Serum complement in chronic liver disease

B. J. POTTER, ANGELA M. TRUEMAN, AND E. A. JONES

From the Department of Medicine, Royal Free Hospital, London

SUMMARY Total serum haemolytic complement activity (CH₅₀) and the serum concentrations of both the third and fourth components of the complement system (C3 and C4) have been measured in 29 control subjects, 92 patients with chronic hepatocellular disease, and eight patients with large duct biliary tract obstruction. The mean C4 concentration was reduced in all types of chronic liver disease studied. However, the mean CH₅₀ and C3 values were increased in compensated primary biliary cirrhosis, were relatively normal in non-cirrhotic chronic active hepatitis, and were decreased in cryptogenic cirrhosis, particularly when ascites was present. There was a significant correlation between CH₅₀ and C3 in patients with chronic liver disease but no correlation between CH₅₀ and C4 or between C3 and C4. Raised values for CH₅₀ and C3 in primary biliary cirrhosis may be due at least in part to concomitant cholestasis since these values tend to be raised in patients with large duct biliary tract obstruction. Although primary biliary cirrhosis, chronic active hepatitis, and cryptogenic cirrhosis are considered to be part of a spectrum of chronic liver disease associated with disturbed immunity, the results of this study emphasize that there are clearly definable differences between these diseases in terms of the pattern of changes in serum complement.

Although some types of chronic liver disease, such as chronic active hepatitis, primary biliary cirrhosis, and cryptogenic cirrhosis are usually associated with evidence of disturbed immunity, so far no immune mechanism has been demonstrated to be of fundamental importance in the pathogenesis of these diseases. One well established cause of cell lysis and death involves the complement system, classically activated by antigen-antibody interaction on a cell surface (Rapp and Borsos, 1970). If this immune process is responsible for liver cell injury in patients with chronic liver disease, there may be associated changes in serum complement. However, changes in the complement system may also arise as a consequence of the disease process itself.

It has previously been shown that patients with chronic liver disease tend to have a reduced total serum complement haemolytic activity (Goldner, 1929; Jordan, 1953; Asherson, 1960; Townes, 1967; Inai, Fujikawa, Naguki, Takahashi, Ozono, and Ishida, 1967; Farini, Gambari, Fagiolo et al, 1970; Pagaltos, Smith, Eddleston, and Williams, 1971; De Meo and Anderson, 1972; Torisu, Yokoyama, Kohler, Durst, Martineau, Schrotter, Amemiya, Groth, and Starzl, 1972) and a reduced serum concentration of the third component of complement (C3), (West, Northway, and Davis, 1964; MacLachlan, Rodnan, Cooper, and Fennell, 1965; Grob, Jemelka, and Muller, 1971; Deo Meo and Anderson, 1972; Torisu et al, 1972) but the values obtained for the two estimates in these studies were correlated neither with the patients' clinical state nor with the results of liver function tests. A comparison has been made between total serum complement haemolytic activity and the serum concentration of individual components of the complement system in patients with acute hepatitis (Alpert, Isselbacher, and Schur, 1971) and serial measurements of the serum concentration of C3 have been made in patients with acute infectious hepatitis and serum hepatitis (Kosmidis and Leader-Williams, 1972). We report here the results of measurements of the total serum complement haemolytic activity (CH₅₀) and the serum concentrations of both the third and fourth components of the complement system (C3 and C4) in control subjects and patients with chronic liver disease, including, in particular, patients with chronic active hepatitis, primary biliary cirrhosis, and cryptogenic cirrhosis. The data have been correlated both with the patients' clinical state and with the results of routine tests of liver function. Although chronic active hepatitis, primary biliary cirrhosis, and cryptogenic cirrhosis are considered to represent part of a spectrum of immunological...
liver disease (Read, 1971), the results of the present studies indicate that there are strikingly different patterns of change in the complement system in each of these disorders.

Patients and Methods

**Control subjects and patients**
The subjects investigated comprised 29 normal healthy controls, 92 patients with chronic hepatocellular disease, and eight patients with cholestasis unassociated with chronic liver disease. The patients with chronic liver disease included 30 patients with cryptogenic cirrhosis, 22 patients with chronic active hepatitis, 32 patients with primary biliary cirrhosis, and eight patients with cirrhosis of the alcoholic. The diagnosis in all of the patients with liver disease had been confirmed by needle biopsy of the liver. The distribution of age in all groups was similar with the exception of the group of patients with chronic active hepatitis who had a younger mean age distribution. There was a predominance of females in the groups of patients with primary biliary cirrhosis and chronic active hepatitis.

**Methods**
Ten ml of clotted peripheral blood was obtained from each subject. The serum was separated and stored at −20°C. Estimations of CH₅₀, C₃, and C₄ concentrations were made within 10 days of the sample being taken.

**Whole serum complement activity**
Duplicate determinations of the whole serum complement activity were made by the method of Kabat and Mayer (1961) as modified by Rapp and Borsos (1970). Sheep red blood cells in Alsever’s solution (Burrough’s Wellcome Ltd), after sensitization with rabbit haemolysin (Burrough’s Wellcome Ltd), were incubated for one hour at 37°C with varying dilutions of the test serum, made up to a total volume of 7.5 ml. The 50% lysis point was then determined by means of a Van Krogh plot, using values (determined spectrophotometrically) between 20 and 80% lysis. The serum volume for 50% lysis was then expressed as a reciprocal value to give CH₅₀ units. All samples were processed in parallel with a standard guinea-pig complement source (Burrough’s Wellcome Ltd). The reproducibility of the method was better than ± 10%.

**The third component of complement (C₃)**
The serum C₃ concentration was measured using the single radial immunodiffusion method of Mancini, Carbonara, and Heremans (1965) and antihuman C₃ prepared in rabbits (Hyland immunoplates). Three reference sera of known C₃ concentration (50, 100, 300 mg/100 ml) (Hyland Laboratories) were incubated at room temperature for 16 to 24 hours, together with each set of test sera. All estimates of C₃ concentration were made in duplicate. The reproducibility of the method was ± 10% which is in satisfactory agreement with the data of Kohler and Muller-Eberhard (1967).

**The fourth component of complement (C₄)**
The serum C₄ concentration was measured using the single radial immunodiffusion method of Mancini (Mancini et al., 1965) and an antihuman C₄ antiserum prepared in rabbits (Behringwerke). A reference serum of known C₄ concentration (18 mg/100 ml) (Behringwerke) was diluted to give several solutions containing different concentrations of C₄. These solutions were incubated for 24 hours at room temperature with each set of appropriately diluted test sera. The concentration of C₄ in diluted test sera always fell within the linear portions of the standard curve. All estimates of C₄ concentration were made in duplicate. The reproducibility of the method was ± 15%.

**Results**
The table gives the mean, SEM, and the number of estimates of CH₅₀, C₃, and C₄ respectively for each group of subjects studied. The values for each of the three estimates obtained in normal subjects agree satisfactorily with other similar data on normal subjects obtained by others (Klemperer, Gotoff, Alper, Levin, and Rosen, 1965; Kohler and Muller-Eberhard, 1967; Alpert et al., 1971).

**Differences in serum complement in different disease groups**
The mean C₄ concentration was significantly reduced in all groups of patients with chronic liver disease: in primary biliary cirrhosis (p < 0.0005), in chronic active hepatitis (p < 0.0005), in cryptogenic cirrhosis (p < 0.0005), and in alcoholic cirrhosis (p < 0.0005). There were clearly defined differences in the mean values for CH₅₀ and C₃ concentration in different groups of patients.

**Primary biliary cirrhosis**
In patients with well compensated primary biliary cirrhosis, whereas the mean C₄ concentration was significantly reduced (p < 0.05), the mean CH₅₀ value was increased (p < 0.0025), and the mean C₃ concentration was also increased (p < 0.0005) (fig 1). However, in patients with primary biliary cirrhosis who had developed ascites both the mean CH₅₀ (p < 0.005) and the mean C₃ concentration (p < 0.0005) were decreased.
Serum complement in chronic liver disease

<table>
<thead>
<tr>
<th></th>
<th>CH₁₀</th>
<th>C₃ (mg/100 ml)</th>
<th>C₄ (mg/100 ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normals</td>
<td>Mean</td>
<td>34.9</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>1.5</td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Cirrhosis</td>
<td>Mean</td>
<td>22.1</td>
<td>84.7</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>1.7</td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Primary biliary cirrhosis</td>
<td>Mean</td>
<td>36.3</td>
<td>170</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>2.5</td>
<td>11.3</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Alcoholic cirrhosis</td>
<td>Mean</td>
<td>33.8</td>
<td>134</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>5.3</td>
<td>23.0</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Chronic active hepatitis without cirrhosis</td>
<td>Mean</td>
<td>29.6</td>
<td>147</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>3.8</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Chronic active hepatitis with cirrhosis</td>
<td>Mean</td>
<td>21.9</td>
<td>64.6</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>3.5</td>
<td>10.1</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Cirrhosis without ascites</td>
<td>Mean</td>
<td>25.9</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>2.5</td>
<td>9.7</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Cirrhosis with ascites</td>
<td>Mean</td>
<td>19.4</td>
<td>67.6</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>2.2</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Primary biliary cirrhosis without ascites</td>
<td>Mean</td>
<td>43.7</td>
<td>208.6</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>2.5</td>
<td>9.9</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td>Primary biliary cirrhosis with ascites</td>
<td>Mean</td>
<td>24.0</td>
<td>91.8</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>3.8</td>
<td>9.0</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Biliary tract obstruction</td>
<td>Mean</td>
<td>33.0</td>
<td>205</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>4.3</td>
<td>25.2</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Table  Serum CH₁₀ and C₃ and C₄ concentrations in chronic liver disease

Fig 1  Serum CH₁₀ and C₃ and C₄ concentrations in normal control subjects and patients with compensated primary biliary cirrhosis.
**Chronic active hepatitis**

In contrast to patients with primary biliary cirrhosis, patients who had chronic active hepatitis that had not progressed to cirrhosis had values for CH$_{50}$ and C3 concentration that were little changed from those in normal subjects. However, in those patients with chronic active hepatitis that had progressed to cirrhosis, the mean CH$_{50}$ was significantly decreased ($p<0.0005$) and the mean C3 concentration was also decreased ($p<0.0005$).

**Cryptogenic cirrhosis**

In the group of patients with cryptogenic cirrhosis, the mean values for both CH$_{50}$ ($p<0.0005$) and C3 concentration ($p<0.0005$) were reduced. The mean values for CH$_{50}$ and C3 were particularly low once the patients had developed ascites (see table).

**Cirrhosis of the alcoholic**

The CH$_{50}$ and C3 values in the small group of patients with alcoholic cirrhosis were similar to those in normal subjects.

**Large duct biliary tract obstruction**

In patients with cholestasis due to large duct biliary tract obstruction, the mean CH$_{50}$ was little changed but the mean C3 concentration was elevated ($p<0.0005$), as was the mean C4 concentration ($p<0.0025$).

**Correlations between CH$_{50}$, C3, and C4**

There was a significant correlation between CH$_{50}$ and C3 in patients with chronic liver disease ($r = 0.672$; $p<0.001$) (fig 2). In contrast there was no significant correlation between CH$_{50}$ and C4 or between C3 and C4.

**Relationship of serum complement to biochemical tests of liver function**

The relationships between values of CH$_{50}$, C3, and C4, and the serum levels of bilirubin, alkaline phosphatase, aspartate transaminase, gamma globulin, and albumin were examined. There were slight but significant correlations between CH$_{50}$ and serum albumin ($r = 0.434$, $p<0.001$) and between C3 and serum albumin ($r = 0.277$, $p<0.05$) in the whole group of patients with chronic liver disease.

There was a negative correlation between C4 and serum gamma globulin in the whole group of patients with chronic liver disease ($r = 0.398$, $p<0.01$). Thus a low C4 concentration tended to be associated with a high gamma globulin concentration.

No other significant correlations were found. In particular values for CH$_{50}$ and C3 concentration in patients with primary biliary cirrhosis and large duct biliary tract obstruction did not correlate closely with the degree of cholestasis as measured by the serum levels of bilirubin and alkaline phosphatase.

**Other observations**

No relationship was found between values of CH$_{50}$ and C3 and C4 concentration and the titres of antimitochondrial antibody, smooth muscle antibody, and antinuclear factor.

Only four patients' sera were positive for hepatitis-associated antigen and the complement levels in these patients were not obviously different from those in

![Fig 2](http://gut.bmj.com/)  
*Correlation between serum CH$_{50}$ and C3 concentration in patients with chronic hepatocellular disease.*
Serum complement in chronic liver disease

similar patients whose sera were negative for this antigen.

No appreciable differences were apparent in values of CH₅₀, C₃, and C₄ in patients who were receiving prednisolone and/or azathioprine, compared with those in patients who were not receiving immunosuppressive therapy.

Discussion

The studies reported here provide results of three different measurements of serum complement in a group of patients with different types of chronic liver disease. Our studies supplement and extend the data of Finlayson, Krohn, Fauconnet, and Anderson (1972). Of particular interest is the finding that although chronic active hepatitis, primary biliary cirrhosis, and cryptogenic cirrhosis are considered to be part of a spectrum of chronic liver disease associated with disturbed immunity (Read, 1971), the results of the current studies indicate that there are clearly definable differences between these diseases in terms of changes in serum complement. In some of the diseases studied, values for CH₅₀, C₃, and C₄ did not change in parallel. This observation is highlighted by the lack of correlation between CH₅₀ and C₄ and between C₃ and C₄.

The pattern of values of serum complement in patients with compensated primary biliary cirrhosis was distinct. Whereas both the mean CH₅₀ and the mean C₃ concentration were increased, the mean C₄ concentration was reduced. These results are at variance with those of Pagaltsos et al. (1971), who found consistently low values for CH₅₀ in patients with primary biliary cirrhosis. However, these authors did not state whether their patients were in a well compensated phase of the disease. The values for CH₅₀ and C₃ concentration did not correlate closely with the degree of cholestasis as measured by the serum levels of alkaline phosphatase and bilirubin. However, raised values for total haemolytic complement activity have been found in patients with cholestasis due to large duct biliary tract obstruction (Jordan, 1953; Mandel and Lange, 1955; Asherson, 1960; Farini et al., 1970; Pagaltsos et al., 1971). The value for CH₅₀ was also raised in a patient with cholestasis due to chlorpromazine (Asherson, 1960). It would appear, therefore, that cholestasis could be a non-immunological cause of an increase in the total haemolytic complement activity.

The increased serum concentration of C₃ in patients with primary biliary cirrhosis is probably associated with an increased synthetic rate of this protein, and hence a higher catabolic rate. In one patient with primary biliary cirrhosis and a raised serum concentration of C₃, highly purified radioiodinated C₃ was injected intravenously and the plasma disappearance curve of radioactivity was defined. The calculated turnover rate of the protein was 9.99% of the intravascular pool per hour in the patient, compared with 1.87% in a control subject who had received some of the same labelled preparation (Potter, Trueman, and Jones, 1973).

An increased value for CH₅₀ may be associated with an increased serum concentration of one or more of the components of the complement system. That an increased mean value for CH₅₀ is associated with a decreased mean C₄ concentration in primary biliary cirrhosis suggests that C₄ is normally present in excess in the serum for normal activation of the complement system. Indeed, it has been suggested that other components, C₂ and C₅, are rate limiting in the complement cascade (Cooper and Muller-Eberhard, 1970). The association of increased concentrations of C₃ with decreased concentrations of C₄ in primary biliary cirrhosis implies that there are fundamentally different mechanisms involved in the control of the serum concentrations of these two proteins.

In contrast to CH₅₀ and C₃, the mean C₄ concentration was reduced in all groups of patients with chronic liver disease. The observation that low C₄ concentration tended to be associated with high serum gamma globulin values suggests an association with abnormal immunological activity but does not necessarily imply the utilization of C₄ in an immune process.

There are a number of possible mechanisms which could account for low values for serum complement in patients with chronic liver disease. (1) If some complement components are synthesized by the hepatic parenchymal cells (Alper, Johnson, Birtch, and Moore, 1969; Colten, 1972), their synthetic rate may be reduced as a direct consequence of injury and death of these cells. (2) If some complement components are synthesized at extrahepatic sites (Colten, Borsos, and Rapp, 1966; Littleton, Kessler, and Burgholder, 1970), then their synthetic rate may be reduced by the effect of metabolic disturbances associated with liver failure on the synthetic mechanisms. (3) There may be circulating inactivators of complement components (Spitzer, Valtota, Forristal, Sudor, Stitzel, Davis, and West, 1969; Peters, Martin, Weinstein, Cameron, Barratt, Ogg, and Lachmann, 1972). (4) There may be increased consumption by antigen-antibody complexes and consequently increased activation of complement (Lachmann, Muller-Eberhard, Kunkel, and Paronetto, 1961; Wilson and Dixon, 1970; Kohler and Ten Bensel, 1969). (5) There may be increased endogenous catabolism or increased loss of these
components into the urinary or gastrointestinal tracts. Finally, the tendency for the plasma volume to be increased in these patients could be a contributory factor (Lieberman and Reynolds, 1967).

Further insight into the mechanisms responsible for low values for serum complement in chronic liver disease may come from studies of the metabolic behaviour in vivo of purified radiodinated complement components and the screening of sera from these patients for conversion products of individual components. In the present series the values for serum complement tended to be particularly low when there was evidence of severe hepatic decompensation, such as ascites. Even in these patients or in patients with massive hepatic necrosis (Fox, Dudley, and Sherlock, 1971) it cannot be assumed that low levels of serum complement can be attributed wholly to a reduced synthetic rate by the liver. The sites of synthesis of the various complement components are not established with certainty and even if their synthetic rate is reduced, there may be concomitant increased consumption of these components.

The authors are indebted to Mr J. Skinner for excellent technical assistance. They gratefully acknowledge financial support from the Stanley Johnson Fund. A.M.T. was in receipt of a research fellowship from the Ingram Trust.

References


B. J. Potter, Angela M. Trueman, and E. A. Jones


Serum complement in chronic liver disease

B. J. Potter, Angela M. Trueman and E. A. Jones

*Gut* 1973 14: 451-456
doi: 10.1136/gut.14.6.451

Updated information and services can be found at:
http://gut.bmj.com/content/14/6/451

**Email alerting service**

*These include:*

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Notes**

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/