Nature of “basal” and “reserve” cells in oviductal and cervical epithelium in man

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SUMMARY The epithelium of the human fallopian tube (oviduct) and cervix were studied by histological, immunohistological, and ultrastructural methods with a view to establishing the nature of the so called “basal” and “reserve” cells. The results indicated that the “basal” cells of the oviductal epithelia were T lymphocytes, with a predominance of T cytotoxic and suppressor cells. A more heterogeneous inflammatory cell population was present in cervical epithelium, although once again T cytotoxic and suppressor cells were the most numerous subtype. The intraepithelial inflammatory cells were quite distinct from the cells commonly referred to as “reserve” cells (reserve cell hyperplasia), which have epithelial characteristics.

The origin of the “reserve” cells is unclear, but they seem to arise within the epithelium. They probably represent an early sign of squamous metaplasia. The lymphoid tissue of the fallopian tube and endocervix shows similarities with that of the endometrium and mucosal associated lymphoid tissue in general.

The “basal” cells of rabbit oviductal and endocervical epithelium were studied ultrastructurally by Odor, who concluded that they were lymphocytes. Evidence for the migration of lymphocytes into oviductal epithelium has been reported in cattle, but in human tissue these cells have been said to resemble endometrial granulocytes or “K-cells.” Furthermore, the “subcylindrical reserve cells of the endocervix” in human tissue have been reported as showing features similar to fibroblasts, and a derivation from Müllerian mesenchymal cells has been suggested. A standard textbook of gynaecological pathology, however, states that the “subcolumnar reserve cells” of the endocervix have general fine structural characteristics similar to the basal cells of mature squamous portio epithelium.

This study was performed to establish the histological, immunohistological, and ultrastructural characteristics of “basal” and “reserve” cells in oviductal and endocervical epithelium with a view to establishing their true nature.

Material and methods

Segments from the ampullary part of normal fallopian tubes were obtained from patients who had undergone sterilisation or incidental salpingectomy at the time of hysterectomy.

Cervical tissue was obtained from the uteri of patients who had undergone a hysterectomy for fibroids, dysmenorrhoea, or dysfunctional uterine bleeding. The blocks were taken to include ectocervical squamous epithelium, the squamocolumnar junction, and the endocervix. None of the patients had clinical cervical disease or any abnormality of the cervix visible to the naked eye.

All of the tissue was received fresh within four hours of operation.

HISTOLOGY

Tissue from six fallopian tubes and fifteen cervices was fixed in 10% neutral buffered formalin for 24–36 hours. The blocks were routinely processed to paraffin wax, and 4 micron sections were cut and stained with haematoxylin and eosin.

IMMUNOHISTOLOGY

Immunohistology was performed on both paraffin embedded tissue and on tissue snap frozen in liquid nitrogen.

Paraffin immunohistology

Examination of the sections stained with haematoxylin and eosin cut from the 15 blocks of cervix showed three cases in which areas of “reserve” cell hyperplasia could easily be found. These three cases,
three cervices in which "reserve" cell hyperplasia was not prominent, and the six fallopian tubes were selected for immunohistological staining.

Sections were cut at 4 microns, floated on to glass slides, dewaxed in xylene, and taken to water via absolute alcohol. They were stained for leucocyte common antigen, epithelial membrane antigen, keratin, and lysozyme using a two stage indirect immunoperoxidase technique. The antibodies were obtained from Dakopatts, High Wycombe. Endogenous peroxidase activity was blocked by incubating the slides with 3% hydrogen peroxide in methanol for 30 minutes. The monoclonal primary antisera to leucocyte common antigen and epithelial membrane antigen were applied to the sections in a 1/10 dilution and incubated overnight. The polyclonal antisera to keratin and lysozyme were applied to the sections in a 1/100 dilution for one hour following trypsinisation (0-1% trypsin in Tris buffer at pH 7-8 for 35 minutes at 37°C). The sections were then washed and incubated with 1/30 peroxidase conjugated rabbit antimouse immunoglobulin (leucocyte common antigen and epithelial membrane antigen) or peroxidase conjugated swine antirabbit immunoglobulin (keratin and lysozyme) for 30 minutes. The peroxidase conjugates were obtained from Dakopatts, High Wycombe. Finally, the sections were washed, developed in diaminobenzidine and hydrogen peroxide, and counterstained with hae-matoxylin.

**Frozen section immunohistology**

Samples from three fallopian tubes and three cervices were selected at random and snap frozen in liquid nitrogen. Cryostat sections were cut at 8 microns, freeze dried overnight, and acetone fixed for 20 minutes at room temperature. The sections were rehydrated in Tris buffer (pH 7-6) and stained using a two stage immunoperoxidase technique. The primary antisera listed in the Table were applied to the sections for 30 minutes. The sections were washed twice in Tris buffer (pH 7-6) and incubated with either 1/50 Dakopatts peroxidase conjugated rabbit antimouse immunoglobulin (monoclonal antibodies) or peroxidase conjugated swine antirabbit immunoglobulin (polyclonal antibodies) for 30 minutes. After washing the sections were developed in diaminobenzidine and hydrogen peroxide with amidazole as catalyst. Finally, the sections were washed, mordanted with 0.5% copper sulphate in isotonic saline, and counterstained with methyl green.

**Electron Microscopy**

Tissue from two of the fallopian tubes was fixed in 3%
buffered gluteraldehyde for three hours, washed overnight in phosphate buffered saline (pH 7.35), and then fixed in osmium tetroxide for one hour. The tissue was dehydrated in alcohol and embedded in Polacbed and Araldite. Ultrathin sections were stained with uranyl acetate and lead citrate and viewed in a Jeol 1200EX electron microscope.

In view of the focal nature of "reserve" cell hyperplasia in the cervix prospective random sampling into gluteraldehyde was considered unlikely to be successful. Formalin fixed tissue from two of the cases identified as exhibiting widespread "reserve" cell hyperplasia was therefore sampled retrospectively and processed for electron microscopy as above.

Results

HISTOLOGY

The "basal" cells of the oviductal epithelium usually had small, dark, round to oval nuclei and a perinuclear "halo" (Fig. 1). A minority of these cells had larger and more irregularly contoured nuclei. Similar cells were present in cervical squamous and columnar epithelium, and I use the term "basal" cell exclusively to denote cells with this morphology. The layer of small cuboidal cells seen beneath the columnar endocervical mucinous epithelium in three of the cervixes was easy to distinguish from "basal" cells (Fig. 2), and the term "reserve" cell is used exclusively for this type of cell.

Paraffin immunohistology

The luminal border of the oviductal epithelium was strongly positive for epithelial membrane antigen, with a minor degree of patchy cytoplasmic positivity. The "basal" cells and stromal cells did not stain for epithelial membrane antigen (Fig. 3). The tubal epithelium also exhibited patchy luminal and cytoplasmic positivity for keratin, and once again the stroma was negative. The "basal" cells were usually positive for leucocyte common antigen, and similar positive cells were scattered throughout the stroma. Lysosome positive cells were present in the stroma, and in one case very occasional lysosome positive cells were present within the oviductal epithelium. The number of lysosome positive cells varied, but in all cases they were outnumbered by leucocyte common antigen positive cells. The lysosome positive cells were mainly granulocytes, with a few histiocytes admixed. The tubal epithelial cells, fibroblasts, and smooth muscle cells were negative for leucocyte common antigen and lysosome.

The cervical squamous epithelium stained positively for epithelial membrane antigen and keratin but was negative for leucocyte common antigen and lysosome. The pattern of staining varied with a tendency for epithelial membrane antigen to stain the surface and keratin the basal layers. Staining was usually strongest in transitional zone or metaplastic squamous epithelium. The columnar mucinous endocervical epithelium was also positive for epithelial membrane antigen and keratin and negative for leuco-
cyte common antigen and lysozyme. Positivity was again patchy, with both antibodies tending to stain the surface of the cells, especially in areas of "reserve" cell hyperplasia. The "reserve" cells showed weak patchy positivity for epithelial membrane antigen but were strongly positive for keratin (Fig. 4). They were negative for leucocyte common antigen and lysozyme. The "basal" cells were positive for leucocyte common antigen, or, less commonly lysozyme, but were negative for epithelial membrane antigen and keratin. There were leucocyte common antigen and lysozyme positive cells within the stroma, and these seemed to be lymphocytes, granulocytes, and macrophages.

**Frozen section immunohistology**

Most of the "basal" cells of the oviductal epithelium were OKT8 positive (Fig. 5). A lesser number of OKT4 positive cells were also present, comprising roughly 15–20% of the T lymphocyte population. A qualitatively and quantitatively similar lymphoid population was present in the stroma. Very occasional OKM5 or Pan B positive cells were seen in the stroma, but none was detected in the epithelium. The B lymphocytes were usually IgA positive.

The inflammatory cell population of the cervix was comparatively heterogeneous. Most of the "basal" cells in the squamous epithelium, the columnar epithelium, and the stroma were once again OKT8 positive (Fig. 6). OKT4 positive cells were present in proportionally greater numbers than in the fallopian tube, comprising about 30–40% of the total T lymphocyte population. Pan B positive lymphocytes (and plasma cells) were present in the stroma but were only rarely seen in the epithelium. Cells positively stained
Most intraepithelial "basal" cells in cervix are OKT8 positive, and once again staining reaction is strikingly similar to that of stromal lymphocytes. (Indirect immunoperoxidase.) × 500.

for each of the light and heavy chains were found, IgM positive cells being slightly predominant. OKM5 positive cells were less common than T or B cells and were present in the stroma and occasionally within the epithelium.

**ELECTRON MICROSCOPY**

The "basal" cells in the oviductal epithelium were usually located close to the basal lamina but could also be found higher up in the epithelium. The nuclei were round to oval and occasionally indented or clefted. Heterochromatin was aggregated peripherally, with clumps of heterochromatin centrally. The nucleus was surrounded by a rather ragged rim of relatively dense cytoplasm in which a few small mitochondria, profiles of endoplasmic reticulum, and membrane bound granules could be seen. Peripherally, the cytoplasm was attenuated, presumably accounting for the "halo" seen in the sections stained with haematoxylin and eosin. Sometimes the cytoplasm extended between adjacent epithelial cells (Fig. 7), but no junctions were seen.

Cells similar to "basal" cells were also present within the endocervical columnar epithelium. They were clearly different to the subcolumnar "reserve" cells, which had larger more convoluted nuclei and relatively homogeneous cytoplasm. The "reserve" cells had quite prominent cytoplasmic filaments, and in some of the cells these were morphologically indistinguishable from tonofilaments. Furthermore, the cells were joined to their neighbours by scant desmosomes (Fig. 8). Although occasional discontinuities in the basal lamina were seen, these seemed to be the result of inflammatory cells migrating into the epithelium or plane of section artefact. No evidence of fibroblast like cells migrating across the basal lamina to form the "reserve" cell layer was seen.

**Fig. 6** Most intraepithelial "basal" cells in cervix are OKT8 positive, and once again staining reaction is strikingly similar to that of stromal lymphocytes. (Indirect immunoperoxidase.) × 500.

**Fig. 7** "Basal" cell (BC) in human oviductal epithelium. Halo seen in paraffin sections seems to be due to peripheral rarefaction of cytoplasm. Cytoplasm of "basal" cells sometimes interdigitates with that of epithelial cells (*). (Uranyl acetate and lead citrate.) × 6000.
Discussion

The results indicate that the “basal” cells of human oviductal epithelium are predominantly T lymphocytes, with a cytotoxic and suppressor (OKT8) to helper (OKT4) cell ratio of about 6:1 in the three cases examined. The presence of a similar lymphocyte population in the stroma suggests that stromal lymphocytes migrate across the basal lamina into the epithelium, presumably in a manner analogous to that postulated in the endometrium. Although a variable number of granulocytes were found in the stroma, they seemed to make a minimal contribution to the intraepithelial inflammatory cell population under physiological conditions. The suggestion that they are “granulocyte-like” is therefore not supported by the findings of this study.

Most of the intraepithelial inflammatory cells (“basal” cells) found within the cervical squamous and columnar epithelium were also T lymphocytes, but B lymphocytes, granulocytes, and macrophages were also found. The cytotoxic and suppressor (OKT8) to helper (OKT4) cell ratio was more variable than that found in the oviduct but was generally about 2:1 or 3:1. Possibly, cross reactivity of OKT4 with monocytes and macrophages may, in part, be responsible for the apparent increase in the proportion of helper cells in the cervix.

The finding that the “basal” cells of the oviductal and cervical epithelia were T cytotoxic and suppressor lymphocytes is in keeping with reported nature of the intraepithelial lymphocytes of the endometrium and other mucosal sites. The possible roles of the mucosal associated lymphocyte tissue have been discussed elsewhere. I would, however, like to draw attention to the link between T lymphocytes and apoptosis and the loss of epithelial cells by apoptosis. Although I have not found any morphological evidence that the intraepithelial T lymphocytes induce apoptosis in the oviduct or cervix, the possibility that they have a role in immune surveillance and the elimination of abnormal cells merits consideration.

Subcolumnar “reserve” cells were found in the cervix but not in the oviduct. They have epithelial characteristics whether examined by light microscopy, immunohistochemistry, or electron microscopy. They seem to differ from the intraepithelial lymphocytes reported in rabbit endocervical tissue by Odor, which are presumably analogous to the intraepithelial lymphocytes in man. Odor does not seem to have studied subcolumnar “reserve” cells as defined in this paper.

The origin of subcolumnar “reserve” cells is uncertain, but I could find no evidence to support the contention that they are fibroblast like cells derived from the Müllerian mesenchyme. There were occasional breaks in the epithelial basal lamina, but no fibroblast like cells were seen in the epithelium, and no epithelial like cells were seen in the stroma. It would seem more likely that they arise within the epithelium, either from an inconspicuous stem cell population or...
by metaplasia of columnar cells. Whatever their origin, they resemble the basal layer of squamous epithelium, which suggests that they are an early manifestation of squamous metaplasia.

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References


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