Brush border enzymes in coeliac disease: histochemical evaluation

J Mercer, M E Eagles, I C Talbot

Abstract
Two hundred and ninety four duodenal and jejunal mucosal biopsy specimens from patients with coeliac disease, treated and untreated, and other conditions were examined histologically and by histochemical staining for five peptidase and three disaccharidase enzymes to determine profiles of activity. Suppression of activity paralleled the histology with the following enzymes: lactase, trehalase, brush border endopeptidase, dipeptidyl peptidase II and isomaltase. Lactase, trehalase, and brush border endopeptidase were specifically suppressed in untreated coeliac disease and were diagnostically useful. Examination of a combination of enzymes is recommended.

Coeliac disease is diagnosed by the finding of subtotal villous atrophy on a jejunal biopsy specimen followed by recovery on a gluten free diet. Clinical recovery, however, may take time to establish and the histological assessment of a biopsy specimen may sometimes be difficult. Although subtotal villous atrophy has been regarded as an essential diagnostic feature, a few patients with less mucosal damage have been found to improve on a gluten free diet, and degrees of villous atrophy have been described in conditions other than coeliac disease. An additional technique which provides supportive evidence for the diagnosis would therefore be useful.

In 1956 Frazer described the disappearance of the toxic effect of gliadin peptides in coeliac disease after digestion with an extract of pig’s intestinal mucosa and concluded that the handling of these peptides occurred in the mucosal wall. Since then there has been considerable interest in the enzymes of the small intestinal mucosa in patients with coeliac disease and various methods have been used to study many different enzymes. In biochemical assays on homogenised mucosa some authors have shown a reduction in peptidase and disaccharidase activities in untreated coeliac disease. Biochemical assays, however, fail to take into account the fact that many of these enzymes have more than one location within the mucosa. Accurate location of enzymes can be achieved by electron microscopy and by immunocytochemistry, but immunoreactivity for lactase and sucrase-isomaltase has been shown to correlate poorly with enzyme activity.

Histochemical techniques show both the location and activity of an enzyme and can be applied to small samples of tissue such as endoscopic biopsy specimens. The histochemical demonstration of enzyme loss in coeliac disease was first described by Padykula et al. Several subsequent histochemical studies have shown a loss or reduction of both peptidase and disaccharidase enzymes in active coeliac disease, and at least partial recovery on a gluten free diet has been found. Such studies can provide a useful assessment of mucosal damage in coeliac disease.

We have used histochemical techniques to assess the activity of three disaccharidase and five peptidase enzymes which are normally located in the upper small intestinal mucosa. Enzyme activity is related to both the histological appearances of the mucosa and to the clinical diagnosis. A simple grading system, which can easily be applied routinely, is used to assess enzyme activity.

Methods
Two hundred and ninety four biopsy specimens were obtained from 267 patients: 20 patients had more than one biopsy specimen taken. The specimens were taken for the diagnosis of clinically suspected coeliac disease, assessment of response to a gluten free diet, and investigation of anaemia, weight loss, diarrhoea, failure to grow in childhood, abnormal butterfat or xylose absorption tests, or a combination of these symptoms. The following information was recorded for each patient: age, sex, diet, duration of gluten free diet, symptoms at presentation and final diagnosis (from subsequent investigation and follow up). The patients were grouped on final diagnosis (table 1). A final diagnosis was not available for every patient as some were lost to follow up and others continue to be investigated. All patients grouped as “normal” had both a histologically normal biopsy specimen and were found to have no clinically important illness as a result of clinical investigations. Biopsy specimens grouped as “other diagnoses not involving gastrointestinal tract” included those from

<table>
<thead>
<tr>
<th>Group</th>
<th>No of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>8</td>
</tr>
<tr>
<td>Untreated coeliac disease</td>
<td>34</td>
</tr>
<tr>
<td>Coeliac on GFD</td>
<td>37</td>
</tr>
<tr>
<td>Other diagnoses affecting gastrointestinal tract</td>
<td>39</td>
</tr>
<tr>
<td>Other diagnoses not affecting gastrointestinal tract</td>
<td>49</td>
</tr>
</tbody>
</table>

GFD = gluten free diet.
Table 2  Histochemical methods

<table>
<thead>
<tr>
<th>Enzyme</th>
<th>Substrate</th>
<th>Notes</th>
<th>Reference for method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactase</td>
<td>IBF (1, 4)</td>
<td>Synthetic substrate</td>
<td>Lojda &amp; Kraml 1971¹</td>
</tr>
<tr>
<td>Isomaltase</td>
<td>Isomaltase (3)</td>
<td>Multistep method using</td>
<td>Lojda 1967²</td>
</tr>
<tr>
<td>Trehalase</td>
<td>Trehalose (4)</td>
<td>GOP-PMS-NBT (1) in agarose</td>
<td>Lojda 1965⁵</td>
</tr>
<tr>
<td>Dipeptidyl peptidase II (DPP II)</td>
<td>Lysoyl-alanine-4MNA (1, 5)</td>
<td>Coupling agent = Fast Blue B</td>
<td>Gossrau 1977²</td>
</tr>
<tr>
<td>Dipeptidyl peptidase IV (DPP IV)</td>
<td>Glycyl-proline-4MNA (1, 5)</td>
<td>As above</td>
<td>Gossrau &amp; Lojda 1980⁸</td>
</tr>
<tr>
<td>Aminopeptidase A (APA)</td>
<td>L-glutamyl-4MNA (1, 5)</td>
<td>As above</td>
<td>Lojda 1979¹</td>
</tr>
<tr>
<td>Aminopeptidase M (APM)</td>
<td>L-leucyl-4MNA (1, 5)</td>
<td>As above</td>
<td>Lojda &amp; Gossrau 1980⁰</td>
</tr>
<tr>
<td>Brush border endopeptidase (BBE)</td>
<td>Glutamyl-alanyl-alanyl-alanine-4MNA (1, 5)</td>
<td>Incubation on semipermeable membrane</td>
<td>Nachlas et al 1960²</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lojda 1979⁹</td>
</tr>
</tbody>
</table>

(1)  IBF = 4-bromo-4-chloro-3-indolyl-β-D-fucoside

4MNA = 4-methoxy-2-naphthalamide

GOP-PMS-NBT = glucose oxidase-phenazine methosulphate-nitroblue tetrazolium.

(2) Sigma, Poole, Dorset
(3) Fluka, Glosop, Derbyshire
(4) Serva, Uniscience Ltd, London
(5) Bachem, Bubendorf, Switzerland
(6) Other chemical sources – agarose type VII – Sigma, Poole, Dorset

patients who, after clinical investigation, had—
for example, iron deficiency anaemia due to
non-gastrointestinal haemorrhage, menorr-
ragia, dietary anaemia, thyrotoxicosis, hypo-
ythroidism, Sjögren’s syndrome, depression and
delayed puberty resulting from hormonal
abnormalities. Those biopsy specimens
grouped as “other diagnoses involving the
gastrointestinal tract” included those from
patients whose final diagnosis was Crohn’s
disease, ulcerative colitis, Menetrier’s syn-
drome, cow’s milk allergy, irritable bowel syn-
drome and diverticular disease. The age range
of patients was 7 months to 89 years. Fifteen
patients were under 1 year old, 59 patients were
between 1 and 15 years, and the remaining 220
were adults.

Biopsy specimens were obtained either
diagnostically or by Crosby capsule and were
received fresh. Half of each biopsy specimen
was fixed, paraffin wax embedded, routinely
processed, and stained with haematoxylin and
eosin for histological examination. The other
half was orientated on cork under a dissecting
microscope and frozen in isopentane cooled
in liquid nitrogen. Samples were placed in
air-tight tubes and stored in liquid nitrogen until
required.

HISTOCHEMICAL TECHNIQUES

Biopsy specimens were processed in batches
of eight. Using cryostat sections 8 µm thick, the
unfixed sections (except those for lactase) were
delipidised in equal parts of chloroform and
acetone at 4°C for five minutes. Sections were
incubated with the substrate appropriate to
each enzyme, as described previously (table
2) 4 15 17–22. After incubation, sections for pep-
tidases were rinsed in distilled water, chelated
in 2% copper sulphate for five minutes, rinsed
again and fixed in 10% formalin for five
minutes, then washed and mounted in
Aquamount. Sections for isomaltase and tre-
halase were washed in warm distilled water
and then fixed and mounted as described for pep-
tidases. Sections for lactase were rinsed, fixed
in 10% formalin, counterstained with 0.1%
nuclear fast red in 5% aluminium sulphate,
was washed, dehydrated, and cleared and mounted
in Xam. Negative controls were treated iden-
tically but lacked only the substrate. All
chemicals were of the highest grade (BDH,
Poole, Dorset), unless otherwise stated
(table 2).

Biopsy specimens were assessed histol-
ogically and grouped as follows: minor
abnormalities; partial villous atrophy; or
subtotal villous atrophy. Histochemical stain-
ing was assessed both for intensity of staining
and location of activity, using the grading
scheme shown in fig 1.

One way analysis of variance was performed,
first for enzyme grade with histological groups
and secondly, for enzyme grade with clinical
groups, for each of the enzymes studied. The
Kruskal–Wallis test was performed using
Minitab statistical software on a VAX com-
puter. The test ranks all cases from all groups as
a single series, calculates the median, the
average rank and the “Z” value for each group.

\[ Z = \frac{\text{(average rank} - (N + 1)/2)\text{SQR}T}{(N + 1)(N)(N + 1)/12} \]

where \( N = \) number of observations for each
group and \( N = \) total number of observations.
"Z" has an approximately normal distribution
about the centre for each group with a mean of 0
and variance of 1.

Figure 1  Grading system for assessment of enzyme activity. Grade 0 = normal staining at all sites; grade 1 = reduced staining, some tips only; grade 2 = reduced staining on most tips; grade 3 = all tips negative; grade 4 = reduced staining of sides and tips negative; grade 5 = sides and tips negative; grade 6 = reduced staining in upper crypts only; grade 7 = negative.
The result of analysis gives the Kruskal-Wallis statistic “H”, which has about the same distribution as $\chi^2$ with degrees of freedom = n-1, where n = the number of groups. Probability values for H were obtained from tables.

### Results

In the normal cases all the enzymes studied showed well localised activity in the brush border of the upper third of the crypts, the sides, and the tips of the villi (fig 2). Both aminopeptidase enzymes also stained the lower two thirds of the crypt epithelium. In abnormal cases the enzyme staining for the pepidases and lactase was lost sequentially from the tips of villi, followed by the sides and crypts. Individual enzymes, however, were affected to a variable degree and examples are shown in figs 3 and 4. The methods used for trehalase and isomaltase gave a more diffuse, generalised staining of the biopsy specimen and so could only be graded as positive (grade 0), reduced (grade 5), or negative (grade 7).

Analysis of variance between enzyme grade and histological group showed a highly significant correlation ($< 0.001$) for each of the following enzymes: lactase, trehalase, isomaltase, DPP II and BBE. The median enzyme grades for each histological group are shown in table 3. Calculation of average rank (not shown) for each group showed ranking, in increasing order, from normal histology to subtotal villous atrophy for these enzymes. Biopsy specimens with subtotal villous atrophy showed the greatest enzyme loss, with a median grade of 7 for all three disaccharidases, and 6, and 6-5, respectively, for DPP II and BBE. Grades for the group with partial villous atrophy were slightly lower than those for subtotal villous atrophy but were significantly higher than for those of the groups with normal histology or minor changes. The best differentiation between groups was given by trehalase, followed, in order, by lactase, BBE, DPP II, and isomaltase.

A significant correlation was also shown between the same enzymes and the clinical diagnosis (lactase, trehalase, and BBE: $p < 0.001$; isomaltase and DPP II: $p < 0.05$). The median enzyme grade for the diagnostic groups are shown in table 4. There was considerable overlap between the enzyme grades for the normal, other disorders, and other gastrointestinal disorders groups but these were clearly distinguished from the two coeliac groups. The untreated coeliac patients gave the highest grades.

There was no significant correlation between enzyme grade and either histology or diagnosis for the enzymes DPP IV, APA, and APM (fig 4). No association was shown between age and enzyme grade or between sex and enzyme grade for any of the enzymes studied.

All of the biopsy specimens with subtotal villous atrophy and all except three of those with partial villous atrophy were from patients with coeliac disease. The three exceptions each presented with iron deficiency anaemia and an abnormal butterfat absorption test. One patient, a 41 year old man, also had B12 deficiency and pernicious anaemia was sub-

### Table 3  Analysis of variance of enzyme grade with histology

<table>
<thead>
<tr>
<th>Histology</th>
<th>Median enzyme grades</th>
<th>Lactase</th>
<th>Trehalase</th>
<th>Isomaltase</th>
<th>BBE</th>
<th>DPPII</th>
<th>DPPIV</th>
<th>APA</th>
<th>APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
<td>3.0</td>
<td>0.0</td>
<td>0.0</td>
<td>3.0</td>
<td>3.0</td>
<td>1.0</td>
<td>1.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Mild changes</td>
<td></td>
<td>3.0</td>
<td>5.0</td>
<td>0.0</td>
<td>2.0</td>
<td>3.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Partial villous atrophy</td>
<td></td>
<td>7.0</td>
<td>7.0</td>
<td>5.0</td>
<td>5.0</td>
<td>4.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Subtotal villous atrophy</td>
<td></td>
<td>7.0</td>
<td>7.0</td>
<td>7.0</td>
<td>6.5</td>
<td>6.0</td>
<td>2.0</td>
<td>2.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Number of observations</td>
<td></td>
<td>244</td>
<td>272</td>
<td>130</td>
<td>173</td>
<td>217</td>
<td>76</td>
<td>78</td>
<td>79</td>
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<tr>
<td>Kruskal-Wallis &quot;H&quot; statistic</td>
<td></td>
<td>0.001</td>
<td>0.001</td>
<td>0.001</td>
<td>0.001</td>
<td>0.001</td>
<td>Not signif</td>
<td>Not signif</td>
<td>Not signif</td>
</tr>
<tr>
<td>Significance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

...
loco 149.173.104.113.133.75.77.78
Untreated coeliac

Table 4 Analysis of variance of enzyme grade with diagnosis

<table>
<thead>
<tr>
<th>Diagnostic group</th>
<th>Lactase</th>
<th>Trehalase</th>
<th>Isomaltase</th>
<th>BBE</th>
<th>DPP II</th>
<th>DPP IV</th>
<th>APA</th>
<th>APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>3.0</td>
<td>0.0</td>
<td>0.0</td>
<td>3.0</td>
<td>3.5</td>
<td>2.0</td>
<td>2.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Non gastrointestinal tract disorders</td>
<td>2.0</td>
<td>0.0</td>
<td>0.0</td>
<td>3.0</td>
<td>4.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other gastrointestinal tract disorders</td>
<td>3.5</td>
<td>0.0</td>
<td>5.0</td>
<td>2.0</td>
<td>3.0</td>
<td>1.0</td>
<td>1.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Coeliac on gluten free diet</td>
<td>7.0</td>
<td>5.0</td>
<td>5.0</td>
<td>4.0</td>
<td>3.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Untreated coeliac</td>
<td>7.0</td>
<td>7.0</td>
<td>5.0</td>
<td>6.0</td>
<td>5.0</td>
<td>75</td>
<td>77</td>
<td>72</td>
</tr>
<tr>
<td>Number of observations</td>
<td>140</td>
<td>173</td>
<td>104</td>
<td>113</td>
<td>133</td>
<td>75</td>
<td>77</td>
<td>72</td>
</tr>
<tr>
<td>Kruskal-Wallis &quot;H&quot; statistic</td>
<td>33.91</td>
<td>49.82</td>
<td>10.83</td>
<td>19.53</td>
<td>13.28</td>
<td>0.7117</td>
<td>1505</td>
<td>0.5827</td>
</tr>
<tr>
<td>Significance</td>
<td>0.001</td>
<td>0.001</td>
<td>0.05</td>
<td>0.001</td>
<td>0.05</td>
<td>Not signif</td>
<td>Not signif</td>
<td>Not signif</td>
</tr>
</tbody>
</table>

Discussion

This demonstration of enzyme loss in the coeliac mucosa generally confirms the findings of others.\textsuperscript{6,12,14,19} Lojda found that individual enzymes were affected to different degrees in coeliac disease and listed the severity of enzyme loss, in decreasing order, as follows: lactase, trehalase, BBE, DPP IV, APA and APM.\textsuperscript{12} Our results confirm that lactase, trehalase, and BBE are severely affected and our failure to show significant loss of DPP IV, APA, and APM suggests that they are variably lost or lost to a lesser extent. Others have found that APM was normal in some cases of coeliac disease,\textsuperscript{12,22} and Riecken \textit{et al}, although using a different selection of enzymes, commented that APM was the least affected enzyme.\textsuperscript{22}

In virtually all our cases of untreated coeliac disease staining for trehalase and for lactase was negative and these enzymes gave the best statistical differentiation of clinical groups. Isomaltase, BBE, and DPP II were also grossly reduced in patients with coeliac disease.

The group of patients with coeliac disease on a gluten free diet showed slightly less depletion of the affected enzymes (lower grades) than the untreated group. This agrees with previous findings of a partial recovery of enzymes on treatment.\textsuperscript{12,18} In the small number of cases for which biopsy specimens before and after treatment were available, recovery seemed to be somewhat variable in individual patients. It was not known, however, how strictly these patients were adhering to their diets.

Previous histochemical studies have been generally based on a smaller number of biopsy specimens and statistical analysis has not been attempted. Our results suggest that some degree of enzyme loss from the tips of villi is within normal limits (table 4); some loss may also possibly occur in other gastrointestinal disorders. It is therefore important to select enzymes which show the highest level of significance in relation to clinical groups if histochemistry is to be used in the diagnosis of coeliac disease. In this study trehalase gave the strongest relation to groups (H = 49.82), followed by lactase (H = 33.91), and BBE (H = 19.53), all reaching a high level of significance (p < 0.001).

The association between enzyme loss and the degree of histological mucosal damage has been noted previously.\textsuperscript{23,25} This relation is not unexpected as the most severe mucosal changes—namely, subtotal and partial villous atrophy—were found in cases of coeliac disease. This finding is consistent with reports that enzyme loss is secondary to mucosal damage and reflects a lack of differentiation of enterocytes in the damaged mucosa.\textsuperscript{14,24}
The exceptional cases, which showed enzyme loss disproportionate to histological changes, are of particular interest. The three patients with anaemia and partial villous atrophy, of which two had normal enzymes, are difficult to explain. Shiner in 1959 reported partial villous atrophy in association with folic acid deficiency, but neither iron deficiency nor pernicious anaemia are usually associated with clinically important mucosal damage. Cases 2, 3, and 4 in Table 5 had only minor histological damage but pronounced enzyme loss and probably all represent true cases of coeliac disease. In two of these subsequent recovery on a gluten free diet tended to confirm this. In case 4 the patient was discharged after improvement on folate treatment and the diagnosis remains open. Repeated sampling of the mucosa in one patient shows variation in the degree of histological damage and our patients may have had more severe mucosal changes at adjacent sites. Enzyme assessment in these cases provided evidence to support a diagnosis of coeliac disease and the diagnosis may have been missed on histology alone.

The grading system used in this study assessed both the site and intensity of staining. Although the site of staining could not be assessed for trehalase and isomaltase, staining for lactase, BBE, and DPP II was frequently absent or reduced on the tips of villi in both clinically normal patients (Table 4) and in histologically normal biopsy specimens (Table 3). The site of staining loss therefore seems to be an important part of the assessment. In subtotal villous atrophy villi are virtually absent and so it is only possible to assess staining along the luminal surface and in the crypts. Staining of the luminal surface for lactase, BBE, and DPP II was invariably absent in subtotal villous atrophy so that assigning a grade to this area was never a problem. Absence of staining on the luminal surface was quite often associated with weak staining of the upper crypts, confirming previous findings that the greatest enzyme loss occurs from the luminal surface.

Enzyme activity has been shown to vary with age, sex, and site of biopsy in biochemical assays. We were unable to show any correlation with age or sex, but the small number of children in this study may be partly responsible for this. Biopsy specimens were obtained both endoscopically and via a Crosby capsule, but any effect of the difference in site was not analysed.

Table 5 Possible cases of coeliac disease with only minor histological abnormalities

<table>
<thead>
<tr>
<th>Case No</th>
<th>Lactase</th>
<th>Trehalase</th>
<th>Isomaltase</th>
<th>BBE</th>
<th>DPP II</th>
<th>Clinical details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17 year old female; coeliac diagnosed at age 7 months, off GFD for 5 years at time of biopsy. Not coeliac.</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>–</td>
<td>38 year old female; diarrhoea, epigastric pain + anaemia at time of biopsy. Repeat biopsy 4 months later – partial villous atrophy. Improved on GFD.</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>7</td>
<td>–</td>
<td>–</td>
<td>7</td>
<td>77 year old female; abdominal pain, weight loss, abnormal butterfly Δ xylose absorption at time of biopsy. Improved on GFD. Died two years later from small bowel lymphoma.</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>64 year old female; folate deficiency and abnormal butterfly Δ xylose absorption at time of biopsy. Improved on folate treatment and discharged without further investigation.</td>
</tr>
</tbody>
</table>

We thank the clinicians who cooperated in this study, especially Dr D Carr-Locke. We are also grateful to Dr Carole Jagger for her invaluable advice on statistical methods, and to Mrs Margaret Hornby for typing the manuscript.


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