Application of immunoblotting to detect soluble Pneumocystis carinii antigen(s) in bronchoalveolar lavage of patients with Pneumocystis pneumonia and AIDS

K K Sethi

Abstract
The technique of immunoblotting for detecting soluble Pneumocystis carinii antigen(s) in bronchoalveolar lavage fluid specimens from patients with AIDS and Pneumocystis pneumonia was evaluated. A soluble 67 kilodalton polypeptide that was immunoactive with an anti-P carinii monoclonal antibody (2G2) was found in the supernatants of 26 lavage samples from patients with pneumocystosis. Intact organisms in lavage sediments were detected by methenamine silver or immunofluorescence staining procedures. The diagnostic use of this technique was shown in four cases in which lavage sediments proved negative for intact Pneumocystis carinii organisms on first examination; 2G2 reactive soluble antigen, however, was identified in the immunoblots of the supernatants from the same samples.

It is concluded that immunoblotting of bronchoalveolar lavage specimens using 2G2 monoclonal antibody as a detection probe may be a useful adjunct to the morphological demonstration of organisms by special staining procedures.

Pneumocystis carinii is responsible for life threatening pneumonia in the immune deficient and has emerged as the leading cause of morbidity and mortality in patients with AIDS. This organism has not been grown in cell free media and limited success has been achieved in maintaining or growing P carinii of human or rat origin in certain types of cell cultures; to date, continuous culturing of the organism has been not documented.

The clinical manifestations of P carinii pneumonia in man are non-specific and can mimic diseases of other aetiologies. Definitive laboratory diagnosis of P carinii infection currently relies mainly on the microscopic demonstration of a characteristic “stage” — namely, cysts in infected lung tissues or respiratory fluids. P carinii cysts can be identified either with the aid of conventional histological stains, especially methenamine silver stain, or by immunofluorescence using specific monoclonal antibodies. Regardless of the staining methods the morphological visualisation of these cysts is generally difficult in specimens which are not properly collected or in instances where only a few organisms are present. A test designed to detect the presence of specific P carinii antigen(s) in body fluids might therefore facilitate diagnosis. There have been reports of the presence of circulating P carinii antigens being shown in the sera of patients by counterimmunoelectrophoresis, enzyme linked immunosorbent assay, and by latex agglutination, but their clinical utility is controversial.

Methods
Bronchoalveolar lavage (BAL) samples from 26 patients with AIDS and both clinical and microscopic evidence of P carinii pneumonia were used. All these patients showed characteristic respiratory symptoms such as dyspnoea, non-productive cough etc, and had abnormal chest radiographs (interstitial or alveolar shadows) and reduced diffusing capacity for carbon monoxide. BAL specimens from 10 patients with bronchial asthma but no clinical or microbiological evidence of P carinii infection served as matched controls. BAL fluid (20 ml) from each patient was available for testing. After removing mucus and other debris the BAL specimens were centrifuged (10 000 x g for 20 minutes), the sediments were used for preparing microscopic slide smears, and the decanted supernatants used for immunoblotting.

A hybridoma cell line (2G2) producing monoclonal antibodies directed specifically against human P carinii was obtained from Dr Kovacs. The hybridoma cells were injected in BALB/c mice treated with pristane and asctic fluids were collected. The antibody purified from asctic fluids was of IgG 2b isotype. A high titered polyclonal antiserum to human P carinii was prepared in rabbits by three repeated subcutaneous injections with purified organism's emulsified in incomplete Freund’s adjuvant, followed by a booster injection of antigen without adjuvant after six weeks. The IgG portion of the immune serum was purified by affinity chromatography on a staphylococcal protein A sepharose CL4B column (Pharmacia Inc).

BAL sediment was suspended in TRIS buffer and after vigorous vortexing drops of the suspension were placed on premarked areas on
Detection of soluble P. carinii antigens in BAL fluid

**Results**

Sediments prepared from BAL specimens of 26 patients with AIDS and clinical manifestations of P. carinii pneumonia contained intact organisms shown by methylene silver stain or a monoclonal antibody based immunofluorescence antibody test. Remarkably high numbers of cysts (10 clusters of cysts per smear) were identified in the BAL sediments of 20 of the 26 cases by both staining procedures. In the six remaining samples fewer than five small clusters of cysts a smear were detectable with the immunofluorescence antibody but none by silver stain. Four of these six patients were receiving aerosol pentamidine treatment when the BAL sample was collected. The other two patients had been receiving antifungal treatment, but developed neutropenia, and treatment was discontinued. In four of these six cases sediments of BAL samples collected initially were negative but sediments from second specimens obtained from the same four patients seven to 10 days later proved positive.

Supernatants of BAL samples from each of the 26 cases with documented pneumocystosis and from 10 controls were examined for the presence of soluble P. carinii antigen(s) by immunoblotting using an anti-P. carinii monoclonal antibody, 2G2, as the detection probe. Immunoblots of the supernatants from all the 26 samples from patients with P. carinii pneumonia showed a distinct band in the region of the 67 kilodalton molecular weight marker (fig 1). Considerable variation was observed in the quantity of 2G2 antibody binding to the antigenic component in individual BAL supernatants, indicated by the intensity of 67 kilodalton bands which varied from intense (14 samples) to faint (12 samples). Interestingly, in the supernatant blots of four BAL samples 2G2 antibody identified multiple bands besides the 67 kilodalton component. No specific reactivity was visible when identical blots were reacted with another monoclonal antibody—namely, 2G11 which is specific for P. carinii of rat origin. Furthermore, no specific bands were identified by 2G2 antibody in blots of supernatants from 10 control BAL M specimens.

**Figure 1** Representative blots of BAL supernatants from three individual patients with P. carinii, reacted with monoclonal antibody 2G2, specific for human Pneumocystis (strips 1, 2, and 3). Note single distinct band in lanes 1 and 2, and three bands in lane 3. Strips 4, 5, and 6 were reacted with monoclonal antibody 2G11, specific only for Pneumocystis of rat origin. Strips 7, 8, and 9 represent conjugate controls. Numbers on left indicate molecular weights of protein standards (in thousands).

**Figure 2** Blots of purified human Pneumocystis organisms developed with rabbit anti-Pneumocystis polyclonal antibodies (strip 2), with normal rabbit serum (strip 1). Numbers on left indicate the molecular weights of protein standards (in thousands).

SDS-PAGE of purified P. carinii organisms of human origin resulted in the separation of the individual polypeptides of the organisms. Blots developed with rabbit anti-P. carinii polyclonal antibodies showed distinct antigens of Pneumocystis including a band of about 67 kilodaltons. Apparently, the 67 kilodalton band identified by polyclonal antiserum in blots prepared from purified organisms corresponds to that observed on BAL supernatant blots probed with 2G2 antibody. No bands appeared on blots of purified Pneumocystis organisms reacted with control rabbit IgG (fig 2).
Discussion
Supernatants from a total of 26 BAL specimens originating from cases with documented pneumocystosis showed a 67 kilodalton band in immunoblots developed with a *P. carinii* specific monoclonal antibody, 2G2. In four of the 26 BAL immunoblots multiple bands were consistently observed, in addition to the 67 kilodalton band. Conversely, no bands were recognised by 2G2 antibody in supernatant blots from 10 control BAL samples which illustrates the specificity of the 2G2 probe. A band corresponding to the 67 kilodalton molecular weight was also seen when purified human *P. carinii* organisms were analysed by immunoblotting with polyclonal rabbit anti-serum against Pneumocystis. The 2G2 reactive 67 kilodalton antigenic component identified in supernatants of BAL samples is probably identical with the antigen recognised in protein blots of purified organisms by *P. carinii* specific polyclonal antibodies in rabbits. The detection of 2G2 antibody reactive soluble Pneumocystis antigen(s) in supernatants of unconcentrated BAL specimens suggests that this antigenic component is released in appreciable quantities in patients with acute disease. Although there is a potential for carryover of intact organisms when supernatants are harvested from BAL samples, this was not observed after rigorous examination by a variety of staining procedures. There were four separate BAL specimens from which the sediments proved negative for Pneumocystis organisms on initial examination, and 2G2 reactive soluble antigen could be identified in the same samples. Whether other soluble antigenic molecules of *P. carinii* also exist in BAL samples of patients with pneumocystosis is not known and requires investigation. In conclusion, 2G2 monoclonal antibody specific for *P. carinii* of human origin facilitated the detection of a soluble antigenic component of Pneumocystis in immunoblots of BAL samples from cases of pneumocystosis. Although the overall sensitivity of the immunoblotting procedure is still to be established, it may be a useful adjunct to the diagnosis of *P. carinii* pneumonia.

This work was supported by grant FKZ: 11-039-87 from the AIDS Program of German Ministry of Research and Technology (BMFT).