Local immunoglobulin production is different in gastritis associated with dermatitis herpetiformis and simple gastritis

K VALNES, P BRANDTZAEG, K ELGJO, R STAVE, K BAKLIEN, AND O FAUSA

From the Laboratory for Immunohistochemistry and Immunopathology, Institute of Pathology, and Department of Internal Medicine A, University of Oslo, The National Hospital, Rikshospitalet; Department of Internal Medicine and Blood Bank and Department of Immunology, Ullevål Hospital, Oslo, Norway

SUMMARY The degree of inflammation and atrophy in gastric body mucosal specimens (n=38) from 28 patients with dermatitis herpetiformis (DH) was graded histologically. Immunoglobulin (Ig) producing cells were enumerated by paired immunofluorescence staining in a 500 μm wide section area from the muscularis mucosae to the lumen (mucosal ‘tissue unit’). The number of immunocytes of the three main classes (IgA, IgM, and IgG) was significantly raised with increasing degree of gastritis. All three classes were increased in specimens showing atrophy compared with those without atrophy. IgA cells predominated as in simple gastritis, but a striking difference was a marked increase of IgM cells in specimens with the most pronounced DH-associated gastritis. Relative class distribution of immunocytes within different mucosal zones showed that the percentage of IgA cells was significantly higher in the luminal than in the basal zone, whereas the contrary was true for IgG cells. IgM cells did not show any zonal preference. No relation was seen between small bowel and gastric lesions. The disproportionate increase of gastric IgM producing cells in DH might nevertheless reflect seeding of precursor cells of the secretory immune system generated in the proximal small intestine where the local IgM response is relatively pronounced.

Occurrence of gluten sensitive enteropathy in patients with dermatitis herpetiformis (DH) is well documented.1 The additional presence of a gastric lesion was first indicated when circulating antibodies to parietal cells were found in such patients.2 A high prevalence of gastric acid hyposecretion and atrophic gastritis associated with DH was later confirmed in several studies.3,4,5

The DH related atrophic gastritis has much in common with that found in pernicious anaemia, both in terms of severity, localisation to the gastric body, and a possible autoimmune pathogenesis. Autoimmune gastritis of pernicious anaemia and other disorders cannot be distinguished from severe atrophic gastritis in patients with dyspeptic diseases by conventional histological examination.6 In a previous study of normal and diseased gastric mucosa we showed that immunoglobulin A (IgA) producing cells always predominated, indicating a highly activated secretory immune system.7 A severe degree of simple chronic gastritis and glandular atrophy, however, was associated with disproportionately increased local production of IgG.8 Although IgG is probably of significance in the gastric mucosa in terms of internal or ‘second line’ defence it may, at the same time, contribute to the pathogenesis of gastritis through immunopathological mechanisms.

The aim of the present study was to characterise such immunological features in the gastric mucosa of
patients with DH as nothing apparently was known about DH-associated gastritis in this respect.

**Methods**

**Sampling and Tissue Preparation**

Gastric body tissue specimens (n=38) were obtained through a radiographically controlled multiple biopsy capsule from nine women and 19 men with DH (median age, 51 years; range, 14–69 years). The diagnosis of DH was based on clinical and histological criteria and on the presence of IgA deposits in uninvolved skin. In 22 of the patients intestinal biopsy specimens were examined for histological grading of the intestinal lesion. Blood samples for determination of serum autoantibodies were obtained from 21 of the patients (matched for age and sex).

Body mucosal specimens (n=117) of simple gastritis associated with various disorders described elsewhere were used as controls. Of the latter material altogether 13 specimens obtained from seven women and four men (median age, 40 years; range, 28–54 years) with untreated coeliac disease (CD) were separately studied in comparison with the DH specimens.

All tissue specimens were prewashed in isotonic phosphate buffered saline (PBS; 0·01 M phosphate buffer, pH 7·6, containing 0·15 M NaCl) for 48 hours at 4°C to remove extracellular Ig and processed by cold ethanol fixation and embedding in paraffin.

**Immunohistochemical Procedures and Tests for Autoantibodies**

The characteristics and applied combinations of fluorochrome conjugates have been reported previously. Immunocytes of two different cytoplasmic Ig classes were counted by paired direct immunofluorescence (DIF) staining in the same tissue section. The three major classes (IgA, IgM, and IgG) were identified by means of both a fluorescein isothiocyanate (FITC) and a tetramethylrhodamine isothiocyanate (TRITC) conjugate in serial sections cut at 6 μm from each specimen, whereas IgD and IgE were stained concurrently in a single section with TRITC and FITC conjugate, respectively.

Indirect immunofluorescence test on cryostat sections of rat tissues was used for detection of serum autoantibodies to nuclear (ANA), smooth muscle (SMA), mitochondrial (AMA) and gastric parietal cell (GPC) antigens. Similar testing for autoantibodies to adrenal cortex (AC) antigens was done on human adrenal tissue. Antibodies to thyroglobulin (THG) and thyroid microsomal (THM) antigens were detected by passive haemagglutination technique using commercially available kits (Thymune T and Thymune M, Wellcome Reagents Ltd, Beckenham, England).

**Microscopy, Cell Counting and Evaluation of Results**

Histopathological classification of the gastric specimens was based on conventional microscopy of serial sections stained with a haematoxylin, azophloxine and saffron (HAS) trichrome method as described elsewhere. This evaluation was carried out blindly by another observer who graded the gastric material according to inflammatory index (0–3) and atrophy (0–2). The intestinal specimens were categorised in three groups by stereomicroscopy and histology: group I (normal or minor abnormality), group II (intermediate abnormality), and group III (major abnormality).

Direct immunofluorescence stained tissue sections were examined and photographed in a Leitz Orthoplan microscope equipped with a Ploem-type vertical illuminator. Counting of Ig producing immunocytes (purely red or green cytoplasmic staining) was done by projecting double exposed colour slides at a final magnification of ×500. The counts were based on a 500 μm wide mucosal 'tissue unit' including the full height of the mucosa. A 200 μm luminal zone and a remaining basal zone of this unit were evaluated separately. Comparison of cell counts was done by Wilcoxon's test for unpaired samples (two-tailed) with a chosen level of significance at 5%.

![Fig. 1](http://gut.bmj.com/images/1590a.png)
**Results**

Both inflammatory changes and atrophy in the gastric body were significantly more pronounced in DH than in CD (Fig. 1). In CD these gastric body histopathological changes were similar to those seen in patients with gastric and duodenal ulcer or various other disorders.

Ig producing cells of the three main classes were clearly visualised with green and red fluorescence by paired DIF staining. Cells with cytoplasmic IgD and IgE were occasionally seen but were discounted because of their small number (<1%).

**Ig producing cells related to grade of gastritis**

Both totally and within each mucosal zone of the DH specimens the number of Ig producing cells increased significantly from gastritis grade 0 to grade 2 and also from grade 1 to grade 3 (Fig. 2). Compared with the other immunocyte classes, however, the increase of IgM cells in grades 2 and 3 was strikingly disproportionate (Table).

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**Table** Numeric increase factors for IgA, IgM and IgG producing cells in gastric body specimens graded histopathologically according to degree of inflammation in patients with dermatitis herpetiformis (DH) or simple gastritis (SG)*

<table>
<thead>
<tr>
<th>Grade of gastritis</th>
<th>DH</th>
<th>SG</th>
<th>DH</th>
<th>SG</th>
<th>DH</th>
<th>SG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1</td>
<td>1-7</td>
<td>2-2</td>
<td>1-9</td>
<td>2-8</td>
<td>1-1</td>
<td>4-3</td>
</tr>
<tr>
<td>Grade 2</td>
<td>6-3</td>
<td>5-5</td>
<td>12-0</td>
<td>6-5</td>
<td>9-5</td>
<td>18-5</td>
</tr>
<tr>
<td>Grade 3</td>
<td>10-9</td>
<td>18-6</td>
<td>18-5</td>
<td>9-7</td>
<td></td>
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</tr>
</tbody>
</table>

*Numeric increase factors represent relative increase of Ig producing cells per mucosal ‘tissue unit’ compared with specimens without inflammation (grade 0) in subjects with or without DH, respectively.

No differences in immunocyte numbers were found when specimens of gastritis grade 0 and 1 in the DH material were compared with the corresponding grades in all patients with simple gastritis (Fig. 2) or in those with concurrent CD. Conversely, in gastritis grade 2 the number of IgM cells was significantly increased.

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**Fig. 2** Median total number and 95% confidence interval (range for n=4 and n=7) of IgA, IgM, and IgG producing cells per mucosal ‘tissue unit’ in gastric body specimens from patients with DH associated (a) and simple gastritis (b) in relation to grade of gastritis. Upper and lower parts of columns indicate median cell numbers in luminal and basal zones, respectively (see text). Percentage class distribution of immunocytes is given below the columns. n= number of specimens. Significant differences between DH associated and simple gastritis in total number of cells is indicated (*).
increased in DH compared with simple gastritis – that is, 31 ± 14.3 cells per mucosal ‘tissue unit’ (Fig. 2). No such comparison could be done for grade 3 because the simple gastritis material did not contain specimens with that grade.

Relative class distribution of immunocytes within different mucosal zones showed in all gastritis groups that the percentage of IgA cells was significantly higher in the luminal than in the basal zone, whereas the contrary was true for IgG cells. IgM cells did not show any zonal preference.

**DISTRIBUTION OF Ig PRODUCING CELLS RELATED TO GRADE OF GLANDULAR ATROPHY**

A significantly increased number of all three immunocyte classes was found when specimens without atrophy were compared with those showing atrophy of grade 1 (Fig. 3). No further increase was observed for grade 2, apparently because the height of the mucosal ‘tissue unit’ was reduced. The percentage class distribution was similar in groups with different grades of atrophy (Fig. 3).

**GASTRIC LESION RELATED TO SMALL INTESTINAL MORPHOLOGY**

In 22 patients gastric and small intestinal morphology could be compared. The inflammatory and atrophic indices for each patient were based on single or multiple tissue sections from 1 to 4 specimens. No relationship was found between gastric and small intestinal lesions (Fig. 4).

**AUTOANTIBODIES IN SERUM**

Gastric parietal cell (GPC) antibodies were detected in three of the 21 patients tested; two had in addition ANA, AC, and THM antibodies. SMA antibodies were detected in two patients and THG and THM antibodies in one patient. Four other patients showed weakly positive reactions against THM. In 10 patients with CD (n=4) or non-ulcer dyspepsia (n=6) no autoantibodies were detected.

**Discussion**

IgA was the predominating class of mucosal immunocytes regardless of the severity of the gastric lesion associated with DH. This feature was consistent with our previously reported results in patients with unspecified ‘simple’ gastritis. The most remarkable finding in DH gastritis was a substantial number of IgM producing cells in specimens with the two highest inflammatory grades (16% and 20% of the immunocytes, respectively). Expressed by numeric increase factors compared with normal mucosa, IgM cells showed the most pronounced rise
in all inflammatory groups. This was different from simple gastritis and has to our knowledge not been reported previously.

Locally produced IgA and IgM contribute to Secretary immunity" but the antigenic stimulus underlying the pronounced gastric IgM response in DH is unknown. It is interesting in this respect that there is an increased number of IgM producing cells in the duodenal mucosa of DH patients who are not on a gluten free diet compared with those who are.20,21 None of our patients was on a gluten free diet when biopsy was carried out.

The subclass distribution of IgA producing cells has indicated a closer relationship between the secretary immune system of the gastric and duodenal mucosa than between the proximal and distal intestine.22 No histopathological relationship was found, however, between the gastric and the small intestinal lesions in this study, which is in keeping with other reports.3,15 Moreover, a recent study showed that the gastric lesion did not improve during gluten free diet.23 This indicates that disturbed small bowel function is not the cause of the gastric abnormality. Several other possibilities have been discussed, such as iron, zinc or other trace metal deficiencies, genetic factors or Dapsone treatment.9

IgM antibodies can activate complement and may thereby contribute to the chronicity of gastritis and glandular atrophy. A higher degree of systemic complement activation has been observed in patients with DH who are not on gluten free diet compared with those who are.9 With intensified gastritis an increase of IgG cells in gastric body mucosa of patients with DH indicated altered mucosal immunologic homeostasis.25 It is of interest in this context that local IgG cells with antibody specificity for intrinsic factor have been observed in pernicious anaemia.26 Dermatitis herpetiformis patients with gastric lesions have a higher prevalence of parietal cell (GPC) antibodies than those without gastric atrophy,9 suggesting that an autoimmune mechanism may be involved in the pathogenesis. The occurrence of GPC and thyroid autoantibodies in the present DH material corresponded roughly to other reports.27

Our finding of a higher degree of inflammation and atrophy in the body mucosa of patients with DH than in those with CD is in keeping with previous studies.2,9 This difference is also true after adjustment for age.9 Patients with CD may have increased prevalence of gastric acid hyposecretion and gastric atrophy,28 however, although other studies have indicated a relative low prevalence of achlorhydria.29,30

The gastric lesion in DH, along with the skin lesion (for review, see ref 27), is the most important difference between DH and CD. It is not known whether there is any relationship between the gastric lesion and the skin lesion. Moreover, the role of circulating immune complexes in the pathogenesis of DH is not clear.13–15 It is interesting that the skin deposits contain dimeric IgA of the IgA1 subclass,31 compatible with an origin from gastric and duodenal plasma cells.22

This study confirms previous reports that severe atrophic body gastritis is frequently associated with DH without being related to the severity of the small bowel lesion. The overall pattern of local Ig production in DH associated gastritis corresponded to that seen in simple gastritis with the exception of a remarkably disproportionate increase of gastric IgM producing cells in DH. This might reflect seeding of precursor cells of the secretary immune system generated in the proximal small intestine where the local IgM response is relatively pronounced. As there is no evidence for gluten involvement, autoantigens may, instead, partly explain the persistent immunopathology of DH associated gastritis.

References


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