Leading article

Cholesterol crystallisation in bile

Cholesterol gallstones occur when at least three simultaneous defects are present: (i) cholesterol supersaturation of bile with formation of cholesterol-rich unstable vesicles; (ii) accelerated crystallisation of cholesterol in bile owing to a defect of crystallisation inhibiting or an abundance of crystallisation promoting factors; and (iii) prolonged bile stasis due to decreased gall bladder motility.1

Precipitation of solid cholesterol crystals from supersaturated bile has an essential role in cholesterol gallstone formation.2 3 The number of days it takes before microscopic plate-like cholesterol monohydrate crystals are observed in human bile has been referred to as the crystal nucleation time.4 This term, however, indicates early aggregation of cholesterol molecules from supersaturated bile into submicroscopic nuclei.5 This crucial step is followed by precipitation, growth and agglomeration of cholesterol crystals, which then become visible at light microscopy. In this respect, the term crystal detection time seems more appropriate than crystal nucleation time.6 Recent data indicate that solid cholesterol can also precipitate as crystal forms other than plate-like structures,6 8 suggesting that crystallisation in bile is a rather complex phenomenon.

The study of pathways leading to cholesterol crystallisation in bile has clinical relevance as the appearance of biliary crystals reliably distinguishes between patients with and without cholesterol gallstones.2 9 Crystallisation of cholesterol is faster in patients with multiple than in those with solitary stones,8 10-12 a finding which might be linked to the increased risk of gallstone recurrence after non-surgical treatment in patients with more than one stone.13-16 Moreover, a better understanding of the physical/chemical events occurring during crystallisation in bile would provide a useful method for the identification of factors delaying or preventing precipitation of cholesterol crystals and, therefore, gallstone formation in humans.

This article will discuss current views on the formation of cholesterol crystals in bile.

Cholesterol secretion in bile

The elucidation of the exact events leading to lipid secretion in bile is still being investigated. In an elegant ultrastructural study, Crawford et al17 have proved that biliary phospholipid molecules are secreted by hepatocytes into the bile canalicular lumina as unilamellar vesicles 63-67 nm in diameter. This process occurs rapidly and seems to be facilitated by the detergent action of luminal bile salts at the level of the exoplasmic part of the canalicular membrane. Cholesterol is also secreted into hepatic bile and is taken up by biliary lipid vesicles in which the cholesterol:phospholipid ratio is normally 0.34–0.38. In lithogenic bile, however, this ratio is larger.18-21 As mixed micelle formation requires the solubilisation of more phospholipid than cholesterol, the cholesterol:phospholipid ratio in the remaining vesicles progressively increases to >1 (about 2:1).22 These cholesterol-rich vesicles tend to aggregate or to fuse into multilamellar vesicles of increasing size. As emphasised by Cohen et al,22 cholesterol solubilisation and transport in bile is explained by the classical paradigm of the simple micelle-mixed micelle-unilamellar vesicle, with multilamellar unstable vesicles heralding the initiation of the lithogenic process. Classic triclinic cholesterol crystals may precipitate from multilamellar vesicles, as observed by video enhanced time lapse microscopy.23 The process of mixed micelle formation starts in the biliary tree but is strongly promoted in the gall bladder11 as the gall bladder absorbs electrolytes actively and water passively. The concentration of biliary lipids then increases and high bile salt concentrations promote mixed micelle formation with growth of cholesterol-rich vesicles. Thus, vesicular cholesterol is important for cholesterol crystal formation.24 Recent studies in cholesterol fed prairie dogs, however, have suggested that supersaturated mixed micelles may also have a role in cholesterol crystal precipitation.25

Biliary proteins and cholesterol crystallisation

Bile from patients with cholesterol stones cannot be discriminated from those of control patients simply on the basis of lipid composition.27 28 Thus, other factors, such as biliary proteins, have been suggested to play a part in the pathogenesis of cholesterol crystallisation and stone formation.29 Although several proteins with cholesterol crystallisation inhibiting as well as promoting properties have been isolated, the active factor has not been identified as yet. Apolipoprotein A-1 and A-230 and a 120 kDa glycoprotein isolated from normal human gall bladder bile31 inhibit cholesterol crystallisation.

Mucin and non-mucin glycoproteins might have a role as promoting agents of cholesterol crystallisation. In fact, gall bladder mucin promotes crystallisation of cholesterol32 33 and mucin hypersecretion precedes cholesterol crystal precipitation and stone formation both in animals34 35 and humans (such as in obese people with weight reduction and gallstone formation).36-38 Mucin provides a microenvironment and might act as a nidus for cholesterol crystal aggregation. In this way sludge is formed, a viscous gel of mucin and entrapped cholesterol crystals or calcium bilirubinate precipitates.39 40 Sludge may disappear spontaneously41 but progressive cholesterol crystal precipitation and subsequent aggregation into macroscopic gallstones may also occur.42 Groen et al43 isolated from T-tube bile of patients with cholesterol gallstones a concanavalin-A binding non-mucin glycoprotein (molecular weight 130 kDa) that stimulates cholesterol crystallisation in model bile. As it is found in hepatic bile, this factor is likely to be of hepatic origin. Other non-mucin factors have crystallisation promoting effects in vitro: a pronase resistant low density lipoprotein particle (±90% lipid),43 aminopropylidase N (a 130 kDa biliary canalicular glycoprotein),44-46 phospholipase C,45 47 immunoglobulins of the IgM, IgA and IgG classes,48-50 fibronectin,51 a biliary anionic polypeptide fraction (APF),52 acute phase proteins, such as a 42 kDa a,53,54 a,-antichymotrypsin,55 and haptoglobin.56 Although the liver secretes promoting and inhibiting factors simultaneously, the ultimate pathophysiological importance of these proteins in human bile remains controversial.57 There is also
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Precipitation of crystalline cholesterol in bile is likely to occur when the cholesterol concentration exceeds the micellar solubility limit and fusion or aggregation of cholesterol-rich vesicles occurs. The “classic” crystallisation pathway was believed to result in the appearance of typical monohydrate cholesterol plates in both human and model bile. Although early studies showed that hypovitaminotic C guinea-pigs fed a high cholesterol diet developed randomly arranged, needle shaped (possibly anhydrous cholesterol) crystals in the gall bladder and that needle shaped crystals existed both in model and human bile, the possibility that crystal forms other than plate-like structures could develop in bile was only recently tackled. In an important study Konikoff et al described filamentous crystals that appeared within two to four hours of dilution of model bile and within one to three days of ex vivo incubation of human gall bladder bile (preliminary report: in six of eight patients with cholesterol gallstones but in none of those with pigmented stones). Over a few days filaments evolved through needle, helical, and tubular structures to end as typical plate-like cholesterol monohydrate crystals. These findings were confirmed in a subsequent study from a taurocholate-rich dilute bile salt-rich model bile. In this system (1.030 g/ml) filamentous crystals reached a maximal concentration at 24 hours and disappeared gradually after 156 hours of incubation, whereas high density (1.045 g/ml) plate-like crystals increased reciprocally. The authors used several analytical procedures which pointed to the mainly anhydrous nature of early cholesterol filaments, with subsequent hydration as water becomes incorporated within the crystals. In an initial report two non-perturbing techniques (that is, cryotransmission electron microscopy and video enhanced light microscopy) were used for direct imaging of cholesterol crystallisation. This study confirmed the dynamic evolution of lipid microstructure which is similar in model and human bile. According to a recent hypothesis, the two putative pathways of cholesterol nucleation in bile might involve (i) precipitation of classic plate-like cholesterol crystals from multilamellar vesicles and (ii) nucleation of anhydrous cholesterol occurring internally as a liquid core within unilamellar vesicles (that is, “internal nucleation”).

Studies on the different habits of cholesterol crystals have been extended in model bile. Our group has studied this in model and human bile. We believe that the complete process of cholesterol crystallisation in bile is still poorly understood and that the pathophysiologically important of the pathway through cholesterol microcrystalline intermediates needs to be carefully investigated. In this respect, a major contribution comes from the recent work of Wang and Carey who used complementary physical-chemical techniques, and have now carefully defined five different crystallisation pathways which are based on the main forms of liquid and solid cholesterol crystals in pathophysiologically relevant model bile. As shown by the analysis of crystallisation sequences as functions of time and increasing lecithin content within the phase diagram for the mixed bile salt-egg yolk lecithin system, at equilibrium five regions were identified above the one-phase micellar zone and named A to E (moving from left to right across the phase diagram). Crystal observation times for plate-like crystals were progressively retarded between pathways A and D, whereas plates never appeared in pathway E. Studies from the same group suggest that the events in model bile correlate with crystallisation pathways in humans and in inbred mice on a lithogenic diet. Accordingly, it is anticipated that factors in bile such as total lipid concentration, phospholipids and bile salt hydrophobicity can modulate crystal growth by shifting the relative composition of bile to different regions of the phase diagram, as discussed in the following paragraphs.

The finding that cholesterol crystallisation is longer in dilute supersaturated gall bladder bile and model bile would be explained by a shift delution of the crystallisation pathway towards the E region (liquid crystals) of the phase diagram. The opposite would apply to concentrated bile.

Phospholipid molecular species and class can influence cholesterol crystallisation in model and human bile. Saturated lecithins delay whereas polysaturated phospholipids accelerate the crystal observation time in model bile. Although the surface layer of phosphatidylcholine, which covers the surface of cholesterol filamentous crystals, might interfere directly with crystal growth, a valid alternative explanation is that modulation of phospholipid species can shift phase boundaries towards pathways where the plate-like crystal observation time is either shorter (a leftward shift) or longer (a rightward shift) within the phase diagram. Possible strategies for cholesterol crystallisation and gallstone prevention might theoretically imply increased biliary secretion of phospholipids as dietary factors can influence phospholipid content. Further studies are warranted on this topic.

Several studies have focused on the relation between cholesterol crystal shape in model bile and the hydrophobic–hydrophilic balance of bile salts, and have concluded that crystallisation of several forms is increased in the presence of more hydrophobic bile salts. At least seven different crystal forms have been identified, including helical, thread-like and ribbon-like structures, the growth of which decreased as bile salt hydrophobicity decreased (that is, deoxycholate > chenodeoxycholate > cholate > taurocholate > ursodeoxycholic acid (UDCA)). Van Erp Ecum et al found that the most striking crystallisation of all cholesterol crystal forms, including large plate aggregates, was seen in the very hydrophobic system in taurodeoxycholate-rich model bile and that bile salt hydrophobicity influenced both crystal shape and extent of crystallisation. Similar studies with an accurate description of cholesterol crystal shapes have been carried out by Juste et al and by Wang and Carey in supersaturated model bile with a number of bile salts at different hydrophobicities. It is possible that hydrophobic bile salts which exhibit lower critical micellar concentrations induce rapid formation of mixed micelles with increased formation of cholesterol-rich vesicles and rapid crystal precipitation. A better explanation is provided by the study of the equilibrium phase diagram: crystallisation pathways shift with increasing bile salt hydrophobicity and the right two-phase area (that is, region E where only liquid cholesterol crystals occur) becomes progressively larger. This mechanism would explain why crystallisation of all forms is greatly inhibited or prevented by very hydrophilic bile salt species such as UDCA, taursodeoxycholate, taurohydoxycholate, etc.

Recently, we studied cholesterol crystal forms in both ultrafiltered (isotropic) bile and native bile of patients with cholesterol or pigment gallstones. Daily polarising microscopy was used to quantify crystal observation time and to construct crystal-time growing curves of the different forms of solid crystals such as arcs, needles, spirals, tubules, plates, and their aggregates over three weeks. Figure 1 shows most of these crystal forms. Pigment stone bile never crystallised; cholesterol gallstone bile, in
with gallstones treated with UDCA. A study in rats demonstrated that UDCA totally prevents the precipitation of cholesterol crystals in bile [1]. This has been described previously in vitro and in vivo studies in UDCA-treated systems. In vitro studies ofUDCA on crystallisation might be due to the expansion of the liquid crystal region of the equilibrium phase diagram by reducing bile salt hydrospecificity. We also found recently that treatment with UDCA leads to a decrease in the concentrations of various crystallisation promoting proteins (IgG, IgA, haptoglobin, and α1-acid glycoprotein, aminopeptidase N, and total proteins) and reduces the crystallisation promoting activity of concanavalin A eluate in patients with cholesterol gallstones. This was confirmed by two independent techniques including a nephelometric assay and microscopy.

**Conclusions**

Rapid crystallisation of cholesterol in bile is a key factor in cholesterol gallstone formation. The original observation that solid cholesterol precipitates only as characteristic plates of monohydrate cholesterol has been recently revised as filamentous, helical and tubular forms of non-hydrated cholesterol have been shown to grow together with plates and aggregates of plates in both isotropic and native bile. Several factors such as biliary proteins and lipids might act as potential cofactors of cholesterol crystallisation. The most active crystallisation of cholesterol in bile is found in patients with multiple cholesterol gallstones. Gall bladder bile enriched with the more hydrophilic bile salts, as salts of glycine and taurine conjugates of UDCA, inhibits cholesterol crystallisation and decreases the concentrations of crystallisation promoting biliary proteins. Exciting studies are awaited to clarify whether prevention of cholesterol gallstone formation in at-risk subjects can be effectively achieved by manipulating biliary factors which have pro-nucleating or antinucleating effects.

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