



The Prognostic Performance of Lung Diffusing Capacity in Preserved Ratio Impaired Spirometry: An Observational Cohort Study

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Purpose: Similar to chronic obstructive pulmonary disease (COPD), the diffusing capacity of the lung (D_{LCO}) might be decreased and associated with poor prognosis in preserved ratio impaired spirometry (PRISm), a clinical entity as a prodromal phase of COPD. The aims of the present study were to evaluate the distributions of D_{LCO} and to assess the association between D_{LCO} and mortality among subjects with PRISm.

Patients and Methods: We conducted an observational cohort study at the National Hospital Organization Fukuoka National Hospital. We classified the 899 patients ≥ 40 years of age with an assessment of D_{LCO} into five groups based on spirometry: preserved spirometry, PRISm, mild COPD, moderate COPD, and severe/very severe COPD. The prevalence of low D_{LCO} ($< 80\%$ per predicted) was compared among the five groups. Using PRISm patients with follow-up data, we further investigated the association of low D_{LCO} with all-cause mortality.

Results: The prevalence of low D_{LCO} in the PRISm group (58.8%) was significantly higher than that in the preserved-spirometry group (21.8%), the mild-COPD group (23.5%), and the moderate-COPD group (36.0%) (all $P < 0.01$), and it was comparable to that in the severe/very severe-COPD group (63.2%). The results remained unchanged after adjusting for potential confounders. Among the PRISm subjects, the overall survival rate was significantly lower in the low- D_{LCO} group than in the preserved- D_{LCO} group ($P < 0.01$). The multivariable-adjusted hazard ratio (HR) for all-cause mortality was significantly higher in the low- D_{LCO} group than in the preserved- D_{LCO} group (HR = 10.10 (95% confidence interval 2.33–43.89)).

Conclusion: Diffusing capacity was more impaired in PRISm subjects than in those with preserved spirometry or mild to moderate COPD. Regarding PRISm, low D_{LCO} was a significant risk factor for all-cause mortality. Clinicians should assess D_{LCO} in the management of PRISm to predict the future risk of overall death.

Keywords: preserved ratio impaired spirometry, chronic obstructive pulmonary disease, diffusing capacity of the lungs, all-cause mortality

Introduction

Preserved ratio impaired spirometry (PRISm), also referred to as restrictive pattern or unclassified spirometry, is a clinical entity associated with an increased risk of developing chronic obstructive pulmonary disease (COPD).^{1,2} Epidemiological studies worldwide revealed that 3.7–22.3% of the general population were compatible with PRISm,^{3–11} indicating that PRISm is a common disease condition. Considering its high prevalence and clinical aspects as a prodromal phase of COPD, PRISm, whose pathophysiology is still largely unknown, is an increasing threat to public health. Since the diffusing capacity of the lung for carbon monoxide (D_{LCO}), a useful biomarker for evaluating the gas transfer properties of the respiratory system,¹² is generally deficient in COPD,¹³ it might be also impaired in cases of PRISm. However, this issue has not yet been investigated.

PRISm has been demonstrated to be associated with an increased risk of premature mortality,^{2,3,11,14} although little is known about the predictive biomarkers for death in PRISm. Since a deficit in D_{LCO} is a strong risk factor for a poor prognosis in COPD,¹⁵ D_{LCO} may also be inversely associated with morbidity and mortality in PRISm. However, there has been no study assessing the influence of D_{LCO} on mortality in subjects with PRISm; therefore, the verification of this hypothesis could be of great benefit for improving the clinical management for such patients.

Based on these considerations, we conducted the present study to evaluate the prevalence of reduced D_{LCO} in subjects with PRISm and to compare it with that in cases of normal spirometry or COPD. We also assessed the clinical implication of D_{LCO} impairment as a biomarker for all-cause mortality among subjects with PRISm.

Materials and Methods

Study Population

The current study was conducted as an observational cohort study through a review of medical records at the National Hospital Organization Fukuoka National Hospital. The entire cohort consisted of 899 patients ≥ 40 years of age who had a D_{LCO} assessment from June 1, 2017, to May 31, 2020, regardless of department, with complete information on all relevant covariates. We classified the subjects into five groups based on the results of spirometry: preserved spirometry, PRISm, mild COPD, moderate COPD, and severe/very severe COPD. PRISm was defined as the coexistence of two major criteria: (i) post-bronchodilator forced expiratory volume in 1 second to forced vital capacity (post-BD FEV_1/FVC) $\geq 70\%$; and (ii) reduction in FEV_1 , that is, post-BD FEV_1 per predicted ($FEV_1\%$ pred) $< 80\%$.³ According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) criteria,¹⁶ the severity of COPD was defined as follows: mild, $FEV_1\%$ pred $\geq 80\%$; moderate, $50\% \leq FEV_1\%$ pred $< 80\%$; severe and very severe, $FEV_1\%$ pred $< 50\%$.

The distribution of D_{LCO} per predicted ($D_{LCO}\%$ pred) and the prevalence of low D_{LCO} by lung function category were evaluated as a cross-sectional analysis using the total cohort. With regard to PRISm, we further investigated the association of low D_{LCO} with all-cause mortality using 111 patients (the PRISm cohort), excluding 8 patients with no follow-up data. For each case in the PRISm cohort, mortality data were collected from June 1, 2017, to December 31, 2021.

Assessment of the Diffusing Capacity and Transfer Coefficient of the Lungs

D_{LCO} and D_{LCO} per alveolar volume (D_{LCO}/V_A) were measured via the single-breath method using a CHESTAC-8900 spirometer (Chest MI, Inc., Tokyo, Japan) in accordance with the American Thoracic Society/European Respiratory Society (ATS/ERS) guidelines.¹⁷ $D_{LCO}\%$ pred and $D_{LCO}/V_A\%$ pred were calculated using the predicted values of D_{LCO} and D_{LCO}/V_A for a person of the same age, gender, and body surface area.¹⁸ In accordance with the clinical review article,¹³ low D_{LCO} was defined as $D_{LCO}\%$ pred $< 80\%$. In the same manner, low D_{LCO}/V_A was defined as $D_{LCO}/V_A\%$ pred $< 80\%$. When dividing the PRISm cohort into three groups based on the tertile distribution of $D_{LCO}\%$ pred, the cut-off values were as follows: lowest, $< 64.0\%$; middle, $64.0\text{--}85.4\%$; and highest, $\geq 85.5\%$ for $D_{LCO}\%$ pred.

Clinical Evaluations

For each case, respiratory physicians reviewed the patient's medical records and assessed the demographic and clinical characteristics: age, gender, height, weight, smoking exposure, and spirometry. Body mass index (BMI; kg/m^2) was calculated as weight divided by height squared. Taking into consideration the guidelines for diagnosing obesity in Japanese subjects,¹⁹ obesity, normal weight, and underweight were defined as BMI $\geq 25.0\text{ kg}/\text{m}^2$, 18.5 to $< 25.0\text{ kg}/\text{m}^2$, and $< 18.5\text{ kg}/\text{m}^2$, respectively. Spirometry was performed before and 15 minutes after BD administration (ie, $200\text{ }\mu\text{g}$ of salbutamol), in line with the guidelines of the Japanese Respiratory Society,²⁰ using CHESTAC-8900. Bronchial reversibility was defined as $\geq 12\%$ and $\geq 200\text{ mL}$ reversibility in post-BD FEV_1 . The predicted values of FEV_1 and slow vital capacity (SVC) for a person of the same age, gender, and height were estimated with the equation for the Japanese population.²¹

Statistical Analysis

R software version 4.1.2 (R Foundation for Statistical Computing, Vienna, Austria) was used to perform all statistical analyses. Two-sided $P < 0.05$ was considered to indicate statistical significance. For baseline characteristics, the

heterogeneity in each variable among the lung function categories was evaluated using the analysis of variance (ANOVA), chi-square test, or Kruskal–Wallis test. Tukey’s test, logistic regression analysis, or the Mann–Whitney *U*-test with Bonferroni correction was used to assess the statistical difference between the PRISm group and any of the other groups. The heterogeneity in the distribution of D_{LCO} % pred and D_{LCO}/V_A % pred across the lung-function categories was also analyzed using an ANOVA. Stratified analysis was performed according to BMI levels or smoking status. The prevalences of low D_{LCO} and low D_{LCO}/V_A were calculated for each lung-function group and compared using unadjusted and multivariable-adjusted logistic regression models and estimated as odds ratios (ORs) with 95% confidence intervals (95% CIs). Adjustments were made for age, gender, BMI, and smoking exposure. We performed a sensitivity analysis after excluding subjects with bronchial reversibility in order to exclude asthmatic patients. Kaplan–Meier curves were constructed to show the overall survival by the levels of D_{LCO} % pred and D_{LCO}/V_A % pred. Log rank testing was performed to study the influence of low D_{LCO} and low D_{LCO}/V_A on all-cause mortality. The trend in overall survival according to the tertile groups of D_{LCO} % pred was assessed with a Cox proportional hazards model. The multivariable-adjusted hazard ratios (HRs) with their 95% CIs of each level of D_{LCO} % pred or D_{LCO}/V_A % pred for all-cause death were estimated using a Cox proportional hazards model adjusted for all aforementioned potential confounders. The same model was used to assess the linear trends in the risk of all-cause death across the tertile groups of D_{LCO} % pred.

Ethical Considerations

The study was approved by the National Hospital Organization Fukuoka National Hospital Institutional Review Board for Clinical Research (#F4-2). The study was conducted in accordance with the Declaration of Helsinki. Informed consent was waived due to the retrospective nature of the study. All the data was anonymized for covering the patient data confidentiality and participant privacy.

Results

Level of D_{LCO} % Pred and Prevalence of Low D_{LCO} for Each Lung-Function Group

The prevalence of PRISm was 13.2% among the entire cohort. [Table 1](#) lists the demographic and clinical characteristics of the total cohort. Among the five lung function groups, the prevalence of male gender, the mean age, the mean BMI, and the amount of smoking exposure were not prominent in the PRISm group. Meanwhile, the mean values of absolute SVC and SVC % pred were lowest in the PRISm group.

[Figure 1](#) shows the level of D_{LCO} % pred for each lung-function group. The mean values of D_{LCO} % pred were 98.4%, 73.9%, 99.3%, 89.4%, and 71.0% in the preserved-spirometry group, the PRISm group, the mild-COPD group, the moderate-COPD group, and the severe/very severe-COPD group, respectively. In the PRISm group, D_{LCO} % pred was significantly lower than in the other lung function groups except for in the severe/very severe-COPD group. Likewise, the prevalence of low D_{LCO} was significantly higher in subjects with PRISm than in those with preserved spirometry, mild COPD, or moderate COPD (all $P < 0.01$); it was as high as about 60% in the PRISm group and the severe/very severe-COPD group ([Figure 2](#)). The results were substantially similar after adjustments for potential confounders; there was a significant increase in OR in the PRISm group as compared to the preserved-spirometry group, the mild-COPD group, and the moderate-COPD group (all $P < 0.01$) ([Table 2](#)). Broadly similar results were obtained in the analysis stratified by BMI levels ([Supplementary Figures S1](#) and [S2](#)) or smoking status ([Supplementary Figures S3](#) and [S4](#)). The results were not substantially changed after excluding asthmatic subjects ([Supplementary Figures S5](#) and [S6](#)). Further, there was no significant decrease in the level of D_{LCO}/V_A % pred or increase in the prevalence of low D_{LCO}/V_A in the PRISm group compared to the group with preserved spirometry, mild COPD, or moderate COPD (all $P > 0.05$) ([Supplementary Figures S7](#) and [S8](#)).

D_{LCO} % Pred and Risk of All-Cause Mortality in PRISm

In the PRISm cohort, all-cause death occurred in 27 of 111 individuals (24.3%) with a median follow-up of 899 days (interquartile range 335–1378). As shown in [Figure 3A](#), the overall survival rate was significantly lower in the low- D_{LCO}

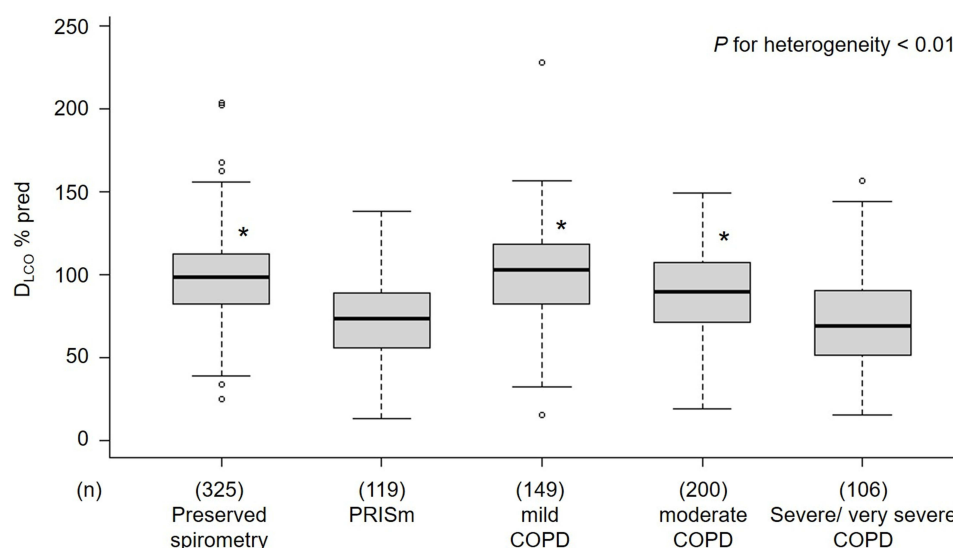
Table I Demographic and Clinical Characteristics of Study Subjects by Lung Function Category

Variables	Preserved Spirometry (n = 325)	PRISm (n = 119)	Mild COPD (n = 149)	Moderate COPD (n = 200)	Severe/Very Severe COPD (n = 106)	P for Heterogeneity
Male gender (%)	53.2	59.7	77.2 [†]	70.5*	83 [†]	< 0.01
Age (years)	67 (12)	68 (10)	70 (9)	70 (10)	72 (9)*	< 0.01
Height (cm)	161 (9)	161 (9)	163 (7)	162 (9)	161 (9)	0.07
Weight (kg)	60.4 (12.1)	59.4 (17.3)	61.4 (10.3)	61.6 (10.7)	55.8 (11.7)	< 0.01
BMI (kg/m ²)	23.3 (3.9)	22.8 (5.6)	23.0 (3.2)	23.4 (3.5)	21.4 (3.4)	< 0.01
Obesity (%)	30.5	24.4	20.8	28.0	16.0	0.02
Smokers (%)	58.2	63.9	78.5 [†]	77.5 [†]	89.6 [†]	< 0.01
Smoking history (pack/year)	10 (0–32)	24 (0–44)	35 (8–49)	38 (10–57)*	41 (25–61) [†]	< 0.01
FEV ₁ (l)	2.44 (0.64)*	1.64 (0.45)	2.36 (0.49) [†]	1.66 (0.41) [†]	0.95 (0.31) [†]	< 0.01
FEV ₁ per predicted (%)	98.3 (12.3) [†]	66.4 (11.9)	91.7 (8.6) [†]	65.8 (8.2)	37.9 (8.9) [†]	< 0.01
FEV ₁ /FVC (%)	79.6 (6.3)*	82.0 (9.2)	63.9 (4.6) [†]	56.9 (8.5) [†]	37.5 (10.6) [†]	< 0.01
Bronchial reversibility (%)	3.7	5.0	10.7	10.5	4.7	< 0.01
SVC (l)	3.05 (0.82) [†]	2.01 (0.63)	3.62 (0.76) [†]	2.86 (0.77) [†]	2.42 (0.71) [†]	< 0.01
SVC per predicted (%)	92.4 (13.8) [†]	60.9 (14.4)	103.9 (11.2) [†]	84.1 (13.8) [†]	71.3 (15.3) [†]	< 0.01

Notes: * $P < 0.05$ versus the PRISm group. [†] $P < 0.01$ versus the PRISm group. Age, height, weight, BMI, FEV₁, FEV₁ per predicted, FEV₁/FVC, SVC, and SVC per predicted are given as the mean with standard deviations. Smoking history is shown as the median with an interquartile range because of the skewed distributions. Other variables are given as percentages. Obesity was defined as BMI ≥ 25.0 kg/m². Smokers were defined as past or current smokers. Bronchial reversibility was defined as $\geq 12\%$ and ≥ 200 mL reversibility in post-BD FEV₁.

Abbreviations: PRISm, preserved ratio impaired spirometry; COPD, chronic obstructive pulmonary disease; BMI, body mass index; FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity; SVC, slow vital capacity.

group than in the preserved-D_{LCO} group ($P < 0.01$). There was a significant linear trend in the association between D_{LCO} % pred and overall survival ($P < 0.01$ for the trend) (Figure 3B). A more significant increase in multivariable-adjusted HR for all-cause mortality was observed in the low-D_{LCO} group than in the others (HR = 10.10 (95% CI 2.33–43.89)) (Figure 4A). In the same analysis, the multivariable-adjusted HR of smoking failed to reach statistical significance ($P = 0.27$). Similarly, the multivariable-adjusted HR for all-cause death was elevated as D_{LCO} % pred decreased ($P < 0.01$ for the trend); as compared with the highest tertile group, the HR was significantly higher in the lowest tertile group (HR =

**Figure I** Level of D_{LCO} % pred by lung-function group.

Note: * $P < 0.01$ versus the PRISm group.

Abbreviations: D_{LCO} % pred, diffusing capacity of the lung for carbon monoxide per predicted; PRISm, preserved ratio impaired spirometry; COPD, chronic obstructive pulmonary disease.

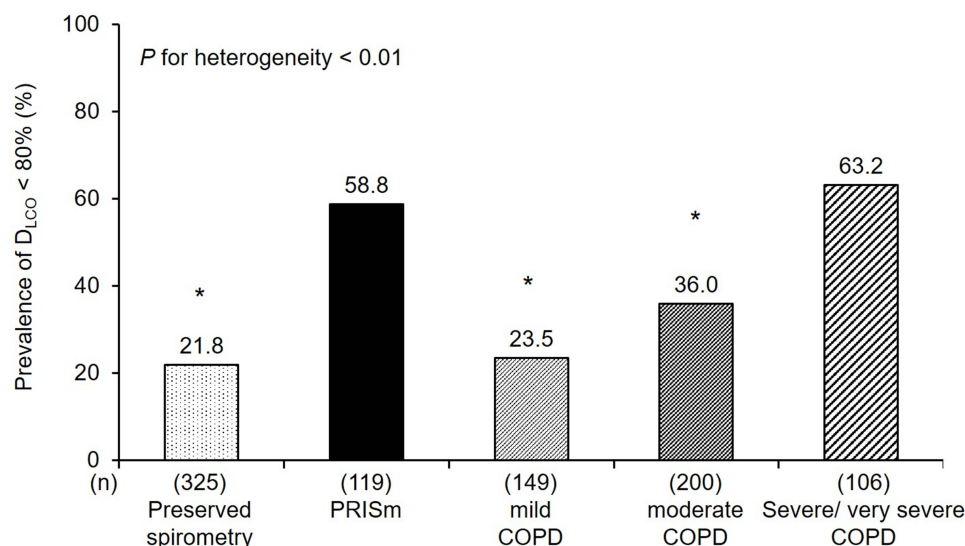


Figure 2 Prevalence of low D_{LCO} by lung-function group.

Notes: * $P < 0.01$ versus the PRISm group. Low D_{LCO} was defined as $D_{LCO} \% \text{ pred} < 80\%$.

Abbreviations: D_{LCO} , diffusing capacity of the lung for carbon monoxide; PRISm, preserved ratio impaired spirometry; COPD, chronic obstructive pulmonary disease.

15.33 (95% CI 3.39–69.37), $P < 0.01$) (Figure 4B). Statistical significance was also observed in the associations between low D_{LCO}/V_A and all-cause mortality (multivariable-adjusted HR = 4.23 (95% CI 1.70–10.50)) (Supplementary Figures S9 and S10).

Discussion

The present study revealed a higher prevalence of low D_{LCO} in patients with PRISm than in those with normal spirometry, mild COPD, or moderate COPD. The diffusing capacity in PRISm was at the same level as in severe COPD. The results were consistent across BMI levels. Our study also showed that impaired $D_{LCO} \% \text{ pred}$ was a significant risk factor for all-cause mortality in cases of PRISm. To the best of our knowledge, this is the first study to evaluate the distributions of $D_{LCO} \% \text{ pred}$ and to investigate the impact of low D_{LCO} on overall survival in PRISm patients.

In the current study, PRISm was accompanied by deficits in diffusing capacity. It has been well known that there are inverse associations between D_{LCO} and disease severity in COPD,¹² since D_{LCO} decreases by alveolar destruction (lung emphysema) and alveolar microvascular damage preceding emphysematous changes.²² D_{LCO}/V_A did not decrease as much as D_{LCO} in PRISm, probably due to attenuated impairment by obesity-related deficits in V_A . Recent

Table 2 Multivariable-Adjusted Regression Analysis for Low D_{LCO} in the Patient Groups Based on FEV₁ Value

Lung Function Category	Number of Events/Cases (%)	Multivariable-Adjusted OR (95% CI) vs PRISm Group	P value
Preserved spirometry	71/325 (21.8%)	0.21 (0.13–0.34)	< 0.01
PRISm	70/119 (58.8%)	1.00	N/A
Mild COPD	35/149 (23.5%)	0.18 (0.10–0.31)	< 0.01
Moderate COPD	72/200 (36.0%)	0.27 (0.16–0.46)	< 0.01
Severe/very severe COPD	67/106 (63.2%)	0.92 (0.51–1.64)	0.77

Note: Adjustments were made for age, gender, body mass index, and smoking exposure.

Abbreviations: D_{LCO} , diffusing capacity of the lung for carbon monoxide; FEV₁, forced expiratory volume in 1 second; 95% CI, 95% confidence interval; PRISm, preserved ratio impaired spirometry; COPD, chronic obstructive pulmonary disease; N/A, not applicable.

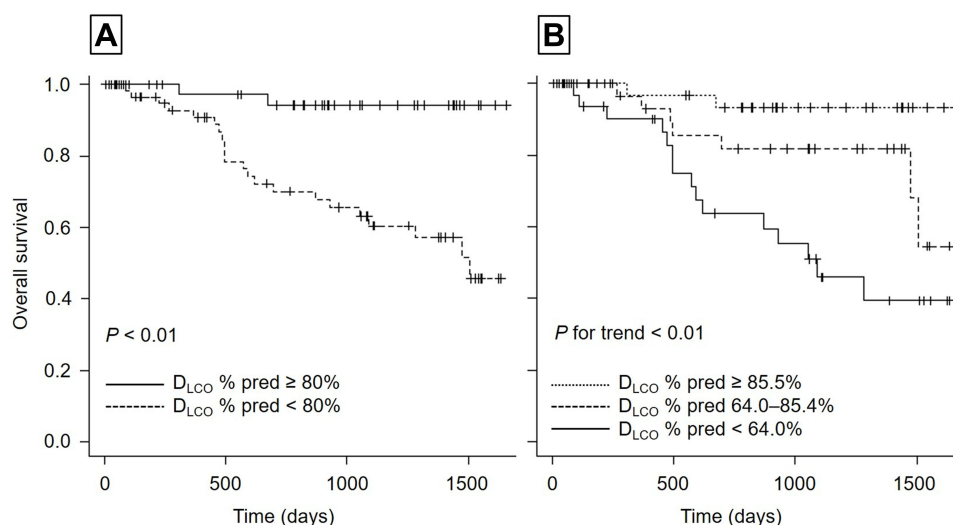


Figure 3 Probability of overall survival according to levels of D_{LCO} % pred among cases of PRISm.

Notes: (A) Preserved and low D_{LCO} were defined as D_{LCO} % pred $\geq 80\%$ and $< 80\%$, respectively. (B) The cut-off values for D_{LCO} % pred were $\geq 85.5\%$ for the highest, 64.0–85.4% for the middle, and $< 64.0\%$ for the lowest tertile groups.

Abbreviations: D_{LCO} % pred, diffusing capacity of the lung for carbon monoxide per predicted; PRISm, preserved ratio impaired spirometry.

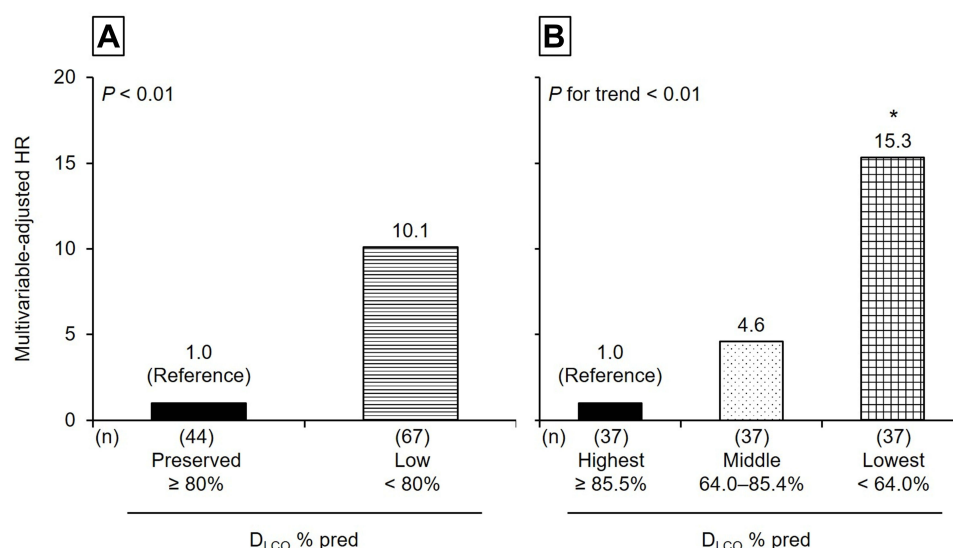


Figure 4 The multivariable-adjusted HRs for all-cause mortality by levels of D_{LCO} % pred among cases of PRISm.

Notes: * $P < 0.01$ versus the reference group. Adjustments were made for age, gender, body mass index, and smoking exposure. (A) Preserved and low D_{LCO} were defined as D_{LCO} % pred $\geq 80\%$ and $< 80\%$, respectively. (B) The cut-off values for D_{LCO} % pred were $\geq 85.5\%$ for the highest, 64.0–85.4% for the middle, and $< 64.0\%$ for the lowest tertile groups.

Abbreviations: HR, hazard ratio; D_{LCO} % pred, diffusing capacity of the lung for carbon monoxide per predicted; PRISm, preserved ratio impaired spirometry.

epidemiological studies have established that PRISm is associated with adverse cardiovascular outcomes and dementia,^{2,3,14,23} probably due to potential hypoxia and/or systemic microvascular atherosclerosis.²³ Our results were in accordance with these reports, considering that D_{LCO} reflects not only lung function impairment but also microvascular damage. Although PRISm has been reported to be at least partly attributed to obesity,^{3,5} which can be linked to increased D_{LCO} % pred,²⁴ diffusing capacity was strongly impaired in PRISm at all BMI levels in the present study, indicating that PRISm is not merely a byproduct of obesity. Deficits in diffusing capacity among subjects with PRISm were observed regardless of subjects' smoking status; we believe that decrease in D_{LCO} in PRISm is unlikely to be explained solely by

smoking exposure. Among PRISm subjects, impairment in D_{LCO} might have been mainly a reflection of enhanced systemic inflammation and oxidative stress,^{2,4} which was considered to result in a high prevalence of cardiovascular disease and diabetes in this population.^{3,5,11}

In the present research, low D_{LCO} was an independent risk factor for all-cause death in PRISm. As for COPD, several cohort studies have demonstrated that impaired diffusing capacity is one of the most robust risk factors for morbidity and mortality.^{15,25} This can be explained by D_{LCO} 's potential as a promising candidate for estimating exercise intolerance and physical functioning in patients with COPD.¹⁵ The current outcome extends these findings to subjects with PRISm. To expand the utility of D_{LCO} in the management of PRISm, we are planning a prospective cohort study to investigate the associations of D_{LCO} with the cardiovascular burden and incidence of dementia in a future work.

The strengths of our study were the relatively large sample size with D_{LCO} assessment, the uniformity in measurements of D_{LCO} by virtue of the single-center survey, the use of regression models adjusting for multiple confounders to evaluate the independent effects of D_{LCO} , and the longitudinal study design to minimize the potential of reverse causation. However, some potential limitations should be noted. First, the D_{LCO} values were based on a single measurement. This may cause misclassification of the levels of D_{LCO} , which could have weakened the associations found in the present study, biasing the results toward a null hypothesis. Second, the present outcomes might lack external validity and generalizability due to the study design as a single-center analysis, although the lung functions of the study population were substantially comparable to those of other PRISm cohorts.^{3,5,6,14,26} Third, we did not have access to prescription data of the study population; it was possible that the increase in the D_{LCO} value was due to BD use. However, long-acting bronchodilators have reportedly been unable to contribute to significant improvements in D_{LCO} .²⁷ In addition, there have been no established treatment options, including BD, for PRISm;^{12,28} we speculate that few cases of PRISm received such treatment, as another survey has demonstrated.⁶ Hence, this limitation may not have altered our conclusions. Fourth, we might have included some asthmatic subjects in the present study. However, the results of sensitivity analysis using only the subjects without bronchial reversibility were comparable to those from the primary analysis. We therefore speculate that this limitation did not alter the conclusion. Fifth, we did not have access to radiographic information for each subject; some of the individuals with PRISm might have had restrictive lung diseases such as interstitial pneumonia rather than pre-COPD or obesity. Considering the very low prevalence of clinically apparent interstitial lung disease,²⁹ however, the majority of PRISm subjects were unlikely to show evidence of interstitial pneumonia.^{3,30,31} Lastly, we were unable to investigate the associations of impaired diffusing capacity with cause-specific mortality due to a lack of data concerning the cause of death.

Conclusion

The diffusing capacity of the lung was more impaired in subjects with PRISm than in those with preserved spirometry or mild to moderate COPD. More than half of the cases of PRISm presented with low D_{LCO} . Additionally, low D_{LCO} was an independent risk factor for all-cause mortality, and there was a linear trend in the risk of death across the levels of D_{LCO} % pred. In managing PRISm, clinicians should assess the diffusing capacity of the lung in order to predict each patient's future risk of death.

Abbreviations

PRISm, preserved ratio impaired spirometry; COPD, chronic obstructive pulmonary disease; D_{LCO} , diffusing capacity of the lung for carbon monoxide; BD, bronchodilator; FEV₁/FVC, forced expiratory volume in 1 second to forced vital capacity; GOLD, Global Initiative for Chronic Obstructive Lung Disease; % pred, percent predicted; V_A , alveolar volume; ATS/ERS, American Thoracic Society/European Respiratory Society; BMI, body mass index; SVC, slow vital capacity; ANOVA, analysis of variance; OR, odds ratio; 95% CIs, 95% confidence intervals; HR, hazard ratio.

Data Sharing Statement

The datasets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

Ethics Approval and Informed Consent

This study was approved by the National Hospital Organization Fukuoka National Hospital Institutional Review Board for Clinical Research (#F4-2). Given the retrospective nature of the study, written informed consent was not requested by the ethics committee.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

The authors declare that they have no competing interests in this work.

References

- Guerra S, Sherrill DL, Venker C, Ceccato CM, Halonen M, Martinez FD. Morbidity and mortality associated with the restrictive spirometric pattern: a longitudinal study. *Thorax*. 2010;65:499–504. doi:10.1136/thx.2009.126052
- Wijnant SRA, de Roos E, Kavousi M, et al. Trajectory and mortality of preserved ratio impaired spirometry: the Rotterdam Study. *Eur Respir J*. 2020;55:1901217. doi:10.1183/13993003.01217-2019
- Wan ES, Balte P, Schwartz JE, et al. Association between preserved ratio impaired spirometry and clinical outcomes in US adults. *JAMA*. 2021;326:2287–2298. doi:10.1001/jama.2021.20939
- Wan ES, Castaldi PJ, Cho MH, et al. Epidemiology, genetics, and subtyping of preserved ratio impaired spirometry (PRISm) in COPD Gene. *Respir Res*. 2014;15:89. doi:10.1186/s12931-014-0089-y
- Kaise T, Sakihara E, Tamaki K, et al. Prevalence and characteristics of individuals with preserved ratio impaired spirometry (PRISm) and/or impaired lung function in Japan: the OCEAN Study. *Int J Chron Obs Pulmon Dis*. 2021;16:2665–2675. doi:10.2147/COPD.S322041
- Washio Y, Sakata S, Fukuyama S, et al. Risks of mortality and airflow limitation in Japanese with preserved ratio impaired spirometry. *Am J Respir Crit Care Med*. 2022;206(5):563–572. doi:10.1164/rccm.202110-2302OC
- Guerra S, Carsin A-E, Keidel D, et al. Health-related quality of life and risk factors associated with spirometric restriction. *Eur Respir J*. 2017;49:1602096. doi:10.1183/13993003.02096-2016
- Mannino DM, McBurnie MA, Tan W, et al. Restricted spirometry in the Burden of Lung Disease Study. *Int J Tuberc Lung Dis*. 2012;16:1405–1411. doi:10.5588/ijtld.12.0054
- Nonato NL, Nascimento OA, Padilla RP, et al. Occurrence of respiratory symptoms in persons with restrictive ventilatory impairment compared with persons with chronic obstructive pulmonary disease: the PLATINO study. *Chron Respir Dis*. 2015;12:264–273. doi:10.1177/1479972315588004
- Schwartz A, Arnold N, Skinner B, et al. Preserved ratio impaired spirometry in a spirometry database. *Respir Care*. 2021;66:58–65. doi:10.4187/respcare.07712
- Higbee DH, Granell R, Smith GD, Dodd JW. Prevalence, risk factors, and clinical implications of preserved ratio impaired spirometry: a UK Biobank cohort analysis. *Lancet Respir Med*. 2022;10(2):149–157. doi:10.1016/S2213-2600(21)00369-6
- Global Initiative for Chronic Obstructive Lung Disease T. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease: 2022 report; 2022. Available from: <https://goldcopd.org/2022-gold-reports-2/>. Accessed October 26, 2022.
- Hughes JMB, Pride NB. Examination of the carbon monoxide diffusing capacity (DLCO) in relation to its K_{CO} and V_A components. *Am J Respir Crit Care Med*. 2012;186:132–139. doi:10.1164/rccm.201112-2160CI
- Marott JL, Ingebrigtsen TS, Çolak Y, Vestbo J, Lange P. Trajectory of preserved ratio impaired spirometry: natural history and long-term prognosis. *Am J Respir Crit Care Med*. 2021;204:910–920. doi:10.1164/rccm.202102-0517OC
- Balasubramanian A, Macintyre NR, Henderson RJ, et al. Diffusing capacity of carbon monoxide in assessment of COPD. *Chest*. 2019;156:1111–1119. doi:10.1016/j.chest.2019.06.035
- Vogelmeier CF, Criner GJ, Martinez FJ, et al. Global strategy for the diagnosis, management, and prevention of chronic obstructive lung disease 2017 report: GOLD executive summary. *Am J Respir Crit Care Med*. 2017;195:557–582. doi:10.1164/rccm.201701-0218PP
- Miller MR, Hankinson J, Brusasco V, et al. Standardisation of spirometry. *Eur Respir J*. 2005;26:319–338. doi:10.1183/09031936.05.00034805
- Burrows B, Kasik JE, Niden AH, Barclay WR. Clinical usefulness of the single-breath pulmonary diffusing capacity test. *Am Rev Respir Dis*. 1961;84:789–806. doi:10.1164/arrd.1961.84.6.789
- The examination committee of criteria for “obesity disease” in Japan, Japan Society for the Study of Obesity T. New criteria for “obesity disease” in Japan. *Circ J*. 2002;66:987–992. doi:10.1253/circj.66.987
- Clinical pulmonary functions committee of the Japanese Respiratory Society. *Guidelines of Respiratory Function Tests: Spirometry, Flow-Volume Curve, Diffusion Capacity of the Lung [in Japanese]*. Tokyo: The Japanese Respiratory Society; 2004.

21. Kubota M, Kobayashi H, Quanjer PH, Omori H, Tatsumi K, Kanazawa M. Reference values for spirometry, including vital capacity, in Japanese adults calculated with the LMS method and compared with previous values. *Respir Investig*. 2014;52:242–250. doi:10.1016/j.resinv.2014.03.003
22. Santos S, Peinado VI, Ramirez J, et al. Characterization of pulmonary vascular remodelling in smokers and patients with mild COPD. *Eur Respir J*. 2002;19:632–638. doi:10.1183/09031936.02.00245902
23. Xiao T, Wijnant SRA, Licher S, et al. Lung function impairment and the risk of incident dementia: the Rotterdam Study. *J Alzheimer's Dis*. 2021;82:621–630. doi:10.3233/JAD-210162
24. Ray CS, Sue DY, Bray G, Hansen JE, Wasserman K. Effects of obesity on respiratory function. *Am Rev Respir Dis*. 1983;128:501–506. doi:10.1164/arrd.1983.128.3.501
25. Lee HY, Kim JW, Lee SH, et al. Lower diffusing capacity with chronic bronchitis predicts higher risk of acute exacerbation in chronic obstructive lung disease. *J Thorac Dis*. 2016;8:1274–1282. doi:10.21037/jtd.2016.04.66
26. Anami K, Murata S, Nakano H, et al. Physical performance in relation to preserved ratio impaired spirometry: a cross-sectional study of community-dwelling older Japanese adults. *Sci Rep*. 2021;11:17411. doi:10.1038/s41598-021-96830-6
27. Santus P, Radovanovic D, Mascetti S, et al. Effects of bronchodilation on biomarkers of peripheral airway inflammation in COPD. *Pharmacol Res*. 2018;133:160–169. doi:10.1016/j.phrs.2018.05.010
28. Wan ES. The clinical spectrum of PRISm (preserved ratio impaired spirometry). *Am J Respir Crit Care Med*. 2022;206(5):524–525. doi:10.1164/rccm.202205-0965ED
29. Raghu G, Weycker D, Edelsberg J, Bradford WZ, Oster G. Incidence and prevalence of idiopathic pulmonary fibrosis. *Am J Respir Crit Care Med*. 2006;174:810–816. doi:10.1164/rccm.200602-163OC
30. Washko GR, Hunninghake GM, Fernandez IE, et al.; COPDGene Investigators. Lung volumes and emphysema in smokers with interstitial lung abnormalities. *N Engl J Med*. 2011;364:897–906. doi:10.1056/NEJMoa1007285
31. Wan ES, Fortis S, Regan EA, et al.; COPDGene Investigators. Longitudinal phenotypes and mortality in preserved ratio impaired spirometry in the COPDGene Study. *Am J Respir Crit Care Med*. 2018;198:1397–1405. doi:10.1164/rccm.201804-0663OC

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