Increased group II phospholipase A\textsubscript{2} in colonic mucosa of patients with Crohn’s disease and ulcerative colitis

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Abstract

The immunochemical protein content of group II phospholipase A\textsubscript{2} (PLA\textsubscript{2}) and PLA\textsubscript{2} enzymatic activity were measured for colonic mucosal biopsy samples obtained from patients with either Crohn’s disease of the colon or ulcerative colitis, and control patients without inflammatory bowel disease. Immunoreactive group II PLA\textsubscript{2} (IR-PLA\textsubscript{2} II) content and PLA\textsubscript{2} activity in actively inflamed colonic mucosa of Crohn’s disease patients were significantly higher than those in inactively inflamed mucosa of Crohn’s disease patients and the colonic mucosa of controls. IR-PLA\textsubscript{2} II content and PLA\textsubscript{2} activity in severely inflamed mucosa of ulcerative colitis patients were significantly higher than those in the colonic mucosa of the controls. Mucosal PLA\textsubscript{2} enzymatic activity was closely correlated with mucosal IR-PLA\textsubscript{2} II content in patients with Crohn’s disease and ulcerative colitis. These results suggest that an increase in PLA\textsubscript{2} enzymatic activity in inflamed colonic mucosa of Crohn’s disease and ulcerative colitis was mainly attributed to increased protein content of group II PLA\textsubscript{2}, and that an increase in mucosal group II PLA\textsubscript{2} may be involved in the pathogenesis of intestinal inflammation of Crohn’s disease and ulcerative colitis.

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Phospholipase A\textsubscript{2} (PLA\textsubscript{2}) hydrolyses the fatty acyl ester bond at the sn-2 position of glycerophospholipids and produces free fatty acids and lysophospholipids. Cellular calcium dependent PLA\textsubscript{2}s have been thought to participate in both the regulation of phospholipid metabolism in biomembranes and eicosanoid biosynthesis.\textsuperscript{1} It has been shown that cellular calcium dependent PLA\textsubscript{2}s of mammalian origin can be classified into at least three groups according to their distinct characteristics in primary structure\textsuperscript{2-4}: the pancreatic type (group I), the viperid and crota1id type (group II), and the cytosolic high molecular weight type. Group I PLA\textsubscript{2} is considered to be one of the digestive enzymes, and it is abundant in pancreatic juice. Human group II PLA\textsubscript{2} was purified from spleen,\textsuperscript{7} platelets, and synovial fluid.\textsuperscript{8} Recently, we purified group II PLA\textsubscript{2} from human ileal mucosa and provided evidence for the presence of immunoreactivity and messenger RNA (mRNA) of group II PLA\textsubscript{2} in human ileal and colonic mucosa.\textsuperscript{8,9}

Recent studies suggest that calcium dependent PLA\textsubscript{2}s, group II enzyme in particular, participate in inflammatory response either through a direct action or through an indirect action by metabolites of phospholipids.\textsuperscript{10-13} It has been reported that immunoreactive group II PLA\textsubscript{2} (IR-PLA\textsubscript{2} II) values and PLA\textsubscript{2} enzymatic activity were increased in serum samples and synovial fluid of patients with rheumatoid arthritis,\textsuperscript{14-16} and in serum samples of patients with septic shock\textsuperscript{17,18} and acute pancreatitis.\textsuperscript{19}

Inflammatory bowel disease – that is, Crohn’s disease and ulcerative colitis – is a chronic intestinal inflammatory disease of unknown aetiology. Arachidonate derived chemical mediators may participate in the pathogenesis of inflammatory bowel disease. Raised intestinal contents of leukotriene B\textsubscript{4} and prostaglandins have been reported in inflammatory bowel disease patients.\textsuperscript{20-22} In this context, increased PLA\textsubscript{2} activity has been reported in ileal and colonic mucosa of patients with Crohn’s disease.\textsuperscript{23,24} We have recently reported an increase in PLA\textsubscript{2} activity and IR-PLA\textsubscript{2} II values in serum samples of patients with Crohn’s disease and ulcerative colitis.\textsuperscript{8,25} The isozymic form, however, of PLA\textsubscript{2} in the inflamed mucosa of patients with inflammatory bowel disease remains to be established.

In this study, to examine the association of group II PLA\textsubscript{2} with intestinal inflammation of inflammatory bowel disease patients, we have measured PLA\textsubscript{2} activity and protein content of group II PLA\textsubscript{2} in colonic mucosal biopsy samples obtained from Crohn’s disease and ulcerative colitis patients.

Methods

PATIENTS

In 21 patients with Crohn’s disease of the colon (12 men and 9 women) aged 15–35 years (mean (SD) age of 23.5 (1.1)), colonoscopy was performed on a total of 27 occasions. One of 21 Crohn’s disease patients had received resection of sigmoid colon. In patients with Crohn’s disease, the colonic mucosa was evaluated with regard to erythema, erosions or ulcers on colonoscopic examination. The presence of any of these signs was considered to show active
inflammation. All Crohn’s disease patients were receiving special diets including elementally and low-fibre. Colonic mucosal biopsy for assay of PLA₂ activity and IR-PLA₂ II content was performed in 13 Crohn’s disease patients during endoscopically diagnosed active phase, of whom seven were receiving treatment with sulphasalazine (0–5–3–0 g/day), and six were receiving no drugs. A similar biopsy was performed in 14 Crohn’s disease patients during endoscopically diagnosed inactive phase, of whom eight were receiving treatment with sulphasalazine (0–5–3–0 g/day), and six were receiving no drugs. In active and inactive Crohn’s disease patients biopsy samples were obtained from macroscopically involved mucosa.

In 21 patients with ulcerative colitis (11 men and 10 women) aged 20–58 years (mean (SD) age of 34.3 (2.6)), colonoscopy was performed on a total of 26 occasions. None of the patients had prior surgical treatment. In patients with ulcerative colitis, all colono- scopic findings were graded from 1 to 4 according to the severity of inflammation using the criteria of Matts.36 When the score was 1 or 2, the inflammation was considered to be mild, and when the score was 3 or 4, the inflammation was considered to be severe. Colonic mucosal biopsy samples for assay of PLA₂ activity and IR-PLA₂ II content were obtained from endoscopically diagnosed mildly inflamed mucosa in 13 ulcerative colitis patients, of whom four were receiving no drugs, three were receiving treatment with sulphasalazine (1–5–3–0 g/day), and six were receiving treatment with prednisolone (5–20 mg/day) in addition to sulphasalazine (1–5–4–0 g/day). Similar samples were obtained from severely inflamed mucosa in 13 ulcerative colitis patients, of whom four were receiving no drugs, seven were receiving treatment with sulphasalazine (1–5–4–0 g/day), and two were receiving treatment with prednisolone (5–30 mg/day) in addition to sulphasalazine (1–5–4–0 g/day).

The control group comprised 15 patients (nine men and six women) aged 23–64 years (mean (SD) age of 41.7 (3.4)) undergoing colonoscopy for the follow up after endo- scopic polypectomy, investigation of gastrointestinal symptoms, or in addition to radiographic investigation for irregular bowel habit. In five of 15 control patients one colon polyp was endoscopically examined, and in the other patients no abnormality was found. Nineteen biopsy samples of histologically normal mucosa were obtained from 15 control patients from ascending or transverse or descending colon: we previously reported that PLA₂ activity and IR-PLA₂ II were uniformly distributed in human colonic mucosa.9

The biopsy samples obtained from controls, and patients with Crohn’s disease and ulcerative colitis were washed twice by cold saline and stored at −35°C until use. Informed consent was obtained in each case of biopsy in controls and patients with Crohn’s disease and ulcerative colitis.

ASSAY FOR PLA₂ ACTIVITY

The biopsy samples were homogenised in 30 volumes of 10 mM TRIS-HCl (pH 7–4), and PLA₂ activity was determined as reported27 28 using 0.8 mM 1-palmitoyl-2-oleoyl-sn- glycerol-3-phospho-glycerol (POPG) as a substrate in the presence of 5 mM cholate. Fatty acids released by PLA₂ action were labelled with 9-anthryl-diazomethane, and the derivatised fatty acids were separated by reverse phase high performance liquid chromatography, and oleic acid was quantitated using manganic acid as an internal standard. Calcium dependent PLA₂ activity was estimated as the difference between the activity assayed in the presence of 5 mM CaCl₂ and that in the presence of 10 mM EDTA.

The protein concentrations of the homogenates of colonic biopsy samples were determined with bichinchoninic acid protein assay reagent (Pierce).

ASSAY FOR IMMUNOREACTIVE GROUP II PLA₂ SOLUBILISED FROM COLONIC BIOPSY SPECIMENS BY 1 M KBr TREATMENT

We previously found that human group II PLA₂ was enriched in the particulate fractions of tissue homogenates, and that it was readily solubilised by treatment with a high concentration of KBr.9 27 For measuring the content of group II PLA₂ in the biopsy samples, an aliquot of the homogenates of the colonic biopsy samples was mixed with an equal volume of 10 mM TRIS-HCl (pH 7–4) containing 2 mM KBr. After the mixture was kept on ice for 60 minutes, it was centrifuged at 40000×g for 40 minutes at 4°C. PLA₂ activity in the supernatant and pellet fractions was measured to estimate its recovery in the former fraction. The supernatant was used for assay- ing IR-PLA₂ II content. The IR-PLA₂ II content was determined by a sensitive radioimmunoassay system specific for human group II PLA₂, using a monoclonal antibody against human splenic group II PLA₂.29 The antibody used in the radioimmunoassay was not cross reactive with human pancreatic PLA₂. The sensitivity of the radioimmunoassay was 0.78 ng/ml, and the interassay coefficient variance was about 5%. To examine the effect of 1 M KBr on measuring IR-PLA₂ II concentrations, the standard human group II PLA₂ was dissolved with 10 mM TRIS-HCl (pH 7–4) containing 1 M KBr, and the concentrations of IR-PLA₂ II in 10 mM TRIS-HCl (pH 7–4) containing 1 M KBr were compared with the standard curve used in the radioimmunoassay for this study. The presence of 1 M KBr did not affect IR-PLA₂ II concentrations in the assay used.

STATISTICAL ANALYSIS

Results are presented as mean (SEM). Data were analysed by unpaired Wilcoxon’s rank test. Regression analysis was used to determine the relations of PLA₂ activity to IR-PLA₂ II content. It was considered significant when p<0.05.
Results

PH DEPENDENCE OF PLA₂ ACTIVITY IN COLONIC MUCOSA HOMOGENATES

It is well established that group II PLA₂ is alkaline active with optimal pH ranging from 8 to 9.5. As Almer et al reported the optimal pH of 6-0 for PLA₂ human colonic mucosa using a labelled Escherichia coli assay, we examined the pH dependence of activity towards mixed micelles of POPG and cholate in a homogenate of colonic mucosal biopsy sample obtained from a control patient (Fig 1). The pH was adjusted using 0-1 M TRIS-HCl buffer (pH 7-9-5) or 2-(N-morpholino) ethanesulphonic acid (pH 5-5-6-5). The maximal activity was found at pH 8-5, and thus this pH was used in this study.

SOLUBILISATION OF PLA₂ ACTIVITY WITH KBR

We examined whether the PLA₂ activity in inflamed colonic mucosa of patients with Crohn’s disease and ulcerative colitis could be extracted by 1 M KBr treatment to the same extent as that in normal colonic mucosa. The recoveries of PLA₂ activity in the supernatant of the homogenates of the colonic biopsy samples obtained from controls, Crohn’s disease patients, and ulcerative colitis patients after the KBr treatment were 94-4% (6-9), 90-4 (4-6), and 91-5 (4-7%), respectively. Because the PLA₂ was fairly efficiently solubilised into the supernatant fraction of each biopsy sample, an IR-PLA₂ II content was defined as ng IR-PLA₂ II in the supernatant fractions/mg of homogenate proteins.

COLONIC MUCOSAL IR-PLA₂ II CONTENT AND PLA₂ ACTIVITY IN INFLAMMATORY BOWEL DISEASE

Figure 2 summarises the IR-PLA₂ II content and PLA₂ activity in the colonic biopsy samples obtained from the controls, and patients with Crohn’s disease and ulcerative colitis. Mucosal IR-PLA₂ II contents of the controls, and all patients with Crohn’s disease and ulcerative colitis were 7-2 (0-9), 37-4 (8-1), and 31-1 (7-2) ng/mg protein, respectively. The content of patients with Crohn’s disease and ulcerative colitis were significantly higher than that of the controls (p<0-01 and p<0-05, respectively). Colonic mucosal IR-PLA₂ II contents of inactive and active Crohn’s disease patients were 20-7 (6-5) and 54-8 (14-1) ng/mg protein, respectively, and those in mildly inflamed and severely inflamed mucosas of ulcerative colitis patients were 30-2 (11-6) and 32-0 (9-1) ng/mg protein, respectively. The IR-PLA₂ II content of active Crohn’s disease patients was significantly higher than that of inactive Crohn’s disease patients (p<0-05) and controls (p<0-01). The content in the severely inflamed colonic mucosa of ulcerative colitis patients was significantly higher than that in the colonic mucosa of controls (p<0-01). No significant difference in IR-PLA₂ II content was found, however, between the mildly inflamed and
severely inflamed colonic mucosas of ulcerative colitis patients. Although mucosal IR-PLA2 II content of inactive Crohn’s disease patients tended to be increased, it did not significantly differ from that of the controls. The same tendency was seen in IR-PLA2 II content in mildly inflamed mucosa of ulcerative colitis patients.

Colonic mucosal PLA2 activities of the controls, and all patients with Crohn’s disease and ulcerative colitis were 9·1 (1·0), 30·0 (5·4), and 28·0 (4·0) nmol/min/mg protein, respectively. The activities of patients with Crohn’s disease and ulcerative colitis were significantly higher than those of the controls (p<0·01). Mucosal PLA2 activities of inactive and active Crohn’s disease patients were 16·8 (4·2) and 44·2 (8·8) nmol/min/mg protein, respectively, and those in mildly and severely inflamed mucosas of ulcerative colitis patients were 25·5 (6·1) and 30·9 (5·1) nmol/min/mg protein, respectively. Mucosal PLA2 activity of active Crohn’s disease patients was significantly higher than that of inactive Crohn’s disease patients (p<0·01) and controls (p<0·01). The activity in severe ulcerative colitis patients was significantly higher than that in the controls (p<0·01). There was no significant difference in PLA2 activity, however, between mildly inflamed and severely inflamed colonic mucosas of ulcerative colitis patients. Although mucosal PLA2 activities of inactive Crohn’s disease or mild ulcerative colitis patients tended to be increased, there was no significant difference between those of the patients and controls.

On regression analysis, PLA2 activity was closely correlated with IR-PLA2 II content in the colonic biopsy samples obtained from the patients with Crohn’s disease (r=0·96, p<0·01) or ulcerative colitis (r=0·92, p<0·01) (Fig 3). There was no significant difference in colonic mucosal PLA2 activity and IR-PLA2 II content between the Crohn’s disease patients not receiving drugs and those receiving treatment with sulphasalazine. There was also no significant difference found in colonic mucosal PLA2 activity and IR-PLA2 II content between the ulcerative colitis patients not treated with drugs and those receiving sulphasalazine, between the patients treated with no drugs and those receiving predonisolone in addition to sulphasalazine, and between the patients treated with sulphasalazine and predonisolone in addition to sulphasalazine. Although significant difference was found in age between Crohn’s disease patients and controls, no correlation was found between patients’ age and either colonic mucosal IR-PLA2 II content or PLA2 activity in the controls.

**Discussion**

Recently, raised intestinal content of arachidonicate derived chemical mediators in inflammatory bowel disease patients²⁰-²² and increased colonic mucosal PLA2 activity in patients with active Crohn’s disease²³ have been reported, suggesting association of PLA2 with intestinal inflammation of inflammatory bowel disease. The isozymic form of intestinal mucosa PLA2 in inflammatory bowel disease patients, however, has not been determined. In this study, we showed that colonic mucosal IR-PLA2 II content and PLA2 activity were significantly increased in inflamed mucosa of patients with Crohn’s disease and ulcerative colitis, and that they were closely correlated with each other. This suggests that increased PLA2 activity in the inflamed mucosa was mainly attributed to increased protein content of group II PLA2. In view of a proinflammatory role of group II PLA2,¹¹-¹³ significant increase of IR-PLA2 II content in inflamed mucosa of Crohn’s disease and ulcerative colitis patients and its association with endoscopically visualised severity of inflammation suggest that group II PLA2 may participate in the pathogenesis of the intestinal inflammatory process in patients with Crohn’s disease and ulcerative colitis, for example, in the development of inflammation by generation of various proinflammatory mediators such as lysosphospholipids, prostaglandins, and...
leukotrienes. It has not been shown that group II $\text{PLA}_{2}$ directly participates in the mobilisation of arachidonic acid; it has been reported that both cytosolic $\text{PLA}_{2}$ and group II $\text{PLA}_{2}$ may participate in prostaglandin $\text{E}_{2}$ synthesis in human umbilical vein endothelial cells. $^{31}$ The functional difference in inflammatory response between cytosolic $\text{PLA}_{2}$ and group II $\text{PLA}_{2}$ should be further investigated.

It is possible that the increase in IR-$\text{PLA}_{2}$ II content seen in inflamed colonic mucosa of Crohn’s disease and ulcerative colitis patients is a consequence of infiltration of inflammatory cells. This study did not show the type of cells responsible for these increments. A preliminary study in our laboratory showed that $\text{PLA}_{2}$ activity of polymorphonuclear and mononuclear leucocytes isolated from peripheral blood cells of patients with Crohn’s disease and ulcerative colitis was much less than that of colonic mucosa (data not shown), and it was reported that group II $\text{PLA}_{2}$ immunoreactivity was not detectable in inflammatory cells infiltrating in synovial tissue of inflamed joints in rheumatoid arthritis. $^{32}$ The precise localisation of group II $\text{PLA}_{2}$ in the inflamed mucosa remains to be determined.

Almer et al. $^{30}$ reported that no significant difference was found in colonic mucosal $\text{PLA}_{2}$ activity between ulcerative colitis patients and control patients without inflammatory bowel disease in contrast with the results of this study. In their study, colonic mucosal $\text{PLA}_{2}$ activity was estimated at an acidic pH value of 6-0 and in the presence of 2 mM CaCl$_{2}$. Under these conditions alkaline active calcium dependent and calcium independent $\text{PLA}_{2}$s, and lysosomal $\text{PLA}_{2}$s with acidic pH optimum may contribute to the measurable activity. On the other hand, we selected a pH of 8-5 for assaying $\text{PLA}_{2}$ activity where group II $\text{PLA}_{2}$ is optimally active and used POG/cholate mixed micelles, the best substrate for group II $\text{PLA}_{2}$. $^{9,28}$ Calcium dependent $\text{PLA}_{2}$ activity was estimated by subtracting the value of activity in the presence of EDTA from that in the presence of Ca$^{2+}$ ion. Therefore, the discrepancy on mucosal $\text{PLA}_{2}$ activity in ulcerative colitis patients could be explained by the difference in assay conditions used.

In previous studies, $^{8,25}$ we reported that serum $\text{PLA}_{2}$ activity and IR-$\text{PLA}_{2}$ II concentrations were increased in active Crohn’s disease patients and reflected the colonscopic severity of inflammation in ulcerative colitis patients. The origin of serum $\text{PLA}_{2}$ in these patients is still unknown. The results of this study suggest that an increased concentration of group II $\text{PLA}_{2}$ in serum samples of patients with Crohn’s disease and ulcerative colitis may be in part explained by leakage of group II $\text{PLA}_{2}$ from the inflamed mucosa.

The mechanism for an increase in group II $\text{PLA}_{2}$ in the inflamed colonic mucosa of patients with Crohn’s disease and ulcerative colitis is unknown. Recently, it has been reported that various cytokines, such as interleukin 1 and 6, and tumour necrosis factor alpha caused an increase in group II $\text{PLA}_{2}$ mRNA and $\text{PLA}_{2}$ activity. $^{12,13,19}$ High concentrations of interleukin 1 and interleukin 6 in mucosal biopsy specimens and an increased production of tumour necrosis factor alpha by mononuclear cells isolated from intestinal biopsy specimens have been reported in patients with active inflammatory bowel disease. $^{34-36}$ These findings raise a possibility that these cytokines stimulate intestinal mucosal group II $\text{PLA}_{2}$ synthesis and secretion, which may play a part in intestinal inflammatory process in inflammatory bowel disease. There is no direct evidence, however, that these cytokines elicit the expression of group II $\text{PLA}_{2}$ in vivo. The role and regulation of group II $\text{PLA}_{2}$ in intestinal inflammation of inflammatory bowel disease remain to be clarified.


