Exposure to Mould and Moisture Damage Is a Potential Risk Factor for the Development of Respiratory Diseases

Opinion

Jouni Lohi1, *, Tiina Tuomela2, Tamara Tuuminen3

1Department of Pathology, Lappland Central Hospital, Rovaniemi, Finland
2Pikkujätti, Medical Center for Children and Youth, Vantaa, Finland
3Kruununhaka Medical Center, Helsinki, Finland

Email address: jouni.lohi@gmail.com (J. Lohi), tiina.tuomela@fimnet.fi (T. Tuomela), tuuminen@gmail.com (T. Tuuminen)

*Corresponding author

To cite this article:

Received: July 17, 2020; Accepted: August 3, 2020; Published: August 10, 2020

Abstract: Adverse health effects due to indoor air moisture damage has been extensively studied already for thirty years. Exposure to dampness microbiota (DM) in buildings is a risk factor for newly onset asthma and other respiratory problems. This exposure increases the rate of upper and lower respiratory tract infections because the function of the cilia cells and the integrity of mucosal layer becomes compromised. The breach of the first defense barrier of innate immunity leads to susceptibility to inhaled impurities and pathogens. Dampness and mould-associated asthma may present with several clinical peculiarities. This asthma may be resistant to treatment, the symptoms may exacerbate during periods with increased outdoor air humidity and rainfalls and this asthma may be associated with chronic obstructive pulmonary disease (COPD). It has been generally recognized that persons sensitized to DM should avoid new and repeated exposure to moldy environment. This recommendation is important especially during the current SARS-CoV2 pandemic.

Keywords: Mold Damage, Asthma, Respiratory Symptoms, COVID19, SARS-CoV2

1. Introduction

Moisture damage is a common problem worldwide. For example, in Finland, moisture damage occurs in at least 25% of school buildings, and these problems are also known to occur in individual houses, etc. Climate change and heavy rainfalls were linked to increased moisture damage in the buildings. Risky constructions, wetting and poor maintenance of building constructions, risky building materials, mechanical inadequate ventilation, too low air pressure in the buildings and switching off mechanical ventilation during weekends and holidays are known factors that cause hazardous indoor air moisture accumulation that damages the constructions [1].

According to WHO (2009), the exposure to dampness microbiota (DM) in the buildings may result in respiratory symptoms. It has become indisputable already since the report of the WHO that the exposure to DM is associated with higher risks for upper and lower respiratory tract infections [2].

2. Methods and Results

Here, we refer to a few selected literature reviews and meta-analyses (one per year after 2009) supporting the previous knowledge that the exposure to the components of moisture damage indeed causes a plethora of respiratory problems, and aggravation of existing asthma or its exacerbation. Moreover, it increases the incidence of respiratory infections (Table 1).

3. Findings and Discussion

On the basis of recent research several peculiarities of moisture-related asthma should be emphasized.

1) DM-associated asthma is more resistant to treatment. Steroid resistance may be associated with the aberrant
bacterial toxins, volatile organic compounds and reviewed 1. DM activate and simultaneously depriv e innate with mould-related disease are typical for allergic alveolitis the CD8+/CD4+ T-cell ratio in the BAL samples of patients responses, long-term production of inflammatory mediators non-mediated mechanisms, excessive or deprived immune Sensitization, histamine release by both IgE-mediated and counts in the blood have been observed too [7]. Changes in lymphocytosis and changes in CD8+/CD4+ T-cell ratios have been reported [6]. Decreased CD19+ B lymphocyte in the blood have been observed too [7]. Changes in the CD8+/CD4+ T-cell ratio in the BAL samples of patients with mould-related disease are typical for allergic alveolitis reviewed 1. DM activate and simultaneously deprive innate inflammation are pathological mechanisms leading to adverse health effects. Exposure to DM can damage mitochondria and trigger autoimmune reactions. In bronchoalveolar lavage (BAL) of individuals exposed to DM who are symptomatic in moisture damaged-buildings, lymphocytosis and changes in CD8+/CD4+ T-cell ratios have been reported [6]. Decreased CD19+ B lymphocyte counts in the blood have been observed too [7]. Changes in the CD8+/CD4+ T-cell ratio in the BAL samples of patients with mould-related disease are typical for allergic alveolitis [reviewed 1]. DM activate and simultaneously deprive innate and adaptive immunity. The components of DM may specifically destroy the function of the cilia cells of the epithelium. Thus, the barrier function of mucosal layer of bronchi may be impaired and inhaled impurities may not be removed properly [1, 8]. This dysfunction of the innate immunity paves the way for better pathogen entry.

From the end of 2019 the Globe has faced an unprecedented epidemiological situation, the pandemic of the SARS-CoV2 virus infection. International health authorities have issued recommendations concerning recognition of the risk groups and their protection, the policy had been adopted almost worldwide. For example, the Centers for Disease Control and Prevention warns people with chronic diseases to take special care during the COVID-19 pandemic (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html). The following risk groups have been identified: the elderly, patients with immune suppression, such as medication, cancer, HIV, genetic immunodeficiencies; patients with hepatitis or chronic renal failure requiring dialysis, asthma or other chronic lung diseases.

DM-associated asthma or a pathological pulmonary condition that is not classified as asthma because not all asthma criteria may have been met, are not mentioned as a risk for COVID-19. This is partly because mould-related disease as a separate nosology has not been yet included into the International Classification of Diseases making statistics of this disease inaccurate and less visible. Therefore, due to this hurdle it is difficult to accumulate evidence that the exposure to DM is indeed a risk factor for COVID-19, but we can extrapolate this claim through the existing knowledge.

### Table 1. A selection of meta-analyses and literature reviews one/year after 2009 providing additional evidence that residential moisture and mould damage are independent risk factors for adverse respiratory health effects and respiratory infections in particular.

<table>
<thead>
<tr>
<th>Publication type and the publication year</th>
<th>Study design and main conclusions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative meta-analysis, 2010</td>
<td>Twenty-three original publications were included. Residential moisture and mould damage are associated with a significant risk for respiratory infections and bronchitis. Odds ratios (95% confidence interval): bronchitis 1.45 (1.32-1.59); respiratory tract infections 1.44 (1.31-1.59); respiratory tract infections excluding nonspecific upper respiratory tract infections 1.50 (1.32-1.70); respiratory tract infections in children and neonates 1.48 (1.33-1.65). Review of publications in peer-reviewed journals by November 2009; Total for references less than 148 because studies may have reported multiple findings. Evident dampness or mould had consistent positive associations with multiple allergic and respiratory effects. Epidemiologic studies and meta-analyses showed indoor dampness or mould to be associated consistently with increased asthma development and exacerbation, current and ever diagnosis of asthma, dyspnoea, wheeze, cough, respiratory infections, bronchitis, allergic rhinitis, eczema, and upper respiratory tract symptoms. Associations were found in allergic and nonallergic individuals. Evidence strongly suggested causation of asthma exacerbation in children.</td>
<td>10</td>
</tr>
<tr>
<td>Updated, comprehensive review of the epidemiological evidence collected from original studies and meta-analyses, 2011</td>
<td>Sixteen studies: 11 cohort and 5 incident case-control studies. The summary effect estimates (EE) based on the highest and lowest estimates for the relation between any exposure and onset of asthma were calculated. The evidence indicates that residential dampness and moulds are determinants of developing asthma. The association of the presence of visible mould and especially mould odour are risk factors for asthma and points towards mould-related causal agents.</td>
<td>11</td>
</tr>
<tr>
<td>Systematic review and quantitative meta-analysis, 2012</td>
<td>Thirty-one studies on rhinitis, allergic rhinitis, or rhinoconjunctivitis were included. The largest risk was observed in relation to mould odor (rhinitis: 2.18 [95% CI, 1.76-2.71]; allergic rhinitis: 1.87 [95% CI, 0.95-3.68]). The risk related to visible mould was also consistently increased (rhinitis: 1.82 [95% CI, 1.56-2.12]; AR: 1.51 [95% CI, 1.39-1.64]; rhinoconjunctivitis: 1.66 [95% CI, 1.27-2.18]). In addition, exposure to dampness was related to increased risk of all types of rhinitis. Remediation of moisture and mold damage is</td>
<td>12</td>
</tr>
<tr>
<td>Review of the literature and quantitative meta-analysis, 2013</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Conclusions

We suggest that recognition of DM-associated asthma and preceding respiratory problems due to DM exposure is important during the COVID-19 pandemic. Avoidance of mouldy environment should be highly recommended.

References


