Triggering Receptor Expressed On Myeloid Cells-1 (TREM-1) As A New Marker In Ventilated Children With Pneumonia

Hala G El Nady², Naglaa Kholoussi¹, Lobna S. Sherif², Nevine R. El Baroudy³, Amira S. El Refay², Rania Fawzy Mahmoud Abdelkawy¹, Assem Abo-Shanab¹, Amr Abd El Aziz El Mekkawy⁴

¹Immunogenetics Department, National Research Centre, Egypt.
²Department of Child Health, National Research Centre, Egypt.
³Department of Pediatrics, Faculty of Medicine, Cairo University, Egypt.
⁴Department of Pediatrics, Faculty of Medicine, Ain Shams University, Egypt.

*Corresponding Author E-mail: ronyfma@yahoo.com

http://dx.doi.org/10.13005/bpj/1826

Pneumonia is the world's leading infectious cause of mortality. This is one of the most common lower respiratory tract infections, which contributes significantly to the burden of antibiotic use. Because of the complexity of the pathophysiology, pneumonia is widely recognized that the clinical diagnosis and prognosis are usually not enough to accurately estimate the severity of the condition. The most difficult task for a doctor is above all the value of risk in patients with community-acquired pneumonia. Early diagnosis is important to reduce hospitalization and death. There are widespread biomarkers, none of which look perfect, and the demand for new biomarkers that maximizes the severity and treatment response for pneumonia has increased lately. Ventilation-related pneumonia (VAP) is a hospital-acquired pneumonia that can occur more than 48 hours after mechanical ventilation. This is a common complication of mechanical ventilation, which has a high mortality rate. VAP can make it difficult for patients to turn off the ventilator and cause longer hospitalizations, which can cause a very large financial burden for patients and the need for large medical resources. The incidence and mortality of VAP have decreased with the progress of prevention strategies in the last few decades. However, VAP is still one of the most common causes of nosocomial infections and a frequent cause of death in intensive care units. Current challenges in VAP treatment include the lack of a gold standard for diagnosis, the lack of effective prevention strategies, and increased antibiotic resistance. Active receptors are expressed on myeloid cells (TREM-1) and are considered to be glycoprotein members of the immunoglobulin family. TREM-1 is an inflammatory receptor that causes inflammation after exposure to extracellular fungi and bacterial pathogens. Elevated TREM-1 levels are a potential marker of lung disease. The aim of this study is to evaluate sTREM-1 levels in the serum of pneumonia patients and their use as new biomarkers, which seem promising for accurate diagnosis, risk and follow-up of VAP, always, however, one of the most common causes is nosocomial infection and one of the leading causes of death most commonly in intensive care units. A comparative study was conducted on children diagnosed with pneumonia admitted to Pediatric Abo El Rish Intensive Care Unit and Abo El Rish Pediatric Hospital, Cairo University, compared to age and sex-matched healthy control group. sTREM-1 level was measured using ELISA technique while CRP by Nephelometry. TREM-1 level was significantly higher in ventilated children with pneumonia compared to the control group. No significant correlation was found between sTREM-1 level and CRP level in the studied children. TREM-1 is not a pulmonary infection marker only but a reliable marker for ventilator-associated pneumonia (VAP).

Keywords: Triggering receptor expressed on myeloid cells-1, CRP, pneumonia, Ventilator-Associated Pneumonia.
Pneumonia is one of the most common causes of death among children even with all the recent advancements in diagnosis and management. Clinical signs of pneumonia may be very vague leading to difficulty to establish a rational therapeutic approach. Certainly, the early managing of respiratory tract infection is vital to ensure good prognosis and avoid complications. The epidemiology of pneumonia is complicated. Moreover, the definitions of the different subtypes of pneumonia are vague and this is an add on an obstacle in early management.

Pneumonia obtained by the community occurs as a whole, although pneumonia associated with a ventilator (VAP) and acquired pneumonia (HAP) is considered as health-related pneumonia. Aspiration pneumonia is another process that can begin in a general situation but is often unfairly referred to as a health event.

Mechanical ventilation is an effective intervention method for critically ill patients to save their lives. This is often used in intensive care units. Ventilation-related pneumonia (VAP) is a nosocomial infection that occurs after more than 48 hours of ventilation. Clinical Guidelines (2016), published by the American Infectious Diseases Society (IDSA) and the American Thoracic Society (ATS), show that VAP mortality in the US is 13%. In Europe, a multicentre prospective study found that the 30-day mortality from VAP was 29.9%. The initial VAP mortality rate was 19.2%, while the late VAP mortality rate was 31.4%. Although the prevalence of VAP has declined in recent years due to the application of therapeutic strategies, it remains one of the most common causes of nosocomial infections and critically ill patients during ICU hospitalization. VAP may make it difficult for some patients to leave the ventilator and stay longer in the hospital, which can be a huge financial burden on patients and a great need for medical resources. Therefore, it is very important to explain VAP risk factors to achieve better VAP prevention and control. Patient characteristics (for example, elderly, male) can increase mechanical ventilation time. Continuous mechanical ventilation, disturbance of consciousness, previous antibiotic therapy, burns, comorbidities, gene polymorphisms, and invasive surgery are internationally recognized risk factors for VAP.

The ideal biomarker for pulmonary infection must allow rapid diagnosis and prognostic value and facilitate therapeutic decision making. The trigger receptors expressed on myeloid cells (TREM-1) are glycoproteins and a member of the immunoglobulin family. TREM-1 acts as an important receptor for the inflammatory response that is regulated by neutrophils and monocytes during inflammation. When it comes to pneumonia, TREM-1 has great promise.

Its expression is upregulated with the presence of extracellular bacteria and fungi and in some noninfectious inflammatory conditions. TREM-1 may be measured in body fluids only in response to infection as it is not detectable in healthy individuals. TREM-1 is a good predictor of VAP; however, claimed that TREM-1 may be found elevated in the bronchoalveolar lavage (BAL) fluid in patients with and without confirmed VAP. Activated phagocytes release soluble forms of TREM-1 (sTREM-1) and are found in all body fluids. This soluble form is closely related to infection. There are many studies on sTREM-1 in adults that show elevated serum levels of sTREM-1 in body fluid samples for various diseases and conditions.

It has been found that sTREM-1 levels increase in bronchoalveolar lavage fluid in patients with pneumonia, in exhaled breath condensation in patients with VAP and in the plasma of septic patients. sTREM-1 acts as a biomarker of known infectious diseases.

The study and cultivation of lung tissue is the gold standard for diagnostic confirmation of VAP because intervention procedures are indispensable for obtaining a lung biopsy and therefore clinical relevance is limited. The trigger receptors expressed on myeloid cell-1 (TREM-1) are members of the immunoglobulin superfamily and are secreted by neutrophils, macrophages, and monocytes. It increases the inflammatory response after exposure to bacterial and fungal cells. Soluble forms of TREM-1 (sTREM-1) are planned as new biomarkers and have been tested in patients with acute infections and have different diagnostic and prognostic results. Increased levels of sTREM-1 in bronchoalveolar lavage (BALF), serum, and ventilatory condensate (EVC) fluids have been reported in patients with VAP.
Identification of vulnerability sites associated with pneumonia in life and childhood. They also postulated that this locus showed evidence of an association with genetic variants related to lung function, immune response, COPD, lung development, and asthma28.

In patients with pneumonia, no nucleotide polymorphism has reached the importance of the genome, although it identifies potential areas of interest. In the analysis of pediatric pneumonia with variants of NGR1 (P = 6.3 × 10-8), PAK6 (P = 3.3 × 10-7) and around MATN1 (P = 2.8 × 10-7). In a lifetime analysis of lung inflammation containing variants in LOC339862 (P = 8.7 × 10-7), RAPGEF2 (P = 8.4 × 10-7), PHACTR1 (P = 6.1 × 10 -7) near PRR27 (P = 4.3 × 10 -7) and near MCPH1 (P = 2.7 × 10 -7). Analysis of childhood lung inflammatory gene tissue including upper tissue development, WNT signaling, DNA damage, apoptosis, inflammation, blood vessel morphogenesis, muscle contraction, and immune response (P d" 0.05). We have identified genes that might be associated with pneumonia risk29.

The aim of this research was to determine the level of TREM-1 in ventilated and non-ventilated children with confirmed pneumonia diagnosis compared to age and sex-matched control group.

**METHODOLOGY**

A comparative study included 43 children selected from those admitted to Pediatric Abo El Rish ICU and Abo El Rish Pediatric Hospital, Cairo University. Another 18 age and sex-matched apparently healthy children were enrolled as control group.

Any child was admitted to Pediatric Intensive Care Unit and Abo El Rish Pediatric Hospital, Cairo University presented by clinical symptoms (e.g., cough, fever, pleurisy) and with an infiltrate seen on chest radiography can be considered eligible as a confirmed pneumonia case30. Then the selected children were divided into 2 groups according to associated mechanical ventilation or no.

Any children were receiving immunosuppressive therapy, started antibiotic therapy, children with chronic lung diseases and patients who were unwilling to participate in this study were excluded from the study.

**Ethical Considerations**

This study follows the guidelines of the ethics committee of the National Research Centre, Egypt for Medical Research, approval number:16/381. Informed consent was collected from legal child parents/guardians prior to participation and Confidentiality of all data was ensured.

**Data collection**

Data were collected include demographic data, clinical features (cough, fever, pleuritic chest pain) and positive findings of lung imaging, the need for hospitalization in pediatric ward versus intensive care unit admission using mechanical ventilation and associated comorbidities (cardiac abnormalities, convulsion and or dehydration).

**Laboratory analysis**

Three ml of blood samples were drawn from the admitted child under complete aseptic conditions and were collected in plain vacutainers. Samples were left to agglomerate for 30 minutes before centrifugation at around 1000 x g for 15 minutes. Serum separated and stored at -20°C. Laboratory blood tests are done in Immunogenetics Laboratory at Excellence centre, National Research Centre (NRC).

**Determination of serum TREM-1**

Samples were analyzed for TREM-1 using the commercially available ELIA EIAab kit. Catalog number: E0213h. In principle, the microtiter plates provided in this kit are pre-prepared with TREM-1 specific antibodies. The standard or sample is then added to the well corresponding to the microtiter plate with the biotin-specific TREM-1 conjugated polyclonal antibody preparation, and the radish conjugated peroxidase conjugate (HRP) radish is added to each microtiter plate well and incubated. Then the TMB substrate solution is added. Only wells containing TREM-1 that are conjugated with biotin antibodies and conjugated with the avidin enzyme show color changes. The enzyme-substrate reaction is ended by adding sulfuric acid solution and the color change is measured spectrophotometrically at a wavelength of 450 nm ± 2 nm. The TREM-1 concentration in the sample is then determined by comparing the O.D. from sample to standard curve.
Determination of serum C-reactive protein (CRP)

Measurement of human C-reactive protein (CRP) in serum is done nephelometrically. Product code: ZK044.L.R, Minineph™, The Binding Site Ltd., PO Box 11712, Birmingham, B14 4ZB, UK. The determination of dissolved antigen concentrations by the nephelometric method involves reactions with antibodies that are bound to latex particles to form insoluble complexes. When light passes through the formed slurry, a portion of the light is scattered and detected by a photodiode. The amount of light scattered is directly proportional to the concentration of specific proteins in the test sample. Concentrations are calculated automatically using a calibration curve that is stored in the instrument.

Statistical method

Data is coded and entered using the SPSS statistical package (Statistical Package for Social Sciences), version 23. Data is collected using the mean, standard deviation in quantitative data, and using frequency (number) and relative frequency (percent). Taking into account the level of sTREM-1, the ANOVA method was used to test the difference in significance between the

Table 1. Demographic and clinical data of the studied cases

<table>
<thead>
<tr>
<th></th>
<th>Ventilated Pneumonia (n=20)</th>
<th>Non-ventilated Pneumonia (n=23)</th>
<th>Control Group (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (months)</td>
<td>12.60±11.821</td>
<td>32.20±26.411</td>
<td>22.47±10.002</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12(60.0%)</td>
<td>12(52.2%)</td>
<td>13 (72.2%)</td>
</tr>
<tr>
<td>Female</td>
<td>8(40.0%)</td>
<td>11(47.8%)</td>
<td>5 (28.8%)</td>
</tr>
<tr>
<td>Fever</td>
<td>20 (100%)</td>
<td>23 (100 %)</td>
<td>0</td>
</tr>
<tr>
<td>History of cough</td>
<td>20 (100%)</td>
<td>23 (100 %)</td>
<td>0</td>
</tr>
<tr>
<td>Associated comorbidity</td>
<td>5 (25%)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 2. TREM-1 and CRP level in the studied cases

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
<th>p- value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TREM-1 (ng/ml)</td>
<td>Control(n= 18)</td>
<td>0.56761</td>
<td>0.739702</td>
<td>0.064</td>
</tr>
<tr>
<td></td>
<td>Pneumonia cases(n=43)</td>
<td>2.20722</td>
<td>3.636479</td>
<td>0.002*</td>
</tr>
<tr>
<td>C-Reactive Protein(CRP)(mg/dl)</td>
<td>Control(n=18)</td>
<td>1.5122</td>
<td>1.85927</td>
<td>0.002*</td>
</tr>
<tr>
<td></td>
<td>Pneumonia cases(n=43)</td>
<td>22.0889</td>
<td>26.55067</td>
<td></td>
</tr>
</tbody>
</table>

Independent Samples Test *p-value
TREM-1 in the Control Group with mean 0.56761±0.739702 has a nonsignificant difference from Pneumonia cases with mean 2.20722±3.636479 (p-value 0.064).

While the CRP level was highly significant higher in the studied pneumonia cases with mean 22.0889 ±26.55067 than the control group with the mean 1.5122±1.85927 (p-value 0.002).

Table 3. Comparison between TREM-1 level in the studied groups according to an associated ventilator or no

<table>
<thead>
<tr>
<th></th>
<th>Ventilated pneumonia (Group 1)</th>
<th>Non-ventilated pneumonia (Group 2)</th>
<th>Control Group (Group 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>p(1vs3)</td>
<td>0.022</td>
<td>0.329</td>
<td>0.586</td>
</tr>
<tr>
<td>p(1vs2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p(2vs3)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TREM-1(ng/ml) 3.20±3.66 1.43±3.50 0.57±0.74 0.022 0.329 0.586

By comparing the TREM-1 Level according to pneumonia with and without a ventilator, a significant difference was found between the control group and the ventilated pneumonia cases (p 0.022).
three groups, and the Dunnett test was used to test the difference in significance for each of the two groups.

**RESULTS**

The clinical presentation and demographic data of the studied groups are illustrated in Table 1. Twenty-four children were female (39.3%) and 37 were males (60.6%). As regards the need of mechanical ventilation, 20 cases (46.5%) needed mechanical ventilation. Only 5 cases (25%) of them suffered from co-morbidity.

**DISCUSSION**

VAP is a leading cause of morbidity and mortality associated with cardiac surgery worldwide, especially in children. Despite advances in diagnosis, early diagnosis of VAP remains difficult, and etiology and therapy are also observed. Because VAP and systemic inflammatory response syndromes have similar characteristics in early development but patients are being treated for VAP, excessive and unnecessary antibiotic treatment is needed in patients with systemic inflammatory response syndrome. This excessive and unnecessary use of antibiotics can lead to increased bacterial resistance and increased costs, emphasizing the importance of early and accurate diagnosis of VAP. In this study, markers of biological infections such as sTREM-1 are being studied to improve the accuracy of VAP diagnoses.

Trigger receptors expressed on myeloid cells (TREM-1) are considered innate inflammatory transmembrane receptors. TREM-1 is expressed on neutrophils, mature monocytes, and macrophages and is related to immunoglobulin superfamily receptors. TREM-1 amplifies inflammation after exposure to extracellular bacterial and fungal pathogen. Therefore, it was initially proposed as the early marker of infection. TREM-1 expression is increased in peritoneal neutrophils of septic shock patients.

Later, the expression has also been founded on various non-immune cells like bronchial epithelium and endothelial cells. A soluble form of TREM-1 (sTREM-1) is present in high concentrations in bronchoalveolar lavage in patients with pneumonia.

Many recent studies demonstrated the role of sTREM-1 as a potential biomarker of bacterial infection to either differentiate between types of infections or as an early marker. In the current study, the level of sTREM-1 was higher in children with pneumonia in comparison to the control group but without a significant statistical difference.

This is in contrast with the results of a meta-analysis study which concluded that sTREM-1 was a reliable biological marker in bacterial infection. On the other hand, another meta-analysis study concluded that though sTREM-1 is a useful marker for bacterial infections, it is not that accurate in some types of infection as urinary tract infection.

The difference between different types of pneumonia especially in ICU patients is not easy. VAP is defined as pneumonia that occurs more than 48 hours after patient intubation and after mechanical ventilation. The diagnosis of VAP requires a high level of clinical suspicion by X-ray examination, nocturnal examination, and microbiological analysis of respiratory secretions.

TREM-1 has a significant diagnostic value when it comes to lung diseases as it has been studied in the diagnosis of ventilator-associated pneumonia (VAP) for ICU patients. sTREM-1 had a good diagnostic performance to differentiate patients with and without VAP.

This supports our findings because significant differences have been identified.

### Table 4. Correlation between TREM-1 Level and CRP in the studied cases

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Pearson Correlation</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRP vs TREM-1</td>
<td>43</td>
<td>0.024</td>
<td>0.883</td>
</tr>
</tbody>
</table>

There was no significant correlation between TREM-1 level and CRP level in the studied cases.
between ventilated cases and control groups and this can be explained by that the ventilation is an add on factor for rising sTREM-1 level with the bacterial infection.

This is in agreement with results of many recent studies which assessed the TREM level either in bronchoalveolar lavage or serum in ICU patient. It was concluded that sTREM-1 is present at a high concentration in patients’ lungs with bacterial infections, which can be used as a reliable early marker for VAP and can accurately discriminate VAP from non-pulmonary infection. Moreover, a study by Baker et al. used TREM to diagnose VAP for trauma patients as trauma itself can make a proinflammatory state mimicking infection, so sTREM-1 was used to facilitate rapid and accurate diagnosis of VAP in trauma.

C-reactive protein (CRP) is a protein of an acute phase and it acts as a well-known biomarker of inflammation. The diagnostic value of CRP was investigated by many researchers. It was compared to many different markers to assess its sensitivity. Since it is an “indirect” marker of infection, the sensitivity and specificity is not 100% and vary. Our study showed significant differences with CRP in the pneumonia cases than the control group (*p=0.002*).

The diagnostic role of CRP and sTREM-1 as biomarkers was investigated recently and moreover, sTREM-1 has shown it to be more specific and sensitive than C-reactive protein (CRP). In our study there was no significant correlation between TREM-1 level and CRP level in the studied children.

**CONCLUSION**

TREM-1 is a superior pulmonary infection biomarker moreover, it can be used to discriminate between types of pneumonia as VAP.

**ACKNOWLEDGEMENTS**

We thank the National Research Centre (NRC) (in-house office for research projects) for the research grants supported this work. Furthermore, we thank Abo El Rish Pediatric Hospital for their help and assistance. This work was supported by NRC, Grant Number 11010172.


