Comparison of serum vitamin B<sub>12</sub> estimation by saturation analysis with intrinsic factor and with R-protein as binding agents

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SUMMARY It has been reported that serum vitamin B<sub>12</sub> levels assayed by saturation analysis methods may give misleadingly high results, so much so that the diagnosis of vitamin B<sub>12</sub> deficiency may be obscured. This defect was ascribed largely to assays using a vitamin B<sub>12</sub> binder other than pure intrinsic factor. To test out this hypothesis two assays were set up, one using saliva (non-intrinsic factor R-binder) and the other using human gastric juice (intrinsic factor) as B<sub>12</sub>-binding agents. Both assays were able to differentiate sera from patients with pernicious anaemia from those from control subjects.

Published results accumulated over the past 10 years indicate that properly designed and performed saturation analysis vitamin B<sub>12</sub> assays are as reliable as microbiological assay methods for detecting low serum B<sub>12</sub> levels. The failure of some methods to do so does not appear to be due to the nature of the B<sub>12</sub>-binding agent.

Routine assay of the serum vitamin B<sub>12</sub> (cobalamin) level is usually carried out by saturation analysis. Many variations of technique have been described, and published series have shown an excellent differentiation between samples from patients with clinical pernicious anaemia and from control groups. It is less certain that equally good results are obtained by others without a special interest in the test.

Doubt concerning the reliability of some of the tests has been expressed by Cooper and Whitehead, who reported that the diagnosis in one-third of patients with pernicious anaemia was missed because a serum B<sub>12</sub> level within the normal range was obtained with saturation analysis. Kolhouse et al. ascribed this to the use of B<sub>12</sub>-binding agents in the test procedure other than intrinsic factor. Two claims were made. Firstly, it was reported, on the basis of chromatography of fractions assayed for B<sub>12</sub> activity by saturation analysis, that not only were cobalamins present in plasma (methylcobalamin, adenosylcobalamin, hydroxocobalamin, and sometimes traces of cyanocobalamin) but other cobamides not detected by microbiological assay with Euglena gracilis or Lactobacillus leichmannii. Only cobalamin was physiologically important, and if the method for saturation assay was not specific for cobalamin the results would be misleading. Secondly, it was claimed that when intrinsic factor was used as the binding agent only cobalamins were measured, and the result was valid in pernicious anaemia. If, however, a non-intrinsic factor binding agent was used, such as serum or saliva, the non-cobalamin factors were measured as well as the cobalamins and the result could then be misleadingly high.

To test this hypothesis two saturation analysis methods were set up based on that described by Carmel and Coltman and Hall. Both were identical but one used a human gastric juice in which 99% of the B<sub>12</sub> binding capacity was due to intrinsic factor and the other saliva in which all the B<sub>12</sub> binding was due to R-protein. We report our results with sera from patients with untreated pernicious anaemia and from control groups.

Material and methods

The method was essentially that described by Carmel and Coltman and modified by adding 1 ml B<sub>12</sub>-free serum extract to all tubes in the standard curve. All dilutions were made in acetate cyanide buffer pH 4.8. Sera for assay were de-proteinised as described below.
SALIVA
Pooled human saliva from laboratory staff was centrifuged to remove debris and stored at −20°C in 1-2 ml aliquots. For use 1 ml was diluted in approximately 25 ml acetate-cyanide solution so that 0-1 ml of the diluted saliva bound 60-70% of 100 pg \textsuperscript{57}Co-B\textsubscript{12}.

GASTRIC JUICE
Human gastric juice was brought to pH 10 to inactivate pepsinogen, and after 20 minutes the pH was adjusted to 7-0. Intrinsic factor concentration and total vitamin B\textsubscript{12} binding capacity was measured. A gastric juice pool containing 99% intrinsic factor and virtually no R-binder was selected for this study. It was stored at −20°C and diluted in the same way as the saliva.

ACETATE-CYANIDE BUFFER pH 4.8
3·0 mol sodium acetate (56·6 ml) is mixed with 3·0 mol acetic acid (43·3 ml), and 20 mg sodium cyanide is added to each litre buffer. This pH gave optimal and complete recovery of B\textsubscript{12} in the assay system.

B\textsubscript{12}-DEFICIENT SERUM EXTRACT
One part pooled serum is added to 3 parts acetate-cyanide buffer and heated in a boiling water bath for 20 minutes. The supernatant is retained, and B\textsubscript{12} is removed by adsorption of 25 ml supernatant with 100 mg serum-coated charcoal. Charcoal is removed first by centrifugation and finally by passing the adsorbed supernatant through a millipore filter (Millex 0·45 μm). It is stored at −20°C.

SERUM-COATED CHARCOAL
Charcoal (Norit GSX) was activated at 160°C for 2 hours. One gram was left at room temperature with 10 ml pooled serum for 10 minutes, and the charcoal was washed with 10 ml acetate-cyanide buffer.

EXTRACTION OF SERA FOR ASSAY
One millilitre serum is mixed with 3 ml acetate-cyanide buffer and heated in a boiling water bath for 20 minutes. The extracts are cooled and the supernatants retained for assay.

THE TEST
Each test consisted of 1 ml serum extract, 1 ml acetate cyanide buffer, and 100 pg \textsuperscript{57}Co-B\textsubscript{12} in 1 ml buffer. These were mixed, and 0·1 ml binding agent (the amount binding 60–70 pg of 100 pg B\textsubscript{12}) was added. After 1 hour at room temperature serum-coated charcoal suspended in 0·5 ml saline was added. The standard curve was set up in a similar manner, 1 ml B\textsubscript{12}-free serum extract replacing the test serum and 1 ml acetate-cyanide buffer containing the serially diluted unlabelled B\textsubscript{12}. Standards for \textsuperscript{57}Co-B\textsubscript{12}, binder, and charcoal controls are included.

Patients

PERNOCIOUS ANAEMIA
Twenty-five sera were available before treatment from 21 patients with pernicious anaemia. All these patients had a macrocytic anaemia with megaloblastic marrow changes, achlorhydria with gastric atrophy, impaired vitamin B\textsubscript{12} absorption improved with additional intrinsic factor, and a low serum B\textsubscript{12} level by microbiological assay with \emph{Lactobacillus leichmannii}. All responded to treatment with B\textsubscript{12} alone.

Blood was obtained from 52 normal subjects, who were members of the hospital and laboratory staff and in normal health.

Results and discussion

The purpose of the study was to compare intrinsic factor and R-binders when used for saturation analysis assay of serum B\textsubscript{12}. The results in Table 1 and the Figure show that an assay using an R-binder was entirely satisfactory in the detection of sera with low levels of B\textsubscript{12}, and all of 25 sera from patients with untreated pernicious anaemia were below the levels obtained with control samples. Taking 200 pg/ml as the lower limit of a normal range, we interpret the data with gastric juice as showing that two ‘normal’ samples are low (Figure) rather than that two pernicious anaemia sera were missed, but we would not argue with anyone who wishes to vary this interpretation. But the differentiation was not as satisfactory with gastric juice as with saliva.

Table 1 Vitamin B\textsubscript{12} estimation by saturation analysis (pg/ml) (mean ± SE)

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<thead>
<tr>
<th></th>
<th>Salivary binder</th>
<th>Gastric juice binder</th>
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<tbody>
<tr>
<td>Controls</td>
<td>224 ± 1000</td>
<td>152 ± 1000</td>
</tr>
<tr>
<td></td>
<td>m 548 ± 187 (48)*</td>
<td>m 425 ± 146 (52)</td>
</tr>
<tr>
<td>Pernicious anaemia</td>
<td>28 ± 216</td>
<td>0 ± 200</td>
</tr>
<tr>
<td></td>
<td>m 140 ± 55 (25)</td>
<td>m 88 ± 50 (25)</td>
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</table>

*No. of sera.
However, we are impressed by the ease with which an assay using charcoal and free B12 binding protein can go wrong and give misleading results in uncrUctical hands. Reassay of the quantity of saliva required should be done at regular intervals.

Results were generally higher with a salivary binder than with an intrinsic factor binder. However, this did not influence the ability of the test to differentiate sera from pernicious anaemia patients from control sera. The higher levels with an R-binder may be related to the manner in which B12 dissociates from the binder. The B12-R-binder complex is relatively stable whereas B12 readily dissociates from intrinsic factor.7 8

Our data are in conformity with published results on B12 assay using a variety of B12 binding reagents. Some of these data are summarised in Table 2. Six studies in which sera from 210 patients with pernicious anaemia were assayed using R-binders showed only three patients overlapping the normal range. One pernicious anaemia sample out of 117 was also just normal when gastric juice was used. These studies assayed over 1000 normal samples. These data do not support the view that one-third of pernicious anaemia cases are missed or that circulating non-cobalamin invalidate the results of some saturation analysis assays. Finally, the diagnosis of pernicious anaemia should be based on all the features of the case, and interpretation of B12 levels must take into account the possibility that an erroneously raised level may sometimes emerge from the laboratory.

References

Table 2 Serum samples assayed for vitamin B12 content by saturation analysis

<table>
<thead>
<tr>
<th>Binder</th>
<th>Number of sera from</th>
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<tbody>
<tr>
<td></td>
<td>Untreated PA</td>
</tr>
<tr>
<td></td>
<td>found to be low</td>
</tr>
<tr>
<td>R-binder 5-8, 10, 13</td>
<td>210</td>
</tr>
<tr>
<td>Gastric juice 4-14, 14</td>
<td>117</td>
</tr>
</tbody>
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PA = pernicious anaemia.
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