Serum sialyl Lewis X-i antigen in lung adenocarcinoma and idiopathic pulmonary fibrosis

H Satoh, H Ishikawa, Y T Yamashita, M Ohtsuka, K Sekizawa

Background: Sialyl Lewis X-i antigen has been used as a diagnostic tool for lung adenocarcinoma. However, serum levels of the antigen are also raised in some patients with idiopathic pulmonary fibrosis (IPF) without coexistent malignancy. Expression of the antigen in serum samples of patients with lung adenocarcinoma was evaluated and compared with that of patients with IPF by Western blotting in order to establish a specific laboratory test to differentiate lung adenocarcinoma from IPF.

Methods: The pattern of antigen expression in serum samples from 23 patients with either lung adenocarcinoma or non-malignant lung disease in whom serum levels of sialyl Lewis X-i antigen (>50 U/ml) were significantly increased was studied by Western blotting.

Results: Thirteen of the 14 serum samples from patients with lung adenocarcinoma had a molecular weight band at 120 or 130 kD, while five of the six patients with IPF had two or three bands at <97.4 kD. The pattern of antigen expression was apparently different between the two diseases. The sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio of this test in 20 patients with lung adenocarcinoma and IPF were 92.9%, 83.3%, 5.57, and 0.09, respectively.

Conclusions: Western blotting analysis of serum samples from patients with raised levels of sialyl Lewis X-i antigen provides some clinical information for a differential diagnosis between lung adenocarcinoma and IPF.

It is well known that various carbohydrate antigens are expressed on the cell surface during tumour progression. Serum levels of the antigens are frequently raised in patients with malignancies, and detection of these antigens may have an adjunctive role to play in their diagnosis. Serum levels of the carbohydrate antigens are, however, also raised in some patients with non-malignant lung diseases such as idiopathic pulmonary fibrosis (IPF), bronchiectasis, and diffuse panbronchiolitis without coexistent malignancy. IPF is defined as diffuse interstitial pulmonary fibrosis of unknown aetiology which has a chronic progression. In patients with IPF the incidence of lung cancer is much higher than that in the general population so, when increased serum levels of the antigen are seen in patients with IPF, further invasive and costly tests are often undertaken to rule out adenocarcinoma of the lung or other organs.

Among the carbohydrate antigens, sialyl Lewis X-i antigen has been used as a tumour marker for lung cancer, especially lung adenocarcinoma. However, raised serum levels of this antigen are observed in some patients with the abovementioned respiratory diseases. Recent studies have shown that, in addition to cancer cells, immature cells which undergo vigorous proliferation in the developing lung of the human embryo and fetus also express the antigen, and that the antigen is selectively expressed in the pulmonary epithelial cells that cover the remodelling alveolar septa in patients with IPF. Although increased serum levels of the antigen have been found not to be specific to patients with lung adenocarcinoma, there is as yet no specific test to differentiate lung adenocarcinoma from other pathophysiological conditions in which the antigen levels are increased.

Judging from their solubility in perchloric acid, Kannagi et al considered that core proteins of cancer associated mucin-type glycoproteins are highly heterogeneous and can be classified into several characteristic molecular species. In the present study we have evaluated the pattern of antigen expression in serum samples from patients with lung adenocarcinoma and compared it with those from patients with IPF by Western blotting analysis in order to establish a specific test to differentiate lung adenocarcinoma from IPF.
Western blotting analysis

Electrophoresis and immunostaining procedures were performed as reported previously.\(^{20,22}\) The serum samples from each patient were electrophoresed in a 6% linear gradient SDS polyacrylamide gel and the glycoproteins were transferred to a nitrocellulose filter. The filter was blocked with a 3% BSA solution and incubated with FH-6. The filter was washed extensively with PBS containing 0.05% Tween-20 and exposed to radiography using ECL (Amersham Life Science, Buckinghamshire, UK). Western blotting was repeated at least three times.

RESULTS

The study population consisted of 23 patients with lung adenocarcinoma and non-malignant lung diseases whose serum levels of sialyl Lewis X-i antigen were >50 U/ml. Malignancy was ruled out clinically in all six patients with IPF, the two patients with diffuse panbronchiolitis, and the one patient with bronchiectasis. Of the nine patients with non-malignant lung diseases, five died of respiratory failure and four are still alive after a 3 year follow-up period to December 2000.

Table 1 shows the age, sex, smoking status (expressed as the Brinkman index\(^{20}\)), and serum level of sialyl Lewis X-i antigen of each patient.

Protein profiles on Coomassie blue staining showed similarities in serum samples from patients with lung adenocarcinoma and those with non-malignant lung disease. In both lung adenocarcinoma and non-malignant lung disease the antigen carries glycoproteins in broad bands with a polyanalytical pattern which is usually observed in Western blotting analysis of glycoproteins.\(^{20–22}\)

Figures 1 and 2 show the results of Western blotting. In each group of patients with the same diagnosis the sialyl Lewis X-i antigen on Western blotting was different from the pattern essentially the same, although it was not as clear as in these two patients. Only one of the 14 patients with lung adenocarcinoma had two bands at <97.4 kD (no 4 in fig 1).

In six patients with IPF the overall pattern of sialyl Lewis X-i antigen on Western blotting was different from the pattern essentially the same, although it was not as clear as in these two patients. Only one of the 14 patients with lung adenocarcinoma had two bands at <97.4 kD (no 4 in fig 1).

In six patients with IPF the overall pattern of sialyl Lewis X-i antigen on Western blotting was different from the pattern essentially the same, although it was not as clear as in these two patients. Only one of the 14 patients with lung adenocarcinoma had two bands at <97.4 kD (no 4 in fig 1).
Serum sialyl Lewis X-i antigen

Figure 2. Western blotting of serum samples of patients 11–23. Antigens were separated by SDS-PAGE on 6% polyacrylamide and electrophoretically transferred to nitrocellulose membranes. Details of electrophoretic and immunostaining procedures with FH-6 antibody are described in the text. Patient numbers are the same as in table 1. IPF=idiopathic pulmonary fibrosis.

19, and 20; figs 1 and 2), while in one patient (no 21 in fig 2) with serum antigen levels of 66.4 U/ml no band was seen at this molecular level. The pattern of antigen expression with two clear bands at <97.4 kD and the absence of bands at 120 or 130 kD was diagnostic for IPF. The sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio in 20 patients with lung adenocarcinoma and IPF were 92.9%, 83.3%, 5.57, and 0.09, respectively.

In two patients with diffuse panbronchiolitis (nos 18 and 23, fig 2) the pattern was similar to that observed in patients with IPF with two clear bands at <97.4 kD and faint bands at 120 or 130 kD. However, in one patient with bronchiectasis (no 22, fig 2) the pattern of expression was similar to that found in patients with lung adenocarcinoma. The Brinkman indices in each group of patients were variable and were not associated with any particular pattern of sialyl Lewis X-i antigen.

**DISCUSSION**

Sialyl Lewis X-i antigen has been used as a tool for the clinical assessment of lung cancers, especially lung adenocarcinoma. However, the carbohydrate antigens including sialyl Lewis X-i antigen are also increased in some patients with non-malignant lung diseases such as IPF without coexistent malignancy.20–22 There is as yet no test to make a specific diagnosis in patients with raised levels of the antigen. When increased serum levels of the antigen are found in patients with IPF without a suspicious mass on the chest CT scan, further invasive and costly tests are often considered to rule out adenocarcinoma originating from other organs. If the core proteins of the antigen in patients with lung adenocarcinoma are not the same as those in patients with IPF, it is expected that the pattern of expression would differ on Western blotting analysis. In order to establish the specific test for a differential diagnosis we evaluated the pattern of expression of the antigen in serum samples of lung adenocarcinoma and compared it with that of IPF by Western blotting analysis.

Western blotting analysis for carbohydrate antigens sometimes reveals several separate bands or diffuse smear-like bands.23–26 The variations in molecular size are now thought to be due to length polymorphism of the gene encoding for apo mucin.27 Mucins are glycoproteins of high molecular weight which contain a large amount of carbohydrate. O-linked to protein through serine and threonine. Mucins exhibit abnormal carbohydrate epitopes or expose a large part of their protein core, resulting in the appearance of different peptide epitopes.28 In this study we showed clear heterogeneity by Western blotting, both in the size and the pattern of expression of the bands, between lung adenocarcinoma and IPF. Our observation may be explained by the presence of different circulating core proteins in the serum of patients with cancer and IPF, and we speculate that these various glycosylated mucins originate from either cancer cells or non-malignant cells. Thirteen of 14 serum samples from patients with lung adenocarcinoma had a band at 120 or 130 kD, and five of the six patients with IPF had molecular weight bands at <97.4 kD. Two patients with diffuse panbronchiolitis had a similar pattern to that observed in patients with IPF. The patterns observed in these two diseases were apparently different from those of lung adenocarcinoma. Higher molecular weight bands (at 120 or 130 kD) may be related to malignancy and smaller molecular weight bands (<97.4 kD) seem to be associated with non-malignant disease. The pattern of sialyl Lewis X-i antigen in one patient with bronchiectasis was similar to that observed in lung adenocarcinoma. Since the serum level of sialyl Lewis X-i antigen rarely exceeds 50 U/ml in patients with bronchiectasis, we were unable to enroll more than one patient into this study so the statistical power is very low. Studies on larger populations are required to elucidate further the biochemical difference or similarity in the core proteins observed between non-malignant lung diseases and adenocarcinoma, although this study may form the basis. Other tests such as gel filtration chromatography might be more sensitive for detecting the antigen.

Our results suggest that Western blotting of sialyl Lewis X-i antigen is of diagnostic value because of its high sensitivity and specificity and its clinical usefulness in differentiating lung adenocarcinoma from other non-malignant diseases such as IPF or diffuse panbronchiolitis.

**REFERENCES**

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