The Utility and Validation of Intraepithelial Lymphocyte Count in Duodenal Biopsies in A Tertiary Care Centre in South India

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ABSTRACT

Background: Intraepithelial lymphocytes (IELs) are seen in between the epithelial cells in small and large intestine with the functions of immune surveillance and activation. Increased IELs can be the sole histological finding in latent celiac disease (CD).

Aims: To study the utility and clinical relevance of IELs in diagnosing non-neoplastic lesions of duodenum and to determine a cut off for IEL to differentiate CD from other conditions.

Materials & Methods: This was a prospective descriptive study. Duodenal biopsies from 101 patients with symptoms of malabsorption were studied. Informed written consent was taken. Clinical details were collected. Histomorphological parameters were studied on hematoxylin and eosin stained sections. Intraepithelial lymphocyte counts were done on CD3, CD4 and CD8 IHC stained sections. Statistical analysis was done using IBM-SPSS software version 21. P value <0.05 was considered statistically significant. The threshold score of IELs with maximum sensitivity and specificity was validated using the Receiver operator characteristic curve to distinguish CD from non-celiac disease conditions.

Results: We studied 101 duodenal biopsies. Our spectrum included 16 patients of CD (15.8%), 15 of autoimmune duodenitis (14%), 13 of nutritional deficiency associated duodenitis (12.8%), 5 of infectious duodenitis (5%) and 41 patients of non-specific duodenitis (40.6%). The threshold levels were 5/20 villous tip IELs, 24 IELs/100 enterocytes on H&E and >31 IELs by CD3 IHC staining.

Conclusion: Our study proposes IEL counts of >31/100 enterocytes in CD3 IHC staining to be significant in South Indian population to differentiate CD from other conditions.

Keywords: Intraepithelial Lymphocytes, Duodenum, Celiac Disease, Immunohistochemistry.

Introduction

Intraepithelial lymphocytes (IELs) are seen in between the epithelial cells in small and large intestine with the functions of immune surveillance and activation. Majority of them are T-cell type and express predominantly surface alpha/beta T cell receptors. About 5% of the normal IELs express surface gamma/delta T-cell receptors which become the predominant population in celiac disease (CD). Increased IELs can be the sole histological finding in latent CD.[1]

The assessment of IEL counts have evolved since 1970s and the normal range for IEL count has been revised recently and it can be better assessed by immunohistochemistry with CD3 antibody. Presently, the normal IEL count in the proximal small intestine, especially in the duodenum is upto 25 IEL per 100 ECs.[2] Borderline intraepithelial lymphocytosis is considered when IEL count is between 26 to 29 on CD3 and definite intraepithelial lymphocytosis when it is ≥ 30 CD3 positive IELs/100 ECs.[3,4]

Apart from celiac disease and tropical sprue, increased IELs in small bowel mucosa are seen associated with a variety of conditions like autoimmune disorders, tropical sprue, food protein intolerance, Helicobacter pylori-associated gastritis, peptic duodenitis, parasitic and viral infections.[5 ]

We intended to study the utility and clinical relevance of intraepithelial lymphocytes in diagnosis of various non-neoplastic lesions of duodenum on endoscopic biopsies. And also aimed at determining if a cut off for IEL count can be determined to differentiate CD from other conditions.

Materials & Methods

It is a descriptive study, conducted from May 2012 to June 2014 and 101 patients who presented with symptoms of malabsorption and evaluated with endoscopic duodenal biopsies were included in the study. The study was approved by the institutional review board and informed written consent was taken from the patients. Histopathological examination was carried out after standard processing & staining procedures. Of the 101 cases, immunohistochemistry with CD 3 antibody was performed for 72 cases. CD4 and CD8 immunostaining
was also done to study the ratio of CD4 and CD8 in various conditions.

Histomorphological parameters studied included villous architecture, crypt architecture, intraepithelial lymphocyte (IEL) count per 100 enterocytes (average of 300 enterocytes), IEL count using CD3, villous tip IEL count per 20 enterocytes were counted, inflammatory cells in lamina propria: type of cells - lymphocytes, neutrophils, eosinophils, epithelioid cells and its severity was graded as mild, moderate and severe. Modified Marsh Oberhuber classification was used to classify celiac disease.[6] Interpretation of IEL count and villous tip IEL count was done according to Datta Gupta et al. [7] Statistical analysis was done using IBM-SPSS software version 21. All statistical tests were carried out at 5% level of significance and P value <0.05 was considered statistically significant. An appropriate cut off for IEL counts in H & E stained sections and on CD3 sections and villous tip IEL counts for celiac disease and non-celiac disease conditions was deduced using Receiver Operator Characteristic (ROC) curve in our study.

Results
We studied 101 duodenal biopsies during a 2 year study period. The various categories of patients included 16 cases (15.8%) of celiac disease, 15 cases (14.9%) of duodenitis associated with autoimmune diseases, 13 cases (12.8%) of nutritional deficiency associated duodenitis, five cases (5%) of infectious duodenitis, 41 cases (40.6%) of non-nutritional deficiency associated duodenitis, five cases (4.9%) of autoimmune diseases, 13 cases (12.8%) of celiac disease, 15 cases (14.9%) of duodenitis associated with autoimmune diseases. The sensitivity of 83.3% was seen from a cut of 24 IELs/100 enterocytes, the specificity was 80%, which was similar to the already established cut off. Though the sensitivity of 81.2% was seen from a range of 22.5 to 24 IELs per 100 enterocytes but maximum specificity was seen at 24 IELs per 100 enterocytes for our study population. Area under the curve was 0.865 which was significant.

IEL counts on H & E stained sections: At a threshold of 24 IELs/100 enterocytes, the sensitivity was 81.2% and specificity 80%, which was similar to the already established cut off. Though the sensitivity of 81.2% was seen from a range of 22.5 to 24 IELs per 100 enterocytes but maximum specificity was seen at 24 IELs per 100 enterocytes for our study population. Area under the curve was 0.865 which was significant.

IEL counts on CD3 IHC stained sections: Maximum sensitivity and specificity was seen at a cut off of 31 IELs/100 enterocytes with sensitivity of 83.3 % and specificity of 79.8% in distinction of CD from other diseases. The sensitivity of 83.3% was seen from a cut of 25.5% IELs/100 enterocytes, but the specificity was very low starting from 62.1%. The area under the curve was 0.872 which was statistically significant. When we applied the cut off of 31 IELs per 100 enterocytes in our cases, only 3 cases of non specific duodenitis had increased IEL counts compared to 10 cases when using the earlier cut off.

Villous tip IEL counts: Maximum sensitivity of 87.5% and maximum specificity of 71.8% was found at a cut off of 5 IELs per 20 enterocytes and maintained till 5.5 IELs per 20 enterocytes. The area under the curve was 0.837 which was statistically significant.
Table 1 shows the sensitivity and specificity at various cut off of IELs on H & E, CD 3 stained sections and villous tip IELs.

Table 1: Sensitivity and specificity at various cut off of IELs on H & E, CD 3 stained sections and villous tip IELs.

| Cut off of IELs | H & E stained sections. | CD 3 stained sections. | Villous tip IELs |
|----------------|-------------------------|------------------------|-----------------|
|                | Sensitivity  | Specificity | Sensitivity  | Specificity | Sensitivity  | Specificity |
| 19.5           | 87.5        | 72.9        | 25.50       | 83.3        | 62.1        | 93.8        | 52.9        |
| 21.00          | 81.2        | 75.3        | 26.50       | 83.3        | 68.2        | 87.5        | 64.7        |
| 22.50          | 81.2        | 78.8        | 27.50       | 83.3        | 69.7        | 5           | 87.5        | 71.8        |
| 24.00          | 81.2        | 80          | 29.00       | 83.3        | 72.7        | 5.50        | 87.5        | 71.8        |
| 25.50          | 68.8        | 83.5        | 31.00       | 83.3        | 78.8        | 6.50        | 75.0        | 74.1        |
| 26.50          | 68.8        | 84.7        | 32.50       | 66.7        | 81.8        | 7.50        | 62.5        | 82.4        |

IELs- Intraepithelial lymphocytes H& E- haemotoxylin and eosin

Table 2 shows the representation of IELs by CD3 in various groups after validation by ROC curve.

Table 2: Representation of IELs by CD3 in various groups after validation by receiver operator characteristic curve.

| Disease conditions | Before & after validation IEL counts by H&E | After validation IEL counts by CD3 | Before validation IEL counts by CD3 |
|--------------------|-------------------------------------------|-----------------------------------|-----------------------------------|
|                    | Normal (≤24) (n,%) | Increased (>24) (n,%) | Normal (≤31) (n,%) | Increased (>31) (n,%) | Normal (≤24) (n,%) | Increased (>25) (n,%) |
| Autoimmune duodenitis (14) | 12(85.7) | 2 (14.3) | 9 (64.3) | 5 (35.7) | 8(57.1) | 6(42.8) |
| Celiac disease (6) | 2 (33.3) | 4 (66.7) | 1 (16.7) | 5 (83.3) | 0 | 0 |
| Nutritional deficiency associated duodenitis (11) | 10 (90.9) | 1 (9.1) | 9 (81.8) | 2 (18.2) | 6(54.5) | 5(45.4) |
| Non specific duodenitis (31) | 31 (100) | 0 | 28 (90.3) | 3 (9.7) | 21(67.7) | 10(32.2) |
| Infectious duodenitis (3) | 2 (66.7) | 1 (33.3) | 2 (66.7) | 1 (33.3) | 2(66.7) | 1(33.3) |

*n – number of cases

Fig. 1 (a): Well oriented villi with villous crypt ratio of 3-5:1(H&E,40 X).Fig 1 (b): Villi showing increased IELs (H&E, 400 X).Fig 1 (c): Villous tip showing increased IELS (H&E, 400 X).Fig 1 (d): Villi showing increased IELs (CD 3,DAKO, 400 X).
**Discussion**

This study was undertaken to know the spectrum of malabsorptive disorders of small intestine in South Indian population and to study the significance of IEL and validate the IEL count with maximum sensitivity and specificity in to distinguish of CD from non-celiac disease conditions.

Celiac disease is one of the common causes of malabsorption in various wheat consuming parts of the world including North India. Very few studies especially case reports and case series are available from South India on CD. All the studies done across different parts of the world reported the prevalence of CD ranging from 0.14 to 1.17%. [8-21] In our study, CD constituted 15.8% of patients with malabsorption who underwent small intestinal biopsies.

The other cases reported in our study were 15 patients (14%) with autoimmune duodenitis. nutritional deficiency associated duodenitis was seen in 13 patients (12.8%), infectious duodenitis was seen in 5 patients (5%) while non specific duodenitis where no etiological agent was found with clinicopathologic correlation was seen in 41 patients, constituting 40.6% of patients. [22]

Histological parameters of villous blunting, atrophy, crypt hyperplasia, increased IEL counts are characteristic in CD but not specific. In our study, villous crypt hyperplasia, villous blunting, villous atrophy, villous tip IEL (>5/20 enterocytes) and increased IELs (> 25/100 enterocytes) were statistically significant in distinction of CD from non-celiac disease conditions by univariate analysis. However, we could not evaluate these parameters for statistical significance by multivariate analysis in view of the smaller numbers in each group.

Increased IEL counts is one of the important histological feature seen in CD along with villous atrophy. But increased IEL counts in architecturally normal duodenal biopsies ranged from 9% to 40% in various studies. [1,25,26] It is important to report it as these patients may be in latent phase of CD and are likely to develop CD in future necessitating close monitoring.

In our study, we had 37 patients (36.6%) of non-celiac disease with increased IELs. Other causes of increased IEL counts in our study were 6 patients (46.7%) of autoimmune duodenitis, 6 patients (46.2%) of nutritional deficiency associated duodenitis, 60% of infectious duodenitis and 39% of non-specific duodenitis. The distribution in our study was comparable with the other studies.[1,27]

Biagi et al counted IEL in villous tips and mentioned in their study that villous tip IEL is sufficient for diagnosing CD. [28] In this study, the mean villous tip IEL scores were 4.6 with range of 1.4–7.8 in non-celiac diseases compared to 9.2 with range of 5.8–21.8 in patients with CD. They concluded that counting villous tip IELs is very simple and quite reliable method. Jarvinen TT et al in their study mentioned that the villous tip IEL counts was significantly higher in early celiacs.[29] Further in their study, the sensitivity of villous tip IELs was 0.84 and the specificity was 0.88 in detecting untreated celiacs especially with no villous abnormalities. Also, they reported villous tip IELs to be superior to CD3+ IEL counts. Also they mentioned that villous tip IELs seems to be similar to gamma/delta+ cells which can be done only on frozen sections.

In our study, the range of villous tip IELs was from 3 to 14 per 20 enterocytes with mean count of 9.2 IELs per 20 enterocytes in celiac patients compared to non celiac disease conditions where it ranges from 0 to 12 with mean count of 4.2 IELs per 20 enterocytes and this was statistically significant. Our findings were similar to the study done by Biagi et al. [28] We can conclude that increased villous tip IELs can help to distinguish CD from other close mimics, thus provides a valuable tool in routine practice.

A cut off threshold of 5 per 20 enterocytes is suggested in the published literature to identify CD. In view of the low prevalence in our study population, we studied the strength of threshold levels of villous tip IELs in distinguishing CD from non-celiac disease conditions, based on Receiver Operating Characteristic (ROC) curve. We found that a threshold of 5/20 villous tip IELs had a sensitivity of 87.5 with specificity of 71.76 and this level was maintained up to 5.5/20 villous tip IELs. Beyond this threshold, the sensitivity for diagnosing CD decreases while the specificity increases. Thus, the threshold of 5 villous tip IEL/20 enterocytes holds good for low prevalence setting of CD in South India.

CD3 immunohistochemistry aids the detection of IELs much easier as some IELs have irregular nuclear outline, and some may resemble epithelial cells. In the study done by S.Nasser-Moghaddam et al, the IEL count was slightly higher in IHC than H&E (21 vs 19) and the two methods showed excellent agreement statistically.[30] In the study done by Pellegrino et al, there was high correlation of IEL counts between H&E and CD3 staining which was statistically significant. [23] In our study, there was no correlation with H&E and CD3 staining for IEL counts and it was statistically significant. Sixteen patients with normal IEL on H & E staining had increased counts when CD3 immunostaining was applied. This study further highlights the importance of CD 3 staining which can pick up near normal patients.

In our study, we validated the threshold of IELs in
distinguishing CD from non-celiac disease conditions by charting the values in ROC curve. We found that at a threshold of 24 IELs/100 enterocytes, the sensitivity is 81.2% and specificity of 80% were at their peak thus confirming to the existing literature. Though the sensitivity of 81.2% was seen from 22.5 to 24/100 enterocytes, but maximum specificity was seen at cut of 24 per 100 enterocytes. However, for CD3 immunohistochemistry the threshold was higher at 31 IELs/100 enterocytes with sensitivity of 83.3% and specificity of 79.8% in the distinction of CD from other diseases. For CD3, the sensitivity of 83.3% was seen from a cut of 25.5% IELs/100 enterocytes but the specificity was very low starting from 62.1%.

Thus in our study, we recommend CD3 immunostaining, as it is statistically significant in comparison with H&E staining with a kappa score of 0.207 in identifying IELs. Hence by using a higher threshold of IELs by CD3 immunostaining, sensitivity increased.

In our series we studied expression of CD4 and CD8 in intraepithelial lymphocytes in 73 patients. The average CD8:CD4 ratio was 6.64 ranging from 6.4 to 6.7. In all the conditions, predominant cell population in the intraepithelial lymphocytes were T suppressor group and there was no difference in CD8:CD4 ratio in CD and non-celiac disease group.

**Conclusion**
We have validated the increase in IEL count using H&E staining and CD3 immunostaining. Our findings strengthen the cut off threshold of > 25/100 enterocytes for increased IEL and > 5/20 enterocytes in villous tip IEL using H&E staining. With CD3 immunostaining, the threshold shift of 31/100 enterocytes as increased IELs was found to increase the specificity in diagnosing CD.

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