Routine immunofluorescence detection of Ro/SS-A autoantibody using HEp-2 cells transfected with human 60 kDa Ro/SS-A

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Abstract

Background—Ro/SS-A autoantibodies associated with systemic lupus erythematosus (SLE) and Sjögren syndrome may be missed during routine screening for antinuclear autoantibodies (ANA) by immunofluorescence using HEp-2 cells.

Aims—To investigate the use of HEp-2 cells transfected with human 60 kDa Ro/SS-A for routine detection of these antibodies.

Methods—10 500 sera were screened at a dilution of 1:200 for Ro/SS-A antibodies, identified by intense immunofluorescence staining in 10–15% of hyperexpressing cells of either the nucleus and nucleolus combined or the nucleus alone.

Results—Ro/SS-A antibodies were identified in 160/2100 ANA positive sera (8%), of which seven were ANA negative (titre < 200) and 33 had weak ANA titres (200) in 85–90% of non-hyperexpressing “background” cells. Enzyme linked immunosorbent assay (ELISA) confirmed the presence of Ro/SS-A antibodies in 110 newly diagnosed Ro/SS-A positive sera. Of these, 50 reacted with Ro/SS-A, 51 with Ro/SS-A and La/SS-B, and nine with Ro/SS-A and other extractable nuclear antigen (ENA) specificities. Fifteen sera which did not show Ro/SS-A antibodies by immunofluorescence tested positive for Ro/SS-A by immunodiffusion, counter-immunoelectrophoresis, or ELISA; of these, 14 had ANA titres > 200. Clinical data from 95 Ro/SS-A positive patients showed that 52% had SLE, 24% Sjögren syndrome, 8% rheumatoid arthritis, and 16% other diseases.

Conclusions—(1) HEp-2 cells transfected with human 60 kDa Ro/SS-A are useful for routine immunofluorescence detection for Ro/SS-A antibodies with a positive predictive value of 100%; (2) sera positive for Ro/SS-A antibodies by immunofluorescence should be tested for ENA by other methods because > 50% of these sera will have another ENA reactivity in addition to Ro/SS-A; (3) detection of Ro/SS-A by immunofluorescence may be missed in the presence of high titre ANAs; (4) with a detection sensitivity of 91%, a negative immunofluorescence result for Ro/SS-A does not exclude the presence of this autoantibody.


Keywords: antinuclear antibody; Ro/SS-A antibodies; systemic lupus erythematosus; Sjögren syndrome

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antibodies by immunofluorescence in a routine diagnostic laboratory. Our report is the largest survey for anti Ro/SS-A antibodies by immunofluorescence to date.

**Methods**

**SERA**

Sera from 10,500 patients were referred for routine tests for antinuclear antibody, predominantly from general practitioners but about 20% from specialists. These included sera from 946 patients referred for testing for antibodies to extractable nuclear antigens.

**IMMUNOFLUORESCENCE**

Sera were screened at a dilution of 1:200 in phosphate buffered saline containing a serum diluent provided by the manufacturers to reduce the background immunofluorescence. The slides were screened using a Leitz immunofluorescence microscope and a ×50 objective to enhance the sensitivity of the detection of positive tests. We selected a screening dilution of 1:200 because preliminary studies carried out to determine the normal reference range in our laboratory had established that this screening dilution gave optimal discrimination between patients with systemic autoimmune diseases and age and sex matched healthy controls. While this screening dilution of 1:200 may seem higher than the 1:40 and 1:80 screening dilutions used by other laboratories, in-house and external quality control programs have validated the use of this dilution for the routine detection of antinuclear autoantibodies in our hands. The slides were screened by either of two experienced scientists (WP or M Lewis), and reviewed by the consultant immunologist (B-HT).

Sera were reacted with the HEp-2000® cell line (Immuno Concepts) in which the cells have been transfected with the 60 kDa Ro/SS-A protein and grown on glass slides. After 30 minutes of incubation at room temperature, the slides were washed and incubated with FITC conjugated goat antihuman IgG (heavy and light chains; catalogue No 2009, Immuno Concepts). The slides were read under ultraviolet light using ×500 magnification. ANA patterns and titres were determined on the “background” non-hyperexpressing cells, while the Ro/SS-A pattern was identified on the hyperexpressing cells. For photomicrography, the stained cells were examined by confocal microscopy (Bio-Rad MRC 1024).

**IMMUNODIFFUSION**

Sera for routine testing for ENA antibodies were screened by immunodiffusion using a commercial kit (Auto ID®, Immuno Concepts) according to the manufacturer's instructions. Sera were tested neat and wells were routinely double filled. Results were read at 48 hours.

**ELISA**

Any sera giving a precipitin line on immunodiffusion or any sera showing the Ro/SS-A pattern by immunofluorescence were further characterised by ELISA using a commercially available ELISA kit (RELISA® ENA, Immuno Concepts). These kits comprise an eight well strip coated with affinity purified Sm, Sm/RNP, Ro/SS-A, La/SS-B, Scl70, and Jo-1. Sera positive by immunodiffusion but negative by ELISA were recorded as having unidentified precipitin lines (UPL). A result of > 40 units was considered positive. The manufacturers state that the ELISA kit has been compared with other similar ELISA assays as well as with other methods of detection including immunodiffusion, counterimmunoelectrophoresis, and immunoblotting. These comparisons showed that the ELISA kit gave a relative sensitivity, specificity, and overall agreement of 94–100%.

**COUNTERIMMUNOELECTROPHORESIS**

This test was carried out as described previously.

**Results**

**ROUTINE IMMUNOFLOUORESCENCE SCREENING FOR RO/SS-A ANTIBODIES**

Antinuclear antibodies were detected in 2100 serum samples from 10,500 sera sent to Gribble’s Pathology (Melbourne branch) for tests for ANA, giving a positive detection rate of
Table 1 Antinuclear autoantibody (ANA) titres of Ro/SS-A positive and Ro/SS-A negative sera detected by indirect immunofluorescence (IIF)

<table>
<thead>
<tr>
<th>ANA titre</th>
<th>Ro/SS-A positive</th>
<th>Ro/SS-A negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1:200</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>1:200</td>
<td>33</td>
<td>–</td>
</tr>
<tr>
<td>&gt;1:200</td>
<td>71</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>15</td>
</tr>
</tbody>
</table>

Tests for Extractable Nuclear Antigens

Over the same period, we also carried out tests for ENA on 946 sera in which these tests were requested, irrespective of whether or not Ro/SS-A antibodies had been demonstrated by immunofluorescence. We tested for ENA antibodies by immunodiffusion followed by ELISA (on sera giving precipitin lines). In all, 192 sera tested positive for ENA, including the 110 Ro/SS-A positive sera detected by immunofluorescence. An additional 15 Ro/SS-A positive sera were identified, giving a total of 125 Ro/SS-A positive sera identified by ELISA. Therefore anti-Ro/SS-A antibodies comprised 65% (125/192) of all positive ENA antibodies.

Thirteen of the 15 sera also tested positive for Ro/SS-A by CIEP, but the other two sera tested negative. Of the 15 sera which did not show Ro/SS-A antibodies by immunofluorescence, 14 had high ANA titres of the background cell (< 200) and one was ANA negative with a titre < 200 (table 1). The high ANA titres may have masked the detection of Ro/SS-A. The ELISA results from these 15 sera are shown in table 2.

Sensitivity and Specificity of Ro/SS-A

Immunofluorescence Test

The positive predictive value of the immunofluorescence test for Ro/SS-A using the transfected cell line was 100% (160/160) and the sensitivity was 91% (160/175). However, as not all sera sent for ANA testing were screened for Ro/SS-A by CIEP, it is possible that the sensitivity of the test may be less than 91%.

ELISA Results

The ELISA values for the 125 Ro/SS-A positive sera ranged from a mean of 124 units for those with a background ANA titre of < 200, to 156 units for those with a titre of 200, and 170 units for those with a titre of > 200.

Clinical Correlation

Clinical information was available on 95 patients who tested positive for Ro/SS-A antibodies by immunofluorescence or by combined immunodiffusion and ELISA (tables 3 and 4).

Discussion

HEp-2 cells transfected with the human 60 kDa Ro/SS-A protein were developed to overcome the insensitivity of the detection of Ro/SS-A antibodies by immunofluorescence using conventional HEp-2 cells. The increased sensitivity for the detection of these antibodies is based on

Table 2 Specificity of Ro/SS-A positive and Ro/SS-A negative sera detected by indirect immunofluorescence (IIF)

<table>
<thead>
<tr>
<th>RELISA specificity</th>
<th>Ro/SS-A positive</th>
<th>Ro/SS-A negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ro/SS-A</td>
<td>50 (46%)</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Ro/SS-A and La/SS-B</td>
<td>51 (49%)</td>
<td>4 (27%)</td>
</tr>
<tr>
<td>Ro/SS-A and other ENA</td>
<td>9 (8%)</td>
<td>8 (53%)</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>15</td>
</tr>
</tbody>
</table>

RELISA, commercial enzyme linked immunosorbent assay kit (Immuno Concepts).

Table 3 Clinical diagnosis of 95 patients with or without Ro/SS-A antibodies detected by indirect immunofluorescence (IIF)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Ro/SS-A positive</th>
<th>Ro/SS-A negative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLE</td>
<td>41 (49%)</td>
<td>8 (67%)</td>
<td>49 (52%)</td>
</tr>
<tr>
<td>Sjogren syndrome</td>
<td>23 (28%)</td>
<td>0</td>
<td>23 (24%)</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>6 (7%)</td>
<td>2 (16%)</td>
<td>8 (8%)</td>
</tr>
<tr>
<td>Other</td>
<td>13 (16%)</td>
<td>2 (16%)</td>
<td>15 (16%)</td>
</tr>
<tr>
<td>Total</td>
<td>83</td>
<td>12</td>
<td>95</td>
</tr>
</tbody>
</table>
Table 4  Extractable nuclear antigen (ENA) specificity of patients with SLE and Sjögren syndrome

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Ro/SS-A positive</th>
<th>Ro/SS-A La/SS-B positive</th>
<th>Ro/SS-A La/SS-B and other ENA positive</th>
<th>Ro/SS-A and other ENA positive</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLE</td>
<td>20 (41%)</td>
<td>23 (47%)</td>
<td>4 (9%)</td>
<td>4 (8%)</td>
<td>49</td>
</tr>
<tr>
<td>Sjögren syndrome</td>
<td>5 (22%)</td>
<td>17 (74%)</td>
<td>1 (4%)</td>
<td>23</td>
<td></td>
</tr>
</tbody>
</table>

the overexpression of the 60 kDa Ro/SS-A protein in about 10–15% of cells. In a comparison of end point titres of 20 Ro/SS-A positive sera on transfected versus non-transfected HEp-2 cells, the overexpressing cells gave an increased mean titre which was 41-fold higher than that of the non-transfected cells. The concordance rate for the detection of Ro/SS-A antibodies in 39 of 53 patients with primary Sjögren syndrome using the 60 kDa Ro/SS-A transfected cell line and CIEP was 100%. In another study, 69 of 73 sera (95%) which were positive for Ro/SS-A by immunodiffusion were also positive by immunofluorescence using the 60 kDa Ro/SS-A transfected cell line. In a previous study, 14 Ro/SS-A positive sera were detected from a total of 240 sera tested using the 60 kDa Ro/SS-A transfected cell line for routine ANA screening. Here, we report the detection of 160 Ro/SS-A positive sera from 10 500 sera screened for ANA, representing therefore the largest experience with the use of this cell line for routine ANA screening to date. We used a screening serum dilution of 1:200, which is higher than the screening dilution of 1:40 used by other laboratories. It is possible that we may have missed the detection of some Ro/SSA positive sera by the use of this screening dilution. However, this is unlikely because cells transfected with human 60 kDa Ro/SSA dramatically overexpress this antigen, resulting in a 41-fold increase in titre compared with non-transfected cells. The Ro/SS-A pattern was typically identified as hyperexpressing cells giving a combined immunofluorescence staining of both the nucleoplasm as well as the nucleolus, a pattern consistent with that of previous reports. In the present study, we also describe one other immunofluorescence staining pattern which has not previously been reported—that is, strong immunofluorescence staining of the nucleoplasm only, without any staining of the nucleolus, in the hyperexpressing HEp-2 transfected cells. We have designated these two patterns of immunofluorescence staining in the hyperexpressing transfected HEp-2 cells as the “Ro/SS-A pattern.” All sera which gave the Ro/SS-A pattern by immunofluorescence were confirmed positive for this specificity by immunodiffusion or ELISA. The ANA status of the “background” non-hyperexpressing cells was negative in seven sera and weakly positive in 33. These observations highlight the value of using the transfected cell line. Importantly sera with negative or weakly positive ANA on the “background” cells had markedly increased ELISA units (> 100).

In a concurrent study of 192 sera which were tested for ENA by immunodiffusion followed by ELISA, 15 tested positive for Ro/SS-A in this way. These 15 sera did not give any immunofluorescence staining for the Ro/SS-A pattern in the HEp-2 cells transfected with the human 60 kDa Ro/SS-A protein. Given that the Ro/SS-A autoantigens comprise a 52 kDa as well as a 60 kDa protein, it is possible that antibody reactivity with the 52 kDa protein may have been missed in these 15 Ro/SS-A negative sera. However, in the present study, 14 of the 15 Ro/SS-A positive sera which tested negative for Ro/SS-A using the transfected cell line had ANA titres > 200, suggesting that the presence of these high titre antibodies may have masked the detection of Ro/SS-A antibodies.

CONCLUSIONS
Ro/SS-A antibodies comprise the majority of all ENA antibodies (65%) and are associated most commonly with SLE and Sjögren syndrome. With a positive predictive value of 100%, the HEp-2 cells transfected with human 60 kDa Ro/SS-A protein are a useful substrate for the routine detection of Ro/SS-A antibodies by immunofluorescence. Sera which test positive for Ro/SS-A antibodies by immunofluorescence should be subjected to further testing for other ENA antibodies by ELISA or by CIEP, because > 50% of sera may have other specificities in addition to Ro/SS-A, including La/SS-B antibodies. Given a sensitivity detection rate in our hands of 91%, Ro/SS-A antibodies should be tested by other methods if screening for these antibodies using the transfected cell line is negative but critical suspicion that they should be present is high.

We thank Mary Lewis for technical assistance, Kate Dunster for CIEP tests for Ro/SS-A, Katie Levick for confocal microscopy, Elly de Gooyer for support, and the referring doctors for clinical information.

6 Itoh Y, Reichlin M. Autoantibodies to the Ro/SS-A autoantigen are conformation dependent. Anti-60 kDa antibodies are mainly directed to the native protein; anti-52 kDa antibodies are mainly directed to the denatured protein. Autoimmunity 1992;14:57–65.