Sudden death in asthma

M S ZACH AND U KARNER

Department of Paediatrics, University of Graz, Austria

SUMMARY Two girls with asthma died suddenly in autumn-winter 1985. On clinical criteria, both had been classified as moderately severe asthmatics, had shown a stabilised disease course, and had complied with antiasthmatic medication. By chance, lung function, bronchial reactivity, and subjective perception of lung function impairment had been assessed five and a half months and one month before death, respectively. For comparative purposes, we measured lung function and bronchial reactivity in a reference group of 37 children who had asthma of the same clinical severity and who were taking the same medication. In comparison with this reference group the index subjects showed a high degree of bronchial reactivity, incomplete recovery of function after bronchodilation, and appreciably reduced perception of severe lung function impairment. Regular assessment of lung function, bronchial reactivity, and perception of breathlessness might help to identify the patient who is prone to a fatal attack of asthma.

Childhood asthma is a major health problem, but updated concepts improve the therapeutic approach to the disease. Nevertheless, there are still some children and adolescents who die of asthma, and many of these deaths occur suddenly. While there are organised attempts to identify these patients, such endeavours are hampered by the current lack of the objective data that are needed for identification of the subgroup at risk. There are only a few published lung function measurements from paediatric patients with asthma who later died suddenly; so far, no observations on the bronchial reactivity of these patients have been reported.

We have previously studied the practical value of cold air challenge for measuring bronchial reactivity in children, and now try to assess bronchial reactivity by this method once a year in all our patients with asthma of at least moderate severity. In autumn-winter 1985, two of our patients died suddenly at home, five and a half months and one month after this functional assessment, respectively. The present study reports measurements of lung function and bronchial reactivity in these two index patients and in a reference group with asthma of comparable severity.

Patients and methods

CASE 1 This girl died suddenly at the age of 14.8 years. She had been attending the local asthma clinic for the last two and a half years. Her case history showed extrinsic asthma beginning in the second year of life, three emergency hospital admissions, one hypoinnatesisation course with pollen antigen, and various courses of medication. In the year preceding death her asthma had appeared well stabilised by combined medication with an inhaled β2 sympathomimetic, a topical steroid, and a sustained release theophylline preparation. She attended school regularly and was able to participate in various physical activities. On clinical criteria her asthma was graded to be of moderate severity (grade three on a scale from one to four); her compliance with medication was considered to be good. A one week peak flow protocol, recorded nine months before death, showed moderately wide diurnal variations and night dipping; subsequently her evening dose of the sustained release theophylline was increased, and two puffs of the bronchodilator aerosol were recommended, when waking up at night because of asthma symptoms.

Assessment of lung function and bronchial reactivity was performed five and a half months before death. In addition, the concentration of serum theophylline, and the presence of specific IgE antibodies to 12 common allergens were determined by fluorescence polarisation immunoassay and a radioallergosorbent assay (RAST), respectively (Abbott and Pharmacia Diagnostics). The concentration of
serum theophylline was 84·4 μmol/l, and specific IgE to seven allergens was found positive.

The girl was last seen in the clinic two months before death. Her asthma appeared well stabilised, and spirometry showed moderate expiratory airflow obstruction; her medication regimen was not altered. Death occurred at home at 0·15 hours in a September night; there were no preceding symptoms of a viral infection, allergen exposure, or asthma exacerbation. The sister, sleeping in the same room, observed that the patient had become restless while still being asleep, then had got up from the bed and collapsed. Resuscitation efforts by family members were unsuccessful, and a local physician pronounced her dead 45 minutes later. In compliance with a request by the parents no post-mortem examination was performed.

**CASE 2**

This girl died suddenly at the age of 9·4 years. She had attended the local asthma clinic for the previous four years. Her case history showed extrinsic asthma beginning in the fourth year of life and one emergency hospital admission. In the last year of life her asthma had appeared well stabilised by a combined medication with an inhaled β2 sympathomimetic, a topical steroid, and a sustained release theophylline preparation. She lived with her divorced mother, attended school regularly, and was able to participate in physical activities at school and at a dancing class. On clinical criteria her asthma was graded to be of moderate severity (grade three on a scale from one to four), and her compliance with medication was considered to be satisfactory.

Assessment of lung function and bronchial reactivity was done one month before death. At this time the serum concentration of theophylline was 81·0 μmol/l; antibodies to six of 12 allergens were found by RAST. After this investigation she was instructed how to use a peak flow meter at home and was asked to record her peak expiratory flow rate twice a day and when having symptoms. This was, however, only done for the next five days and was subsequently neglected.

Death occurred at home around 7·00 hours on a November morning. The girl had suffered from a common cold for five days and had told her mother at 6·30 hours that she did not want to go to school because of feeling tired and short of breath. The mother found her lifeless on the floor of her room at about 7·15 hours. After emergency transport to a local hospital, she was pronounced dead on admission. Postmortem examination showed hyper-inflated lungs with extensive mucus plugging of the peripheral airways.

**REFERENCE GROUP**

We recruited patients from the local asthma clinic, who were older than 8 years of age, and suffering from asthma of comparable clinical severity, and who were taking the same antiasthmatic medication as the index patients (β2 sympathomimetic by metered dose inhaler, topical steroid, sustained release theophylline). This resulted in a reference group of 37 patients (28 boys, nine girls) with a mean age of 11·8 years (range 8·3 to 15·2).

**ASSESSMENT OF LUNG FUNCTION AND BRONCHIAL REACTIVITY**

Measurements in index and reference group patients were part of a routine programme and followed the same protocol. Informed consent by patients and parents was a prerequisite for all measurements. Functional assessment was done in a stable clinical condition twice within 10 days. Patients arrived at 9·00 hours, rested for 30 minutes, and then had baseline lung function testing.

At the first visit patients then inhaled a sympathomimetic β2 bronchodilator (salbutamol, 0·02 ml of the 0·5% solution per kg of body weight) from a jet type nebuliser (Inhalerboy). Fifteen minutes after bronchodilator inhalation lung function testing was repeated.

Before the second visit, the sustained release theophylline medication was withheld for four days and the sympathomimetic for 12 hours. After baseline lung function testing, patients underwent a standardised cold air challenge according to a method described previously, administered by a commercially available heat exchanger (RHES, Jaeger), which was set to apply absolutely dry air with a temperature of −10°C. Each challenge consisted of four minutes of isocapnic hyperventilation at 75% of maximal voluntary ventilation. The response was assessed by lung function testing three minutes after the termination of the cold air challenge. In addition, the patients were asked before and after the cold air challenge to score their subjective feeling of chest tightness as 'none', 'mild', 'moderate', or 'severe'.

Pulmonary function tests for baseline determinations and for measuring the responses were done on a pneumotachygraph spirometer (Pneumotest Junior, Jaeger). The patients performed several forced vital capacity manoeuvres, which were recorded in form of a maximum expiratory volume time and flow volume curve. Forced expiratory volume in the first second (FEV1) and maximum expiratory flow at 25% remaining vital capacity (Vmax25) were measured and expressed as percent of predicted normal values. Thro thus investigation resulted in two baselines,
one measurement after the bronchodilator and one after the cold air challenge. These measurements were then interpreted according to a previously described concept of 'functional dimensions'. Dimension one is baseline lung function. The second dimension is the level of function after bronchodilator medication, termed 'functional optimum'. Dimension three is a 'functional minimum', defined as a reproducible minimum function at maximum response to a standardised cold air challenge. The 'range of reactivity' is the distance from optimum to minimum.

Furthermore a 'perception score' was calculated for the pulmonary function tests before and after cold air challenge by multiplying the baseline and the post cold air challenge measurements (in percent predicted) with the subjective perception. For this purpose, a value of 1 was assigned to 'no', 2 to 'mild', 3 to 'moderate', and 4 to 'severe chest tightness'. Thus a low perception score stems from the combination of a low lung function measurement and underperception.

**Results**

Lung function from index patients and the reference group are compared in the table. Baseline function was better at the first visit—that is, on full treatment—than at the second visit—that is, without preceding bronchodilator medication. The second baseline measurements of case 1 were in the lower part and those of case 2 below the reference range. After the β2 bronchodilator (functional optimum), both index patients normalised their FEV1, but failed to completely normalise their Vmax25; thus they compared with the lower half of the reference range. After cold air challenge (functional minimum), both index patients showed a pronounced further increase of expiratory airflow obstruction and thus compared with the lower end of the reference range. The resulting range of reactivity (distance optimum to minimum) of the two index patients was in the middle of the reference range for Vmax25, and in the upper part of the reference range for FEV1. For all lung function situations assessed, both index patients as well as the reference group showed a tendency towards more obstruction in Vmax25, than in FEV1.

The perception score assessed at baseline and the functional minimum is shown in the figure. Both index patients were below or at the lower end of the reference range for both functions.

**Discussion**

This study shows that two patients, who subse-
Sudden death in asthma

The present study employed FEV$_1$ and end expiratory flow for characterising large and small airway obstruction respectively. In both index patients and in the reference group as well, V$_{max25}$ was found more compromised than FEV$_1$. Further-

1. Abuse of adrenergic medication,
2. Unsuspected pathology, especially tension pneumothorax, is unlikely in our two patients, but cannot be definitely excluded for case 1. Abuse of adrenergic aerosols can be excluded for causing the death of case 1, and remains a somewhat unlikely causative factor for the death of case 2. It therefore appears reasonable to assume that both index cases are true examples of 'sudden death in asthma'.

4. The present study employed FEV$_1$ and end expiratory flow for characterising large and small airway obstruction respectively. In both index patients and in the reference group as well, V$_{max25}$ was found more compromised than FEV$_1$. Further-

1. The present study employed FEV$_1$ and end expiratory flow for characterising large and small airway obstruction respectively. In both index patients and in the reference group as well, V$_{max25}$ was found more compromised than FEV$_1$. Further-

2. Unsuspected pathology, especially tension pneumothorax, is unlikely in our two patients, but cannot be definitely excluded for case 1. Abuse of adrenergic aerosols can be excluded for causing the death of case 1, and remains a somewhat unlikely causative factor for the death of case 2. It therefore appears reasonable to assume that both index cases are true examples of 'sudden death in asthma'.

3. At present, any comparative discussion of different treatment strategies for the fatality prone asthma patient remains a speculative one.
more, in neither of the index patients was \( V_{max25} \) normalised after the bronchodilator. Correspondingly, another report on bronchodilator induced lung function changes in children who later died of asthma showed incomplete or absent responses for forced mid expiratory flow rates.\(^3\) These observations correlate with the concept of childhood asthma as a disease of the small airways.\(^2\) Inclusion of small airway related lung function measurements into the evaluation of paediatric asthma patients might be useful for better characterising disease severity.

In conclusion, we observed pronounced airway hyper-reactivity and severe underperception of airflow obstruction in two children with asthma who later died suddenly. These two observations do not suffice for a general explanation of sudden death in childhood and adolescent asthma. They do, however, suggest that repeated assessments of airway reactivity, complemented by the patient’s subjective scoring of breathlessness, might be a promising approach towards better defining those children prone to sudden death from asthma.

References


Correspondence to Professor MS Zach, Univ. KinderKlinik Graz, Auenbruggerplatz, A-8036 Graz, Austria.

Accepted 11 April 1989

Commentary

S MCKENZIE

Rush Green Hospital, Romford, Essex

Much has been written about the shortcomings in the care of asthmatics who have died in this country. The British Thoracic Association’s review identified only 10 of 90 asthmatics in whom death was considered unavoidable.\(^1\) It would be impossible, however, to test whether management is more deficient in those who die than in asthmatics in general because of the difficulty in recruiting controls from the same practice. Carswell, in a review of 30 deaths in children, concluded that inadequate management had probably contributed to many of these deaths.\(^2\) Twelve of the 30 children had never attended hospital. Speight and colleagues in 1983 highlighted the problem of underdiagnosis and undertreatment of childhood asthma;\(^3\) one wonders what overall effect educational programmes have since had in addressing this very serious problem. Two American studies of asthma deaths in children drew attention to the unsatisfactory psychosocial profiles of many of the patients and their families, which resulted in erratic treatment.\(^4\) It is difficult to compare the American experience with that in Britain because of
Sudden death in asthma.

M S Zach and U Karner

Arch Dis Child 1989 64: 1446-1451
doi: 10.1136/adc.64.10.1446

Updated information and services can be found at:
http://adc.bmj.com/content/64/10/1446

Email alerting service

These include:
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/