



Diagnosing primary ciliary dyskinesia

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- 16 **Yasufuku K**, Chiyo M, Koh E, *et al*. Endobronchial ultrasound guided transbronchial needle aspiration for staging of lung cancer. *Lung Cancer* 2005;50:347–54.
- 17 **Leschber G**, Holinka G, Linder A. Video-assisted mediastinoscopic lymphadenectomy (VAMLA)—a method for systematic mediastinal lymphnode dissection. *Eur J Cardiothorac Surg* 2003;24:192–5.
- 18 **Venissac N**, Alifano M, Mouroux J. Video-assisted mediastinoscopy: experience from 240 consecutive cases. *Ann Thorac Surg* 2003;76:208–12.
- 19 **Kimura H**, Iwai N, Ando S, *et al*. A prospective study of indications for mediastinoscopy in lung cancer with CT findings, tumor size, and tumor markers. *Ann Thorac Surg* 2003;75:1734–9.
- 20 **Eschmann SM**, Friedel G, Paulsen F, *et al*. FDG PET for staging of advanced non-small cell lung cancer prior to neoadjuvant radio-chemotherapy. *Eur J Nucl Med Mol Imaging* 2002;29:804–8.
- 21 **Detterbeck F**, Falen S, Rivera MP, *et al*. Seeking a home for a PET, Part 2: Defining the appropriate place for positron emission tomography imaging in the staging of patients with suspected lung cancer. *Chest* 2004;125:2300–8.
- 22 **Farrell MA**, McAdams HP, Herndon JE, *et al*. Non-small cell lung cancer: FDG PET for nodal staging in patients with stage I disease. *Radiology* 2000;215:886–90.
- 23 **Detterbeck FC**, Vansteenkiste JF, Morris DE, *et al*. Seeking a home for a PET, Part 3: Emerging applications of positron emission tomography imaging in the management of patients with lung cancer. *Chest* 2004;126:1656–66.
- 24 **Bryant AS**, Cerfolio RJ, Klemm KM, *et al*. Maximum standard uptake value of mediastinal lymph nodes on integrated FDG-PET-CT predicts pathology in patients with non-small cell lung cancer. *Ann Thorac Surg* 2006;82:417–23.

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A nationally funded diagnostic service should lead to improved outcome

The National Specialist Commissioning Advisory Group (NSCAG) has funded three centres to establish and provide a national diagnostic service for England for children and adults suspected of suffering from primary ciliary dyskinesia (PCD). This is welcomed, as state of the art diagnostic testing will be available nationally which will increase the numbers of patients diagnosed with a condition in which early diagnosis has a very significant effect on both short-term and long-term morbidity. Inheritance is autosomal recessive with an incidence of around 1:15 000 in the Caucasian population and, as expected, we have found a much higher incidence in ethnic groups where consanguineous marriages are common. Accurate diagnosis will allow appropriate genetic counselling for families.

PCD is caused by one of a number of different ciliary defects that result in ineffective mucociliary clearance. Although most patients with PCD have symptoms from birth or early infancy,¹ the diagnosis is frequently delayed² and it is likely that a significant number of patients are never diagnosed.³ Failure to diagnose PCD leads to progressive and permanent lung destruction owing to obstruction of the airways with secretions and subsequent infection, leading to bronchiectasis. Early diagnosis of PCD is important as deterioration in lung function can largely be prevented by specialist respiratory care.⁴ Failure to recognise the condition frequently leads to inappropriate ear, nose and throat (ENT) surgery. Grommet insertion may lead to persistent aural discharge with little improvement

in hearing loss. A number of patients with unrecognised PCD present in infertility clinics. Infertility in males, although not inevitable, is due to sperm tails being affected as part of their PCD. There is an increased incidence of ectopic pregnancy due to defective movement of the cilia in the fallopian tube.⁵

As PCD testing is not a front line test for those with respiratory problems, who should be referred? Patients with situs inversus, which occurs in 40–50% of individuals with PCD, is an obvious indication. Of patients referred to our laboratory with situs inversus, 75% have been confirmed to have PCD. Of patients without situs inversus, those with bronchiectasis and life-long nasal symptoms in whom no other cause has been identified should be considered for referral. A significant number of patients with PCD will have a history of unexplained neonatal respiratory distress and persistent rhinitis from birth. The real aim, however, is to diagnose children before bronchiectasis develops and before they are subjected to repeated ENT surgery. The investigation of children with host defence problems—including PCD—who are at risk of developing bronchiectasis is frequently delayed. Reasons for the delay include the child’s tendency to swallow rather than expectorate sputum, a distinct lack of auscultatory findings and temperature even during acute exacerbations, and the fact that the chest radiograph often appears normal.

So, how do we recognise a young child at risk of developing bronchiectasis? The important sign is that of a persistent

“wet” sounding cough. If such a cough persists for more than 8 weeks or improvement is seen with antibiotic treatment but symptoms return when stopped, paediatric review should be arranged. In patients with PCD the cough never goes completely even with treatment and “has always been there”. Testing for PCD should be considered if standard first line investigations to exclude cystic fibrosis (CF) and screening for immunological defects are negative and the child has a life-long history of a “wet” sounding cough and persistent nasal symptoms. A number of patients will have a history of unexplained neonatal respiratory distress. Hearing problems are only seen in half of cases. If the child is from a consanguineous marriage, suspicion should be higher. Nonetheless, symptoms may be mild; in one series, diagnosis was made in 10% as a result of family screening after the diagnosis in an index case.⁶

Diagnosis to date has largely been provided on an ad hoc basis, with lack of standardisation of, and inaccessibility to, diagnostic testing for the majority of patients in the UK. Screening tests for PCD exist, but there are problems associated with them. The saccharin test used to assess mucociliary function is difficult to perform and is unreliable in children. Measurement of nasal nitric oxide, which is very low in patients with PCD, is now accepted as the most sensitive and specific screening test for PCD.⁷ Unfortunately this is not widely available and cannot be used in young children. The development of new methodologies over the last few years has allowed improved diagnostic testing for PCD. The traditional measurement of ciliary beat frequency alone has been shown to miss a proportion of patients with PCD whose ciliary beat frequency is normal but beat pattern abnormal.⁸ Diagnostic assessment following biopsy will now include measurement of ciliary beat frequency, high speed analysis of ciliary beat pattern,⁸ detailed electron microscopy of ciliary ultrastructure and, in cases where there are diagnostic uncertainties, cell culture⁹ from biopsies. Although the genetics of

PCD are slowly being unravelled, owing to the multiple phenotypes of the disease and more than 200 different proteins used to construct the ciliary axoneme, it is likely to be some time before such tests are widely used in the diagnostic examination of patients with PCD.

The diagnostic service is able to accept appropriate referrals from hospital consultants. However, the service does not extend to providing care for patients diagnosed with PCD. As experience of care for patients with PCD is limited, we would suggest a model similar to that for CF where patients should have access to a specialist paediatric respiratory consultant or thoracic physician with an interest in CF or non-CF bronchiectasis and be followed up regularly for life. The diagnostic service will allow a national database of patients with PCD to be established, facilitating clinical trials to help provide an evidence base for management. An active PCD patient and

parent support group has been established which we encourage newly diagnosed patients to contact (www.pcdsupport.org.uk).

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REFERENCES

- 1 **Greenstone M, Rutman A, Dewar A, et al.** Primary ciliary dyskinesia: cytological and clinical features. *Q J Med* 1988;**67**:405–23.
- 2 **Noone PG, Leigh MW, Sannuti A, et al.** Primary ciliary dyskinesia: diagnostic and phenotypic features. *Am J Respir Crit Care Med* 2004;**169**:459–67.
- 3 **Bush A, Cole P, Hariri M, et al.** Primary ciliary dyskinesia: diagnosis and standards of care. *Eur Respir J* 1998;**12**:982–8.
- 4 **Ellerman A, Bisgaard H.** Longitudinal study of lung function in a cohort of primary ciliary dyskinesia. *Eur Respir J* 1997;**10**:2376–9.
- 5 **Afzelius BA, Eliasson R.** Male and female infertility problems in the immotile-cilia syndrome. *Eur J Respir Dis Suppl* 1983;**127**:144–7.
- 6 **Coren ME, Meeks M, Morrison I, et al.** Primary ciliary dyskinesia: age at diagnosis and symptom history. *Acta Paediatr* 2002;**91**:667–9.
- 7 **Narang I, Ersu R, Wilson NM, et al.** Nitric oxide in chronic airway inflammation in children: diagnostic use and pathophysiological significance. *Thorax* 2002;**57**:586–9.
- 8 **Chilvers MA, O'Callaghan C.** Analysis of ciliary beat pattern and beat frequency using digital high speed imaging: comparison with the photomultiplier and photodiode methods. *Thorax* 2000;**55**:314–7.
- 9 **Jorissen M, Willems T, Van der Schueren B, et al.** Ultrastructural expression of primary ciliary dyskinesia after ciliogenesis in culture. *Acta Otorhinolaryngol Belg* 2000;**54**:343–56.

Biomarkers in COPD

Biomarkers in COPD: time for a deep breath

R A Stockley

Biomarkers need to fulfil several distinct requirements before they can be considered a valid indicator of chronic diseases such as COPD

Chronic obstructive pulmonary disease (COPD) has become recognised as a priority area for management of healthcare resources and development of new therapeutic strategies. This is based largely on economic burden and the excessive morbidity and mortality associated with the condition. The result has been a profusion of publications in recent years, many of which start with the observations that "COPD is currently the fifth and by the year 2020 will become the third or fourth leading cause of morbidity and mortality worldwide".

More recently, the COPD literature has entered a second phase. This has arisen from the appreciation that COPD is more than a respiratory inflammatory condition and is associated with manifestations outside the lung. This has led to the concept that COPD is a systemic disease and has resulted in a rapid increase in papers exploring this aspect. Initial studies were primarily based on the association of

reduced body mass index with severe COPD and common inflammatory pathways have been implicated.¹ In particular, the central role of tumour necrosis factor (TNF) α has been proposed,² and muscle biopsies in patients with COPD have shown apoptotic changes within skeletal muscle³ thought to be the result of the systemic inflammation.

In addition to the association of skeletal muscle dysfunction, it is also being appreciated that other co-morbidities such as cardiovascular disease,⁴ type II diabetes⁵ and osteoporosis⁶ are more commonly associated with patients with COPD than the general population. Indeed, the inflammatory basis for these other conditions is also gradually becoming appreciated, and there are many common pathogenic processes between them and COPD.¹

Research in COPD is now entering its third phase. Many pharmaceutical companies are becoming involved in drug discovery programmes based on the

development of new treatments to modulate the inflammatory processes in COPD. However, as with all chronic diseases, the progression of COPD is slow but continuous. Thus, not only does the complexity of the inflammatory pathway present a challenge to research workers and pharmaceutical companies, but also the conventional pathway of progressing from drug discovery through phase I and phase II to phase III controlled clinical trials is impaired by the lack of early "read outs" in phase II.

The traditional surrogate for progression in COPD is a physiological measurement (forced expiratory volume in 1 s (FEV₁)) which can vary day-to-day more than the overall progression over several years. Thus, although many drugs have been developed and marketed based on FEV₁ and evidence of symptomatic relief, the progression of the disease has remained unaltered. As interventions related to progression require many years of physiological follow-up, pharmaceutical companies have been hampered by the lack of specific or surrogate markers (closely linked to the pathogenic process in COPD) that are sensitive to facilitate short-term phase II proof of concept studies. Since these are the key to subsequent investment in large and lengthy phase III studies, there is an urgent need to identify such biomarkers. Understanding the inflammatory process involved in the pathophysiology of chronic diseases such as COPD provides the potential to identify more robust surrogate markers of the disease process that are sensitive to short-term interventions.