Original research

Host transcriptome signatures in human faecal-washes predict histological remission in patients with IBD

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ABSTRACT

Background Colonoscopy is the gold standard for evaluation of inflammation in inflammatory bowel diseases (IBDs), yet entails cumbersome preparations and risks of injury. Existing non-invasive prognostic tools are limited in their diagnostic power. Moreover, transcriptomics of colonic biopsies have been inconclusive in their association with clinical features.

Aims To assess the utility of host transcriptomics of faecal wash samples of patients with IBD compared with controls.

Methods In this prospective cohort study, we obtained biopsies and faecal-wash samples from patients with IBD and controls undergoing lower endoscopy. We performed RNAseq of biopsies and matching faecal-washes, and associated them with endoscopic and histological inflammation status. We also performed faecal mass-spectrometry proteomics on a subset of samples. We inferred cell compositions using computational deconvolution and used classification algorithms to identify informative genes.

Results We analysed biopsies and faecal washes from 39 patients (20 IBD, 19 controls). Host faecal-transcriptome carried information that was distinct from biopsy RNAseq and faecal proteomics. Transcriptomics of faecal washes, yet not of biopsies, from patients with histological inflammation were significantly correlated to one another (p=5.3×10−12). Faecal-transcriptome had significantly higher statistical power in identifying histological inflammation compared with transcriptome of intestinal biopsies (150 genes with area under the curve >0.9 in faecal wash samples vs 10 genes in biopsy RNAseq). These results were replicated in a validation cohort of 22 patients (10 IBD, 12 controls). Faecal samples were enriched in inflammatory monocytes, regulatory T cells, natural killer-cells and innate lymphoid cells.

Conclusions Faecal wash host transcriptome is a statistically powerful biomarker reflecting histological inflammation. Furthermore, it opens the way to identifying important correlates and therapeutic targets that may be obscured using biopsy transcriptomics.

INTRODUCTION

Mucosal healing, assessed via colonoscopy, is the desired outcome in therapy of inflammatory bowel disease (IBD) patients.1 Histological healing (as per mucosal biopsy obtained during colonoscopy and analysed by a pathologist) is considered a more stringent therapeutic goal.2 In a recent publication on 101 patients with ileal Crohn’s disease (CD) in clinical remission, histological healing, but not endoscopic healing, was associated with decreased risk of clinical relapse, medication escalation or corticosteroid use.3 Biological therapies have revolutionised therapy for moderate to severe IBD.4 While 50%–60% of patients significantly improve
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with biologics and experience less hospitalisations and surgeries, many patients are either primary non-responders or experience loss of response over time. Non-invasive markers that may provide information on histological inflammation, and therefore predict patient prognosis or response to therapies, are critically needed.

Several studies performed RNA sequencing of colonic biopsies obtained during lower endoscopies, with the aim of staging the disease and predicting therapeutic outcomes. Furthermore, certain mucosal micro-RNA and long noncoding RNA have been associated with IBD natural history. Recent studies used single cell RNA sequencing (scRNAseq) and single cell mass-cytometry of IBD biopsy samples to reveal distinct populations and genes that are altered in specific disease states. In addition to transcriptomics, unique DNA methylation patterns have been identified in biopsies of patients with IBD compared with controls. Data from RNA bulk sequencing of intestinal biopsies has also been integrated with genome-wide-associations to identify genes most associated with regulatory pathways in IBD. Nevertheless, an outstanding challenge of the analysis of biopsies is that they provide localised information and may miss out on inflammatory processes, especially in cases where endoscopic inflammation is not apparent.

A complementary method to assess intestinal inflammation is the use of faecal samples. A recent study demonstrated that patients with active CD had a distinct microRNA profile measured in their stool. Faecal proteomics can also inform on intestinal inflammation status. Indeed, calprotectin, a leucocyte protein, is a widely applied biomarker of intestinal inflammation. Nevertheless, the calprotectin assay is limited in sensitivity and specificity and only few additional proteins have been shown to be both resistant to proteolysis and associated with inflammation. An advantage of faecal samples is that they may provide broad sampling of processes that occur throughout the gastrointestinal tract. Recent works demonstrated that faecal host transcriptomes may carry prognostic information related to colorectal cancer, however, the utility of this approach to staging and prognosis in IBD has not been explored.

Here, we perform transcriptomics of host mRNA of faecal washes (faecal samples obtained by suction of colonic fluid at the beginning of a colonoscopy, before any through-the-scope washing is applied) and demonstrate that this approach provides markers for identifying histological inflammation. Faecal wash host transcriptomics enables broad sampling of the shed cells throughout the colonic axis, preferentially capturing the immune cells involved in intestinal inflammation. It can, therefore, constitute an alternative, potentially less invasive, method for predicting patient outcome and tailoring personalised medicine.

METHODS

Patient population

In this cross-sectional study, patients arriving for a lower endoscopy at Sheba Medical Centre Gastroenterology institute were recruited. For this pilot study, we deliberately focused on patients with IBD with inflammation of the colon, so that the study groups included patients with ulcerative colitis (UC) or Crohn’s colitis, or healthy controls. All control patients performed lower endoscopy for colorectal screening purposes and patients with IBD underwent the procedure due to clinical indications (screening for dysplasia/assessment of disease status). Clinical and demographic parameters were obtained from patients’ computerised files.

Sample collection

On endoscopy, biopsies (two consecutive biopsies per patient—‘double bite’) from the sigmoid colon were obtained and faecal fluid was suctioned from the sigmoid colon at the beginning of the procedure, before any through-the-scope washing was applied. In patients with endoscopic inflammation of the sigmoid colon, the biopsies were obtained from the inflamed area, adjacent to ulcers, if detected. Samples were snap-frozen in liquid nitrogen and stored i n −80°C until further analysis. In addition, stool samples were obtained from four patients (two patients with IBD and two controls) for concomitant proteomics analysis and stool calprotectin measurements. Stool calprotectin was also measured in additional 22 patients’ faecal washes, comprising the validation cohort.

Study outcomes

The primary outcome was to map the transcriptomic profile of faecal washes in different patient groups (control, IBD with or without endoscopic and histological inflammation) and to identify biomarkers for classifying these groups. Secondary outcomes included a comparison of faecal washes with colonic biopsies and inference of the cellular composition of the faecal washes using computational deconvolution based on scRNAseq data.

Exclusion criteria

► Patients younger than 18.
► Undetermined diagnosis of UC or CD (IBD unclassified).
► Missing clinical/demographic data.
► Patients with active endoscopic inflammation in the right colon only.

Biomarker measurements

Stool calprotectin was measured using a commercially available ELISA assay (Quantum Blue Calprotectin Quantitative Lateral Flow Assay, LF-CAL25, Buhlmann laboratories, Switzerland).

Definition of clinical remission

Clinical status was determined by HBI (Harvey-Bradshaw index) for CD and by SCCAI (Simple Clinical Colitis Activity Index) for UC patients. Clinical remission was defined as HBI ≤5 for CD patients and SCCAI ≤3 for UC patients.

Definition of mucosal healing and histological healing

Endoscopic and histological inflammation were graded according to standardised indices and by blinded gastroenterologists and pathologists respectively. Endoscopic scores were determined prospectively during lower endoscopy. Mucosal healing was defined as absence of ulcers and lack of inflammation on endoscopic examination, for CD and UC, respectively. Histological inflammation was determined by a certified pathologist at the Sheba medical centre based on biopsies from the same sigmoid colon region used for the biopsy transcriptomics. Histological healing was retrospectively defined as grade 0 on the Nancy histological index. Histologically active disease was graded between 1 and 4 by certified blinded pathologist.

RNA extraction

For colonic biopsies—snap frozen tissues (2 × 2 mm) were thawed in 300 µL Tri-reagent and mechanically homogenised with bead beating, followed by a short centrifugation step to pull down beads and any tissue left-overs. For colonic washes—Tri-reagent was added at a ratio of 3:1, samples were allowed to thaw on ice followed by thorough mixing. A first centrifugation step was
used (1 min, 18,000 rpm) to eliminate faecal solids. Following this, ethanol was added in a ratio of 1:1 to the supernatant from the previous step and continued according to the manufacturer instructions of Direct-zol mini and micro prep kit (ZYMO Research, R2052).  

**RNA sequencing of samples**

RNA was processed by the mcSCRBeq protocol with minor modifications. RT reaction was applied on 10 ng of total RNA with a final volume of 10 μL (1× Maximahour Buffer, 1 mM dNTPs, 2 μM TSO* E5V6NEXT, 7.5% PEG8000, 20U Maxima H enzyme, 1 μL barcoded RT primer). Subsequent steps were applied as mentioned in the protocol. Library preparation was done using Nextera XT kit (Illumina) on 0.6 ng amplified cDNA. Library final concentration of 2 nM was loaded on NextSeq 500/550 (Illumina) sequencing machine aiming at 20 M reads per sample with the following setting: Read1—16 bp, Index1—8 bp, Read2—66 bp. A total of 8/78 samples in the original cohort failed due to insufficient RNA for extraction / insufficient UMI counts for either wash or biopsy. Only samples which had a UMI count of above 10,000 were included in the analysis. In total 7/39 washes were not included in the analysis due to insufficient RNA for sequencing (2 controls) or due to insufficient UMI counts after sequencing (two UC patients and three controls). One biopsy was also removed due to insufficient UMI count after sequencing (colon CD patient).

**Proteomic analysis**

Faecal samples were lysed in lysis buffer containing 5% SDS, proteins were extracted, digested with trypsin, and tryptic peptides were subjected to LC-MS/MS analysis. Acquired raw data were analysed using the MaxQuant software while searching against the human protein database, and downstream quantitative comparisons were calculated using the Perseus software.

**Bioinformatics and computational analysis**

Illumina output sequencing raw files were converted to FASTQ files using bcl2fastq package. To obtain the UMI counts, FASTQ files were aligned to the human reference genome (GRCh38.91) using zUMI package. Statistical analyses were performed with MATLAB R2018b. Mitochondrial genes and non-protein coding genes were removed from the analysis. Protein coding genes were extracted using the annotation in the Ensembl database (BioMart) for reference genome GRCh38 V91, using the R package ‘biomaRt’ (V2.44.4). Gene expression for each sample was consequently normalised by the sum of the UMIs of the remaining genes. Samples with less than 10,000 UMIs over the remaining genes were removed from the analyses. Clustering and principle component analysis (PCA) were performed in MATLAB using the Zscore-transformed expression matrix. Clustering was done with the matlab function clustergram, using Spearman distances. Differential gene expression was performed using Wilcoxon rank-sum tests and Benjamini-Hochberg FDR corrections. Computational deconvolution was performed using CIBERSORTx using signature tables obtained from a single cell atlas of control and UC patients. Original cell type annotations were used, but subsequently coarse-grained into small number of cell types (online supplemental table 1). M cells were removed from the analysis due to their low abundance. Receiver Operating Curve analyses were performed using the MATLAB function perfcurve. Gene Set Enrichment Analysis (GSEA) was performed over the Hallmark and Kegg gene sets.

**RESULTS**

**Cohort characteristics**

In total, 39 biopsies and 39 matching faecal wash samples were obtained from 16 patients with UC, 4 patients with Crohn’s colitis and 19 control subjects undergoing colonoscopy at Sheba Medical centre. Pairs of biopsies and matching washes were obtained concomitantly (figure 1, table 1). Control patients were those undergoing lower endoscopy for screening purposes, recommended over the age of 50, and, therefore, they were significantly older than the IB patients (p<0.0008), with more comorbidities, other than IB (p=0.0015, table 1). Eleven (58%) of all patients with IB were treated with immunomodulator/biological therapy and five (26%) were on concomitant steroids at time of enrolment. Nine (47%) of the patients were in clinical remission, twelve (63%) were in endoscopic remission and seven (37%) achieved histological remission as determined on the day of the lower endoscopy. Five faecal wash samples were excluded from the analysis due to technical drop-outs. Validation cohort consisted of 10 patients with IB and 12 controls (see online supplemental table 2 for demographic and clinical parameters).

**Faecal wash host transcriptome is more informative than biopsy transcriptome in classifying patient disease status**

We performed bulk RNA sequencing of all samples using the UMI-based mcSCRBeq protocol (see Methods) and mapped the reads to the human genome (online supplemental table 3). We found that gene expression signatures of colonic biopsies were different from those of colonic washes (figure 2A,B). Biopsy samples with histological inflammation were not distinct from biopsy samples of patients without histological inflammation in the PCA or clustering analysis (figure 2B, C). In contrast, colonic faecal wash samples showed a clear separation between samples with and without histological inflammation (figure 2D).

We next sought to quantify the comparative ability of biopsy and faecal wash transcriptomics to inform on histological inflammation (evaluated by the Nancy score). To this end, we examined correlations between gene expression profiles of pairs of samples
Inflamed faecal washes exhibit distinct cellular composition

We inferred cell compositions among inflamed vs non inflamed faecal washes and biopsies using CIBERSORTX\textsuperscript{28} (Methods/ Bioinformatics and computational analysis), using gene expression signatures of human colonic cell types that we parsed based on a recent scRNAseq study\textsuperscript{29} (Methods, online supplemental figure 3). We found elevated representation of distinct immune cell subtypes in the washes of patients with histological inflammation (figure 4). Cell types that were elevated in faecal washes from patients with histological inflammation included regulatory T cells (p=3.6×10\textsuperscript{-10}), natural killer (NK) cells (p=5.2×10\textsuperscript{-10}), inflammatory monocytes (1.4×10\textsuperscript{-8}) and innate lymphoid cells (ILCs, p=2.6×10\textsuperscript{-9}). The increased differential representation of these immune subsets was higher in faecal washes when compared with biopsies (figure 4B, online supplemental figure 4A,B). Moreover, expression levels of the genes that were most variable across the Nancy score classes increased more sharply with severity in the faecal wash transcriptomics compared with the biopsy transcriptomics (online supplemental figure 4C).

More genes have expression levels that are highly predictive of histological inflammation in faecal washes compared with biopsies

We next sought to assess whether expression levels of individual genes can classify samples as belonging to patients with or without histological inflammation. We performed receiver operating characteristic curve (ROC) analysis for all genes in the biopsies and faecal washes and examined the area under the curve (AUC, figure 5A). We found that in the washes, the expression levels of multiple individual genes were significantly more predictive of histological inflammation compared with the biopsies. This was evident by the significantly higher AUC of the 5% genes with the highest AUC levels in both groups (p=1.5×10\textsuperscript{-79}, figure 5B). Faecal washes included 150 genes with AUC >0.9, whereas biopsies had only 10 such genes (figure 5C–E). Pathway analysis demonstrated that the 5% genes with the highest AUC in faecal washes were enriched for TNFα signalling via NF-κB, and...
Validation cohort demonstrates high overlap between inflammation-predicting faecal wash genes

To examine the robustness of our findings we replicated the study on an independent validation cohort of 22 additional patients (10 IBD and 12 controls, UMI-based reads listed in online supplemental table 3). In the validation cohort, gene expression values in the faecal washes were more indicative of histological inflammation than in biopsies (online supplemental figure 5A–C). A total of 155 genes had AUC higher than 0.9 in the faecal washes vs only 5 genes in the biopsies. Moreover, we found that the overlap in the two cohorts between the inflammation-predicting faecal wash genes was highly significant (47%, 219/467, of the genes that were in the top 10% AUC values overlapped, hypergeometric p<1e-15). Online supplemental figure 5G–I shows examples of ROC curves over the validation cohort for three of the top classifying faecal wash genes detected in the original cohort. Online supplemental table
Figure 3  Differentially expressed genes between inflamed and non-inflamed faecal washes. (A) Volcano plot, each dot is a gene, x-axis is the log2-ratio of expression between samples with and without histological inflammation, y axis is –log10 (p value), where p value is computed using Wilcoxon rank-sum tests. Genes with corresponding q-values below 0.1 are marked in red (q-values computed using Benjamini-Hochberg FDR correction). Names of representative up-regulated genes are shown. (B) GSEA analysis over the Hallmark and Kegg sets. Shown are all gene sets with q-value <0.3. Inflamed washes (red circles) were associated with immune cell pathways, while non-inflamed washes (blue circles) expressed more epithelial cell related pathways. Naming nomenclature: sample name-condition-endoscopic inflammation (0/1)—histological inflammation (0/1). FDR, false discovery rate; GSEA, gene set enrichment analysis.

Figure 4  Cell compositions of inflamed versus non inflamed faecal washes and biopsies, inferred by computational deconvolution. (A) hierarchical clustering of cell type representation in faecal wash samples and colonic biopsies. Faecal washes from patients with histological inflammation are marked in red. (B) Inferred relative representation of genes associated with different cell types in histologically inflamed and non-inflamed colonic biopsies and faecal washes. Immune-related cell types, more abundant in the faecal washes of patients with histological inflammation, are marked with a red box. Naming nomenclature: sample name-condition-endoscopic inflammation (0/1)—histological inflammation (0/1). White circles are medians, grey boxes denote the 25th–75th percentiles. P values computed using Kruskal-Wallis tests.
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5 presents this set of overlapping genes that are indicative of histological inflammation. Notably, overlap between the most inflammation-predicting biopsy genes was insignificant (10% (51/480), p=0.27). The AUC values were significantly correlated between the cohorts in the faecal wash data, yet not in the biopsy data (online supplemental figure 5D,E, R=0, p=2.3e-130 for biopsies, R=0.34, p=2.3e-130 for washes, Online supplemental table 6).

We further assessed the predictive power of faecal-wash host transcriptomics in the validation cohort compared with ELISA-based calprotectin levels (online supplemental figure 6A). We found that calprotectin levels had lower statistical power for classification of histological inflammation compared with faecal host transcriptomics (equal error rate of 0.14 for calprotectin vs equal error rate of 0 for 17 of the faecal wash host genes online supplemental figure 6B–D).

Figure 5  Expression of individual genes in faecal washes has a higher statistical power in classifying histological inflammation compared with biopsy gene expression. (A) ROC curve example for the gene NFKBIA using faecal washes (blue, AUC=0.97) and biopsies (red, AUC=0.67). (B) AUC of 5% genes with the highest AUC for biopsies and washes. The AUC of the top classifier genes is significantly higher for faecal washes compared with biopsies (p=1.85*10−72). (C) Comparison of AUC for individual genes based on biopsies (x axis) and faecal washes (y axis). NFKBIA (red dot) is shown as an example. Grey boxes mark the top AUC (>0.9) for both groups. Faecal washes contain 150 genes with AUC >0.9 whereas biopsies contain only 10 such genes. (D, E) Expression levels for the eight genes with the highest AUC levels for washes (D) and biopsies (E). White circles are medians, grey boxes mark the 25th–75th percentiles. AUC, area under the curve; inf-W, inflamed faecal washes; NFKBIA, NF-kappa-B inhibitor alpha; non-inf-W, non-infamed faecal washes; ROC, receiver operating characteristic.
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DISCUSSION

In the current study, we analysed biopsies and faecal washes of 39 IBD and control patients. We found that transcriptomes of faecal washes were significantly more powerful in identifying histological inflammation compared with transcriptomes of intestinal biopsies. This was also demonstrated in a validation cohort of 22 IBD and control patients. The increased statistical power of faecal host transcriptomics over biopsy transcriptomics could be related to two underlying features—the broader sampling of the intestinal wall, and the increased representation of cell populations directly involved in inflammation. Since faecal washes include cells that are shed throughout the gastrointestinal tract, their measurement may detect inflammatory processes that may be missed out when sampling a specific biopsy, thereby providing broad sampling.

We found that faecal washes of patients with histological inflammation were enriched in inflammatory monocytes, regulatory T cells, NK cells and ILCs (figure 4). Consistently, faecal washes from histologically-inflamed samples were enriched in genes associated with TNFα signalling, IL6 signalling, chemokine signalling pathway and NK cytotoxicity, whereas non-inflamed samples expressed mostly genes associated with pathways such as glycolysis and glutathione metabolism (figure 3). This result is in line with recent findings of increased leukocyte trafficking to the intestine and to the gut-associated lymphatic tissue on inflammation.32 33 Whereas epithelial cells are constantly shed off in the intestine, the process of active inflammation may involve increased shedding of immune cells. Unlike bulk measurements of biopsies, consisting mainly of fibroblasts and epithelial cells (figure 4), the faecal washes enable zooming in on the immune cell populations, avoiding ‘masking’ by other stromal cell types that are abundant in biopsies.

Faecal microbial RNA analysis has been shown to differentiate between CD and UC and alterations in microbiota diversity have been linked with disease activity.34 However human faecal mRNA has scarcely been studied so far,35–38 and has not been applied in IBD. While our analyses focused on faecal washes, preliminary data suggests that host transcriptomics from stool samples may also provide comparable information (Ungar et al, in preparation). Challenges involved in stool samples, including the ability to sample mRNA from recently-shed cells, will be addressed in future studies.

In recent years, faecal calprotectin has been established as a leading biomarker assisting in the diagnosis and non-invasive management of IBD. Notably, the calprotectin assay’s sensitivity and specificity is on the order of 80%.39 Our study found only weak correlation between faecal protein levels and matching mRNA expression levels (figure 6B). This discrepancy could be a result of differences in protein and RNA degradation rates, which are often non-correlated.40 The similarity between human and bacterial RNAses, which are both abundant in human stool, probably also affects human faecal mRNA instability.41 Furthermore, several studies have reported elevated levels of faecal protease activity in patients with certain gastro-intestinal diseases including IBD and irritable bowel syndrome (IBS), potentially compromising proteomic, but not necessarily transcriptomics measurements in these diseases.32

This study analysed 39 patients with 78 faecal wash and biopsy samples and additional 22 validation—cohort patients. While this cohort revealed the power of faecal transcriptomics in
identifying histological inflammation, future studies with larger sample sizes could detect differences in various subgroups, such as patients with differential responses to biological therapy, or certain age-groups. Endoscopic inflammation and histological inflammation were graded according to standardised indices and by blinded gastroenterologists and pathologists, yet, as in other studies, sampling errors and variations in scaling are possible.

In conclusion, we have demonstrated that faecal wash host transcriptome constitutes a statistically powerful biomarker in IBD, specifically for the challenging identification of histological inflammation. Expression levels of mRNA in faecal washes discriminate between histologically inflamed and non-inflamed patients significantly better than mRNA expression of colonic biopsies. Pathways common to genes associated with inflammation in faecal washes were those related to TNFα, JAK-kinase and IL-6, central pathways that are thought to be mechanistically associated with IBD pathology. Hence, it seems that the colonic washes constitute an ‘extract’ of exfoliated inflammatory cells in the gut, which is highly indicative of histological inflammation in patients with IBD. Although faecal washes require gut cleansing, they obviate the need for full colonoscopy, with its discomfort, need for sedation and risk for perforation. Future studies will assess the ability of faecal host transcriptome to predict disease course in specific IBD patient populations, to predict response to therapy and risk for perforation. Future studies will also demonstrate whether stool samples, without bowel lavage, could be similarly analysed.

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Contributors SI and BU conceived the study and drafted the manuscript; SI performed the bioinformatics analysis and was the guarantor of the study; BU was involved in study conception, performed experiments, analyses and interpretation of data; MY, EF, OP, YL and AS took part in sample retrieval and analysis. SB-R performed the bioinformatics analysis and is the guarantor of the study; BU was involved in study design and data analysis. UK, RE and DS participated in study design and drafting of the manuscript. IB and SB-R participated in data interpretation and in critical revision of the manuscript. SD and CM were involved in final revision of the manuscript. All authors have approved the final draft submitted.

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