Alimentary tract and pancreas

Systemic and local antibody responses to gastric Campylobacter pyloridis in non-ulcer dyspepsia

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SUMMARY Antibody titres to Campylobacter pyloridis in serum and gastric juice were estimated by an enzyme linked immunosorbent assay (ELISA) to whole organisms obtained from bacterial culture in 39 patients with non-ulcer dyspepsia. Whereas 20 of the 21 patients with chronic gastritis had gastric C pyloridis, 17 patients with no C pyloridis had normal histology in the gastric antrum and body. Significantly raised serum IgG and IgA antibody titres to C pyloridis were found in colonised patients with gastritis. Patients with raised IgG antibody to C pyloridis were also shown to have significantly raised titres to other Campylobacter species, suggesting antigenic cross reactivity. Gastric juice antibodies were also studied and IgA titres to C pyloridis were detected in a proportion of patients with gastritis, together with low levels of IgM, but no IgG.

The presence of spiral organisms in the stomach has been noted on a number of occasions dating back to 1938.1-3 It was only recently, however, that the significance of gastric spiral organisms was recognised by Warren4 and Marshall5 who identified the previously detected curved bacilli on the gastric epithelium of the majority of patients with active chronic gastritis by the Warthin-Starry silver stain. Morphologically, and in respect to their atmospheric requirements and DNA base composition, these organisms are most closely related to the genus Campylobacter.6 Reports from a number of workers have all confirmed the presence of these organisms in the majority of patients with gastritis.6,7 The organism was originally described as a ‘Campylobacter-like organism’ (CLO) but has now been formally named Campylobacter pyloridis.1 2 It remains to be seen whether C pyloridis is involved in the pathogenesis of chronic gastritis, or is merely a commensal organism.

Little is known of host defences to C pyloridis, either at the systemic or the local level. Jones et al11 studied circulating antibody to C pyloridis by agglutination and complement fixation techniques. They showed raised titres in C pyloridis positive patients, but did not analyse the response by antibody class, and hence shed little light on the host response.

To further characterise the serum and local antibody response, we have studied circulating and gastric juice antibodies to C pyloridis, with particular reference to antibody class. In addition, we compared serum antibody titres with other strains of gastric C pyloridis isolated from different patients, and to other Campylobacter species.

Methods

Patients
Thirty nine patients (21 men, mean age 41 years) without peptic ulceration were studied. Endoscopic biopsies were obtained for histology and bacterial isolation and culture. Serum and fasting gastric juice were collected for antibody assay.

Endoscopy
The examination was carried out by one endoscopist using an Olympus GIF-T fiberoptic gastroendoscopy, sterilised between patients with Dettox (Reckitt & Colman). Fasting gastric juice samples were collected and stored at −20°C. Biopsies were taken from the gastric body on the greater curve and the antral floor. The biopsies for histology were immediately fixed in 10% buffered formalin. An additional antral biopsy was also placed in Stuart’s
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transport medium (Oxoid) before microaerophilic culture.

HISTOLOGY
Antral and body biopsies were routinely processed and stained with haemotoxylin and eosin, to determine the presence of chronic gastritis, and with a Warthin-Starry silver stain technique to identify the C pyloridis. One histopathologist (JW), without knowledge of the clinical details, examined the sections using the classification of Whitehead et al.13 to determine the presence and degree of chronic gastritis.

Bacterial cultures
Gastric antral biopsies were suspended in 0·5 ml 1% tryptone diluent and homogenised using a glass Griffiths tube. Ten microlitre aliquots of homogenate were cultured on heated blood agar incubated at 37°C under microaerophilic conditions for at least four days. The organisms produced characteristic 0·5–2 mm light brown convex entire colonies, identified by their characteristic biotyping, being gram negative, oxidase positive, catalase positive, indole negative, hydrogen sulphide positive, urease positive and nalidixic acid resistant.14 The positively identified organisms were purified and stored in glycerol broth in liquid nitrogen.

C pyloridis preparations for the ELISA (enzyme linked immunosorbent assay, see next section) were derived from stored strains, grown in freshly prepared brain heart infusion medium (Oxoid) supplemented with 10% calf serum and 5 μg/l haemin under microaerophilic conditions at 37°C for two days with continuous agitation. Cells were harvested by centrifugation at 1500 g for 10 minutes, washed twice in PBS (phosphate buffered saline) and fixed in 4% formaldehyde in PBS for 10 minutes. The C pyloridis were then washed three times in PBS and stored in PBS containing 0·1% azide at 4°C until used.

Strains of C fetus and C faecalis were kindly provided by Dr M D Skirrow (Worcester). C spurtorum subspecies sputorum (NCTC 11528) was obtained from the National Collection of Type Cultures and C jejuni from the departmental collection. For certain experiments a strain of Escherichia coli 0 type 011 was used in place of C pyloridis.

ENZYMELINKEDIMMUNOSORBENTASSAY(ELISA)
An indirect ELISA procedure15 was used wherein whole formalised bacteria from one patient were attached to 'Microtitre' plates (Dynatech Laboratories) at 5 × 10⁶ organisms/well by means of methyl glyoxal.16 After washing in PBS containing 0·1% Tween 20 (PBS/Tween), active sites were quenched with 0·5% bovine serum albumin (BSA) in PBS/Tween. Serum samples were diluted in PBS/Tween containing 1% BSA. Gastric juice samples were neutralised to pH 6·5–7 by 1/3 dilution in 0·67 M Tris-HCl pH 7·4 in 0·15 M saline. All samples were incubated in sextuplicate for 90 minutes at 37°C. Plates were washed four times in PBS/Tween, and re-incubated with alkaline phosphatase-conjugated anti-human IgG, IgA or IgM (Sigma) diluted 1/200 in PBS/Tween/BSA as above. After a further four washes, antibody binding was estimated by reactivity with p-nitrophenyl phosphate substrate at 25°C, and quantitated by optical density measurement at 405 nm.

Control sera and blanks were included in each assay. Values for test samples were normalised with respect to the control references to correct for minor day-to-day variations in the assay.15 The in-run coefficient of variation was <5% and the between-run coefficient <10%.

Total immunoglobulin contents were estimated by ELISA using polyclonal anti-Ig as the solid phase with class specific conjugates.

The ELISA data are presented as optical measurements at 405 nm and statistical analysis was by the two tailed Mann-Whitney U-test.

Results
Eighteen patients had entirely normal antral and body mucosa, 21 had chronic gastritis, which was limited to the gastric antrum in seven. There were no patients with an inflamed gastric body and a normal gastric antrum. The histology is summarised in Table 1. No C pyloridis were detected on biopsies from patients with normal histology, while all but one of the patients with chronic gastritis had demonstrable C pyloridis in one or both biopsies.

SERUM ANTIBODIES TO CLOs
C pyloridis cultured from one patient were used to

<table>
<thead>
<tr>
<th>Degree of Gastritis*</th>
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<tbody>
<tr>
<td></td>
<td>Nil</td>
<td>Superficial or mild atrophic</td>
</tr>
<tr>
<td>Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C pyloridis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- positive</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>- negative</td>
<td>18</td>
<td>0</td>
</tr>
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The presence and degree of chronic gastritis in 39 patients with or without Campylobacter pyloridis.

*Assessed by the criteria of Whitehead et al.11
assay the circulating antibody titres (Fig. 1). While all sera examined contained antibody to *C pyloridis*, the *C pyloridis* positive patients had significantly higher IgG and IgA titres than the *C pyloridis* negative patients; the difference being more marked for IgG. IgM titres were not statistically different between the two groups, each showing a wide range of values. Total serum IgG, IgA and IgM showed no significant difference in titres between the two groups, as did an assay of antibodies to *Escherichia coli* (Table 2).

**Circulating IgG to Different Patients**

*C pyloridis*

To investigate antigenic differences between strains of *C pyloridis* from different patients, six samples of serum showing high IgG titres to our reference *C pyloridis* were compared with six low titre sera. Assays were carried out using five different *C pyloridis* strains under identical conditions. The high titre sera to the reference *C pyloridis* strain also showed consistently high titres to the other strains of *C pyloridis*, implying antigenic cross reactivity (Fig. 2). There was marked variability in the ranking order of the high titre sera to different *C pyloridis*, which suggests a degree of antigenic variation between the strains.

**Circulating IgG to Other Campylobacter Species**

Using the same six high and six low titre samples to the reference *C pyloridis* strain, the assay was

### Table 2  Immunoglobulin and antibody levels to *E coli* in Campylobacter pyloridis positive and negative patients

<table>
<thead>
<tr>
<th>Immunoglobulin class</th>
<th>Total serum immunoglobulins</th>
<th>Antibody* to <em>E coli</em></th>
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<tbody>
<tr>
<td></td>
<td><em>C pyloridis</em></td>
<td><em>Negative</em></td>
</tr>
<tr>
<td>IgG</td>
<td>91±16</td>
<td>95±14</td>
</tr>
<tr>
<td>IgA</td>
<td>134±10</td>
<td>128±13</td>
</tr>
<tr>
<td>IgM</td>
<td>77±32</td>
<td>72±28</td>
</tr>
</tbody>
</table>

Mean values (±standard deviations) for total immunoglobulins and antibody titres of *E coli* organisms for patients with and without *Campylobacter pyloridis*. Results are based on ELISA optical density measurement.

*Arbitrary values not directly comparable with serum immunoglobulin concentrations.

### Fig. 1  Serum IgG, IgA and IgM titres to *C pyloridis* in bacteria positive (●) and negative (○) patients. Statistical analysis by the two tailed Mann-Whitney U-test.

### Fig. 2  IgG antibody titres to five different *C pyloridis* strains (obtained from different patients) in six patients with high titres (H) and six patients with low titres (L) to the reference *C pyloridis*. The differences between high and low titre groups were significant (p<0.05) for all *C pyloridis* strains.
Fig. 3  IgG antibody responses to four different Campylobacter species in six patients with high titres (H) and six patients with low titres (L) to the reference C pyloridis. The differences between high and low titre groups were significant (p<0.05) for the four species tested.

Fig. 4  Gastric juice IgG, IgA and IgM titres to C pyloridis in bacteria positive (●) and negative (○) patients, showing demonstrable titres in a proportion of the C pyloridis positive patients.

repeated using the listed Campylobacter species. Patients with high serum titres to the reference C pyloridis were found to have consistently higher titres against the other Campylobacters, which suggests antigenic cross reactivity (Fig. 3).

GASTRIC JUICE ANTIBODIES TO C PYLORIDIS
IgG, IgA and IgM titres were studied in 22 fasting gastric juice samples from C pyloridis positive and negative patients. Raised IgA titres were seen in a proportion of the C pyloridis positive patients and IgM was detected in a smaller number. No significant IgG titres were detected in either C pyloridis positive or negative groups (Fig. 4).

Discussion
To date, no satisfactory explanation for the pathogenesis of chronic gastritis has been advanced; it has been generally accepted that chronic gastritis represented the end result of many different insults to the gastric mucosa. The discovery of gastric C pyloridis associated with chronic gastritis raises the possibility that these organisms may be involved in pathogenesis. Alternatively, they may represent an opportunistic coloniser taking advantage of the alterations of mucus or epithelium. It is also possible that gastric C pyloridis are secondary pathogens colonising patients with inactive chronic gastritis,
but causing the active polymorphonuclear cell response(134,595),(824,638) which is usually seen in colonised patients.4

Whatever the role of the organism in gastritis and its mode of spread, it appears that C pyloridis is ubiquitous. It is not surprising to find that all patients tested had measurable serum antibodies to C pyloridis: what is of more interest is that although serum IgG and IgA titres in the C pyloridis positive group were significantly raised, the IgM titres in both groups were similar. This is most likely explained by the C pyloridis colonisation being relatively longstanding. One would only expect a raised IgM response to the initial infection, whereas with continued colonisation, the IgM response would decrease and, even with subsequent recolonisation or recrudescence of infection, no further IgM response would be expected.

The assay technique used was aimed at detecting surface coat antigens. Our results with other Campylobacter species suggest a degree of antigenic crossreactivity, although absorption experiments are necessary to confirm this and are the subject of further study. Using an acid extracted bacterial cell lysate, a specific assay for C jejuni antibodies has been developed17; by using a similar technique for antigen preparation, it may be possible to assay for antibodies specific for the various species of Campylobacter.

Circulating IgG antibodies are clearly of major importance in the immune defence against invasion by microorganisms, but they probably have little relevance to local mucosal surface immunity. The dominant antibody class of seromucous secretions is dimeric secretory IgA. Although the exact role of secretory IgA in local immunity is unclear, its ability to render bacteria mucophilic may be an important factor in the defence against microorganisms.18 In chronic gastritis, the ability to secrete IgA is enhanced in the mucous neck cells19; it has been proposed that this secretory mechanism develops as a result of increased epithelial immaturity,20 which is secondary to the increased epithelial cell turnover associated with chronic gastritis.21 We have detected IgA antibodies to C pyloridis in the gastric juice of gastritic C pyloridis positive patients and have some evidence to suggest that C pyloridis on gastritic mucosae may be coated with IgA antibodies.22 Nevertheless, the presence of anti-C pyloridis IgA class antibody in the stomach clearly does not eliminate the infection in gastritic patients. The local gastric antibody response, possibly causing the organisms to be mucophilic, may itself partly explain the characteristic position of colonising C pyloridis, deep in the gastric mucus layer.

In conclusion, we suggest that C pyloridis are ubiquitous organisms capable of eliciting both a systemic and local antibody response in patients with chronic gastritis. Our data suggest that the secretory antibody response does not eliminate colonisation. This antibody response, however, may be of some importance in inhibiting bacterial adherence and invasion.

References
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