

Original Research Article

SERUM BILIRUBIN LEVEL IN PATIENTS WITH COPD DURING ACUTE EXACERBATION

Abstract

Aim of the work: To study the relationship between serum bilirubin level and patients with chronic obstructive pulmonary disease during exacerbation.

Patients and Methods: Forty patients (37) males and (3) females patients with

COPD during exacerbation were admitted to chest department, Benha university hospital were included in this study. All patients were submitted to full history taking general and clinical examination, plain chest x-ray (P.A. and lateral view), Body mass index, Pulmonary function tests (spirometry) before and after bronchodilatation, Electrocardiography, complete blood count, liver function tests, kidney function tests and fasting blood sugar. We excluded patients with any disease that may result in elevation of Serum bilirubin like, hepatic diseases, inflammatory bowel diseases, end- stage renal disease , diabetes mellitus, hypertension, ischemic heart, arthritis, cerebral vascular diseases and any systemic infection or inflammation that could be associated with increased bilirubin level. Also patients were excluded if they had tuberculosis, bronchiectasis and malignancy.

Results: The level of serum total bilirubin was high in COPD patients with acute exacerbation(range = 0.76-1.98 . mean $\hat{A}\pm SD = 1.32\hat{A}\pm 0.73$), The correlation between FEV1/FVC pre-bronchdilator and total bilirubin was statistically significant. The correlation between serum indirect bilirubin and post-bronchodilator FEV1/FVC was statistically significant. The correlation between serum total bilirubin and smoking index was non-significant.

Conclusion: The bilirubin may be a helpful indicator in exacerbation of COPD and the patient may get useful effect with hyper bilirubinemia.

Key words: COPD exacerbation, Serum bilirubin, ventilatory function tests, smoking index.

Introduction

The prevalence and burden of COPD are projected to increase in coming decade due to combined exposure to COPD risk factors and changing age structure of world's population with more people living longer , and thus reaching the age at which COPD normally developed (1). Bilirubin is metabolite of the haeme proteins, mainly hemoglobin. It is excreted into the intestine and bile from the liver. The site of the catabolism of haemoglobin is the reticuloendothelial system (RES) bilirubin is then released into the blood stream where it's bind tightly to albumin and is conjugated to the acid to form bilirubin mono and diglucuronide that are water soluble metabolism or direct bilirubin. Elevation of total serum bilirubin may occur due to excessive hemolysis or destruction of the red blood cells e.g. hemolytic diseases (2). Oxidant/antioxidant imbalance has been implicated in the pathogenesis of chronic obstructive pulmonary disease. Exogenous oxidant are contained in cigarette smoke the major risk factor for COPD and are produced by the inflammatory cells that characterize the pathology of COPD. Oxidative stress induces a cascade of signaling mechanism which activate transcription factors leading to up regulation of gene coding for proinflammatory and anti inflammatory cytokines and enzyme haem oxygenase and inducible nitric oxide (3). Catalyse the degeneration of haem to bilivirdin which is then reduced to bilirubin producing free ions and carbon monoxide has been suggested to have important antioxidant capacity and significance in protecting lung cells against oxidant exposure. Hemeoxygenase was demonstrated to be induced by variety of injurious stimuli including reactive oxygen species (ROS). Chronic smoker exhibit increased expression of heamoxygenase in their alveolar spaces that have a very important role in the pathogenesis COPD (4).

Aim of the work

Was to study the relationship between serum bilirubin and chronic obstructive pulmonary disease patients during exacerbation.

Patients and Methods

This study was included 40 patients(37) males and(3) females with acute exacerbation of COPD, were admitted in chest department Benha university hospital between November 2010 and Feb 2012 .All subjects were submitted to full history taking (including smoking history) and clinical examination, body mass index (BMI),radiological examination (plain CXR postero-anterior and lateral views),Electrocardiography, complete blood count, liver function tests including serum total, direct and indirect bilirubin level measurement, kidney function tests , fasting blood sugar, ventilatory function tests (spirometry) before and after bronchodilatation by using Sensor-medics V max series, 2130 spirometer, V6200 Autobox, 6200DL .

Inclusion criteria:

1-COPD patients were in acute exacerbations.

2-Post-bronchodilator FEV1/FVC < 70% and reversibility is <12% (confirming the diagnosis of COPD).

Exclusion criteria:

1- Any disease that may result in elevation of Serum bilirubin .

- Cardiovascular co- morbidities like hypertension, ischemic heart diseases and cerebral vascular diseases.
- Hemolytic disorders
- Diabetes mellitus.
- Inflammatory bowel diseases.
- Arthritis.
- Hepatic cirrhosis.
- End stage renal disease.
- Any systemic infection or inflammation that could be associated with increased bilirubin level.

2- Patients were also excluded if they had tuberculosis, bronchiectasis, malignancy or connective tissue disorders.

Statistical presentation and analysis of the present study was conducted, using the mean, standard deviation, analysis of variance [ANOVA] test and chi-square test by SPSSV(5).

Results

Table(1):Demographic data of studied subjects as regards number, age, sex, body mass index smoking index and serum bilirubin(total, direct and indirect).

Item	Result
Number	40 patients
Age/year	54.04±9.59 R:41 – 79
Sex	Male :37 Female:3
BMI (Kg/m ²)	27.67±6.48 R:19.57 - 45.27
Smoking index	481.4±311.3 140-1500
Total bilirubin (mg/dl)	1.32±0.73 R:0.76-1.98
Direct bilirubin (mg/dl)	0.37±0.22 R: 0.1-0.95
Indirect bilirubin (mg/dl)	0.69±0.26 R: 0.18-1.4

The demographic data of the studied patients included, the number of the patients was 40 (37 male and 3 female), the mean BMI was 27.67±6.48 Kg/m², the mean smoking index 481.4 ± 311.3 , the mean total bilirubin was 1.32±0. 73 mg/dl , the mean direct bilirubin was 0.37±0.22 mg/dl and the mean indirect bilirubin was 0.69±0.26 mg/dl. These results revealed higher level of total and indirect bilirubin in COPD patient with acute exacerbation.

(2): Correlation between Pre-and Post bronchodilator FEV₁/FVC % and serum total bilirubin.

Variables	Pearson correlation	P- value
Pre FEV1/FVC % total bilirubin	0.61	<0.05
Post FEV1/FVC% total bilirubin	0.71	<0.05

Significant positive correlation between serum total bilirubin with pre-and post- bronchodilator FEV1/FVC% ,in which serum total bilirubin increased with increase of pre-and post- bronchodilator FEV1/FVC% .

Table (3): Correlation between Pre-and Post bronchodilator FEV₁/FVC % and indirect bilirubin.

Variables	Pearson correlation	P- value
Pre FEV1/FVC% Indirect bilirubin	0.22	<0.05
Post FEV1/FVC% Indirect bilirubin	0.28	< 0.05

Significant positive correlation between serum indirect bilirubin with pre-and post- bronchodilator FEV1/FVC% ,in which serum indirect bilirubin increased with increase of pre-and post- bronchodilator FEV1/FVC% .

Table (4): Correlation between FEV1% predicted with serum total and indirect bilirubin.

Variables	Pearson correlation	P-value
FEV1% predicted total bilirubin	0.005	> 0.05
FEV1% predicted indirect bilirubin	0.003	> 0.05

Non significant positive correlation between FEV1% predicted with serum total & indirect bilirubin in which serum total & indirect bilirubin increased-non significantly with increase of FEV1% predicted .

Table (5): Correlation between FEF₂₅₋₇₅% predicted with serum total and indirect bilirubin.

Variables	Pearson correlation	P-value
FEF ₂₅₋₇₅ % predicted total bilirubin	0.34	< 0.05
FEF ₂₅₋₇₅ % predicted indirect bilirubin	0.17	< 0.05

Significant positive correlation between FEF₂₅₋₇₅% predicted with serum total and indirect bilirubin so increase FEF₂₅₋₇₅ % predicted associated with increase in both total and indirect bilirubin .

Table (6): Correlation between serum bilirubin and smoking index .

	Pearson correlation	P-value
Total bilirubin Smoking index	- 0.062	> 0.05

Non significant negative correlation between serum total bilirubin and smoking index

Discussion

The current study was done to assess the relationship between serum bilirubin level in patients with chronic obstructive pulmonary disease during exacerbation, the demographic data of the studied patients included, the number of the patients was 40 (37 male and 3 female), the mean BMI was $27.67 \pm 6.48 \text{ Kg/m}^2$, the mean smoking index 481.4 ± 311.3 , the mean total bilirubin was $1.32 \pm 0.73 \text{ mg/dl}$, the mean direct bilirubin was $0.37 \pm 0.22 \text{ mg/dl}$ and the mean indirect bilirubin was $0.69 \pm 0.26 \text{ mg/dl}$. These results revealed higher level of total and indirect bilirubin in COPD patient with acute exacerbation. This result in agreement with cohort study among 504206 adult from the UK primary care research database (the health improvement network with serum bilirubin level recorded with no evidence of hepatopillay or heamolytic diseases (2). In the current study there was significant positive correlation between serum total and indirect bilirubin with pre-and post-bronchodilator FEV1/FVC% ,in which serum total and indirect bilirubin increased with increase of pre-and post- bronchodilator FEV1/FVC%, also there was significant positive correlation between FEF25-75% predicted with serum total and indirect bilirubin so increase FEF25-75 % predicted associated with increase in both total and indirect bilirubin (P-value <0.05).On the reverse there was non significant positive correlation between FEV1% predicted with serum total & indirect bilirubin in which serum total & indirect bilirubin increased-non significantly- with increase of FEV1% predicted (P-value >0.05).These results in agreement with Jama etal. 2011. They concluded that, beneficial effects of elevated serum bilirubin-within the range- have been observed on respiratory health. Higher bilirubin concentrations were associated with lower incidence of lung cancer, chronic obstructive lung disease and lung cancer mortality, as well as height-standardized lung function previous population-based studies. These results suggest that bilirubin might have protective effects in tissues exposed to the outer environment, such as the lungs, possibly by counteracting subclinical inflammation(6).The significant associations with FEF25–75% and FEV1/FVC might point to an inverse relationship with small airway obstruction. Due to their large surface area, small airways are an important compartment of chronic respiratory disease development (7,8) We can currently only speculate about the mechanisms by which serum bilirubin might influence lung function. Intracellular mechanisms may be more important in the lung than the known effects in serum and blood vessels, as bilirubin penetrates cell walls at physiological pH values (9). Besides scavenging

oxidants, bilirubin inhibits membrane-bound nicotinamide adenine dinucleotide phosphate-oxidase, one of the major intracellular sources of reactive oxygen species (10). Furthermore, bilirubin infusions have been shown to down-regulate inflammation in murine lung injury models (11). Oxidative stress in COPD is generated by both endogenously produced oxidants and exogenous sources such as cigarette smoke. Oxidants induce damage to proteins, DNA, and lipids (12). Animal studies have revealed that bilirubin has a greater affinity in preventing oxidation of lipids than proteins, (13) and inhibition of bilirubin synthesis results in significant increases in lipid peroxidation products(13) Within human lungs, lipid peroxidation causes damage to multiple cell membrane components and impairs cell structure and permeability(14) Patients with COPD have higher levels of lipid peroxidation products in sputum, (15) and serum levels of these products are higher in patients with severe airflow limitation compared with those with moderate limitation thus, bilirubin may protect the COPD lung by inhibiting lipid peroxidation (16). COPD is also associated with oxidative stress despite smoking cessation, (17) and this persistent inflammation may overwhelm the capacity of biliverdin reductase to recycle oxidized bilirubin, resulting in lower serum bilirubin in those with higher levels of oxidative stress regardless of smoking status. Smoking has also been associated with lower serum bilirubin and may further deplete bilirubin, resulting in borderline significance when this relationship was adjusted for smoking status(18).

Our study revealed, there was non significant negative correlation between serum total bilirubin and smoking index(P-value > 0.05).Jama et al. 2011 also identified an inverse association between bilirubin and smoking intensity that was not statistically significant in the European cohort(6). This finding can be explained by, Bilirubin in human plasma appears to be depleted on exposure to reactive oxidative species such as those found in cigarette smoke, which could explain these findings (6) Thus, passive smoking or cigarette type (e.g, unfiltered) could have slightly confounded the results, but this seems unlikely given that adjusting for smoking intensity and duration had almost no effect on the associations(19).

Conclusion

This study support the hypothesis that bilirubin has a protective effect on COPD disease, possibly through its anti-oxidant actions. Bilirubin may prove useful as an easily accessible and readily available blood based COPD biomarker. Further researches are needed to investigate the causal association between bilirubin level and COPD patients outcome a fuller

under standing of these mechanisms may lead to the potential use of targeted clinical treatment that mildly suppress some enzymatic activity and increase bilirubin level .

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