Assessing the feasibility and acceptability of online measurements of exhaled volatile organic compounds (VOCs) in children with preschool wheeze: a pilot study

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ABSTRACT

Background  Investigating airway inflammation and pathology in wheezy preschool children is both technically and ethically challenging. Identifying and validating non-invasive tests would be a huge clinical advance. Real-time analysis of exhaled volatile organic compounds (VOCs) in adults is established, however, the feasibility of this non-invasive method in young children remains undetermined.

Aim  To determine the feasibility and acceptability of obtaining breath samples from preschool children by means of real-time mass spectrometry analysis of exhaled VOCs.

Methods  Breath samples from preschool children were collected and analysed in real time by proton transfer reaction–time of flight–mass spectrometry (PTR–TOF–MS) capturing unique breath profiles. Acetone (mass channel m/z 59) was used as a reference profile to investigate the breath cycle in more detail. Dynamic time warping (DTW) was used to compare VOC profiles from adult breath to those we obtained in preschool children.

Results  16 children were recruited in the study, of which eight had acute doctor-diagnosed wheeze (mean range age 3.2 (1.9–4.5) years) and eight had no history of wheezing (age 3.3 (2.2–4.1) years). Fully analysable samples were obtained in 11 (68%). DTW was used to ascertain the distance between the time series of mass channel m/z 59 (acetone) and the other 193 channels. Commonality of 12 channels (15, 31, 33, 41, 43, 51, 53, 55, 57, 60, 63 and 77) was established between adult and preschool child samples despite differences in the breathing patterns.

Conclusion  Real-time measurement of exhaled VOCs by means of PTR–MS is feasible and acceptable in preschool children. Commonality in VOC profiles was found between adult and preschool children.

INTRODUCTION

Wheezing in the preschool years is extremely common.1 This group of children represent a diagnostic challenge because they cannot easily perform reliable lung function testing. Furthermore, invasive investigations such as bronchoscopy and obtaining samples by bronchoalveolar lavage are not warranted or justifiable in the vast majority of cases. A reliable biomarker associated with steroid-responsive disease, such as sputum or blood eosinophils in adults, has yet to be identified in children.2 3 As such, there is a clear mandate for the identification and validation of non-invasive means of assessing airway inflammation and pathology in these young children.

The area of breath metabolomics, often referred to as ‘breathomics’ is a rapidly developing technology used to assess respiratory conditions, with promising results in patients with lung cancer,4 cystic fibrosis5 and asthma.6 Metabolites are either released into the blood stream following metabolic processes in tissue or generated directly in the lung such as nitric oxide resulting from...
Methods

Study population

Children were recruited from the Leicester Royal Infirmary, UK, aged between 2 and 6 years inclusive with acute wheezing symptoms and controls of the same age range with no wheezing symptoms. Diagnosis of acute wheeze and the decision to be deemed clinically safe to participate was made by the treating physician. For comparison, samples of breath taken from adult patients attending the emergency department at the Leicester Royal Infirmary, UK, were included.

Study protocol

Selection phase

The selection phase for the preschool breath samples was conducted over a 10-month period (predominately June and July 2015). Eligible children and their families were approached by a research physician and provided with patient information sheets and given 1 hour to review the information before consenting to participate. A random selection of the breath samples collected from adults attending the emergency department at Leicester Royal Infirmary over a 2-month period was used for comparison.

Sample collection phase

A 10-min acclimatisation period was given in the sample collection room, which was a quiet and calm setting to enable the participant to become familiar with the breath sampler and the face mask/apparatus. After this period, a background sample was taken for 80s.

The children were fitted with a disposable, size-appropriate facemask (Intersurgical, Wokingham, Berkshire, UK) attached to an electrostatic bacterial/viral filter (Flexicare Medical Limited, Mountain Ash, Mid Glamorgan, UK) which was connected to the Loccioni breath sampling apparatus (Loccioni Human Care, Sofia, Incentive and Tidal Breath Samplers, Italy). A diagram of the instrument set-up is shown in figure 1. Children performed tidal breathing through the facemask connected to a non-rebreathing valve system, while games, books and toys were provided for them to be distracted with. Measurement of the exhaled VOCs was taken for 80s with repeat samples being taken using the same process as above after 15 min. The PTR–MS instrumentation was used as described previously in detail by Blake et al.20 The sample line between the apparatus and the instrument was heated to 40°C to avoid condensation, reducing loss of VOCs and a heated blanket (Infroheat Limited, Wolverhampton, UK) surrounded the entire sampling apparatus, which was also heated to 40°C. The heated transfer line was connected to the PTR–TOF–MS. The TOF–MS monitored all of the mass channels (m/z) simultaneously, providing real-time VOC profiles across a mass range of m/z 15–230. Each m/z is the mass of an ion (m) relative to its charge (z).

Breath profile and data analysis

To ensure any variations observed in the exhaled VOCs between individuals were not an artefact of variations in the background or variations in the abundance of the primary reagent ion (H₃O⁺), the data were normalised as described by Wyche et al.27 (using the same m/z), which is an accepted practice within the field of PTR–MS, and the background signal subtracted.

Acetone (m/z 59) was chosen as a reference signal for comparison of VOCs which related to the breath cycle owing to its abundant signal in breath, typically >100 ppbV.22,23 While investigating concentrations and distribution of volatile metabolites in the exhaled breath of healthy adult volunteers, Spanel et al.24 identified acetone as one of the compounds found in higher concentrations with median values of 363
Acetone thus appears to be a good candidate to monitor the breath cycle, as a potentially suitable control compound to identify other compounds/mass channels that specifically vary with the respiratory cycle. Each breath sample was screened for adequacy by assessing the time profile of m/z 59. Poor samples with no recognisable trace for the m/z 59 spectrum matching the capnography profile (recorded by the sampler) were discarded at this point without further analysis.

Dynamic time warping (DTW) was used to obtain the distance between the time series of mass channel m/z 59 (acetone) and the remaining mass channels. The DTW library in R was used to perform DTW. The underlying principle behind DTW is to compare two time series; a test series X and a reference series Y, with the dissimilarity (the DTW distance) between the two series being the extent to which the two series must be deformed or warped in order that the two series resemble each other. The DTW distance provides a very useful measure of similarity between time series and has advantages over the Euclidean distance in that it can accommodate situations where the time axis is not aligned. We used DTW as a measure of similarity between children and adult breath samples as this allows comparison of VOC profiles despite differences in level and pattern of detection.

**RESULTS**

**Participants**

During the study period 54 families were screened of whom 16 met the inclusion criteria and provided written, informed consent to participate in this study. Table 1 displays the demographic and clinical characteristics of the eight preschool children with wheeze and eight controls recruited. Diagnosis of control patients included foreign body in the nose (n=2), fever of unknown origin (n=1), musculoskeletal injury (n=2), swallowed foreign body (n=1), gastrostomy (n=1) and pneumonia (n=1). Eleven of the 16 children recruited (68%, 95% CI 0.44 to 0.86) were able to provide fully analysable breath samples, seven within the acute preschool wheeze group and four within the control group. Five children did not produce a fully analysable sample because they did not keep the facemask on for long enough to allow collection of sufficient breath data. There was no difference between group (preschool wheeze vs control), age or other demographics in ability to produce an analysable sample. None of the children were distressed by the procedure and the procedure was deemed safe by the

![Figure 1](Illustration of apparatus setup)

![Figure 3](Example of channel 59 (acetone) for a preschool child and an adult. These figures show that when using acetone (ie, an abundant VOC in exhaled breath) as a marker, the adult trace has a regular pattern that represents tidal breathing. In the preschoolers, it is clear that the pattern is irregular, however, the trace for acetone has a similar pattern which corresponds to the capnography trace demonstrating that this methods is measuring exhaled breath VOCs in real time despite the irregular pattern of tidal breathing. VOC, volatile organic compound.)

![Figure 2](Illustration of apparatus setup)
medical and the research team with no adverse incidents reported (0%, 95% CI 0 to 0.19).

A total number of nine adult samples were selected at random from >170 samples for comparison. The mean age of these adult subjects was 54.1 years (range 33–78). The presentations of the adults included were; chest pain (n=1), gastrointestinal bleed (n=3), back pain (n=2), collapse (n=1), head injury (n=1) and breathlessness (n=1).

Figure 2 shows an example time profile of m/z 59 (acetone) in a preschool child (a) and its accompanying capnography trace (b) to highlight how the peaks on the time profile for acetone correspond with exhalation. This is compared with an adult sample (figure 3) and it is apparent that the profiles differ in that the adult sample shows smooth tidal breathing with a regular pattern emerging compared with the more irregular pattern in the profile of the preschool child. However, the comparable peaks of the mass spectrometric data with the capnography data illustrate that the mass spectrometer is analysing the exhaled breath of the preschool child in real time, providing instantaneous data.

**DTW distance of mass channels from m/z 59**

An example of DTW for m/z 59 and 15 is illustrated in figure 4 The average DTW distance of each mass channel from m/z 59 for all the child and adult samples were ranked from smallest to the largest, the top 20 are shown in Figure 5.

**DISCUSSION**

The principle aim of the study was to assess the feasibility and acceptability of collecting and analysing breath samples from preschool children using real-time PTR-TOF-MS. We found that breath sampling in young children was well tolerated. Methods of distraction and maintaining a calm environment resulted in the successful
exchange within the conductive air
coefficient acetone and other channels is similar between adults and
is not surprising that they produce different VOC profiles.
Laboratory pattern is different in children and adults hence it
produced by paediatric and adult participants. The respira-
tory pattern.
as tidal breathing reflects the child’s normal breathing
with acute wheezing and minimal expiration was needed
in leaks and failure to collect a fully analysable sample.
This approach was clinically safe in children admitted
with acetone having a blood:air partition coefficient >100, that is, its high solubility allows for some
exchange within the conductive airways, its abundance
in breath provides a clear exhalation profile. Figure 1
demonstrates the use of acetone as a marker herein for
assessing the breath profile. The end-tidal portion of the
breath is often targeted as the desired portion of breath
to analyse as it is believed to best represent VOCs from
the alveolar region which best represent the metabolites
endogenous to the body.

Differences were observed in the sample profiles
produced by paediatric and adult participants. The respira-
tory pattern is different in children and adults hence it
is not surprising that they produce different VOC profiles.
We show, however, that the relationship between the
acetone and other channels is similar between adults and
children. Despite acetone having a blood:air partition
coefficient >100, that is, its high solubility allows for some
exchange within the conductive airways, its abundance
in breath provides a clear exhalation profile. Figure 1
demonstrates the use of acetone as a marker herein for
assessing the breath profile. The end-tidal portion of the
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to analyse as it is believed to best represent VOCs from
the alveolar region which best represent the metabolites
endogenous to the body.

An important finding from this study is that we were
able to collect samples of breath from preschool chil-
dren and analyse them using online PTR–TOF–MS. The
real-time similarity measurement from DTW provides a
measure for comparing VOC profiles by correcting for
differences in breathing pattern. Despite the differences
in breathing patterns, of the top 10 VOC profiles based
on the DTW scores, eight were common to both children
and adults.

Limitations
We acknowledge that this is a single-centre pilot study
in which children and adults were recruited from acute
settings, mainly the emergency department. There is a
potential for selection bias since the apparatus is oper-
ated by trained personnel, therefore patients could only
be recruited at times when these staff were present. For
those preschool children who were unable to provide
an analysable sample, we did not perform interviews
or administer questionnaires as part of this study. We
acknowledge that this may have provided valuable feed-
back, however, this had not formed part of our research
ethics committee application. Furthermore, there is
unexplained variation in the PTR–TOF–MS profiles, and
we do not know the relative contribution of disease factors
to the pattern of VOCs we found because of the small
pilot sample size. Equally, the contribution of patient
factors such as respiratory rate or pattern, body mass and
medication taken to VOC profiles was not attributable.
In order to avoid experimental factors influencing the
breath profiles as much as possible, the PTR–TOF–MS
setup was kept constant for all children. The sampling
lines, and breath device were kept small to reduce dead
volume and the use of a ToF–MS detector ensured a fast
and consistent acquisition rate. The use of DTW allowed
assessment independent of breathing rate.

There are several key areas that need to be further
explored in relation to this technology in young chil-
dren. It is important that we understand why some
groups of mass channels vary with the breath cycle (in
both adults and children) and why others do not. Due
to the more irregular breathing pattern in children, the
end-expiratory phase of the breath cycle is harder to
identify and an alternative may be to analyse throughout
the entire breath cycle. Furthermore, the influences
of different breathing patterns, environment, season,
time of day, medication and disease phenotype need to
be explored. This requires breath samples from large
cohorts of children.

In summary, we investigated the feasibility of real-time
breath sampling in a pilot study involving preschool chil-
dren and found it an acceptable method for capturing
breath profiles in the majority of patients. We found
commonality of VOC profiles detected by online PTR–
TOF–MS in preschool children and adults. This combined
with over two-thirds of preschool children providing an
adequate sample demonstrates that this technology has
potential as a non-invasive method to study metabolic
processes associated with disease in preschool children.

Contributors KH, MM, PM, TC and EAG designed the study. MM and KH recruited
the participants and collected data. MM, MW and MR analysed the data. KH, MM
and MW prepared the manuscript with MW and MR creating the figures. The final
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REFERENCES


