Cytosolic retinoic acid binding protein in the human pancreas

J K JUTLEY, J KELLEHER, T G BRENNAN, M E DENYER, AND C J MITCHELL

From the Departments of Medicine and Surgery, St James's University Hospital, Leeds

SUMMARY Cytosolic retinoic acid receptor in carcinoma, chronic pancreatitis, and normal pancreatic tissue were examined using sucrose density gradient centrifugation, isoelectric focussing on agarose gel and saturation analysis. Thirteen patients were studied. Cytosolic retinoic acid binding protein (cRABP) was detected in all the samples with chronic pancreatitis and pancreatic carcinoma, but not in the normal tissue. Using sucrose gradient centrifugation, the highest concentrations of cRABP were found in pancreatic carcinoma tissues, ranging from 5·5–23·9 pmol/mg protein. These concentrations were markedly different than in chronic pancreatitis tissue (0·7–2·7 pmol/mg protein). Saturation analysis of cRABP showed a mean dissociation constant of 21·5 nM and maximum binding sites of 5·2 pmol/mg protein. Cytosolic retinoic acid binding protein was separated at an isoelectric point of 4·5 on agarose gel. The presence of cRABP suggest that retinoic acid may have a role to play in the function of the pancreas.

Retinoic acid is essential for normal growth and differentiation of epithelial cells. There is a large body of evidence to suggest that retinoic acid and its synthetic analogues may prevent preneoplastic changes caused by carcinogens in epithelial cells.1–3 Chemically induced benign and malignant states in in vitro systems were prevented by vitamin A and its analogues.4–6 Thaller and Eichele' have recently reported that chick limb buds contain endogenous retinoic acid which acts as a chemical mediator with morphogenic properties.

The mechanism by which retinoic acid mediates its effects is poorly understood. Murtaugh et al9 reported that retinoic acid induces alteration in gene expression, as seen on normal and leukaemic myeloid cells, whereby retinoic acid enhances tissue transglutaminase mRNA concentrations. It is thought to act through specific binding proteins, in a manner analogous to steroid hormones, which control differentiation of target organs.9–10 Cytosolic retinoic acid binding protein have been shown in various human tissues including breast, lung, ovary, bladder, prostate, and epidermoid carcinoma.11–17 It has been reported that the presence of cRABP in various carcinoma tissues may suggest retinoic acid as a clinical marker and may be of future therapeutic relevance.12–13 The presence of specific RABP in the human pancreas would suggest that it is a target organ for retinoic acid and therefore the aim of this study was to examine human pancreatic tissue for the presence of cRABP. The presence of cRABP in human pancreas has not been reported previously in the literature.

Methods

Patients
Fresh pancreatic tissue was collected at operation from 13 patients (aged 43–80 years) undergoing total or subtotal pancreatectomy. The tissue used was taken immediately adjacent to that used for histology. Based on histopathology, seven patients were subsequently shown to have chronic pancreatitis, and three patients had carcinoma of the pancreas. Three normal pancreatic tissue samples were collected from organ donors.

All-trans-11, 12 retinoic acid, sodium molybdate,
activated charcoal and dextran were purchased from Sigma Chemical Co Ltd, UK. Ultrapure sucrose was purchased from Serva, Feinbiochemica, Heidelberg. All other chemicals were bought from BDH Chemicals, UK. All-trans-11, 12-[H] retinoic acid (specific activity 860 GBq/mmol) was a generous gift from Hoffmann La Roche, Basel. Retinoic acid was stored at -70°C and the purity checked monthly by thin layer chromatography using cyclohexane:ethyl acetate (3:2: v/v) as a solvent system. The purity of the compound never fell below 87%.

Tissue preparation
Freshly obtained pancreatic tissue was collected on ice, immediately frozen in liquid nitrogen and stored at -70°C until assayed. All further procedures were carried out at 4°C. One to two grams of tissue was washed in 0-9% saline and blotted dry. The tissue was pulverised using a Braun Mikro-Dismembrator II (FI Scientific Instruments Ltd, Tewkesbury, Glos, UK) and suspended in 2x the volume with TEDGM buffer (10 mM Tris, pH 7-4, 1-5 mM EDTA, 10 mM dithiothreitol (DTT), 1-4 M glycerol, 5 mM sodium molybdate). The suspension was centrifuged at 100,000×g for one hour at 4°C, in a swing-out rotor (MSE Superspeed 65) to obtain the cytosolic fraction.

Sucrose density gradient centrifugation
One hundred and eighty microlitres of cytosol was incubated with [H] retinoic acid (60 nmol) in the presence and absence of 100-fold excess unlabelled ligand at 4°C in the dark for 18 hours. Unbound retinoic acid was removed by adding 20 μl charcoal (2-5% activated charcoal, 0-25% dextran in TED buffer – 10 mM Tris, pH 7-4, 1-5 mM EDTA, 10 mM DTT) to the incubate. After 10 minutes incubation, charcoal was sedimented by centrifugation at 1500×g for 10 minutes at 4°C.

Two hundred microlitres of the above supernatant was layered onto a 5 to 20% (w/v) sucrose gradient and centrifuged at 400,000×g for 22 hours. External standards (myoglobin and bovine serum albumin) were run on separate gradients to locate the 2-0 S and 4-6 S fractions respectively. Two hundred microlitre fractions were harvested and the amount of radioactivity counted. Protein content was determined using the Bradford method.

Twenty microlitres of the above supernatant (after the charcoal step) was also run on a 1% “IEF” agarose containing ampholines at pH 2-5 to pH 5 and pH 3-5 to pH 10 at 150 v for two hours (4°C). Radioactivity from 3 mm gel fractions was counted in a scintillation counter.

Retinoic acid binding assay
For the saturation analysis, the cytosol was chromatographed on a 0-9×15 cm column of sephadex G-75 in TE buffer (10 mM Tris, 1-5 mM EDTA, pH 7-4). Protein concentration in the cytosolic retinoic acid binding protein fraction was adjusted to 2-0–3-5 mg/ml. Fetal calf serum (0-1%, v/v) was added and 180 μl aliquots were incubated
with increasing concentration (5–60 nmol) of [3H] retinoic acid for 18 hours at 4°C in the presence and absence of 100-fold molar excess of unlabelled ligand. Unbound retinoic acid was removed by the addition of charcoal as described above and the radioactivity determined.

Results

Sucrose density gradient centrifugation of cytosol incubated with [3H] retinoic acid revealed a peak at the 2-0 S region, which coincides with the 2 S of the external standard. This peak was abolished in the presence of 100-fold molar excess unlabelled retinoic acid, indicating the specificity of the ligand binding in this region. A profile for cRABP in the human pancreas is shown in Figure 1. The area under the 2 S peak for each tissue sample was calculated and specific cRABP was determined as the difference in dpm between the non-suppressed peak and the suppressed baseline. The levels of cRABP varied from 0-7–2-7 pmol/mg protein in the seven chronic pancreatitis tissue, and from 5-5–23-9 pmol/mg protein in carcinoma tissue, but was not detected in any of the three normal samples of pancreatic tissue (Fig. 2). There is a clear difference between normal, chronic pancreatitis and carcinoma of the pancreas, and there is no overlap between the three groups. Although the numbers of carcinoma and normal tissues were small, carcinoma of the pancreas clearly had much greater number of cRABP binding sites compared with normal and chronic pancreatitis tissue.

Figure 3 shows the separation of retinoic acid receptor on IEF agarose. The peak at isoelectric point of 4-5 is abolished when a 100-fold molar excess cold ligand is added. This peak indicates the specific cRABP site, while the peak at isoelectric point of 5-2 is that of non-specifically bound proteins. The separation of the specific cRABP from non-specifically bound protein was much clearer on IEF agarose than on sucrose density gradient centrifugation. The results obtained on the IEF agarose gel confirm the data obtained on sucrose density gradient centrifugation.

Scatchard plots, constructed from saturation analysis data from five patients with chronic pancreatitis revealed a single class of high affinity binding sites for retinoic acid in the pancreas (Fig. 4). The dissociation constant was 21.5 nmol (5-7) (SE) and the maximum binding capacity was 5.2 pmol/mg protein (2-6) (SE). Saturation analysis with a fixed amount of cytosol incubated with increasing concentration of [3H] retinoic acid showed a saturation of binding at 60 nmol retinoic acid.

Discussion

The saturation analysis of cRABP in the human pancreas is difficult to evaluate because of the different affinity of binding at the 2 S and the 4-6 S region. This problem is reduced by subjecting the cytosol to a sephadex G-75 column and obtaining the cRABP fraction for the assay. Protein concentration is adjusted to about 3 mg/ml before performing the saturation analysis. The mean dissociation constant obtained from a Scatchard plot constructed from the saturation analysis was 21.5 nmol and maximum binding sites of 5-2 pmol/mg protein. The dissociation constant of 21-5 nmol obtained for the pancreatic tissue was similar to that obtained by us for human prostatic tissue (15-0 to 31-5 nmol) and by
Cytosolic retinoic acid binding protein has been shown to be distinct from cytosolic retinol binding protein (cRBP) by sucrose density centrifugation and immunologically. Using radioimmunoassays, cRBP has been shown to be immunologically distinct from serum RBP.

It is of interest that there was a marked difference between chronic pancreatitis and pancreatic carcinoma tissue. Palan et al also found significantly raised concentrations of cRABP in carcinoma tissues from human cervix, endometrium, and ovary compared with normal tissues. Similar trends were reported by Clamon et al from lung tissue, Ong et al from lung and breast tissue and Bichler et al from squamous cell carcinomas of otorhinolaryngologic region. In clinical assessment of breast and prostatic carcinoma, high concentrations of androgen and oestrogen binding protein are used to predict clinical response to steroid treatment. The observed variation in the specific cRABP concentrations may have a functional significance comparable to steroid receptors. Thus the data on the 10 human pancreatic specimens with chronic pancreatitis and carcinoma of the pancreas, where cRABP was present (albeit at low concentrations in some cases of chronic pancreatitis), suggest that this parameter may be a useful marker for the detection of pancreatic disease. It is possible to assay cRABP on pancreatic biopsy using the IEF-agarose method. This method has been successfully developed by us for the assay of cRABP in prostatic biopsies. Second, Schwartz et al reported that retinoic acid has a protective function in Langerhan's cell population in the hamster cheek pouch where it enhances local immune function. In the light of these suggestions, it was postulated that treatment with retinoic acid, in man, may enhance local immune function, and act as prophylactic agent for individuals having a high risk of oral cancer.

If these hypotheses are correct, then the presence of cRABP in chronic pancreatitis and carcinoma tissues may be of significance. It may indicate that treatment with retinoic acid may enhance local immune function and inhibit the risk of pancreatitis and carcinoma in addition to having a functional significance. The numbers of samples presented here is small and further studies are required to support our proposal.

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