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Identification of *Helicobacter pylori* and Other *Helicobacter* Species by PCR, Hybridization, and Partial DNA Sequencing in Human Liver Samples from Patients with Primary Sclerosing Cholangitis or Primary Biliary Cirrhosis

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*Helicobacter pylori* was identified in human liver tissue by PCR, hybridization, and partial DNA sequencing. Liver biopsies were obtained from patients with primary sclerosing cholangitis (n = 12), primary biliary cirrhosis (n = 12), and noncholestatic liver cirrhosis (n = 13) and (as controls) normal livers (n = 10). PCR analyses were carried out using primers for the *Helicobacter* genus, *Helicobacter pylori* (the gene encoding a species-specific 26-kDa protein and the 16S rRNA), *Helicobacter bilis*, *Helicobacter pullorum*, and *Helicobacter hepaticus*. Samples from patients with primary biliary cirrhosis and primary sclerosing cholangitis (11 and 9 samples, respectively) were positive by PCR with *Helicobacter* genus-specific primers. Of these 20 samples, 8 were positive with the 16S rRNA primer and 9 were positive with the 26-kDa protein primer of *H. pylori*. These nine latter samples were also positive by Southern blot hybridization for the amplified 26-kDa fragment, and four of those were verified to be *H. pylori* by partial 16S rDNA sequencing. None of the samples reacted with primers for *H. bilis*, *H. pullorum*, or *H. hepaticus*. None of the normal livers had positive results in the *Helicobacter* genus PCR assay, and only one patient in the noncholestatic liver cirrhosis group, a young boy who at reexamination showed histological features suggesting primary sclerosing cholangitis, had a positive result in the same assay. *Helicobacter* positivity was thus significantly more common in patients with cholestatic diseases (20 of 24) than in patients with noncholestatic diseases and normal controls (1 of 23) (P < 0.00001). Patients positive for *Helicobacter* genus had significantly higher values of alkaline phosphatases and prothrombin complex than *Helicobacter*-negative patients (P = 0.0001 and P = 0.0003, respectively). Among primary sclerosing cholangitis patients, *Helicobacter* genus PCR positivity was weakly associated with ulcerative colitis (P = 0.05). Significant differences related to blood group or HLA status were not found.

During the past few years *Helicobacter* infections have been reported to be associated with certain diseases in the liver of some animal species such as *Helicobacter canis* in dogs (10), *Helicobacter pullorum* in poultry (31), and *Helicobacter hepaticus* (33) and *Helicobacter bilis* (12) in mice. These findings, in conjunction with the role of *Helicobacter pylori* as a major pathogenic factor of chronic gastritis, peptic ulcer disease, gastric mucosa-associated lymphoma, and gastric cancer (7), demand further studies to explore the possibility of a relationship between *Helicobacter* infection and liver disease in humans.

Primary sclerosing cholangitis (PSC) and primary biliary cirrhosis (PBC) are diseases affecting the human liver. The etiology of PSC is unknown (6). There is ample evidence that the disease, but not the course of it, is associated with specific HLA antigens (24). About 65% of PSC patients are positive for anti-neutrophil cytoplasm antibody in serum (1). Few studies have suggested that pathogens may cause PSC (29), but this was not confirmed (4). Clinical symptoms are jaundice, pruritus, right upper quadrant pain, fever, and fatigue (25). Complications involve bacterial cholangitis, hepatosplenomegaly, and gallbladder and biliary stones (6, 13). The disease is characterized by fibrosis of the extra- and/or intrahepatic bile ducts, biliary fibrosis and cirrhosis, portal hypertension, liver failure (6, 13), and cholangiocarcinoma (3). Diagnosis is based on the cholangiographic demonstration of multiple stenoses, dilatations of the biliary tree, and a cholestatic liver laboratory profile. PSC is correlated with ulcerative colitis (UC), Crohn’s disease, and other forms of inflammatory bowel disease (6, 26).

PBC is an autoimmune disease characterized by destruction of the intrahepatic bile ducts and inflammation of the portal system, followed by tissue fibrosis and liver failure. Lethargy, pruritus, jaundice are common symptoms (16), and PBC may be associated with inherited abnormalities of immunoregulation (16). Diagnosis is based on a cholestatic liver laboratory profile, the demonstration of serum antimitochondrial antibodies, and a characteristic histological picture.

The aim of this study was to investigate if *Helicobacter* gene sequences in general, and *H. pylori*, *H. bilis*, *H. pullorum*, or *H. hepaticus* in particular, could be detected in human liver samples from patients with PSC, a disease with many features suggestive of an infectious etiopathology. For comparison, we studied liver samples not only from patients with another cholestatic disease, namely, PBC, but also from patients with noncholestatic liver cirrhosis (NCLC) as well as from controls with normal livers.


**TABLE 1.** Clinical features of the four patient groups and laboratory values at the time of liver transplantation in the PSC, PBC, and NCLC groups

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value for group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PSC</td>
</tr>
<tr>
<td>Total patients</td>
<td>12</td>
</tr>
<tr>
<td>Mean age (yr)</td>
<td>47 ± 2</td>
</tr>
<tr>
<td>Female/male</td>
<td>8/4</td>
</tr>
<tr>
<td>Mean bilirubin (µmol/liter)</td>
<td>234</td>
</tr>
<tr>
<td>Mean ALP (µkat/liter)</td>
<td>23</td>
</tr>
<tr>
<td>Mean PTK (%)</td>
<td>68</td>
</tr>
</tbody>
</table>

* ND, not determined.

(Part of this study was presented at the European Helicobacter pylori Study Group Workshop in Helsinki, Finland, in September 1999 [22a].)

**MATERIALS AND METHODS**

**Patients and samples.** Liver specimens were collected from explanted livers from patients with PSC (n = 12), PBC (n = 12), NCLC (n = 13) and from autopsy livers with normal histology (n = 10) at the Sahlgrenska University Hospital. The group of patients with NCLC comprised patients with alcoholic cirrhosis (n = 6), cirrhosis from chronic autoimmune hepatitis (n = 4), and cryptogenic cirrhosis (n = 3). Clinical and laboratory features are summarized in Table 1. The diagnosis of PSC and PBC was based on the criteria mentioned in the introduction. The samples were paraffin embedded prior to histological examination and deembedded by washing in xylene and ethanol. Biopsy samples (15 to 20 mg/specimen) were homogenized in 300 µl of phosphate-buffered saline (pH 7.2) by using a plastic microcentrifuge tube-adapted pestle.

DNA extraction. The DNA extraction method has been described previously (21). Briefly, 5 to 50 µl of homogenized tissue was added to 100 µl of extraction buffer (75 mM KCl, 3 mM EDTA, 150 mM Tris·HCl [pH 8.0], 0.75% Tween 20), and the mixture was vortexed and incubated at 22°C for 15 min. The samples were heated at 90°C for 10 min and cooled on ice for 2 min. An ion-exchange resin (AG 50-X8, 20 to 50 mesh; Bio-Rad Laboratories, Hercules, Calif.) was added to a final concentration of 10% (wt/vol). Samples were vortexed and centrifuged at 10,000 × g at 4°C. The upper phase, containing the DNA, was used as the template in the PCR.

Primer specificity. The various primers were tested for amplification specificity using the following panel of Helicobacter and Flexispira strains: H. pylori CCUG 17874, H. hepaticus CCUG 33637, H. catus CCUG 33835, H. felis CCUG 28539, H. pullorum CCUG 33838, H. bilis CCUG 38995B, H. muridarum CCUG 29262, H. mustelae CCUG 23950, and F. rappini K0210, Helicobacter strains and Flexispira ruminis were obtained from the Culture Collection at the University of Gothenburg. A clinical isolate of F. rappini (H1) and F. rappini K0210, isolated from dog feces, were kindly provided by M.-L. Hanninen, Department of Veterinary and Environmental Hygiene, University of Helsinki, Helsinki, Finland. Salmonella typhi, Proteus mirabilis, and Escherichia coli were clinical isolates from Lund University Hospital. DNA was extracted as described above. A range of bacterial strains was used previously to test the specificity of the different primers used in this study (28, 32).

PCR amplification. PCR was performed as previously described (22), with minor modifications. Two units of Taq polymerase (MBI Fermentus, Vilnius, Lithuania) and 3 mM MgCl2 were used. Five to 10 µl of an extracted sample was added to the PCR reaction mixture. All primers were purchased from Scottish National Gene Synthesis (Köping, Sweden). PCR was performed in a Techne Genius thermal cycler (Cambridge Ltd., Duxford, Cambridge, United Kingdom). The amplified products were visualized on 1.5% (wt/vol) agarose gel (Bio-Rad Laboratories), gels, and the sizes of the PCR products were estimated by comparison with 100-bp DNA size markers (MBI Fermentas). At each amplification event a corresponding Helicobacter DNA extract was used as a positive control. For the Helicobacter genus PCR, H. pylori or H. bilis DNA was used as the positive control. Double-distilled water was used as the negative control.

**E. coli 16S rRNA PCR.** PCR with E. coli 16S rRNA broad-range bacterial primers was performed as previously described (21). These primers yield an 812-bp product from several bacterial genus and strains (28). Helicobacter DNA extracts from the PSC, PBC, and NCLC patients were analyzed by this PCR assay.

**PCRs for Helicobacter genus.** Initially, samples were amplified by Helicobacter genus-specific 16S rRNA primers (designated HC) (9). The forward (C97) and the reverse (C98) primer amplifies a product of approximately 400 bp. Amplification consisted of initial denaturation at 94°C for 4 min, followed by denaturation at 94°C for 1 min, primer annealing at 35°C for 1.5 min, and extension at 72°C for 2 min. The samples were amplified for 35 cycles, with a final extension step at 72°C for 10 min.

**Species-specific PCR analyses.** Samples generating a positive result in Helicobacter genus PCR were subsequently analyzed with different sets of primers. A primer pair (designated HpD), amplifying a 298-bp product, based on the partial DNA sequence of a species-specific gene encoding a 26-kDa cell surface protein of H. pylori (The Institute for Genomic Research [TIGR] database accession number M55070) was previously described (28). Primers based on a specific H. pylori 16S rRNA sequence (designated HpACT), amplifying a 537-bp product, were used in a second amplification protocol for H. pylori, as previously described (32). PCR primers based on 16S rRNA amplified H. hepaticus (2), H. bilis (using primers C62 and C12 [12]), and H. pullorum (31) according to published methods.

**Southern blot hybridization.** Hybridization was performed using a probe generated by amplification of H. pylori strain CCUG 17874 with the species-specific HPD primers (see above), using the digoxigenin DNA labeling kit (Boehringer Mannheim) according to the manufacturer's instructions. Ten microliters of the PCR product was transferred to a nylon membrane (Amersham, Buckinghamshire, United Kingdom) by the capillary blotting technique. The membrane was prehybridized at 65°C for 4 h, freshly denatured probe hybridization performed at 67°C for 6 h before the membrane was washed and bound probes were detected by using the digoxigenin nucleic acid detection kit (Boehringer Mannheim) according to the manufacturer’s instructions.

**DNA sequencing.** PCR-amplified Helicobacter genus-specific PCR products were purified from agarose gels by the JETsorb DNA extraction kit (Genomed, GmbH, Bad Oeynhausen, Germany). Sequence analysis was performed with the Applied Biosystems DNA sequencer (Perkin-Elmer, Applied Biosystems, Foster City, Calif.) by the protocols of the manufacturer, using the ABI PRISM Big Dye Terminator Cycle Sequencing Ready Reaction Kit. For sequencing, primer C97 or C98 (9) was used. Sequence comparison was carried out using the Blast program (Genetics Computer Group, Madison, Wis.) and the GenBank and EMBL databases.

**Statistical analyses.** For comparison between continuous data we used the Mann-Whitney U test, and for comparison between numerical data, a contingency table was used. The level of significance was set to 5%.

**RESULTS**

**Specificity test.** Helicobacter genus specificity was examined using a panel of Helicobacter strains by PCR with the genus-specific primer sets designated HC. The HpACT (H. pylori 16S rRNA) and HpD (gene for the H. pylori 26-kDa protein) primer sets indicated PCR positivity only with H. pylori DNA. As previously described (28, 32), a wide range of Helicobacter strains were negative by PCR using the H. pylori 16S rRNA or 26-kDa protein primers. Primers for H. bilis, H. pullorum, and H. hepaticus were PCR positive only with the corresponding strain (data not shown). The bacterial DNA extracts from non-Helicobacter species did not react with any of the Helicobacter primers used in this study.

**E. coli 16S rRNA PCR.** The results of the broad-range E. coli 16S rRNA PCR of the PSC, PBC, and NCLC patients are shown in Table 2. Generally, a high level of PCR positivity was found equally distributed among these patients.

**PCRs for Helicobacter genus.** Helicobacter genus-specific 16S rRNA primers (designated HC) identified Helicobacter species
in 20 of 24 samples of the PSC and PBC patient groups. Under UV illumination the size of the PCR product corresponded to the expected 400 bp (Fig. 1). As shown in Table 2, a high level of PCR positivity was found in the PSC and PBC patient groups, whereas only one sample was positive in the NCLC group and among the normal liver controls. In comparing total Helicobacter genus positivity of the cholestatic liver disease patients (20 of 24) and the control groups (1 of 23) a high level of significance was found (P = <0.00001).

**PCR for species identification.** The Helicobacter genus-positive samples from the PSC and PBC patients that were positive using primers for the H. pylori gene encoding the 26-kDa protein (HpD) and for H. pylori 16S rRNA (HpACT) are shown in Table 2. The sizes of the PCR fragments generated with the HpD primers (298 bp) and the HpACT primers (537 bp) corresponded to the respective expected sizes. Several samples positive by Helicobacter genus-specific PCR were negative using both sets of primers targeting H. pylori genes (Table 2). None of the 20 Helicobacter genus-positive PSC and PBC samples reacted in PCR assays using primers for 16S rRNA of Helicobacter spp., H. pullorum, or H. hepaticus. The NCLC patient that was Helicobacter genus positive was negative in all species-specific PCR assays.

**Southern blot hybridization.** The liver samples that were positive by PCR using primers targeting the gene for the 26-kDa protein of H. pylori were all positive by Southern blot hybridization with a digoxigenin-labeled probe generated by PCR using the species-specific HpD primers. A representative Southern blot hybridization is shown in Fig. 2. The results of the hybridization confirm the presence of gene sequences of H. pylori in liver tissue samples obtained from patients with a chronic cholestatic liver disease.

**DNA sequencing.** Four 16S ribosomal DNA fragments, obtained by PCR using C97 and C98 primers, from Helicobacter genus-positive samples were sequenced. All were found to be at least 98% identical to H. pylori strain 399 and Helicobacter spp. liver 16S ribosomal DNA (GenBank accession number AF 142585). One of the Helicobacter species-positive but H. pylori-negative 16S rDNA fragments was also sequenced. Sequence comparison showed only low homology to Helicobacter spp. pig F8 16S rDNA (GenBank accession number AF 142151), H. suis (GenBank accession number AF 27028), and Helicobacter spp. liver 16S ribosomal DNA.

**Clinical correlation to Helicobacter positivity.** Patients positive for Helicobacter genus had significantly higher values of alkaline phosphatases (ALP) and prothrombin complex (PTK; i.e., coagulation factors II, VII, and X) than patients negative for Helicobacter genus (Table 3). It is notable that the only patient in the NCLC group who was positive for Helicobacter genus had the highest ALP value (70% higher than the upper reference value) in that group. In fact, at microscopic reexamination, the pathologist found the microscopical pattern suggestive of PSC. We also found a significantly higher prevalence of Helicobacter genus positivity for patients with UC. It should be observed that UC was only present in PSC patients. The difference in prevalence of Helicobacter spp. positivity between PSC and PBC patients was not significant. We failed to demonstrate significant differences related to blood group or HLA status.

**DISCUSSION**

The detection of gene sequences of Helicobacter species in liver tissue samples of patients with PSC and PBC (Table 2) is interesting, since some previous reports have suggested an association of Helicobacter and liver disease (5, 9, 20, 23, 30). In one study using PCR and subsequent sequencing of a part of the amplified ureA gene, H. pylori was detected in 3 of 7 human bile samples collected by percutaneous transhepatic cholangiography from patients with pancreatic head tumors, suggesting that H. pylori may be associated with asymptomatic cholangitis (20). Another study using PCR and immunohistochemical staining observed a H. pylori-like organism in the gallbladder mucosa of a 41-year-old woman admitted to the hospital with fever and upper right quadrant pain (17). A high prevalence of antibodies to H. pylori in the serum of patients with liver diseases was also reported (30). These observations prompted us to explore a possible association of Helicobacter and chronic liver disease in Swedish patients.

Twenty of 24 liver samples from patients with PSC or PBC were positive by PCR analysis using Helicobacter genus-specific primers. Nine of these 20 samples were positive for H. pylori by
PCR analysis. Lin et al. (20) detected *H. pylori* in bile samples with primers based on the *ureA* gene. We detected *H. pylori* by analysis with two independent PCR assays, based on the sequence of a gene encoding a species-specific 26-kDa surface protein and 16S RNA, respectively, to avoid the possibility of cross-reaction with other *Helicobacter* species. Each liver biopsy was homogenized, extracted, and amplified on different occasions by different investigators. PCR results with *Helicobacter* genus-specific as well as *H. pylori* species-specific primers were reproduced very well. These precautions were taken to certify that laboratory contamination did not account for the positive PCR results. Moreover, reagent mixing, sample addition and thermocycling were performed separately. One sample, positive with the *H. pylori* 26-kDa protein primers, was negative using *H. pylori* 16S RNA primers. An explanation for this one negative sample in the 16S PCR could be strain variation at one of the primer sites, especially one located in a variable region. *H. pylori* has been shown to be sensitive in vitro to the major bile acids in human bile, deoxycholic and chenodeoxycholic acid (15), arguing against *H. pylori* colonizing the liver. However, it is possible that *H. pylori* in vivo adapts to bile acids, as shown by studies recovering *H. pylori* in human feces (19). Moreover, under certain pathological conditions, such as bile duct obstruction, bile components inhibitory for the growth of *H. pylori* may change (34), and duodenogastric bile reflux does not seem to affect the growth of *H. pylori* in the antrum (18).

The predominant association with cholestatic liver disease is underlined by the significantly higher ALP and PTK levels in the *Helicobacter* positive patients. On the other hand, the lack of difference in bilirubin levels between *Helicobacter*-positive and -negative patients, and the significantly higher PTK levels in the *Helicobacter*-positive patients show that the *Helicobacter* positivity was not primarily related to severe liver failure. The fact that not all patients with the two cholestatic liver diseases were positive for *Helicobacter* should be considered against the fact that there is a considerable sampling variability as to histologic changes, especially for patients with PSC (27), but also for patients with PBC (14). Thus, the possibility remains that even more patients with these two diseases could be *Helicobacter* positive.

The large-duct involvement in PSC and the frequent occurrence of fever in PSC, in contrast to PBC, initiated the study in patients with PSC and PBC. This argues against a specific etiopathogenic role of *Helicobacter* in either of the diseases. Our findings do not exclude, however, the possibility that *Helicobacter* may have a triggering effect, where the response is modified by host factors.

Previous studies have found immunoglobulin G serum antibodies to *H. pylori* to be more common in cirrhotic compared with noncirrhotic patients (30). However, in a recent study, PBC patients with negative gastric biopsy colonization for *H. pylori* often had high antibody titers in an *H. pylori* enzyme immunoassay (8). The reason for this is unclear, but a past *H. pylori* infection or cross-reactivities of antibodies against other *Helicobacter* species are possible factors accounting for this (11). *H. hepaticus* and *H. bilis* have been shown to be possible causes of inflammatory disease in the liver of mice (11). Primary sclerosing cholangitis is often accompanied by inflammatory bowel disease in human patients, and Fox et al. (9) recently reported on *H. bilis*, *H. pullorum*, or *H. rappini* in gallbladder as well as bile samples of humans with chronic cholecystitis by cloning and sequencing of amplified 16S rRNA PCR products. In our present study, 9 of 20 samples found to be *Helicobacter* genus positive by PCR were identified as *H. pylori*, a finding which was verified for 4 of the 9 by sequence analysis. None of the *Helicobacter* genus-positive samples were positive in PCR assays targeting *H. bilis*, *H. pullorum*, or *H. hepaticus*. The samples not identified to the species level may represent other possible hepatic *Helicobacter* species. The sequence of one such 16S rDNA fragment was determined, and the result from sequence comparison showed only weak homology to *Helicobacter* spp. Further studies are needed to establish the role of *H. pylori* and *Helicobacter* species in PSC and PBC.

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**REFERENCES**


