Sequential changes of KL-6 in sera of patients with interstitial pneumonia associated with polymyositis/dermatomyositis

Shuji Bandoh, Jiro Fujita, Yuji Ohtsuki, Yutaka Ueda, Satoko Hojo, Michiaki Tokuda, Hiroaki Dobashi, Noriyuki Kurata, Takeo Yoshinouchi, Nobuoki Kohno, Jiro Takahara

Abstract

Objective—KL-6 is a mucin-like high molecular weight glycoprotein, which is strongly expressed on type II alveolar pneumocytes and bronchiolar epithelial cells. It has been demonstrated that the KL-6 antigen is a useful marker for estimating the activity of interstitial pneumonia. In this study, it is hypothesised that serum KL-6 is a useful marker to evaluate the activity of interstitial pneumonia associated with polymyositis/dermatomyositis (PM/DM).

Methods—KL-6 was measured in sera in 16 patients diagnosed with PM/DM. Five had non-specific interstitial pneumonia (NSIP), three had diffuse alveolar damage (DAD), and eight had no pulmonary involvement, and 10 were normal non-smokers as a control group. The correlation was also evaluated between the KL-6 level and each clinical course in patients with pulmonary involvement associated with PM/DM. Immunohistochemical analysis using monoclonal anti-KL-6 antibody was also performed.

Results—KL-6 concentrations in sera of patients with interstitial pneumonia associated with PM/DM were significantly higher compared with those of PM/DM without interstitial pneumonia, and normal non-smokers. KL-6 concentrations in sera in patients with DAD significantly increased compared with those of other groups. KL-6 values in sera changed according to the progression or improvement of interstitial pneumonia. Immunohistochemical study using pulmonary tissues obtained from patients with DAD demonstrated that the hyaline membrane, proliferating type II pneumocytes, bronchiolar epithelial cells and some endothelial cells in pulmonary veins were stained by antihuman KL-6 antibody.

Conclusion—These data demonstrate that measurement of serum KL-6 was a useful marker to evaluate the activity of acute interstitial pneumonia associated with PM/DM.
Table 1  Patient characteristics and response to treatment

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Age/sex</th>
<th>Diagnosis</th>
<th>Pathological findings</th>
<th>Autoantibodies</th>
<th>KL-6 (U/ml)</th>
<th>PaO2 (%)</th>
<th>CT findings</th>
<th>Treatment</th>
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<td>Corticosteroid pulse + cyclosporin</td>
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<td>2</td>
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<td>DAD</td>
<td>Jo-1(−) RF(+)</td>
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<td>45.1</td>
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<tr>
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<td>Jo-1(−) RF(+)</td>
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<td>Jo-1(−)</td>
<td>2711</td>
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<td>Ground glass</td>
<td>Corticosteroid pulse + CPM</td>
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<td>NIP</td>
<td>Jo-1(+)</td>
<td>1530</td>
<td>59.8</td>
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<td>Ground glass</td>
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<td>Jo-1(−), ANF(+)</td>
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<td>NIP</td>
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<td>(−)</td>
<td>Jo-1(−), ANF(+)</td>
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<td>Jo-1(−), ANF(+)</td>
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<td>95.6</td>
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<tr>
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<td>56F</td>
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<td>Jo-1(−)</td>
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<td>Jo-1(−), SS-B(+)</td>
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<td>Jo-1(−)</td>
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<td>16</td>
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<td>Jo-1(+), RA(+)</td>
<td>303</td>
<td>86.2</td>
<td>84.1</td>
<td>Normal</td>
<td>Corticosteroid pulse</td>
</tr>
</tbody>
</table>

RF = rheumatoid factor, ANF = antinuclear factor, NA = not analysed, CPM = cyclophosphamide. *Died of respiratory failure.

Methods

SUBJECTS
We studied 16 patients with a diagnosis of PM/DM (table 1). PM/DM was diagnosed according to the criteria of Bohan et al": (a) symmetric muscle weakness; (b) typical histological findings on muscle biopsy; (c) increased activities of muscle enzymes in the sera; (d) compatible electromyographic findings; and (e) characteristic dermatological manifestations. Among 16 patients, five had non-specific interstitial pneumonia (NSIP), three had DAD, and eight had no pulmonary involvement. All patients with lung disease had the recent onset of interstitial pneumonia. The median age of 16 patients with PM/DM was 58 years old with a range of 42 to 70 years (2 men and 14 women). There was one current smoker. The diagnoses of interstitial pneumonia were made on clinical, radiological, physiological, and histological grounds. The criteria used included: history of exertional dyspnea and cough, fine crackles on physical examination, compatible findings on the chest radiograph, physiological abnormalities of restrictive lung defects including decreased diffusing capacity, and abnormal PaO2 at rest or with exertion, or both. In all patients, high resolution computed radiographic scanning of the lungs (HRCT) was performed. Histological confirmation was obtained in all cases by open lung biopsy or necropsy. No patients received immunosuppressive treatment such as corticosteroid or cyclophosphamide at the time of initial diagnosis. The histological examination of five patients with NSIP was successively measured in these three patients. All patients with DAD died of respiratory failure.

All patients received the immunosuppressive treatment such as corticosteroid and cyclophosphamide after diagnosis.

BLOOD SAMPLES
Peripheral venous blood samples with and without EDTA were obtained before breakfast. After centrifugation at 1000 g for 10 minutes at 4°C, the serum was frozen and stored at −70 °C until used. Arterial blood samples were analysed for PaO2 and PaCO2 using a blood gas analyser

MEASUREMENT OF KL-6 CONCENTRATIONS IN SERUM
The serum concentration of KL-6 antigen was measured by a sandwich type enzyme linked immunosorbent assay using KL-6 antibody.12 In brief, polystyrene cups coated with KL-6 antibody were incubated with 0.1 ml of 10-fold serum at 25°C for one hour. Then, the cups were washed again, 0.1 ml of ABTS solution (1.5 mg/ml 2,2'-azino-bis [3-ethylbenzthiazoline-6-sulphonic acid], 0.02% H2O2, and 0.1 M citrate buffer, pH 4.2) was added, and incubation was performed at 25°C for one hour. Finally, 0.013 M NaN3 was added to terminate the peroxidase reaction and absorbance at 405 nm was measured. The cut off value for serum KL-6 was that reported by Kohno et al, who measured the KL-6 concentrations of 160 healthy control subjects using the same method and set the upper limit of the normal range as 520 U/ml.11

KL-6 concentrations were successively measured in eight patients with interstitial pneumonia associated with PM/DM at the time of diagnosis. Serial KL-6 concentrations were obtained from six of eight patients.
IMMUNOHISTOCHEMICAL STAINING

The KL-6 antigen was identified in the formalin fixed tissue sections by means of monoclonal KL-6 antibody (10 ng/ml in concentration) using the labelled streptavidin biotin (LSAB) method (Dako LSAB kit, Dako Corp, Kyoto, Japan), according to the kit manual. In brief, intrinsic peroxidase activity of each dewaxed section was inactivated by treatment with 0.3% H$_2$O$_2$ in methanol for 30 minutes after blocking with normal goat serum. The specimens then were washed and incubated with monoclonal KL-6 antibody at room temperature for 60 minutes. Culture supernatant of MOPC-21 cells, a mouse myeloma cell line secreting IgG, antibodies, was used as a negative control. After washing, sections were treated with biotinylated goat antimouse IgG for 10 minutes and then for 10 minutes with avidin-biotin-conjugated horseradish peroxidase complex. The immunohistochemical reaction was developed for three minutes with freshly prepared colour development solution (0.2 mg/ml 3,3’-diaminobenzidine tetrahydrochloride (Sigma Chemicals, Germany), 0.01% H$_2$O$_2$, in PBS, pH 7.0). The sections were counterstained with haematoxylin.

Results

KL-6 concentrations in sera of patients with interstitial pneumonia associated with PM/DM (mean (SEM) 2260.8 (243.0) U/ml) were significantly increased as compared with normal non-smokers (219.9 (23.0) U/ml, p<0.01) and patients without interstitial pneumonia associated with PM/DM (237.5 (24.8) U/ml, p<0.01). KL-6 concentrations in sera of patients with DAD associated with PM/DM (2918.3 (93.8) U/ml) were significantly increased compared with the other groups (fig 1). KL-6 concentrations in sera in patients with DAD are extraordinary high compared with other lung diseases previously reported.2–6 13

In six patients with interstitial pneumonia associated with PM/DM, KL-6 concentrations were measured successively and relations between the sequential changes of KL-6 concentrations and clinical courses were also evaluated. Progression or improvement of the disease was determined by PaO$_2$ values, pulmonary function tests, and changes of chest computed tomographic findings one month after treatment. In patients with interstitial pneumonia complicated with PM/DM, KL-6 concentrations increased according to the progressive clinical course (fig 2). Additionally, in patients in whom NSIP was improved by treatment, KL-6 values decreased along with the clinical course. Interestingly, KL-6 concentrations in sera did not correlate with LDH, CRP or CPK values in sera (fig 3).

Immunostaining of the hyaline membrane with antihuman KL-6 monoclonal antibody was positive in a necropsy case of DAD as shown in figure 4A. Although the hyaline membrane was mostly positive in all cases examined, the intensity of immunostaining varied in parts of the lung. Especially in a case of DAD revealing a high concentration of serum KL-6, immunopositivity was generally strong and was widely detected including endothelial cells as described later. Proliferating type II pneumocytes (fig 4B) were stained more densely than the hyaline membrane (fig 4C). Although endothelial cells in pulmonary arteries were not stained with this monoclonal antibody, some endothelial cells in pulmonary veins were stained weakly, and all bronchiolar epithelial cells were stained weakly (fig 4D).

There was no significant increase or decrease of
the KL-6 staining in endothelial cells in pulmonary veins of the patients with dermatomyositis as compared with those with polymyositis. Capillary endothelial cells were negative.

Discussion
In this study, we demonstrated that the KL-6 concentrations in serum of patients with interstitial pneumonia associated with PM/DM were significantly high compared with patients without interstitial pneumonia. In addition, KL-6 concentrations were extraordinary high in patients with diffuse alveolar damage associated with PM/DM.

Pathological findings of interstitial lung disease in patients with PM/DM have been previously reported. Tazelaar et al reviewed specimens obtained from 15 patients with PM/DM (14 at open lung biopsy and one at necropsy) and reported three major groups based on the histological patterns: bronchiolitis obliterans organizing pneumonia, usual interstitial pneumonia, and DAD. Tazelaar et al also described one case of chronic interstitial pneumonia, distinct from usual interstitial pneumonia, and termed it "cellular interstitial pneumonia". Recently, Katzenstein and Fiorelli reported that 10 of their 64 patients with NSIP had an association with connective tissue diseases, including two patients with PM. In the two patients, the pulmonary disease preceded the onset of muscle weakness. They also reported that the lesion of cellular interstitial pneumonia termed by Tazelaar et al corresponds well to that of NSIP. It has been reported that the prognosis of NSIP is favourable. In contrast, the prognosis of patients with DAD is very poor. Therefore, the reliable markers that can predict the pathological findings of pulmonary fibrosis associated with PM/DM are clinically very important.

KL-6, a mucin-like molecule, is expressed on type II pneumocytes and respiratory bronchiolar epithelial cells in normal lungs. Proliferating regenerating type II pneumocytes in interstitial pneumonitis, such as idiopathic pulmonary fibrosis (IPF) and radiation pneumonitis, express the antigen more strongly than normal type II pneumocytes. Therefore, Kohno et al speculated that the increased KL-6 in sera of patients with interstitial pneumonitis is derived from the damaged or regenerating epithelial cells in the lower respiratory tract, thus KL-6 value reflects the tissue damage to the parenchymal cells in peripheral lung tissue. They also speculated that the change of serum KL-6 concentration, may give useful information to assess the state of the peripheral lung tissues in a variety of inflammatory interstitial lung diseases.

Acute interstitial pneumonia (AIP) is the rapidly progressive interstitial lung disease that has been pathologically characterised by extensive pulmonary septal oedema, and desquamation of type I and II pneumocytes. The pathological hallmark of AIP is defined as DAD. DAD is manifested by injury to the alveolar lining and endothelial cells, pulmonary oedema, and the hyaline membrane formation, and later by proliferative changes involving alveolar and bronchiolar lining cells, as well as interstitial cells. The pathological appearance of DAD can be separated into acute exudative, subacute proliferative, and chronic fibrotic phases. DAD observed in AIP is identical to the alveolar damage found in adult respiratory distress syndrome.

Kobayashi et al reported that the KL-6 value is increased in patients with interstitial lung diseases such as hypersensitivity pneumonitis, pneumonitis related to collagen disease, and idiopathic interstitial pneumonia (1187 (689) U/ml; range 224 to 2656 U/ml, n=51). Kohno et al also reported that increased serum KL-6 antigen concentrations are very high in cases of interstitial pneumonitis, especially in those with IPF who also have a positive uptake of "Ga-citrate in their lung field. Therefore, increased serum KL-6 antigen concentration...
in patients with DAD strongly suggests massive inflammation in the alveoli. In addition, our data suggest that KL-6 values in serum of patients with interstitial pneumonia associated with PM/DM correlated with the clinical course. These results suggest the usefulness of serial measurements of serum KL-6 for the treatment of interstitial pneumonia associated with PM/DM. Similar results were reported in patients with lung cancer who developed radiation pneumonitis. Kohno et al reported that KL-6 is much more sensitive than LDH for detecting radiation pneumonitis. In this manner, KL-6 values in patients with DAD may also predict the dose of corticosteroid and/or immunosuppressant for treatment.

Furthermore, immunohistochemical staining demonstrated that anti-KL-6 antibody stained the hyaline membrane in moderate density, and the type II pneumocytes strongly, together with respiratory bronchiolar epithelial cells and some endothelial cells in pulmonary vein. Either the release or secretion of KL-6 antigen molecules from type II pneumocytes, may have been mainly responsible for the increase in the serum KL-6 antigen concentration, as these cells strongly expressed the KL-6 antigen. However, the exact mechanism of the increase in KL-6 in patients’ sera remain unclear. In addition, the presence of KL-6 was clearly demonstrated in the hyaline membrane as well as the increased expression of KL-6 in proliferating type II pneumocytes. Secreted KL-6 antigen from type II pneumocytes may have been observed in alveoli by an exudative mechanism. This evidence suggests that the KL-6 concentrations in sera reflected the disease activity in patients with interstitial pneumonia associated with PM/DM, and KL-6 was a useful marker to prove the existence of the pulmonary epithelial cell damage. Although the mechanism was unclear, some endothelial cells in pulmonary veins were stained with anti-KL-6 antibody. Further study will be required to clarify the mechanism of KL-6 staining in endothelial cells.

The significance of KL-6 as a prognostic factor in DAD, and the usefulness of KL-6 measurement compared with other inflammatory cytokines, such as interleukin 1β, interleukin 1 receptor antagonist, soluble interleukin 2 receptor, interleukin 6, interleukin 8, tumour necrosis factor α and interferon γ should also be evaluated in future studies.

In conclusion, our data demonstrate (1) KL-6 in serum increased in patients with interstitial pneumonia associated with PM/DM; (2) KL-6 concentrations in sera reflected the clinical course in PM/DM associated interstitial pneumonia; (c) proliferating and regenerating type II pneumocytes in particular, secreted KL-6 in pulmonary tissues with DAD, and the hyaline membrane; (d) further studies of positive staining of endothelial cells are necessary. These results suggest that serum KL-6 might be a good marker for interstitial pneumonia associated with PM/DM.


7 Mills ES, Matthews WH. Interstitial pneumonitis in dermatomyositis. JAMA 1956;160:1467–70.


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