Immunohistochemical identification of lysozyme in intestinal lesions in ulcerative colitis and Crohn’s disease

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SUMMARY  Lysozyme (LZM) was identified in ulcerative colitis in granulocytes, monocytes, and macrophages of the intestinal lamina propria. In contrast with findings in normal colon or rectum, in ulcerative colitis LZM was also detected in some mucosal crypt cells and metaplastic Paneth cells. In both ulcerative colitis and Crohn’s disease LZM was present in inflammatory cells of crypt abscesses. In Crohn’s disease intense LZM staining was seen in epitheloid cell granulomas. The present observations permit one explanation for the raised concentration of serum-LZM in patients with ulcerative colitis and Crohn’s disease.

In inflammatory bowel disease the differential diagnosis as well as the evaluation of specific morphological, chemical, and histochemical indices still present serious difficulties. The recent proposal by Falchuk et al. (1975a) that changes in the concentration of a specific serum marker—namely, lysozyme (LZM)—might be an aid in the differential diagnosis of uncomplicated ulcerative colitis and active Crohn’s disease has been questioned by a number of authors (Dronfield and Langman, 1975; Peeters et al., 1975; Pounder et al., 1975; Pruzanski and Marcon, 1975; Hylander et al., 1976; Johansson and Ursing, 1976). However, the determination of the serum concentration of LZM has been reported to be of value in estimating disease activity in Crohn’s disease (Falchuk et al., 1975b). An increased LZM content has been observed in the colonic exudates and stools of patients with ulcerative colitis (Hiatt et al., 1952). This variation in the serum and stool LZM concentration has been attributed to the increased number of LZM-containing cells in the inflammatory intestinal lesions. Recently, Mason and Taylor (1975), using an immunoperoxidase technique, detected LZM positive histiocytes in granulomas of the bowel affected by Crohn’s disease.

The present study was undertaken to investigate, with immunohistochemical techniques, the distribution of LZM-containing cells in the intestinal lesions of patients with ulcerative colitis and Crohn’s disease.

Methods

Fifteen patients with ulcerative colitis, seven patients with Crohn’s disease, and 24 control patients were studied (Table). Intestinal biopsies were taken either at the surgical resection of affected segments of the small or large bowel. The diagnosis in these cases was based on typical clinical, radiological, and morphological findings. Biopsies were also obtained from the normal small and large intestines of control patients operated on for a disease other than an acute or chronic inflammatory bowel disease, most often for a localised carcinoma of the colon.

The biopsy specimens, none larger than 2 mm in thickness, were fixed in 1.5% aqueous glutaraldehyde (TAAB Laboratories, Reading) for 90 minutes, dehydrated in absolute ethanol and xylene, and then embedded in paraffin. Paraffin sections were cut to 6 μm in thickness, deparaffinised and rehydrated, and then washed in 0.01 M phosphate-buffered saline (PBS), pH 7.2, twice for five minutes each time. The presence of LZM in tissues was demonstrated with an immunoglobulin-enzyme bridge method (Mason et al., 1969) described in detail elsewhere (Klockars and Reitamo, 1975). Briefly,
this technique consists of the sequential application,
first, of the following antisera: (1) rabbit antihuman
LZM, (2) sheep antirabbit gamma globulin (Sycco
Sylvana, N.J.), and (3) rabbit antihorseradish
peroxidase. After each application of antiserum the
sections were washed with PBS twice for five min-
utes each time. After incubation in horseradish
peroxidase at a concentration of 250 μg/ml the
sections were stained with the method of Graham
and Karnovsky (1966) and then counterstained with
cresyl echt violet. To abolish the intrinsic peroxidase
activity of granulocytes and erythrocytes, sections
were pretreated with methanol-H2O2 (Streefkerk,
1972). For control of the specificity of the reaction
between tissue LZM and the primary antiserum—
that is, rabbit antihuman LZM—this antiserum was
replaced by a rabbit antiserum raised against hen
egg white LZM, known to be immunologically


different from its human counterpart.

Results

CONTROL SUBJECTS

In the normal ileum LZM was present only in the
Paneth cells of the intestinal crypts and in granulo-
cytes and macrophages in the intestinal lamina
propria. In normal colon no LZM was detected in
surface epithelial cells or in mucous crypt cells, nor
was LZM present in the lamina propria except in a
few granulocytes. Normal rectum contained no
LZM-positive cells (Table).

ULCERATIVE COLITIS

In the colon and rectum of patients with ulcerative
colitis, LZM staining was most prominent in the
numerous invading inflammatory cells of the lamina
propria (Fig. 1), with intense staining seen pre-
dominantly in granulocytes but also in monocytes
and macrophages. Colonic surface epithelial cells
were LZM negative. However, in three out of five
colonic specimens, and in four out of 10 rectum
specimens the cytoplasm of occasional mucosal
crypt cells, displayed clear LZM staining (Table).
This staining was most often diffuse but in a few
cells granular (Fig. 2) and in some colonic crypt cells
the cytoplasmic morphology and LZM staining was
identical with that in the ileal Paneth cells (Fig. 2).

Table Occurrence of immunohistochemically detectable
lysozyme in rectal and colonic epithelial cells.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Region of intestine</th>
<th>Patients (no.)</th>
<th>Positive lysozyme staining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controls</td>
<td>Colon</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Rectum</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Ulcerative colitis</td>
<td>Colon</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Rectum</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Crohn’s disease</td>
<td>Colon</td>
<td>2*</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Rectum</td>
<td>6*</td>
<td>1</td>
</tr>
</tbody>
</table>

*In one patient biopsies were obtained from both sites.

Fig. 1 Colonic mucosa in ulcerative colitis. The LZM
is seen as a black precipitate in the inflammatory cells
of the lamina propria; no LZM staining is seen in
mucosal crypt cells. Counterstaining with cresyl echt
violet, × 220.

Fig. 2 Cytoplasmic LZM staining in mucosal crypt cells
and in inflammatory cells of the lamina propria in
ulcerative colitis. In the upper part of the mucosal gland,
LZM-positive Paneth cells can be seen. Counterstaining
with cresyl echt violet, × 560.
LZM staining of the colonic epithelial cells or metaplastic Paneth cells was not related to the number of infiltrating inflammatory cells but could also be seen in areas of quiescent colitis. In the colon of one patient, numerous LZM-positive granulocytes were seen in diapedesis between epithelial cells.

CROHN'S DISEASE
LZM-positive granulocytes and monocytes were present in numerous microabscesses along the intestinal wall (Fig. 3). Most cells of epitheloid granulomas stained intensely for LZM (Fig. 4). In one patient some mucosal crypt cells stained for LZM (Table). Lymphocytes, plasma cells, and fibrous tissue showed no LZM staining.

Discussion

In normal conditions about 80% of the total pool of LZM is thought to be of granulocyte origin (Hansen, 1974), and in some tissues the concentration of LZM is related to the number of granulocytes, monocytes, and macrophages (Lippman and Finch, 1972; Klockars and Reitamo, 1975). In both ulcerative colitis and Crohn's disease, affected lesions of the intestine contained large numbers of LZM-positive cells, which provides at least one explanation for raised concentrations of plasma LZM in patients with these disorders (Kane et al., 1974; Dronfield and Langman, 1975; Falchuk et al., 1975; Pounder, et al., 1975). That both the total vitamin B12-binding capacity and the LZM activity of serum are increased in these disorders might indicate that the pool of granulocytes is enlarged and their turnover accelerated (Kane et al., 1974).

In many patients with ulcerative colitis and in one patient with Crohn's disease, the presence of LZM in occasional gland cells, although not contributory to the raised levels of serum LZM, contrasts with the absence of LZM of normal colonic mucosa. The LZM in these cells might be a consequence of (1) a transformation of colonic mucosal cells to a cell type with either the capacity to synthesise LZM or reabsorb LZM from its surroundings or (2) of an altered composition of mucosubstances within these cells. The occurrence of neutral mucosubstances in rectal columnar cells in some cases of ulcerative colitis (Gad, 1969) might eliminate a possible block-
ing effect of the acidic mucosubstances on the anti-
genic determinants critical for the detection of LZM
with the present method. The presence of LZM in
secretory cells in normal organs has been observed to
be associated with the presence of neutral mucos-
substances (Klockars and Reitamo, 1975).
The occurrence of typical LZM-positive Paneth
cells in mucosal glands adjacent to mucosal crypt
cells with positive cytoplasmic granular LZM stain-
ing raises the question of whether a transition occurs
between mucous gland cells and Paneth cells
(Watson and Roy, 1960; Paterson and Watson, 1961;
Lewin, 1969). Whereas the origin and 'stem cell' of
Paneth cells is still unknown, the results of the
present study support the possibility that glandular
cells of the mucosa are transformed into Paneth cells.
Our preliminary observations show that meta-
plastic Paneth cells associated with gastric carcinomas
also retain their capacity to elaborate LZM.
In patients with Crohn's disease the epitheloid
cells of intestinal granulomas are an end stage in the
transformation of monocytes and macrophages.
Morphological (Sutton and Weiss, 1966) and bio-
chemical studies (Cohn and Benson, 1965) show that
both the number of lysosomes and the concentra-
tion of lysosomal enzymes, including LZM, increase
during the course of this transformation. Similarly,
strong LZM activity has been observed in epitheloid
cell granulomas in sarcoidosis and in Kveim-
positive subcutaneous nodules (Mason and Taylor,
1975).
Although the findings presented here do not provide
any conclusive information about possible differences
in serum concentrations of LZM in Crohn's disease
and ulcerative colitis (Falchuk et al., 1975a), it is
possible that the fate of LZM-containing inflam-
matory cells and their enzymic content might differ
in these diseases. Fixed mononuclear phagocytes
may lose their enzymic content into the circulation,
whereas the granulocytes in ulcerative colitis might
ultimately reach the colonic lumen by diapedesis
(Anthonisen and Riis, 1962).
In the absence of any known substrate for LZM
in mammalian cells, the physiological consequences
of the presence of high local concentrations of LZM
might be related to the effects of LZM on cell
membranes (Osserman et al., 1973), to its anti-
bacterial effects (Chipman and Sharon, 1969), to its
enhancing effect on phagocytosis (Klockars and
Roberts, 1976), or to its tendency to form complexes
with a variety of anionic molecules (Imoto et al.,
1971).

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