Chronic obstructive pulmonary disease among women using biomass fuels in some rural areas of Fayoum governorate
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Introduction
Chronic obstructive pulmonary disease (COPD) is an important public health problem; it represents an important health challenge in terms of both prevention and treatment. Although smoking is recognized as the most important risk factor for COPD, rural women in developing countries have a greater risk not as a result of smoking, as smoking is uncommon there, but due to smoke from domestic biomass fuel combustion, which is another potential risk factor.

Aims
The aim of this study was to investigate exposure to biomass fuel as a potential risk factor for COPD among women in the rural areas of Fayoum governorate in whom cigarette smoking was not the risk factor.

Materials and methods
This study included 100 nonsmoker women who used biomass fuels and 100 women who had not used biomass throughout their life who served as controls. All groups in the study were subjected to questionnaire on respiratory symptoms, clinical examination, and were investigated using spirometer.

Statistical analysis
Data were analyzed using SPSS, version 11. Quantitative data were analyzed using the $\chi^2$-test, whereas the $t$-test was used for comparison between groups as regards quantitative data.

Results
Biomass fuel is an important risk factor for development of COPD among rural nonsmoker women who use biomass. The decline in forced expiratory volume in first second and forced expiratory flow 25–75% is significantly related to the duration of exposure to biomass fuels.

Conclusion
It was detected that biomass fuel is an important risk factor for development of COPD. Biomass fuels affect pulmonary functions and this is strongly related to the duration of biomass use. *Egypt J Broncho* 2015 9:227–230 © 2015 Egyptian Journal of Bronchology.
All patients and controls were subjected to the following:

1. History taking.
2. Thorough clinical examination.
3. Routine laboratory investigations.
4. Chest radiography (posteroanterior and lateral views).
5. Simple spirometric study before and after bronchodilator (the apparatus used was Winspiro PRO spirometry [MIR Spirodoc Oxi Diagnostic Spirometer/Winspiro PC software. Intermedics supply, Inc, Miami, USA]).
6. Arterial blood gas analysis at room air if SpO_2 is less than 92%.

**Inclusion criteria**
1. Age 40–60 years.
2. Female sex.
3. History of nonsmoking.
4. History of biomass exposure.

**Exclusion criteria**
1. Age less than 40 and more than 60 years.
2. Male sex.
3. Absent history of biomass exposure.
4. Individuals with medical history of bronchial asthma, chronic heart diseases, chronic liver diseases, chronic renal diseases, or occupational lung diseases.

**Statistical analysis**
Data were computed and analyzed using SPSS, version 11 (Statistical Package for Social Sciences (SPSS)/IBM company/SAGE UK, London). Quantitative data were analyzed using the \( \chi^2 \)-test, whereas the \( t \)-test was used for comparison between groups as regards quantitative data. A multivariate analysis was used to identify the most relevant factors affecting COPD.

**Ethical consideration**
This study was reviewed by the Faculty of Medicine Research Ethical Committee. The participants were informed about the objectives of the study, the examination, and the investigation that would be carried out. Confidentiality of their information was assured and the participants had the right to refuse to participate in the study. All patients gave their formal consent. The protocol was approved the Ethical Committee of the Fayoum University.

**Results**
The study was carried on 200 women attending our chest clinic in Fayoum University Hospital. The age of the women enrolled in this study ranged between 40 years as a minimum age and 60 years as a maximum age, with a mean age of 50.64 ± 6.34 years.

The control group had normal forced expiratory volume in first second/forced volume capacity (FEV_1/FVC) ratio, whereas the case group was classified as follows: 23 women had normal ratio, 13 had obstructive abnormality, and 64 had restrictive abnormality, with statistically significant difference between the case and control groups (\( P = 0.000 \)) (Table 1).

The case group was classified as follows: 22 cases had normal FEV_1, 49 cases had mild affection, 24 cases had moderate affection, and five cases had severe affection, with statistically significant difference between the case and control groups (\( P = 0.000 \)) (Table 2).

Among cases with the duration of biomass usage of 10–20 years, seven were considered normal, one as obstructive, and 13 as restrictive (Table 4). Among cases with the duration

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**Table 1** Relation between FEV_1/FVC ratios and the case and control groups

<table>
<thead>
<tr>
<th>FEV_1/FVC ratio</th>
<th>Cases = 100 [N. (%)]</th>
<th>Control = 100 [N. (%)]</th>
<th>Total = 200 [N. (%)]</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>23 (23.0)</td>
<td>100 (100)</td>
<td>123 (61.5)</td>
<td>0.000*</td>
</tr>
<tr>
<td>Obstructive</td>
<td>13 (13.0)</td>
<td>0 (0)</td>
<td>13 (6.5)</td>
<td></td>
</tr>
<tr>
<td>Restrictive</td>
<td>64 (64.0)</td>
<td>0 (0)</td>
<td>64 (32.0)</td>
<td></td>
</tr>
</tbody>
</table>

FEV_1, forced expiratory volume in first second; FVC, forced volume capacity; *Significant.

**Table 2** Classification of the studied group on the basis of the value of FEV_1

<table>
<thead>
<tr>
<th>FEV_1</th>
<th>Cases = 100 [N. (%)]</th>
<th>Control = 100 [N. (%)]</th>
<th>Total = 200 [N. (%)]</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>+80</td>
<td>22 (22.0)</td>
<td>100 (100)</td>
<td>122 (61.0)</td>
<td>0.000*</td>
</tr>
<tr>
<td>+50–80</td>
<td>49 (49.0)</td>
<td>0 (0)</td>
<td>49 (24.5)</td>
<td></td>
</tr>
<tr>
<td>+30–50</td>
<td>24 (24.0)</td>
<td>0 (0)</td>
<td>24 (12.0)</td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>5 (5.0)</td>
<td>0 (0)</td>
<td>5 (2.5)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100 (100)</td>
<td>100 (100)</td>
<td>200 (100)</td>
<td></td>
</tr>
</tbody>
</table>

FEV_1, forced expiratory volume in first second; *Significant.
of biomass usage for more than 20–30 years, there were 16 normal, six obstructive, and 41 restrictive cases. Cases using biomass for more than 30 years had no normal ratio, had six obstructive abnormality, and 10 restrictive abnormality, with statistically significant difference between the case and control groups ($P = 0.000$).

**Discussion**

COPD is a leading cause of morbidity and mortality worldwide and results in an economic and social burden that is both substantial and increasing [1]. Although smoking remains the predominant risk factor for COPD [6], it needs to be emphasized that the prevalence of COPD in nonsmokers suggests the existence of other risk factors such as passive smoking, occupational exposure, and indoor air pollution [7]. In recent times, exposure to biomass smoke resulting from household combustion of solid fuels has been identified as an important risk factor for COPD, with rural women in developing countries being more exposed to disease [8]. In addition to respirable particulate matter, biomass combustion results in high levels of pollutants such as carbon monoxide, oxides of nitrogen and sulfur, formaldehyde, and benzene that are a major source of respiratory irritants in the etiopathogenesis of COPD [9].

In our study, 200 women were recruited from the rural areas of Fayoum governorate. Women aged between 40 and 60 years, with the mean age 50.64 ± 6.34 years, were included in the study. Our study showed a strong relationship between biomass fuel use and prevalence of COPD in rural nonsmoker women, as well as presence of a significant percentage of restrictive patterns, denoting association of biomass with other restrictive lung diseases. The decline in FEV$_1$ and FEF25–75% in populations using biomass was higher in individuals exposed to biomass smoke in rural Nepal compared with nonexposed participants (8.1 vs. 3.6%). However, in this study, postbronchodilator lung function was not measured. The study showed significant reduction in FEV$_1$ and FEF25–75% in populations using biomass across all age groups, but there was no significant association between FVC and biomass use. Despite significant decline in FEF25–75%, they stated that FEF25–75% is not recommended in clinical practice for the diagnosis of small airway obstruction, although its deficit provides additional evidence for the presence of airflow obstruction. These results are similar to those reported in our study on significant reduction in FEV$_1$ and FEF25–75% in relation to biomass use. Kiraz et al. [14] showed higher prevalence of COPD in rural than in urban women from Turkey (12.4 vs. 3.9%). The study showed that values of FEV$_1$ were relatively low in rural than in urban women. This was in agreement with our results in which values of FEV$_1$, were low in women who used biomass fuel compared with those who did not use biomass fuel. Liu et al. [15] showed that the total prevalence of COPD in the studied population was 19.4%, with higher prevalence in rural than in urban areas of Guangdong Province in China (12 vs. 7.4%). Priscilla et al. [12], in contrast to our study, reported no statistically significant results in the detection of COPD in rural women of Tamil Nadu, but they showed that higher COPD was detected in biomass fuel users than in clean fuel users. Justino et al. [13] showed that 13% of nonsmoking women had FEV$_1$/FVC less than 70%, with a slight increase in women using biomass fuel compared with those using gas stoves (82.8 vs. 79.9%) in rural Mexico. The study revealed that most of the cases using biomass had moderate decline in FEV$_1$, similar to that reported in our study, in which 47% of cases had moderate decline in FEV$_1$ (50–80%). There was a small significant difference in FEV$_1$ and FVC between women using biomass and those using gas stoves. Ekicia et al. [17] suggested that biomass smoke was an important contributing factor to the development

<table>
<thead>
<tr>
<th>Normal</th>
<th>10–20</th>
<th>+20–30</th>
<th>+30</th>
<th>Total</th>
<th>$P$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>100 (50)</td>
<td>7 (3.5)</td>
<td>16 (8.0)</td>
<td>0 (0)</td>
<td>123 (61.5)</td>
</tr>
<tr>
<td>Obstructive</td>
<td>0 (0)</td>
<td>1 (0.5)</td>
<td>6 (3)</td>
<td>6 (3)</td>
<td>13 (6.5)</td>
</tr>
<tr>
<td>Restrictive</td>
<td>0 (0)</td>
<td>13 (6.5)</td>
<td>41 (20.5)</td>
<td>10 (5.0)</td>
<td>64 (32.0)</td>
</tr>
<tr>
<td>Total</td>
<td>100 (50)</td>
<td>21 (10.5)</td>
<td>63 (31.5)</td>
<td>16 (8.0)</td>
<td>200 (100)</td>
</tr>
</tbody>
</table>

FEV$_1$, forced expiratory volume in first second; FVC, forced volume capacity; *Significant.
of COPD in nonsmoking women living in rural areas. Mejza et al. [16] showed an independent relationship of farming, in addition to biomass use, with lower FEV₁/FVC values, as well as increased COPD risk, in a random population sample of Malopolska inhabitants. The study showed significant reduction in lung function in individuals using biomass. Filip et al. [18] showed significantly low FEV₁/FVC ratio in individuals exposed to biomass combustion and occupational exposures among Malopolska inhabitants, with 26.6% having a ratio less than 70%. The study showed significant decrease in lung function in individuals using biomass with stage 2 or higher COPD (FEV₁ 50–80%).

Acknowledgements
Conflicts of interest
None declared.

References