# Instructions for use

**Regional bronchodilator response assessed by computed tomography in chronic obstructive pulmonary disease**

**Author(s)**
Shimizu, Kaoruko; Makita, Hironi; Hasegawa, Masaru; Kimura, Hirokazu; Fuke, Satoshi; Nagai, Katsura; Yoshida, Takayuki; Suzuki, Masaru; Konno, Satoshi; Ito, Yoichi M.; Nishimura, Masaharu

**Citation**
European journal of radiology, 84(6): 1196-1201

**Issue Date**
2015-06

**Doc URL**
http://hdl.handle.net/2115/61986

**Rights**
© 2015, Elsevier. Licensed under the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International

**Rights(URL)**
http://creativecommons.org/licenses/by-nc-nd/4.0/

**Type**
article (author version)

**Additional Information**
There are other files related to this item in HUSCAP. Check the above URL.

**File Information**
- supplement.pdf (Supplementary data)
Online data supplement

Regional bronchodilator response assessed by computed tomography in chronic obstructive pulmonary disease

Kaoruko Shimizu¹, Hironi Makita¹, Masaru Hasegawa¹, Hirokazu Kimura¹,
Satoshi Fuke¹, Katsura Nagai¹, Takayuki Yoshida¹, Masaru Suzuki¹, Satoshi Konno¹,
Yoichi M. Ito² and Masaharu Nishimura¹*

¹First Department of Medicine, Hokkaido University School of Medicine
N-15 W-7, Kita-Ku, Sapporo 060-8638, Japan

²Department of Biostatistics, Hokkaido University Graduate School of Medicine
N-15 W-7, Kita-Ku, Sapporo 060-8638, Japan

*Correspondence to: Masaharu Nishimura, M.D.
First Department of Medicine, Hokkaido University School of Medicine
N-15 W-7 Kita-ku, Sapporo 060-8638, Japan

Fax: +81-11-706-7899; Tel: +81-11-706-5911
E-mail: ma-nishi@med.hokudai.ac.jp
Methods

Computed tomography and airway analysis

Our software provides the value of lung volume (LV) from CT measurements. In short, an image of the whole lung, including airways (A), is extracted from the 3D image of the thorax, resulting in deletion of the heart and major vessels in the lungs. Then, the bronchial skeleton (B) is extracted from the whole lung, leaving the lung parenchyma without either major vessels or proximal bronchial trees. LV is defined as (A) – (B). We confirmed that the difference in lung volume assessed by CT should be <10% in two measurements, considering the effect of lung volume on Ai.

Pulmonary Function Tests

We measured spirometry, diffusing capacity for carbon monoxide, and lung volumes assessed by the helium closed-circuit method (CHESTAC-33; Chest M.I., Tokyo, Japan). Pulmonary function tests were conducted according to the Japanese Respiratory Society guidelines, which are similar to those of the American Thoracic Society. Peak
expiratory flow within 10% of the maximum, a rapid start, absence of major flow
fluctuations and adequate expiration time were required. The best results were taken as
the FEV1 and FVC values obtained from acceptable maneuvers. FEV1 and FVC were
expressed as percentages of predicted values following the prediction equations of the
Japanese Respiratory Society. The diffusing capacity of the lung for carbon monoxide
(DLco), based on the single-breath method, was also measured in all subjects according
to the pulmonary function test guidelines of the Japanese Respiratory Society. DLco
divided by alveolar volume (VA) was expressed as percentage of predicted values
according to the prediction equations of Burrows.1 Lung volumes (total lung capacity
(TLC), functional residual capacity (FRC), and residual volume (RV)) were measured
by the helium closed circuit method. Lung volumes were expressed as percentages of
predicted values following the prediction equations of Nishida.3

RESULTS

Magnitude of bronchodilation caused by SFC in comparison with that of
a non-intervention group

As a non-intervention group, we randomly chose patients with moderate to severe
COPD from the Hokkaido COPD cohort study, in whom CT data were obtained at an interval of 1 year and the difference in FEV1 was < 50 ml on two occasions. Some other pulmonary function parameters such as FEV1/FVC (p=0.047) only slightly but significantly increased and DLco (p=0.038) decreased after one year interval (Table S1). On the other hand, in the good responders from the SFC study, vital capacity (VC) (p=0.001), FVC (p<0.001), FEV1 (p<0.001), FEV1/FVC (p<0.001), RV (p=0.012) and RV/TLC (p=0.008) were significantly improved, whereas in the poor responders, significant improvement was seen only FEV1 (p=0.020) (Table S1).

There were significant differences in percentage increase in airway inner luminal area (ΔAi%) of 3rd and 4th generation bronchi even between a non-intervention group and the poor responders (3rd generation: p=0.0075; 4th generation: p=0.0475) (Figure S1).

However, we could not find statistically significant difference in ΔAi% of 5th or 6th generation between a non-intervention group and the poor responders (5th generation: p=0.0824; 6th generation: (p=0.8895).

**Inter-observer variability**

Mean differences in the average values of ΔAi% were -0.51%, -0.65%, -11.0%, and -1.0% for the 3rd, 4th, 5th, and 6th generation bronchi, respectively. Intra-class correlation (ICC) was 66.74% for the average value of ΔAi% of 3rd generation bronchi, 83.38% for
4th generation, 34.38% for 5th generation, and 68.21% for 6th generation bronchi (Figure S2).
<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>After one year</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>RV/TLC, %</td>
<td>48.5±2.4</td>
<td>45.1±1.7</td>
<td>0.601</td>
</tr>
<tr>
<td>RV, l (%predicted)</td>
<td>2.92±0.27</td>
<td>2.89±0.25</td>
<td>0.920</td>
</tr>
<tr>
<td>FRC, l (%predicted)</td>
<td>3.87±0.34</td>
<td>3.95±0.30</td>
<td>0.833</td>
</tr>
<tr>
<td>TLC, l (%predicted)</td>
<td>5.98±0.37</td>
<td>6.33±0.37</td>
<td>0.535</td>
</tr>
<tr>
<td>Dlco/VA, ml/min/mmHg (%predicted)</td>
<td>3.14±0.35</td>
<td>3.25±0.22</td>
<td>0.136</td>
</tr>
<tr>
<td>DLco, ml/min/mmHg (%predicted)</td>
<td>11.31±1.43</td>
<td>9.99±1.62†</td>
<td>0.038</td>
</tr>
<tr>
<td>FEV1/FVC, %</td>
<td>36.9±1.6</td>
<td>38.2±1.5†</td>
<td>0.047</td>
</tr>
<tr>
<td>FEV1, l (%predicted)</td>
<td>1.14±0.09</td>
<td>1.26±0.07 †</td>
<td>0.363</td>
</tr>
<tr>
<td>FVC, l (%predicted)</td>
<td>3.10±0.21</td>
<td>3.27±0.16 ‡</td>
<td>0.139</td>
</tr>
<tr>
<td>IC, l</td>
<td>1.85±0.07</td>
<td>2.32±0.15</td>
<td>0.834</td>
</tr>
<tr>
<td>VC, l (%predicted)</td>
<td>3.01±0.20</td>
<td>3.41±0.16 ‡</td>
<td>0.537</td>
</tr>
</tbody>
</table>

*Data are shown as means ± standard error of mean. †p<0.05, ‡p<0.01.*
References


FIGURE LEGENDS

Figure S1. Comparison of bronchodilation in 3rd to 6th generation bronchi between a non-intervention group and those treated with SFC.

There was a significant difference in percentage increase in airway inner luminal area (ΔAi%) of 3rd and 4th generation bronchi between a non-intervention group and the poor responders or the good responders. A significant difference was also found between ΔAi% of 5th generation bronchi between a non-intervention group and the good responders.

Figure S2. Inter-observer variability in average percentage increases in airway inner luminal area by generation from the 3rd to 6th generation bronchi.

Solid lines and dotted lines represent the values of mean and 2SD, respectively.
Figure S1

- $p < 0.0001$
- $p = 0.0075$

- $p < 0.0001$
- $p = 0.0475$

- $p < 0.0001$
- $p = 0.095$
Figure S2

3rd generation
Difference in ΔAI%
Mean in ΔAI% [%]

4th generation
Difference in ΔAI%
Mean in ΔAI% [%]

5th generation
Difference in ΔAI%
Mean in ΔAI% [%]

6th generation
Difference in ΔAI%
Mean in ΔAI% [%]