisingly difficult. Of the 507 ISOC-88 codes in the Kennedy et al. AJEM, 133 (26%) could not be reliably mapped into BOC-2000 codes, and 224 (44%) of the 509 BOC-2000 codes had no mapping. An additional 74 BOC-2000 codes had multiple, inconsistent ISOC-88 mappings. Accordingly, we created new exposure ratings for over half of those in the new AJEM. Factors that made the mapping from ISOC-88 to BOC-2000 difficult included distinctions in education/skill level and in company size in ISOC-88 that are not present in BOC-2000. **Conclusions:** We have successfully adapted the Kennedy et al. AJEM to a tool that is more suitable for use in the U.S., where jobs are commonly coded using the U.S. BOC coding system. This will enable efficient assessment of occupational exposures to agents associated with asthma.

This Abstract is Funded by: CDC-NIOSH

### Utility of Pulmonary Function and Cardiopulmonary Exercise Testing in Field Settings

M.B. Schenker<sup>1</sup>, R. Lupercio<sup>1</sup>, P.L. Enright<sup>2</sup>, R.J. Zeballos<sup>3</sup>, M.T. Stoecklin<sup>1</sup>. <sup>1</sup>Epidemiology & Preventive Medicine, University of California, Davis, Davis, CA; <sup>2</sup>Respiratory Sciences Center, University of Arizona, Tucson, AZ; <sup>3</sup>Internal Medicine, Texas Tech University Health Sciences Center, El Paso, TX.

**RATIONALE:** Previous studies have found no effect of chronic low-dose paraquat exposure on spirometry; however, paraquat is known to cause interstitial fibrosis with acute high-dose exposure. The study purpose was to assess utility and correlation of measures of restrictive lung disease in a field study of agricultural workers in Costa Rica. **METHOD:** Paraquat exposure and respiratory health was assessed in 340 farmworkers (mean age 37 yrs, SD=10.5). We measured single breath diffusion capacity (DLCO), cardiopulmonary exercise testing (CPET), and spirometry. Data collection was done at farms by technicians following ATS guidelines. CPET participants were screened for cardiovascular disease according to American Association of Sports Medicine criteria. Eligible participants were <=40 years of age. Results were graded for acceptability according to previously published criteria. Correlations and regression modeling assessed relationships between measures of pulmonary interstitial disease. **RESULTS:** 4% were unable to complete spirometry, and 3% had readable tracings that failed to meet ATS reproducibility criteria. DLCO was completed in 293 of 305 subjects. Reasons for failure to complete DLCO included inability to hold breath for 10 secs, lack of gas mixture in the field, and loss to follow-up with rescheduling of tests. 130 subjects were excluded from CPET because of age (33%), prior cardiac disease (4%) or back and knee problems (1%). In linear regression modeling, higher R-square values were seen between FVC and DLCO than between those measures and measures of CPET. **CONCLUSIONS:** CPET may provide more sensitive measures of interstitial lung disease than spirometry but has more limited use in population-based field studies.

This Abstract is Funded by: Syngenta, Research Agreement 002994

### Portable Spirometer for Occupational Respiratory Epidemiology

D.K. Milton<sup>1</sup>, S.R. Sama<sup>1</sup>, S.J. Derk<sup>2</sup>, P.K. Henneberger<sup>2</sup>, J. Masiello<sup>3</sup>, A. Wetzel<sup>3</sup>, C. Buess<sup>3</sup>, P.A. Preusse<sup>4</sup>, K.J. Stemple<sup>2</sup>. <sup>1</sup>Harvard School of Public Health, Boston, MA; <sup>2</sup>CDC-National Institute of Occupational Safety and Health, Morgantown, WV; <sup>3</sup>NDD Medical Technologies, Andover, MA; <sup>4</sup>Fallon Clinic Research Department, Worcester, MA. Email: dmilton@hsph.harvard.edu

**Introduction:** Workplace challenge tests are a gold standard for diagnosis of work-related asthma. A highly accurate portable electronic spirometer is needed to facilitate research and clinical diagnosis. **Methods:** Detailed specifications were developed, including adherence to ATS spirometry recommendations, an algorithm to collect basic data on workers' activities regardless of shift, and incorporation of an investigator-defined questionnaire. The instrument passed all ATS waveforms when tested at NIOSH. Features include: user feedback on maneuver quality; storage of flow-volume curves and parameters for the three best blows within session; pre- and post-bronchodilator test capability; and award of incentive points. The data can be downloaded via modem. The algorithms were tested with simulated work schedules and by workers with asthma. The algorithm collects activity information necessary for analysis in the OASYS-2 software package. Data is stored in Microsoft Access format. **Results:** Standard diagnostic software was successfully modified to adapt a lightweight highly accurate portable spirometer for use in occupational respiratory epidemiology. The final software is accurate, user-friendly, and customizable to various research settings. **Conclusion:** Use of the small lightweight portable hand-held spirometer enables researchers and health care professionals to observe workers, in their workplace and home environments over a period of weeks, to establish work-related asthma status.

This Abstract is Funded by: CDC, NHBLI



AMERICAN JOURNAL OF

# Respiratory and Critical Care Medicine

Volume 167 • Number 7 • April 2003

**Abstracts**

**2003  
INTERNATIONAL  
CONFERENCE**

May 16–21, SEATTLE, WASHINGTON  
AMERICAN THORACIC SOCIETY

*This is a supplement of the American Journal of Respiratory and Critical Care Medicine*

AN OFFICIAL JOURNAL OF THE AMERICAN THORACIC SOCIETY