Histological changes associated with wheat protein antibodies in the absence of villous atrophy

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SUMMARY A retrospective study was conducted to assess the association of α-gliadin antibodies with intraepithelial lymphocyte counts. Twelve subjects with apparently normal small intestinal histology and raised α-gliadin antibody titres had significantly increased intraepithelial lymphocyte counts (42 (SEM) 5-9) when compared with 16 subjects with normal α-gliadin antibody titres (17 (3-2); p < 0-001). These findings show that in the absence of gross pathology raised α-gliadin antibody titres are associated with increased numbers of intraepithelial lymphocytes and may reflect continuous immunological processes in the small intestine.

Raised intraepithelial lymphocyte (IEL) counts are characteristic of the coeliac small intestinal lesion. The numbers decrease if the patient maintains a strict gluten free diet, although values generally remain abnormal. Raised titres of α-gliadin antibodies (AGAs), which decrease with treatment, are also associated with coeliac disease and are found in 90% of newly diagnosed adult patients and 95% of children with coeliac disease.

As part of a continuing investigation into coeliac disease in this centre small intestinal biopsy specimens and AGA titres are examined routinely in patients with possible malabsorption. A proportion of these subjects (15%) have raised AGAs, although their small intestinal histology appears to be normal. This retrospective study investigates whether there is an association between raised AGA titres and increased IEL counts in these subjects.

Patients and methods

Fifty three subjects were studied retrospectively. There were two distinct groups. In 25 patients with abnormal small intestinal histology, coeliac disease was diagnosed using established criteria; and a gluten free diet was prescribed. Ten of these patients were positive for AGAs and 15 were negative for AGAs at the time of diagnosis. The remaining 28 patients had normal small intestinal histology and the diagnosis of coeliac disease was excluded; 16 were negative for AGAs and 12 were positive for AGAs. The table lists the clinical features of these 28 patients.

AGAs were estimated using the enzyme linked immunosorbent assay (ELISA) described previously. An ELISA index greater than two standard deviations above the mean of a group of 30 healthy subjects was said to be positive.

During the initial investigation, routine histological analysis was carried out on each biopsy specimen. Subsequently, as part of the retrospective study, the lymphocytic infiltrate between surface epithelial cells (intraepithelial lymphocytes) was assessed using the technique previously described by Ferguson et al.

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<th>Table</th>
<th>Clinical features of 28 patients in whom diagnosis of coeliac disease was excluded because small intestinal histology appeared to be normal</th>
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<td>Alpha gliadin antibody positive (n = 12)</td>
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<td>Iron deficiency anaemia</td>
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<td>Diarrhoea; weight loss</td>
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<td>Dermatitis herpetiformis</td>
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<td>Recurrent oral ulceration</td>
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<td>Alpha gliadin antibody negative (n = 16)</td>
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<td>Healthy volunteers</td>
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<td>Iron deficiency anaemia</td>
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<td>Irritable bowel syndrome</td>
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Accepted for publication 29 April 1987
Between 500 and 1000 epithelial cells were counted and the number of lymphocytes present was expressed as a percentage. This method is currently accepted as suitable for quantifying IEL counts in patients being investigated for coeliac disease. Because the data were not normally distributed, the Mann-Whitney U test was used to assess the significance of the differences in IEL counts between the two groups.

Results

Using standard microscopy, all 25 patients with coeliac disease showed the typical histological pattern of villous atrophy, crypt hyperplasia, enterocyte disarray and inflammatory infiltrate. The histology of the small intestine of the remaining 28 patients appeared to be normal with normal villi, surface epithelium, and cellular infiltrate.

On retrospective analysis of patients with apparently normal small intestinal histology, IEL counts were increased in those positive for AGAs (42.4 (5-9)) when compared with those negative for AGAs (17 (3-2)). This difference was highly significant p < 0.001. Increased IEL counts were also seen in both groups of patients with coeliac disease. Although the count was higher in those positive for AGAs (82.5 (9-5)) when compared with those negative for AGAs (74.3 (5-6)), the difference was not significant (figure).

Discussion

This study shows that increased intraepithelial lymphocyte (IEL) counts are found in patients with otherwise normal small intestinal histology who have raised titres of α-gliadin antibodies (AGAs). The importance of this finding is unknown, although the association of an enhanced humoral response to a dietary antigen and an increase in one population of gastrointestinal immunocompetent cells suggests that the mucosal immune system is activated. These features may not be associated with any specific pathogenic process but may simply characterise those subjects with a pronounced gastrointestinal immune response.

Raised titres of wheat protein antibodies and increased IEL counts that decrease on maintenance of a gluten free diet are commonly associated with coeliac disease. Gluten sensitive disease, however, has also been described when the only small intestinal histological abnormality was increased IEL counts. Dermatitis herpetiformis is a gluten sensitive skin disease that is sometimes associated with villous atrophy. Patients with this disease whose small intestinal histology appears to be normal have increased IEL counts which decrease after treatment with a gluten free diet. In another study eight patients with gluten sensitive diarrhoea and normal small intestinal histology had increased IEL counts that returned to normal with a gluten free diet. Increased IEL counts and raised AGA titres may therefore be useful indicators of wheat protein sensitive disease in the absence of gross small intestinal abnormality.

The precise role of IELs in the normal intestine is unknown, although these cells have been shown to be of suppressor phenotype and so may have an immunoregulatory role. Studies on animals have indicated that raised IEL counts are associated with a local cell mediated immune response in the intestine. It has been suggested that this response is the first in a chain of events which can lead to the generation of mucosal damage. Increased numbers of IELs in untreated wheat protein sensitive disease, together with the decrease seen on removal of gluten from the diet and the increase on gluten challenge, suggest that IELs participate in a gluten specific immune response which may be pathogenic.

It has been argued that the reduction in epithelial volume, associated with the small intestinal damage

![Figure](http://jcp.bmj.com/figure.png)
characteristic of untreated coeliac disease, causes an increase in IEL density but not necessarily in cell numbers. In our study patients with coeliac disease had high IEL counts, irrespective of whether they had raised or normal AGA titres. The mechanical effect of villous atrophy on IEL density probably masks the more subtle influence of a local gluten sensitive immune response on IEL infiltration. In a study of patients with treated coeliac disease whose small intestinal mucosa had returned to normal a dose dependent incremental rise in absolute numbers of IELs occurred on challenge with varied small doses of gluten before any deterioration in gross mucosal architecture. Thus it seems likely that a local immune response to wheat protein indicated by IEL infiltration and raised AGA titres may precede a more severe manifestation of gluten sensitive disease.

In conclusion, we have shown that patients whose small intestinal mucosa appears to be normal but whose AGA titres are raised have increased numbers of IELs. The association of increased numbers of circulating wheat protein antibodies with increased numbers of IELs may reflect an active immunological process, which is related to the presence of gluten in the small bowel.

References