Effects of Spice Dust on Lung Functions and Respiratory Symptoms in Spice Factory Workers in Selangor

HAMDAN NOOR, WAHIDAH SANSI, ZOLKEPLI OTHMAN and FARIDAH MOHAMAD

Jabatan Biologi, Fakulti Sains dan Pengajian Alam Sekitar,
Universiti Putra Malaysia
43400 UPM Serdang Selangor, Malaysia

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ABSTRACT
Exposure to spice dust has long been associated with increased prevalence of respiratory symptoms and reduced lung function in man. This study was carried out to investigate the effect of such exposure on the workers' lung function and respiratory symptoms in three spice-processing factories in Selangor. Spirometry measurements (VC, vital capacity; FVC, forced vital capacity; FEV1, forced expiratory volume in 1 second) were performed on 56 workers (39 males, 17 females) who were occupationally exposed to 2496µg/m³ respirable fine dust, PM10. The subjects also completed a set of standard respiratory questionnaires (modified ATS questionnaires). 61 persons from Universiti Putra Malaysia (36 males, 25 females) served as controls. The PM10 measurement in UPM was only 101µg/m³. Significant differences in VC, FVC and FEV1 were observed between the two groups for both the male and the female. In addition to the decrease in spirometric values, the workers also reported higher prevalence of respiratory symptoms compared to controls. Therefore, the study suggests that exposure to spice dust in the spice factories leads to an increased prevalence of respiratory symptoms and impaired lung function.

INTRODUCTION
As a multi-racial country, Malaysians enjoy a variety of dishes; many are hot and spicy. One of the major food ingredients is spice; dried parts of various plants cultivated for their aromatic and pungent components. The spice includes chili pepper, cinnamon, coriander, ginger, garlic etc (Zuskin et al. 1988). Because of the high demand, spice-processing factories become one of the major food-processing industries in Malaysia, involving many labourers.

Since the process of spice preparation involves grinding, the labourers are constantly exposed to spice dust. The health of workers exposed to highly dusty environment (especially particles less than 10µm) is of serious concern because it has been implied that chronic pulmonary problems afflict one of every five persons...
exposed to dust. Such problems include reductions in spirometry values, increases in chest tightness, and also wheezing (U.S. National Research Council 1989).

Occupational exposure to spice dust has been reported to cause allergic reactions manifested by dermatological, gastrointestinal or neurological symptoms (Zuskin et al. 1988). Adverse effect of the exposure on the respiratory system has been widely reported elsewhere. Brooks (1985) reported an association between numerous spices and occupational asthma. The spices includes garlic dust (Felleroni et al. 1981), cinnamon (Uragoda 1984), coriander, mace, ginger and paprika (Toorenenbergen and Dieges 1985), and buckwheat aerosols (Gohte et al. 1983). Fuller et al. (1985) reported irritation of the airways in relation to inhaled capsicum aerosols. In terms of other respiratory symptoms, Uragoda (1966) observed a very high incidence of sneezing, runny nose and cough among workers occupationally exposed to chili peppers. Blanc et al. (1991) confirmed the association between the exposure with complaints of cough. A high percentage of upper respiratory tract infections (URTI) symptoms including sneezing and runny nose was also observed in spice grinders in Singapore (49.2%) as reported by Chan et al. (1990).

Despite the above-mentioned evidence, no study on this occupational hazard has yet been reported in Malaysia although there are a large number of spice-processing factories in this country. This study was carried out to investigate the effect of exposure to respirable spice dust (PM$_{10}$) to the lung function and respiratory symptoms of workers employed in three spice factories in Selangor.

**MATERIALS AND METHODS**

This study involved a total of 117 participants and the usage of health questionnaires (for respiratory symptoms survey), a spirometer (lung function test) and a diaphragm pump (dust measurement). All instruments were calibrated prior to every session of test in every study location.

**Subjects and Locations**

Three similar spice factories located in Selayang, Puchong and Rawang were randomly selected as the study locations to represent spice factories in Selangor and Universiti Putra Malaysia (UPM) for the control.

Since smoking and asthma are known to be among the dominant confounders in spirometry studies, only those who were non-smokers and non-asthmatics were randomly selected to perform the spirometry test. The selected 56 workers (39 males, 17 females) from the 3 factories were constantly exposed to mixed spice dust including coriander, turmeric, chili, pepper, cardamom and cloves during the work-shifts. Almost all subjects did not wear masks to protect against dust inhalation. Such exposure was not experienced by the 61 controls (36 males, 25 females).

All parameters known to be major confounders in spirometry studies (sex, age, height, race) were taken into account in the analysis (Table 1).

**TABLE 1**

<table>
<thead>
<tr>
<th></th>
<th>Male (mean ± SD)</th>
<th>Female (mean ± SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Controls(36)</td>
<td>Workers(39)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>35.24 ± 62.46</td>
<td>37.05 ± 59.27</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>163.49 ± 34.80</td>
<td>164.83 ± 34.53</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>65.78 ± 72.56</td>
<td>67.78 ± 55.08</td>
</tr>
<tr>
<td>VC (L)</td>
<td>3.08 ± 3.24</td>
<td>2.65 ± 3.62</td>
</tr>
<tr>
<td>FVC (L)</td>
<td>3.14 ± 4.02</td>
<td>2.39 ± 3.56</td>
</tr>
<tr>
<td>FEV₁ (L)</td>
<td>2.26 ± 3.24</td>
<td>1.81 ± 3.18</td>
</tr>
<tr>
<td>FEV₁/FVC%</td>
<td>78.37 ± 3.05</td>
<td>71.36 ± 4.86</td>
</tr>
<tr>
<td>FEF₂₅-₇₅%</td>
<td>1.95 ± 4.20</td>
<td>2.08 ± 7.37</td>
</tr>
<tr>
<td>FMF₇₅ (s)</td>
<td>0.99 ± 3.56</td>
<td>0.86 ± 3.56</td>
</tr>
</tbody>
</table>

*significant difference (t-test, p<0.05)
Dust Measurement
Physiologically, only particles less than 10\(\mu\)m or PM\(_{10}\) (also termed as respirable dust) is known to be inhaled into the inner respiratory system, affecting the ventilatory lung function and also responsible for the prevalence of respiratory symptoms (Brewis 1985). Therefore, only PM\(_{10}\) was measured instead of total dust in the working areas. The PM\(_{10}\) concentration was determined using a diaphragm pump (Kimoto MP-1) that trapped particles less than 10\(\mu\)m on a 37mm diameter, 0.8\(\mu\)m pore size cellulose acetate filter paper. The PM\(_{10}\) concentration in \(\mu\)g/m\(^3\) was calculated using the formula below:

\[
\text{PM}_{10} \ (\mu\text{g/m}^3) = \frac{W \times 10^9}{F \times L \times T}
\]

W = weight of particles trapped on filter paper in gram
F = flow rate of air drawn into the sampling device (2L/min)
T = duration of sampling

The aerial sampling in both UPM and the factories was done continuously from 9.00 am-5.00 pm (working hours). The machine was placed as close to the workers as possible without disturbing them.

Lung Function Tests
Lung function tests were performed by the subjects during working hours using a spirometer (Vitalograph, England; ATS standards) with standard techniques (American Thoracic Society 1979). Each subject performed at least three attempts of VC (vital capacity) and FVC (forced vital capacity) with a gap of at least a minute between attempts. From the best curve, FEV\(_1\) (forced expiratory volume in 1 second) was determined, and other parameters including FEF\(_{25-75}\) (mid-expiratory flow volume) and FMFT (forced mid-expiratory flow time) were calculated. The measurements were then converted into BTPS unit. Height was also measured.

Respiratory Symptoms
Structured questionnaires based on the American Thoracic Society (1979) were distributed to each subject prior to lung function test. All of the participants were required to answer the questions in detail with regard to their personal and medical background, respiratory symptoms and history, smoking habit and occupational history.

RESULTS
Dust Measurement
Fig. 1 shows the values of PM\(_{10}\) concentration measured in UPM and the spice factories. In UPM, the dust concentration was only 101\(\mu\)g/m\(^3\). The mean concentration in the factories was 2496\(\mu\)g/m\(^3\), which was more than 20-fold higher than the control area. However, the level is far below the OSHA standards of 5000 for respirable dust for 8-hour exposure for workers. The high concentration measured in Factory 3 might be due to the non-stop working hours (2 shifts) and the fact that it was the largest operating spice factory compared to the other two. Despite the high concentration, the majority of the workers did not wear any mask.

Subjects
The subjects and controls were 16 to 59 years of age. Table 1 shows the physical background of the respondents. There is no significant difference in the physical parameters among the male
subjects, while for the females, a significant difference was observed in height (t-test, p<0.05).

Lung Function Tests
Table 1 also shows the spirometry values of the subjects. The workers performed significantly lower VC, FVC and FEV₁ compared to controls (t-test, p<0.05) for both the male and female groups respectively. The male workers also exhibited lower FEV₁/FVC% compared to controls, suggesting a possible obstructive problem in their lungs. Since other confounders such as age and height between the male workers and controls did not show any significant difference, a reduction in their lung functions could possibly be associated with exposure to spice dust. In the female groups, the reductions in lung functions of the workers were expected due to the significantly lower values of height compared to controls. However, the reductions might also be attributed to the additive effect of exposure to high concentration of spice dust during working hours.

Table 2 shows the spirometry values of the male workers according to period of employment. The male workers (no difference in other physical characteristics) who had worked more than 5 years showed significantly lower mean values of VC and FVC compared to those with less duration of service. These statistical results suggest that lung function might worsen if the workers are constantly exposed to spice dust over a long period of time.

Respiratory Symptoms
Table 3 compares the prevalence of chronic respiratory symptoms in the workers and control subjects. The most frequently reported symptoms was morning coughs, experienced by more than 80% male workers compared to none for the controls; followed by chest tightness, experienced by most of the workers especially during work-shifts. The female workers showed a higher percentage of respiratory symptoms compared to controls and the male groups.

### TABLE 2

<table>
<thead>
<tr>
<th>Period of employment</th>
<th>Less than 5 years</th>
<th>More than 5 years</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of subjects</td>
<td>15</td>
<td>24</td>
<td>0.1359</td>
</tr>
<tr>
<td>Age (years)</td>
<td>33.12 ± 11.58</td>
<td>37.48 ± 8.71</td>
<td></td>
</tr>
<tr>
<td>Height (cm)</td>
<td>164.89 ± 5.69</td>
<td>162.04 ± 5.66</td>
<td>0.0798</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>64.85 ± 9.39</td>
<td>66.76 ± 14.45</td>
<td>0.5761</td>
</tr>
<tr>
<td>VC (L)</td>
<td>2.85 ± 0.44</td>
<td>2.44 ± 0.64</td>
<td>0.0105*</td>
</tr>
<tr>
<td>FVC (L)</td>
<td>2.58 ± 0.32</td>
<td>2.22 ± 0.72</td>
<td>0.0250*</td>
</tr>
<tr>
<td>FEV₁ (L)</td>
<td>1.85 ± 0.35</td>
<td>1.77 ± 0.40</td>
<td>0.5694</td>
</tr>
<tr>
<td>FEF25-75%</td>
<td>1.95 ± 0.70</td>
<td>2.21 ± 1.54</td>
<td>0.4359</td>
</tr>
<tr>
<td>FMFT (s)</td>
<td>0.94 ± 0.59</td>
<td>0.78 ± 0.54</td>
<td>0.3191</td>
</tr>
</tbody>
</table>

*significant difference (t-test, p<0.05)

### TABLE 3

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Male Controls</th>
<th>Male Workers</th>
<th>Female Controls</th>
<th>Female Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Morning cough 4-5 times a week</td>
<td>–</td>
<td>86.3</td>
<td>–</td>
<td>96.4</td>
</tr>
<tr>
<td>2. Phlegm 4-5 times a week</td>
<td>2.5</td>
<td>49.0</td>
<td>4.0</td>
<td>50.0</td>
</tr>
<tr>
<td>3. Chest tightness During sickness During workshift</td>
<td>2.5</td>
<td>84.3</td>
<td>4.0</td>
<td>96.4</td>
</tr>
<tr>
<td></td>
<td>2.5</td>
<td>62.7</td>
<td>4.0</td>
<td>57.1</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>76.5</td>
<td>–</td>
<td>75</td>
</tr>
</tbody>
</table>
DISCUSSION
Our study suggests that constant exposure to high levels of spice dust in spice factories (even below the OSHA standards) might have possible adverse effects on the lung functions of the workers. Studies done on Yugoslavian spice workers showed similar findings even though the workers were exposed to a much lower dust concentration (Zuskin et al. 1988).

Despite the homogeneity in age, height and weight (determinants of lung capacity) between the participants, the workers showed significantly lower values of VC, FVC and FEV₁ compared to controls. Therefore, the reduction might be attributed to the difference in exposure level between the study groups.

The effect of spice dust on the workers was further evidenced by the significantly lower spirometry values shown by workers who have worked for more than 5 years, despite the insignificant difference in other confounders compared to those with less period of service. This observation strengthens our hypothesis that reduction in lung function is strongly associated with the constant exposure to spice dust over a long period of time.

Besides this chronic decrease in lung function, Zuskin et al. (1988) also reported acute reductions in lung functions after a work-shift in spice factory workers. Other researchers had also observed similar trend in workers exposed to tea and coffee dust (Jayawardana and Udupihille 1997; Zuskin et al. 1979; Zuskin and Skuric 1984).

As expected, higher prevalence of respiratory symptoms was reported by the workers. This phenomenon is in perfect agreement with other studies elsewhere, some of which had reported a higher incidence of respiratory symptoms even without significant reduction in pulmonary function (Blanc et al. 1991).

So far, this study on the effect of spice dust in Selangor is the first that had been reported in Malaysia. Therefore, comparison with data of a matched population from other parts of the country is not possible. No further study has yet been carried out to determine the chemical properties of the spice aerosols inhaled by these workers and the mechanisms of toxicity of the aerosol on their respiratory system.

However, we strongly believe that the mechanisms proposed by Zuskin et al. (1988) could play an important role in reducing lung function and increasing the prevalence of respiratory symptoms in the spice workers. The mechanisms include hyperreactivity due to increased permeability of the airway mucosa to irritants, resulting in the direct effect on the airway muscle damage to the airway mucosa, as represented by the presence of cough in most of the workers (Nadel et al. 1954; Boushey et al. 1980); repeated damage of the airway epithelium (Widdicombe 1954); and development of inflammation in the airways causing airway responsiveness (Cooper et al. 1986).

Zuskin et al. (1988) also suggested that the adverse effects of spice dust might be due to the release of mediators in the airway that might constrict airway smooth muscle directly or by reflex. Using disodium cromoglycate (DSC), they reported that spice dust affects airway cells causing the release of these mediators and therefore concluded that food spice has a bronchoconstrictor potential, resulting in reduced lung function and increased prevalence in respiratory symptoms, as observed in this study.

CONCLUSION
Observation from this study suggests that exposure to high PM₁₀ of spice dust in spice-producing factories in Selangor leads to increased prevalence of respiratory symptoms in the workers. The decrease in lung function among the workers also suggests that they might be facing other acute and chronic lung diseases. In addition, the high concentration of dust measured in the factories suggests that there is a need to improve the ventilation in these factories, and introduce personal protective equipment such as mask, in order to safeguard the respiratory system of workers.

REFERENCES


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