Serum specific IgA antibody to *Chlamydia trachomatis* in patients with chlamydial infections detected by ELISA and an immunofluorescence test

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**SUMMARY** Sera obtained from 34 men with *Chlamydia trachomatis* positive non-gonococcal urethritis, 34 men with *C trachomatis* negative non-gonococcal urethritis, 42 women with acute salpingitis, 38 healthy women, and 34 healthy men were studied for the presence of specific serum *C trachomatis* IgA and IgG antibodies. Serological results were correlated with *C trachomatis* isolation in cell culture.

An enzyme linked immunosorbent assay (ELISA) for *C trachomatis* specific serum IgA was employed using highly purified elementary bodies of *C trachomatis* serotype L2 grown in LLC-MK2 cells. Results obtained for *C trachomatis* IgA antibody by the ELISA test were compared with results obtained for the same sera by a single antigen immunofluorescence technique. A good correlation (*r* = 0.91) was found between two methods. Serum IgG antibody was also determined in the same sera by the immunofluorescence technique.

Patients with *C trachomatis* positive non-gonococcal urethritis had a significantly (*p* < 0.0005) higher prevalence (94.1%) of serum IgA antibody by ELISA compared with patients with *C trachomatis* negative non-gonococcal urethritis (20.5%) or healthy men (5.9%). Similarly, women with acute salpingitis had a significantly (*p* < 0.005) higher prevalence of serum IgA antibody (45.2%) compared with healthy controls (5.2%). Comparable results were obtained for *C trachomatis* serum IgA antibody using the immunofluorescence technique.

The prevalence of *C trachomatis* IgG antibody was significantly higher in patients with *C trachomatis* positive non-gonococcal urethritis (97.0%) compared with those with *C trachomatis* negative non-gonococcal urethritis (33.3%) and healthy controls (23.5%). A significantly (*p* < 0.05) higher prevalence of serum IgG antibody was also found in women with acute salpingitis (52.4%) compared with healthy controls (26.3%).

The importance of using specific *C trachomatis* serum IgA in the identification of chlamydial infection is discussed.

*Chlamydia trachomatis* is now generally considered the most common sexually transmitted agent. In addition to its recognised role in urethritis, cervicitis, salpingitis, proctitis, conjunctivitis, and pneumonia,1 4 subclinical infections by *C trachomatis* appear to be a major cause of infertility in women.1 5

The diagnosis of chlamydial infection is generally made after isolation in cell culture. Reliable cultures, however, are generally available only in large medical centres with extensive experience in tissue culture techniques.

The microimmunofluorescence test of Wang and Grayston7 has been shown to be both sensitive and specific for the detection of chlamydial antibodies. Efforts to simplify the test have entailed the use of a single broadly reacting antigen, usually L2. Serotype E or serotype L2 have also been used in single antigen immunofluorescence assay.8 9

More recently, the detection of chlamydial anti-
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Serum specific immunoperoxidase assay (ELISA), radioimmunoassay, and immunoperoxidase assay has been described.

To date, little is known about the role of serum IgA antibodies in chlamydial and viral infections. With regard to viral infection, several studies have suggested that specific IgA antibody may be an indicator of an active infection.

In order to verify the feasibility of determining C. trachomatis specific IgA serum antibody as an additional test for patients with chlamydial infections, a single antigen enzyme linked immunosorbent assay was adapted for specific C. trachomatis serum IgA and compared with an immunofluorescence test. Serum IgG detection by an immunofluorescence technique was also performed on the same sera. Serological results were correlated with C. trachomatis isolation in cell culture.

Material and methods

STUDY POPULATION
Serum samples and urethral or cervical cultures for C. trachomatis were obtained from patients included in a multicentre study of sexually transmitted diseases. These included 34 men (mean age 25-4 years) with C. trachomatis positive non-gonococcal urethritis, 34 men (mean age 24-4 years) with C. trachomatis negative non-gonococcal urethritis, and 42 women (mean age 28-3 years) with acute salpingitis. The clinical diagnosis of acute salpingitis was based on common criteria, which included lower abdominal pain, abnormal vaginal discharge, adnexal tenderness, erythrocyte sedimentation rate >15 mm in the first hour, and usually fever (>38°C).

Thirty eight healthy women (mean age 27-2 years) and 34 healthy men (mean age 26 years) were also studied. Cultures for C. trachomatis were not obtained from these two population groups.

Ten sera from children negative by the immunofluorescence test for serum IgA to C. trachomatis were used as negative controls in the ELISA test.

CHLAMYDIAL ANTIGEN AND ELISA PROCEDURE
The LLC-MK2 cell line derived from monkey kidney cells was used for growing C. trachomatis. The cells (which are highly susceptible to C. trachomatis) were grown in 75 cm² tissue culture flasks with Eagle's minimum essential medium containing 10% fetal calf serum and 10 µg/ml gentamicin. When confluent monolayers had formed, the medium was replaced with the same medium containing 5% fetal calf serum, 10 µg/ml gentamicin, 1 µg/ml cycloheximide, and 30 µM glucose. LLC-MK2 cell monolayers were infected with C. trachomatis serotype L2 (434-BU strain, provided by J Schachter, San Francisco, California). The infected cultures were incubated at 37°C for 48 h.

Elementary bodies of C. trachomatis were purified by the method of Caldwell et al, by Renografin gradients, with minor modifications. Briefly, infected cells were ruptured by sonication and centrifuged. The supernatant was layered over 8 ml of a 35% (vol/vol) Renografin (ER Squibb and Sons Inc, Princeton, New Jersey, USA) solution in 0.01 M HEPES and centrifuged at 43 000 g for 1 h at 4°C in a SW 27 rotor (Beckman Instruments Inc, Fullerton, California.) The pellet was resuspended in 0.01 M sodium phosphate (pH 7.2) and layered over discontinuous Renografin gradients (13 ml of 40%, 8 ml of 44%, and 5 ml of 52% Renografin, vol/vol), centrifuged at 43 000 g for 1 h at 4°C in a SW 27 rotor. The elementary body band was collected by Pasteur pipette, diluted in 0.01 M HEPES, and then centrifuged at 30 000 g for 30 min. The protein content of preparations was determined by the method of Lowry et al.

Control antigen was prepared in the same way from uninfected LLC-MK2 cells.

Micro ELISA plates (Dynatech M129A) were coated with 100 µl of elementary bodies or control antigen in carbonate-bicarbonate buffer pH 9.6 for 1 h at room temperature. The final protein concentration of elementary body or control antigen preparations was 20 µg/ml. Coated plates were washed five times with phosphate buffered saline (PBS)-TWEEN (Sigma Chemical, St Louis, Missouri) and used immediately. Serial twofold dilutions of human sera in PBS-Tween were made in the test plate. Each serum dilution was tested in elementary body and control antigen coated wells. A known positive and one negative serum sample were assayed on each plate. The plate was then incubated at 37°C for 1 h and washed 10 times with PBS-TWEEN. Antihuman IgA (α-chain) peroxidase labelled (Dako, Copenhagen, Denmark) diluted 1/400 in PBS-Tween was added in a volume of 100 µl per well. The plate was incubated for 1 h at 37°C, washed 10 times with PBS-Tween. Thereafter, 100 µl of the citric acid phosphate buffer (pH 5-6) containing 40 mg 1-2 phenylenediaminedihydrochloride (Merck, Darmstadt, West Germany) and 20 µl of 30% H₂O₂ per 100 ml buffer was added per well. The enzymatic reaction was stopped after 15 min by adding 100 µl of 2 N H₂SO₄ per well. The result of the test was read at 492 nm by a Dynatech Micro-elsa autoreader MR, 580. All readings were made against a blank well, which received all of the above treatments except that human serum was replaced by PBS-TWEEN.
The reproducibility of the results was in the range of twofold dilutions.

**Immunofluorescence Test**
All sera were tested for chlamydial antibodies of the IgG and IgA classes by a single antigen test using the L2 strain of *C. trachomatis* inclusions in LLC-MK2 cells, as previously described. Fluorescein labelled antihuman IgG or IgA antibodies (Dako) and dilutions of 1/40 or 1/10 respectively were used. 

**Chlamydial Cultures**
Isolation of *C. trachomatis* from clinical specimens was done in McCoy cells, which were pretreated with 5'-iodo-2'-deoxyuridine as previously described.

**Statistical Analysis**
Statistical significance was evaluated by the χ² test with Yates's correction, or by Student's *t* test.

**Results**

**Standardisation of ELISA for Determination of *C. Trachomatis* IgA**
An optimal concentration of 20 μg/ml for elementary bodies was used for coating the microtitre plate. At this antigen concentration serial twofold dilutions (from 1/80 to 1/512) of high, medium, and low positive sera showed a linear relation to absorbance (Fig. 1).

Antibody titres were expressed as the reciprocals of the highest serum dilution that yielded an optical density at 492 nm > 5 standard deviations over the mean of values obtained with sera from 10 children negative by immunofluorescence for serum IgA to *C. trachomatis*, and tested by ELISA in a separate experiment. The IgA antibody titres ranged from 8 to 512.

The titration results for all sera tested with ELISA and immunofluorescence tests are shown in Fig. 2. Of the 182 sera tested 120 were negative and 59 were positive by both techniques. Three samples were positive by ELISA and negative by the immunofluorescence test (see below).

The correlation coefficient for IgA with the two methods was 0.91, showing good agreement.

**C. Trachomatis IgA Antibody**
Antichlamydial serum IgA antibody was found by ELISA in 32 (94.1%) of 34 men with *C. trachomatis* positive non-gonococcal urethritis, with a mean titre of 24.8, whereas only seven (20.5%) of 34 men with *C. trachomatis* negative non-gonococcal urethritis (p < 0.0005) had IgA serum antibody with a mean titre of 28.7. Only two (5.9%) of 34 healthy controls had serum IgA to *C. trachomatis*.

Women with acute salpingitis had a significantly higher prevalence of *C. trachomatis* IgA.
antibodies compared with control women: 19 (45.2%) of 42 women with acute salpingitis and two (5.2%) of 38 healthy women were positive for serum IgA to C trachomatis. The mean titre of IgA seropositive patients with acute salpingitis was 54.4.

Of the 42 women with acute salpingitis, three (7.1%) had positive cervical cultures for C trachomatis. All three patients had serum IgA to C trachomatis with high titres ranging from 64 to 128. Comparable results were obtained by the immunofluorescence technique.

C TRACHOMATIS IgG ANTIBODY

Patients with C trachomatis positive non-gonococcal urethritis had a significantly (p < 0.0005) higher prevalence of C trachomatis IgG seropositivity than healthy controls (97.0% and 23.5% respectively). A higher prevalence of C trachomatis IgG antibody was also found in patients with C trachomatis negative non-gonococcal urethritis compared with healthy controls (33.3% vs 23.5%), but this difference was not significant.

A significantly (p < 0.05) higher prevalence of C trachomatis IgG antibodies was also found in patients with acute salpingitis compared with controls (52.4% vs 26.3%) (Table).

Discussion

The feasibility of the ELISA technique for chlamydial serology has been shown previously.11–13 We have developed an ELISA test in which the elementary bodies of C trachomatis L2 serotype were used as antigen for the detection of specific serum IgA antibodies to C trachomatis in human serum. The results obtained by ELISA were compared with those obtained by the immunofluorescence technique: a positive correlation (r = 0.91) was found. Higher titres were obtained by ELISA than by immunofluorescence. With only three exceptions, however, (three samples positive by ELISA and negative by the immunofluorescence technique) there was agreement as far as IgA seropositivity and IgA seronegativity was concerned.

Two infections which can be caused by C trachomatis have been considered in this study: acute salpingitis in women and non-gonococcal urethritis in men. Recent investigations24–26 have shown that C trachomatis can be associated with acute salpingitis. The relative importance of C trachomatis as a cause of acute salpingitis varies greatly depending on the population, ranging between 5 and 36% and 20 and 62% when cultural or serological25,27 data respectively are considered.

In the current study C trachomatis IgG antibodies were determined by the indirect immunofluorescence technique and IgA antibodies were determined by both ELISA and the immunofluorescence technique.

Women with acute salpingitis had a significantly higher prevalence (p < 0.05) of C trachomatis IgG antibodies compared with matched controls (52.4% vs 26.3%). The mean IgG titre (82.0) of the patients with acute salpingitis was significantly (p < 0.05) higher than that of controls (13.1). Relatively high C trachomatis IgG titres (>64) were noted in 30.9% of the acute salpingitis group, and none of the healthy controls had IgG titres >64. These results are in agreement with previous studies using microimmunofluorescence techniques28,29 in which a higher prevalence of raised IgG titres was found in patients with acute salpingitis compared with controls. C trachomatis IgG titres >64 by the microimmunofluorescence technique have been suggested to be associated with current chlamydial infection.28 C trachomatis IgG antibody, however, may indicate only previous chlamydial infection in sites other than the fallopian tube.

We have shown by both ELISA and the immunofluorescence technique a higher prevalence of serum IgA antibody to C trachomatis detected both by ELISA and by an immunofluorescence technique compared with chlamydial IgG antibody detected by an immunofluorescence test in different study populations.
and raised *C. trachomatis* IgA antibody titres in patients with acute salpingitis compared with matched controls. By the ELISA technique, patients with acute salpingitis showed a significantly (p < 0.005) higher prevalence of IgA antibodies to *C. trachomatis* than the control group (45.2 ± 5.2%). The mean IgA titre of women with acute salpingitis by the same technique was significantly (p < 0.01) higher than that in controls (54.4 ± 15.8). Relatively high *C. trachomatis* IgA titres (≥32) were found in 35.7% of patients with acute salpingitis, while none of the control group had IgA titres ≥32. Similar results were also obtained by the immunofluorescence technique.

Since the half life of *C. trachomatis* IgA was five to six days in normal subjects the presence of these antibodies may be a better marker for active *C. trachomatis* infection than *C. trachomatis* IgG antibody. Confirmation of this will require relating the presence of *C. trachomatis* serum IgA antibody with the isolation of the agent from the fallopian tube.

The availability of a serological marker of *C. trachomatis* infection in patients with acute salpingitis would be of considerable value and might obviate the need for invasive procedures in the diagnosis of acute salpingitis.

A clear cut association between *C. trachomatis* specific serum IgA and active *C. trachomatis* infection was found in men with *C. trachomatis* positive non-gonococcal urethritis. Of these, 94.1% had *C. trachomatis* serum IgA compared with only 20.5% of *C. trachomatis* negative non-gonococcal urethritis patients (p < 0.0005) and 5.9% of healthy subjects (p < 0.0005). Ninety seven per cent of *C. trachomatis* positive non-gonococcal urethritis patients also had serum IgG compared with 33.3% of *C. trachomatis* negative non-gonococcal urethritis patients (p < 0.0005) and 23.5% of healthy men.

In a previous study, Thero and Meurman, using a radioimmunoassay technique, found serum IgA in only 53% of isolation positive as against 21% isolation negative men with urethritis. The different results obtained in the current study can be tentatively explained both by the different population examined and by the methods used. In this study specific *C. trachomatis* IgA antibody was always found in association with serum IgG antibody: the higher the IgG titre the higher the IgA titre, the highest IgA titres being found in patients with acute salpingitis. In *C. trachomatis* positive non-gonococcal urethritis patients serum IgA was also found in the presence of low (16-32) IgG titres.

In conclusion, the presence of serum IgA antibody to *C. trachomatis* seems to be correlated with active *C. trachomatis* infection, at least in patients with chlamydia non-gonococcal urethritis. Hence, IgA detection may be a useful further test in chlamydia serology. However, the possibility that *C. trachomatis* serum IgA can be used as a marker of a current *C. trachomatis* infection needs further investigation. The appearance and persistence of *C. trachomatis* IgA have to be examined in prospective studies and correlated with the development of symptomatic or asymptomatic *C. trachomatis* infections.

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