Table 3 Immunohistochemical studies in patients with histologically node-negative gastric cancer diagnosed by hematoxylin–eosin staining

Years	Study	No. of patients	Average no. of LNs	Depth of invasion	Method	Antibody	No. of sections for IHC	Definition of micrometastasis	No. of patients with micrometastases (%)	5-year survival (positive vs. negative)	*P*	Prognostic significance
1996	Maehara et al. [20]	34	12.4	Tl	IHC	CK (CAM5.2)	–	pN0 by HE staining	8 (23.5)	–	<0.05	Yes
2000	Cai et al. [21]	69	25.0	T1b	IHC	CK (CAM5.2)	Single	pN0 by HE staining	17 (24.6)	82.0 vs. 100.0 %	<0.01	Yes
2000	Harrison et al. [22]	25	9.0	T1–T4	IHC	CK (CAM5.2)	–	pN0 by HE staining	9 (36.0)	35.0 vs. 66.0 %	0.048	Yes
2001	Nakajo et al. [23]	67	26.3	T1–T3	IHC	CK (AE1/AE3)	Single	pN0 by HE staining	10 (14.9)	–	<0.05	Yes
2001	Fukagawa et al. [24]	107	41.9	T2–T3	IHC	CK (AE1/AE3)	Multiple	pN0 by HE staining	38 (35.5)	94.0 vs. 89.0 %	0.86	No
2001	Morgagni et al. [25]	139	10.7	Tl	IHC	CK (MNF 116)	Multiple	pN0 by HE staining	24 (17.3)	87.0 vs. 88.0 %	0.6564	No
2002	Choi et al. [26]	88	25.8	T1b	IHC	CK (35βH11)	Single	pN0 by HE staining	28 (31.8)	92.9 vs. 95.0 %	0.6836	No
2002	Yasuda et al. [27]	64	31.9	T2–T4a	IHC	CK (CAM5.2)	Multiple	pN0 by HE staining	20 (31.3)	66.0 vs. 95.0 %	<0.01	Yes
2003	Morgagni et al. [28]	300	18.0	Tl	IHC	CK (MNF 116)	Multiple	pN0 by HE staining	30 (10.0)	94.0 vs. 89.0 %	0.7797	No
2006	Miyake et al. [29]	120	29.1	Tl	IHC	CK (AE1/AE3)	Multiple	≤0.2 mm	27 (22.5)	–	–	–
2007	Yonemura et al. [30]	308	39.0	T1–T4	IHC	CK (AE1/AE3)	–	≤0.2 mm	37 (12.0)	–	0.014	Yes
2008	Kim et al. [31]	184	27.1	Tl–T4a	IHC	CK (AE1/AE3)	–	pN0 by HE staining	31 (16.8)	58.5 vs. 91.8 %	<0.001	Yes
2008	Ishii et al. [32]	35	29.4	Tlb–T2	IHC	CK (O.N.352)	Multiple	pN0 by HE staining	4 (11.0)	–	–	–
2009	Kim et al. [33]	90	39.2	Tl	IHC	CK (AE1/AE3)	–	≤2 mm	9 (10.0)	100 vs. 100 % (DSS)	–	No
2011	Cao et al. [34]	160	10.4	Tl	IHC	CK (AE1/AE3)	–	pN0 by HE staining	34 (21.3)	55.9 vs. 92.9 %	<0.001	Yes
2011	Wang et al. [35]	191	22.0	T1–T3	IHC	CK (AE1/AE3)	Multiple	>0.2 and ≤2 mm	54 (28.3)	27.8 vs. 87.1 %	<0.001	Yes

Table 4 RT-PCR studies in patients with histologically node-negative gastric cancer diagnosed by hematoxylin–eosin staining

Years	Study	No. of patients	No. of total LNs	Depth of invasion	Method	Markers	No. of patients with micrometastases (%)
2001	Okada et al. [37]	24	335	Tl–T4a	RT-PCR	CEA, CK20, MAGE3	10 (41.7)
2002	Matsumoto et al. [38]	50	312	T1–T4	RT-PCR	CEA	14 (28.0)
2005	Arigami et al. [39]	80	1,862	T1–T3	RT-PCR	CEA	25 (31.3)
2006	Sonoda et al. [40]	33	310	Tl	RT-PCR	MUC2, TFF1	11 (33.3)
2007	Wu et al. [41]	10	–	–	RT-PCR	CK20	2 (20.0)

with pN0 gastric cancer [39]. LNM was identified in 9 of 80 patients (11.3 %) and in 34 of 1,862 nodes (1.8 %) by IHC, whereas RT-PCR assay demonstrated LNM in 25 patients (31.3 %) and 66 nodes (3.5 %). Of those 66 nodes, 33 were detected only by RT-PCR. The detection rate of LNM was generally higher by RT-PCR than by IHC due to the high sensitivity of RT-PCR. These reports did not examine the relationship between LNM and prognosis, so further investigation will be necessary in the future.

Lymph node micrometastasis in colorectal cancer

Table 5 summarizes findings for LNM determined by RT-PCR in patients with colorectal cancer [42–55]. According to 14 reports, the number of patients and average number of lymph nodes ranged from 30 to 395 and from 5.3 to 21.3, respectively. Almost all reports dealt with relatively early-stage cancer, such as stage II or Dukes A–B. CK antibody was commonly used for detection of LNM, as for esophageal and gastric cancer. LNM was examined using multiple sections in many reports. LNM was defined as newly found metastasis in patients showing pN0 status on routine HE staining in 9 of 16 reports. In the others, LNM was defined according to the size of metastasis. The incidence of LNM ranged from 5.1 to 70.9 % and the detection rate was >30 % in half of the reports (7/14). Detection rates were >30 % for 33.3 % (4/12) of reports on esophageal cancer and 25.0 % (4/16) of reports on gastric cancer. The incidence of LNM was thus higher in colorectal cancer than in esophageal and gastric cancer. In terms of prognostic impact, a significant correlation was found in only 3 of 13 reports (23.1 %). Positive rates for a prognostic impact of LNM were high in both esophageal and gastric cancer, at 58.3 % (7/12) and 64.3 % (9/14), respectively, compared with colorectal cancer. Rahbari et al. [56] conducted a systematic review with meta-analyses of studies that evaluated the prognostic significance of molecular tumor-cell detection in regional lymph nodes. Meta-analysis revealed that molecular tumor-cell detection in regional lymph nodes was associated with poor overall survival, disease-specific survival, and disease-free survival. Subgroup analyses showed the prognostic significance of molecular tumor-cell detection independent of the applied detection method, molecular target, or number of retrieved lymph nodes. They concluded that molecular detection of occult disease in regional lymph nodes is associated with an increased risk of disease recurrence and poor survival in patients with node-negative colorectal cancer. In node-negative patients, LNM is thought to represent a crucial prognostic factor, since it indicates metastatic potential.

Four studies have examined LNM detected by RT-PCR in colorectal cancer (Table 6) [44, 57–59]. The numbers of patients and numbers of examined nodes were relatively small. Like esophageal and gastric cancer, CEA and/or CK were used as markers. The detection rate of LNM was high, at >50 % in three of the four reports. In esophageal and gastric cancer, no reports showed detection rates over 50 %. As with IHC, a high positive rate of LNM with RT-PCR was seen for colorectal cancer. The difference may be due to organ specificity. Interestingly, all authors found a significant correlation between LNM and prognosis. In comparison, a significant association was found in only 23 % of studies using IHC, differing markedly from the RT-PCR method. As the meta-analysis by Rahbari et al. [56] included results from both IHC and RT-PCR, LNM might be a prognostic factor in colorectal cancer. Comparing prognostic significance of LNM between IHC and RT-PCR in the same cases thus seems warranted.

Clinical utility and future perspectives for lymph node micrometastasis

The presence of LNM means that the process of metastasis from the primary tumor has already started. According to the results of this review, a high incidence of LNM ≥10 % is present in patients with pN0 GI cancer. Whether all tiny tumor cells implant and grow in lymph nodes remains unclear, but the potential presence of LNM should be kept in mind. In our study, LNM already showed proliferative activity even in ITC [36]. If LNM is present in patients diagnosed as pN0, we think that such patients should be

Table 5 Immunohistochemical studies in patients with histologically node-negative colorectal cancer diagnosed by hematoxylin–eosin staining

Year	Study	No. of patients	Average no. of LNs	Tumor stage	Method	Antibody	No. of sections for IHC	Definition of micrometastasis	No. of patients with micrometastases (%)	5-year survival (positive vs. negative)	*P*	Prognostic significance
2001	Yasuda et al. [42]	30	21.3	Dukes B	IHC	CK (CAM5.2)	Multiple	pN0 by HE staining	21 (70.0)	–	–	–
2002	Noura et al. [43]	55	12.0	T1–T3	IHC	CK (AE1/AE3)	Multiple	pN0 by HE staining	27 (49.1)	–	0.817	No
2002	Noura et al. [44]	64	5.5	Stage II	IHC	CK (AE1/AE3)	Multiple	pN0 by HE staining	35 (54.7)	90.8 vs. 85.1 %	n.s.	No
2003	Palma et al. [45]	38	10.3	Dukes B	IHC	CK (AE1/AE3)	Multiple	pN0 by HE staining	6 (15.8)	–	0.804	No
2003	Bukholm et al. [46]	156	5.5	Stage II	IHC	CK (CAM5.2)	Multiple	≤0.2 mm	59 (37.8)	–	0.029	Yes
2005	Perez et al. [47]	56	9.6	Stage II (post-CRT)	IHC	CK (AE1/AE3)	Multiple	pN0 by HE staining	4 (7.1)	–	n.s.	No
2006	García-Sáenz et al. [48]	105	6.3	Stage II	IHC	CK (AE1/AE3)	Multiple	pN0 by HE staining	26 (24.8)	–	0.759	No
2006	Messerini et al. [49]	395	20.9	Stage IIA	IHC	CK (CK20; clone K 20.8)	Multiple	>0.2 mm and < 2 mm	39 (9.9)	64.1 vs. 78.1 %	0.046	No
2008	Davies et al. [50]	105	5.3	Dukes A–B	IHC	CK (AE1/AE3, MNF 116)	–	pN0 by HE staining	49 (46.7)	–	0.54	No
2008	Bosch Roig et al. [51]	39	9.8	Stage II	IHC	CK (AE1/AE3)	Multiple	>0.2 and <2 mm	2 (5.1)	–	<0.0001	Yes
2008	Park et al. [52]	160	17.8	Stage I–II	IHC	CK (CK20; clone K 20.8)	Multiple	pN0 by HE staining	8 (5.0)	91.7 vs. 93.1 %	0.59	No
2010	Uribarrena-Amezaga et al. [53]	85	10.8	Dukes A-B	IHC	CK (AE1/AE3)	–	pN0 by HE staining	31 (36.5)	–	0.2916	No
2011	Oh et al. [54]	124	19.2	Stage II	IHC	CK (AE1/AE3)	Single	<2 mm	33 (26.6)	96.3 vs. 97.6 %	0.75	No
2011	Faerden et al. [55]	126	–	Stage I–II	IHC	CK (CAM5.2)	Multiple	≤2 mm	39 (31.0)	75.0 vs. 93.0 %	0.012	Yes

Table 6 RT-PCR studies in patients with histologically node-negative colorectal cancer diagnosed by hematoxylin–eosin staining

Years	Study	No. of patients	No. of total LNs	Tumor stage	Method	Markers	No. of patients with micrometastases (%)	5-year survival (positive vs. negative)	*P*	Prognostic significance
1998	Futamura et al. [57]	13	202	Stage I-III	RT-PCR	CEA, CK20	13 (100)	–	–	–
1998	Liefers et al. [58]	26	192	Stage II	RT-PCR	CEA	14 (53.8)	50.0 vs. 91.0 %	0.02	Yes
2002	Noura et al. [44]	64	350	Stage II	RT-PCR	CEA	19 (29.7)	78.2 vs. 95.3 %	0.015	Yes
2002	Rosenberg et al. [59]	85	25 (median)	Stage I–II	RT-PCR	CK20	44 (51.8)	70.6 vs. 95.9 %	0.001	Yes

categorized as pN1. Examination of LNM is thus useful for accurate staging, particularly in pN0 patients. Since prognosis differs significantly between patients with and without LNM according to several reports, adjuvant therapy seems to be necessary for patients with LNM. Prospective randomized controlled studies should be conducted to examine the effectiveness of adjuvant therapies in patients with LNM.

Recently, rapid examination using IHC and RT-PCR has been developed to detect LNM even during surgery. Particularly when performing less-invasive surgeries, intraoperative diagnosis of lymph node metastasis, including LNM, is essential. For example, we applied intraoperative diagnosis of LNM to esophageal cancer surgery in which supraclavicular lymphadenectomy was omitted if negative results were obtained for LNM at the recurrent nerve and cervical paraesophageal nodes [60]. In recent years, sentinel node navigation surgery (SNNS) has been clinically introduced for breast cancer and malignant melanoma [61, 62]. SNNS has also been trialed for GI cancer. We investigated LNM in all dissected lymph nodes, including the sentinel node (SN), as SN mapping using IHC and RT-PCR, yielding good results in patients with esophageal and gastric cancer classified as clinical T1 and N0 [63, 64]. We thus think that SNNS is applicable to clinical T1 and N0 patients based on intraoperative identification of LNM. In fact, if intraoperative histological and molecular examinations demonstrate no metastasis in any SNs identified from cT1 and cN0 patients, treatment using thoracoscopic and laparoscopic approaches with SN dissection may be feasible. On the other hand, standard surgery with standard lymph node dissection is currently necessary in patients with SN metastasis verified by intraoperative diagnostic tools. Furthermore, in the future, endoscopic submucosal dissection (ESD) with thoracoscopic and laparoscopic SN dissection might serve as an ultimate organ-preserving surgery to avoid lymph node recurrence in selected patients with extended indications for ESD. SNNS will add to the development of minimally invasive surgeries with individualized lymphadenectomy and good postoperative quality of life.

In conclusion, LNM needs to be recognized as the first step on the path to lymphatic metastasis. Minimally invasive surgery can be safely performed in clinical situations with accurate diagnosis of LNM. New treatment strategies applying the diagnosis of LNM are to be expected for each type of cancer.

Acknowledgments This work was supported in part by grants-in-aid for scientific research from the Ministry of Education, Science, Sports, and Culture, Japan.

Conflict of interest The authors declare that they have no conflict of interest.

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Original Article

Clinical Significance of Circulating Tumor Cells in Peripheral Blood From Patients With Gastric Cancer

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BACKGROUND: The authors hypothesized that circulating tumor cells (CTCs) in patients with gastric cancer are associated with prognosis and disease recurrence. In this study, they evaluated CTCs in gastric cancer and clarified the clinical impact of CTCs. **METHODS:** In total, 265 consecutive patients with gastric cancer were enrolled. Fourteen patients were excluded from the analysis, including 12 patients who another cancer and 2 patients who refused the treatment. The remaining 251 patients were divided into 2 groups: 148 patients who underwent gastrectomy (the resection group) and 103 patients who did not undergo gastrectomy (the nonresectable group). Peripheral blood samples were collected before gastrectomy or chemotherapy. A proprietary test for capturing, identifying, and counting CTCs in blood was used for the isolation and enumeration of CTCs. **RESULTS:** CTCs were detected in 16 patients (10.8%) from the resection group and in 62 patients (60.2%) from the nonresectable group. The overall survival rate for the entire cohort was significantly lower in patients with CTCs than in those without CTCs ($P<.0001$). In the resection group, relapse-free and overall survival in patients with CTCs was significantly lower than in patients without CTCs ($P<.0001$). It was noteworthy that the expression of CTCs was an independent factor for determining the overall survival of patients with gastric cancer in multivariate analysis ($P=.024$). In the nonresectable group, the overall survival rate was significantly lower in patients with CTCs than in those without CTCs ($P=.0044$). **CONCLUSIONS:** The evaluation of CTCs in peripheral blood may be a useful tool for predicting tumor progression, prognosis, and the effect of chemotherapy in patients with gastric cancer. ***Cancer* 2013;119:3984-91**. *© 2013 American Cancer Society.*

KEYWORDS: circulating tumor cells, gastric cancer, prognosis, peritoneal dissemination, hematogenous recurrence.

INTRODUCTION

The presence of circulating tumor cells (CTCs) has been evaluated in blood from patients with gastrointestinal cancers.[1-4] The early detection of CTCs has the possibility of providing useful information before the start of treatment, including surgery and/or systemic chemotherapy. Some patients develop recurrent disease after surgery, even after undergoing complete resection of their primary tumor. Currently, the prognosis for patients with gastric cancer has been improved by the development of new anticancer drugs However, if the presence of CTCs is confirmed before surgery, then the use of neoadjuvant chemotherapy may be indicated, and this may have an impact on the timing of surgical intervention. Furthermore, the presence of CTCs in patients with distant metastasis would be a useful parameter for evaluating the effect of chemotherapy. Various methods for detecting rare CTCs have been attempted using a molecular biologic approach, such as reverse transcriptase-polymerase chain reaction (RT-PCR) analysis and flow cytometry in gastric cancer.[4-7] Although CTCs have been evaluated in blood from patients with gastric cancer, the clinical significance of CTCs remain unclear. Several authors have reported that the detection of CTCs using RT-PCR in gastric cancer is useful for predicting prognosis.[8-11] The detection of CTCs in blood requires high sensitivity and reproducibility.

The CellSearch system (Veridex LLC, Warren, NJ) was developed to identify CTCs in blood, and its utility has been reported in patients with breast cancer and prostate cancer.[12,13] The presence of CTCs is correlated with shorter overall survival in patients with metastatic disease. However, there have been few reports regarding the evaluation of CTCs in patients with gastric cancer using the CellSearch system. We hypothesized that CTCs in patients with gastric cancers are

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We are grateful to Mr. K. Kitsugi, Mr. M. Ueno, Ms. Y. Nishizono, and Ms. A. Harada for technical assistance.

DOI: 10.1002/cncr.28309, **Received:** May 6, 2013; **Revised:** June 27, 2013; **Accepted:** July 1, 2013, **Published online** August 20, 2013 in Wiley Online Library (wileyonlinelibrary.com)

associated with prognosis and the recurrence. In this study, we evaluated CTCs in patients with gastric cancer and explored the clinical impact of CTCs using the CellSearch system.

MATERIALS AND METHODS

Gastric Cancer Cell Line

To prepare for an examination of the CellSearch system, we used the KATO III gastric cancer cell line for the analysis. KATO III cells were cultured in RPMI 1640 (Nissui Pharmaceutical Company, Ltd., Tokyo, Japan) supplemented with 10% fetal calf serum (Mitsubishi Kasei, Tokyo, Japan), 100 U/mL penicillin, and 100 U/mL streptomycin. Cancer cells were grown at 37°C in a humidified atmosphere containing 5% CO_2, as previously described.

Clinical Study Design

Patients with gastric cancer who received treatment at 2 medical centers (Kagoshima University Hospital and Jiaikai Imamura Hospital, Kagoshima, Japan) were analyzed using prospectively collected data. Informed consent was obtained from all patients in accordance with the ethical standards of the Committee on Human Experimentation of Kagoshima University Hospital and Jiaikai Imamura Hospital. We evaluated the usefulness of measuring CTC levels with regard to the overall survival of patients with gastric cancer. In total, 265 consecutive patients with gastric cancer were enrolled between February 2005 and December 2012 at 2 medical centers. Two hundred twenty-eight patients from Kagoshima University Hospital and 37 patients from Jiaikai Imamura Hospital were registered on the study. Fourteen patients were excluded from the analysis, including 12 patients who had another cancer, such as esophageal, colorectal, or prostate cancer, and 2 patients who refused the treatment for gastric cancer. The patients were divided into 2 groups; those who underwent gastrectomy (the resection group; N = 148) and those who did not undergo gastrectomy (the nonresectable group; N = 103) (Fig. 1). Patients in the resection group underwent gastrectomy with standard lymphadenectomy. Patients who had received any preoperative radiotherapy or chemotherapy were excluded from this study. Peripheral blood samples were collected before gastrectomy. Clinical stage was assigned according to the TNM classification.[14]

Patients in the nonresectable group did not undergo surgery because of the presence of distant metastasis or recurrence. Peripheral blood was collected before the beginning of chemotherapy in these patients. In the current study, various chemotherapy regimens were used and mainly included the oral fluoropyrimidine S-1, such as S-1 alone, S-1 plus cisplatin, S-1 plus paclitaxel, and so on.

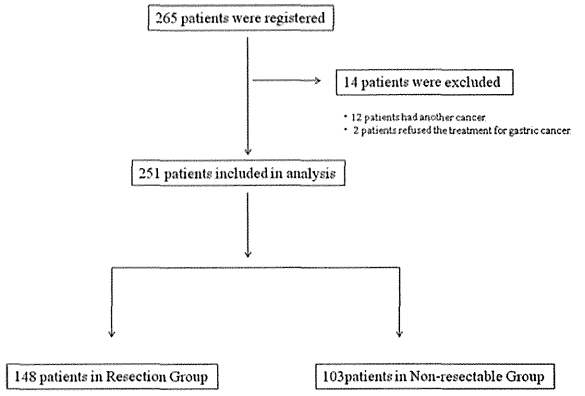

Figure 1. In total, 265 consecutive patients with gastric cancer were enrolled in the study. Fourteen patients were excluded from the analysis: 12 patients had another cancer, and 2 patients refused the treatment for gastric cancer. There were 148 patients with gastric cancer in the resection group and 103 patients who did not undergo gastrectomy in the nonresectable group.

All patients in the resection group were followed after discharge by physical examinations, routine blood tests, serum tumor marker tests (carcinoembryonic antigen [CEA] and cancer antigen 19-9 [CA 19-9]), and computed tomography scans every 3 to 6 months. Follow-up data after discharge were obtained for all patients, and the median follow-up was 31.6 months (range, 4-72 months). In the nonresectable group, patients were evaluated for chemotherapy every 2 to 3 months until death.

Isolation and Enumeration of Circulating Tumor Cells

Ten-milliliter blood samples were drawn into CellSave Preservative Tubes (Veridex, LLC). The samples were maintained at room temperature and processed within 72 hours after collection. All evaluations were performed by technical assistants without knowledge of the clinical status of the patients. The CellSearch system was used to isolate and enumerate CTCs using 7.5 mL of the 10-mL samples. CellSearch is a semiautomated system for the preparation of a sample and is used with the CellSearch Epithelial Cell Kit. The procedure enriches the sample for cells that express epithelial cell adhesion molecule (EpCAM) with antibody-coated magnetic beads, and it labels the nucleus with the fluorescent nucleic acid dye 4,2-diamidino-2-phenylidole dihydrochloride (DAPI).

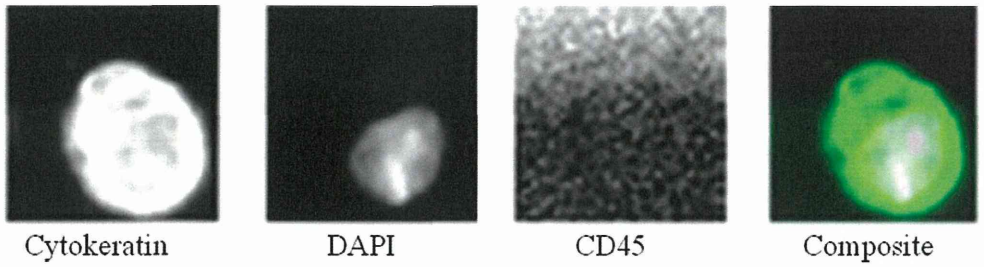

Figure 2. Circulating tumor cells were defined as nucleated cells that lacked allophycocyan (CD45) and expressed cytokeratin. DAPI indicates 4,2-diamidino-2-phenylidole dihydrochloride.

Fluorescently labeled monoclonal antibodies specific for leukocytes (CD45 allophycocyan) and epithelial cells (cytokeratin 8, cytokeratin 19, and 19-phycoerythrin) are used to distinguish epithelial cells from leukocytes. We identified and enumerated CTCs using the Celltracks analyzer II (Veridex, LLC), a semiautomated, fluorescence-based microscopy system that permits the computer-generated reconstruction of cellular images. CTCs were defined as nucleated cells that lacked CD45 and expressed cytokeratin (Fig. 2). Criteria used in the CellSearch system to define a tumor cell have been described previously. The results are expressed as the number of cells per 7.5 mL of whole blood.

Peripheral blood samples for use as a control group were obtained from 15 healthy volunteers who consented to participate. No volunteers had any illness or past history of cancer.

A spiking study was conducted to investigate the detectable limit of the CellSearch system. Therefore, the sensitivity and linearity of the CellSerach system was assessed by spiking a series of 10-fold serial dilutions of KATO III cells (10^2, 50, 10^1, 5, 10^0, and 0 cells) into whole blood from a normal healthy volunteer who did not have any cancer. This in vitro experiment was repeated 3 times for each series.

Statistical Analysis

The chi-square test and the Fisher exact test were used to compare the status of CTCs with categorical clinicopathologic factors. The Kaplan-Meier method was used for survival analysis, and the differences in survival were examined using the log-rank test. Prognostic factors were assessed in univariate and multivariate analyses using Cox proportional hazards regression models. All statistical calculations were performed using SAS statistical software (SAS Institute, Inc., Cary, NC). A P value $< .05$ was considered statistically significant.

RESULTS

Patient Characteristics

The 170 men and 81 women in the cohort ranged in age from 28 to 87 years (mean age, 64.4 years). Sixty-four percent of all patients remained alive at the time of this analysis.

In the resection group, 82 patients underwent distal gastrectomy, 13 patients underwent proximal gastrectomy, and 53 patients underwent total gastrectomy. The final pathologic findings indicated that all patients with disease greater than stage II had oral S-1 recommended as adjuvant chemotherapy for 1 year after surgery. Seventy-four patients (88.1%) were able to tolerate S-1; however, 10 patients (11.9%) were not able to tolerate S-1 because of anorexia and leucopenia. Twenty-six patients (17.6%) in the resection group had developed recurrent disease at the time of this analysis. These patients relapsed an average of 14.9 months after surgery.

In the nonresectable group, 72 patients had primary tumors of the stomach and distant metastasis, and 31 patients had recurrent distant metastasis after gastrectomy. Sixty-one patients had peritoneal dissemination, and 24 patients had para-aortic lymph node or Virchow lymph node swelling. Hematogenous distant metastases were identified in 24 patients. All patients in the nonresectable group received treatment with chemotherapy. The chemotherapy for gastric cancer consisted of S-1 plus cisplatin in 51 patients and S-1 plus paclitaxel in 52 patients.

CTCs were not identified in any samples from the healthy volunteers. In this study, the presence of ≥ 0 CTCs per 7.5 mL of blood was considered a positive result.

Circulating Tumor Cells and Clinical Correlation

Seventy-eight of 251 patients had CTCs detected. CTCs were detected in 16 patients (11.3%) from the resection

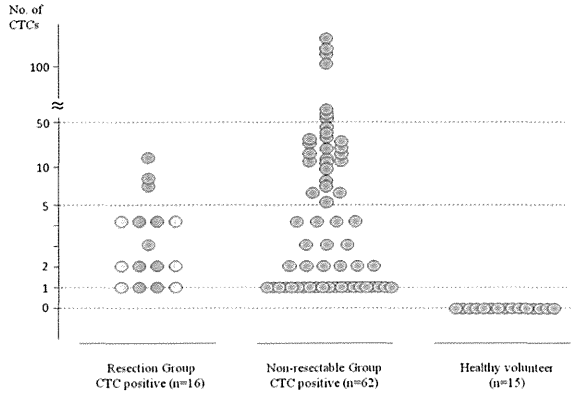

Figure 3. Circulating tumor cells (CTCs) were detected in 16 patients (10.8%) from the resection group and in 62 patients (60.2%) from the nonresectable group. The average number of CTCs was 3.5 in the resection group and 109.3 in the nonresectable group. CTCs were not observed in any samples from healthy volunteers.

group and in 62 patients (60.2%) from the nonresectable group. There was a significant difference in the positive rate between the 2 groups ($P < .0001$). Among those who had CTCs detected, the average count was 3.5 CTCs in patients from the resection group and 109.3 CTCs in patients from the nonresectable group (Fig. 3). The overall survival rate for all patients was significantly lower among those who had CTCs detected than among those who did not ($P < .0001$) (Fig. 4A).

In the resection group, CTCs were detected in 1 patient (1.6%) with a T1 tumor, in 2 patients (11.1%) with T2 tumors, in 6 patients (16.2%) with T3 tumors, and in 7 patients (23.3%) with T4 tumors. Clinicopathologic findings from the resection group are provided in Table 1. CTCs in patients who underwent gastrectomy were significantly correlated with the depth of tumor invasion, lymph node metastasis, distant metastasis, disease stage, vessel invasion, and lymphatic invasion. Although serum tumor markers like CEA and CA 19-9 were added to our analysis to be compared with CTCs, there was no significant correlation between CTCs and serum tumor markers.

Among 132 patients without CTCs, 14 patients (10.6%) had a recurrence after surgery. Eight patients had peritoneal dissemination, and 3 patients had hematogenous recurrences. Conversely, 12 of 16 patients (75%) with CTCs had a recurrence after surgery. The patients who had CTCs detected had a significantly higher relapse rate compared with patients who did not have CTCs detected ($P < .0001$). Two patients without recurrence on diagnostic imaging had transient elevation of serum CEA.

TABLE 1. Characteristics of Patients in the Resection Group

Variable	CTCs: No. of Patients (%)		
	Positive, n = 16	Negative, n = 132	*P*
Sex			
Men	11 (68.8)	88 (66.7)	.867
Women	5 (31.2)	44 (33.3)	
Age, y			
<70	8 (50)	83 (62.9)	.317
>70	8 (50)	49 (37.1)	
Tumor classification			
T1	1 (6.3)	62 (47)	.009
T2	2 (12.5)	16 (12.1)	
T3	6 (37.5)	31 (23.5)	
T4	7 (43.8)	23 (17.4)	
Lymph node classification			
N0	2 (12.5)	80 (60.6)	< .0001
N1	0 (0)	19 (14.4)	
N2	1 (6.3)	17 (12.9)	
N3	13 (81.3)	16 (12.1)	
Distant metastasis			
Yes	3 (18.8)	5 (3.8)	.012
No	13 (81.2)	127 (96.2)	
Stage			
I	1 (6.3)	63 (47.7)	.0002
II	1 (6.3)	25 (18.9)	
III	11 (68.8)	39 (29.5)	
IV	3 (18.8)	5 (3.8)	
Lymphatic invasion			
0	1 (6.3)	71 (53.8)	.0003
1	15 (93.7)	61 (46.2)	
Vessel invasion			
0	3 (18.8)	73 (55.3)	.006
1	13 (81.2)	59 (44.7)	
Histologic type			
Differentiated	3 (18.8)	39 (29.5)	0.365
Undifferentiated	13 (81.2)	93 (70.5)	—

Abbreviations: CTCs, circulating tumor cells.

Peritoneal dissemination was the most common pattern of recurrence, and 5 patients had hematogenous recurrences (Table 2). There were no significant differences in the recurrence pattern between patients with and without CTCs. However, all patients who had CTCs detected, at the least, had either peritoneal dissemination or hematogenous distant metastases. The sensitivity and specificity for predicting recurrences were 46.2% and 96.7%, respectively.

When we analyzed relapse-free survival according to whether patients were positive for CTCs, relapse-free survival in patients who were positive for CTCs was significantly lower than in those who were negative ($P < .0001$) (Fig. 4B). Furthermore, the 5-year survival rate also was significantly lower in patients with CTCs than in those without CTCs ($P < .0001$) (Fig. 4C). Multivariate analysis demonstrated that the presence of CTCs was an

independent prognostic factor (Table 3). Factors that we included in this analysis were CTCs, tumor classification, lymph node classification, lymphatic invasion, and vessel invasion, all of which were considered to be significant characteristics in these patients. It is noteworthy that positive expression of CTCs in peripheral blood was identified as an independent factor for overall survival in patients with gastric cancer (hazard ratio, 1.73; 95% confidence interval, 1.08-2.77; $P = .024$).

All patients of the nonresectable group received chemotherapy. There was no significant correlation between the presence of CTCs and nonresectable factors (Table 4). In these 103 patients, the presence of CTCs was correlated with a lower survival rate ($P = .0044$) (Fig. 4D). The median survival was 248 days in patients with CTCs and 582 days in patients without CTCs.

TABLE 2. Recurrence Pattern of 16 Patients With Circulating Tumor Cells in the Resection Group

Postgastrectomy	No. of Patients (%)
Recurrence pattern	12 (75)
Peritoneal dissemination	9 (56.3)
Liver metastasis	2 (12.5)
Bone metastasis	2 (12.5)
Adrenal gland metastasis	1 (6.3)
Lymph node metastasis	1 (6.3)
No recurrence	4 (25)

Sensitivity of the CellSearch System With Cell Line

KATO III cells were used for the analysis of sensitivity and linearity of the CellSearch system. Representative results from the expected number of KATO III cells spiked into healthy donor samples plotted against the actual number of KATO III cells observed in the samples are illustrated in Figure 5. Regression analysis of the

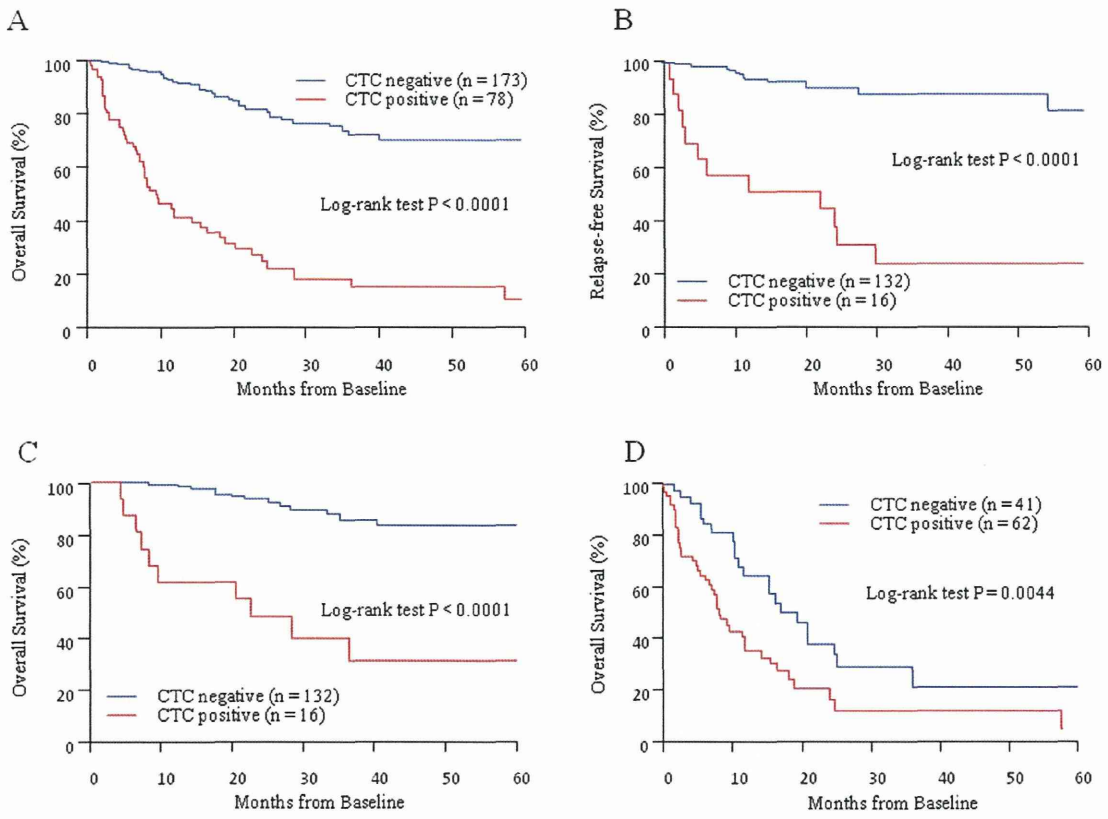

Figure 4. (A) Circulating tumor cells (CTCs) were detected in 78 of 251 patients. The 5-year survival rate was significantly lower in patients with CTCs than in those without CTCs ($P < .0001$). (B) In the resection group, the relapse-free survival rate was significantly lower in patients with CTCs than in those without CTCs ($P < .0001$). (C) The overall survival rate also was significantly lower in patients with CTCs than in those without CTCs ($P < .0001$). (D) In the nonresectable group, the overall survival rate was significantly lower in patients with CTCs than in those without CTCs ($P = .0044$). The median survival was 248 days in patients with CTCs and 582 days in patients without CTCs.

TABLE 3. Univariate and Multivariate Analysis in the Resection Group

	Univariate Analysis		Multivariate Analysis	
Independent Factor	HR (95% CI)	*P*	HR (95% CI)	*P*
Depth of tumor invasion	2.33 (1.56-3.69)	< .0001	1.45 (0.82-2.69)	.204
Lymph node metastasis	2.60 (1.80-4.04)	< .0001	1.53 (0.91-2.69)	.114
Distant metastasis	3.85 (1.11-10.28)	.035	0.87 (0.23-2.59)	.807
Lymphatic invasion	10.41 (3.05-65.08)	< .0001	1.73 (0.33-13.90)	.541
Vessel invasion	7.53 (2.58-31.99)	< .0001	1.62 (0.39-9.07)	.526
CTCs	2.77 (1.81-4.18)	< .0001	1.73 (1.08-2.77)	.024

Abbreviations: CI, confidence interval; CTCs, circulating tumor cells; HR, hazard ratio.

TABLE 4. Nonresectable Factors in the Nonresectable Group

	No. With CTCs		
Nonresectable Factor	Positive	Negative	Incidence of CTCs, %
Liver metastasis	9	7	56.3
Lung metastasis	0	2	0
Bone metastasis	4	1	80
Brain metastasis	2	0	100
Peritoneal dissemination	40	23	63.5
Lymph node metastasis	12	12	50
Direct invasion to peripheral organs	2	3	40

Abbreviations: CTCs, circulating tumor cells.

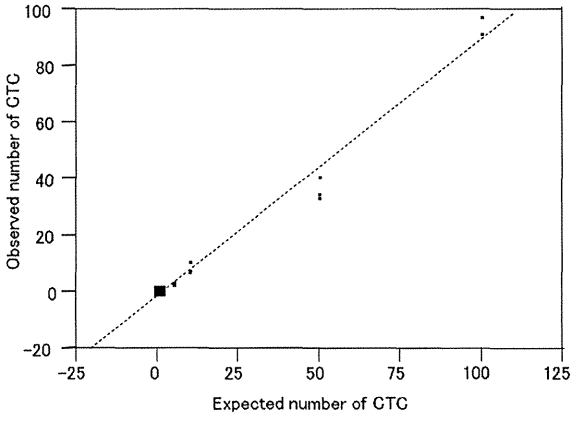

Figure 5. Regression analysis of the number of observed tumor cells versus the number of expected tumor cells produced a correlation coefficient (R^2) of 0.985. Even a single cell spiked into the samples was detected using this system.

number of observed tumor cells versus the number of expected tumor cells produced a correlation coefficient (R^2) of 0.985. Even a single cell spiked into the samples was detected using this system.

DISCUSSION

CTCs measured with the CellSearch system and clinical correlation of the results were analyzed in 251 patients with gastric adenocarcinoma. The system was sensitive, and the results were correlated with relapse-free survival, the 5-year survival rate, and the overall survival rate in all patients, including the resection group and the nonresectable group. Although previous studies have reported the presence of CTCs determined by RT-PCR, reports of the morphologic detection of CTCs are few.[15-19] Furthermore, ours was a large-scale, prospective study that enrolled 265 patients with gastric cancer. To our knowledge, this is the first longitudinal analysis evaluating CTCs using the CellSearch system in such patients.

In Japan, almost all patients who have stage II or III tumors after undergoing gastrectomy receive adjuvant chemotherapy in the form of oral S-1 according to data from the Adjuvant Chemotherapy Trial of TS-1 for Gastric Cancer (ACTS-GC).[20] However, ≥60% of patients at this stage do not have a recurrence without adjuvant chemotherapy. If recurrence after surgery can be predicted, then information regarding CTCs could help patients avoid unnecessary adjuvant chemotherapy. This distinction is necessary to determine whether or not patients are eligible for curative resection. The measurement of CTCs in gastric cancer will be useful for determining treatment strategies if more accurate staging of the patient can be performed. Moreover, patients with gastric cancer who have CTCs should receive neoadjuvant chemotherapy before they undergo surgery.

Patients who had breast cancer, prostate cancer, or colorectal cancer with hematogenous metastasis had a high incidence of CTCs according to several reports.[12,13,21] However, no significant correlation between positive CTCs and hematogenous distant metastasis in gastric cancer has been demonstrated. In the current study, peritoneal dissemination was the most frequently observed pattern of recurrence. The detection of CTCs may be a useful diagnostic tool for predicting

peritoneal dissemination, which is difficult to detect on imaging studies, such as computed tomography, ultrasonography, and positron emission tomography.

The prognosis of patients in our nonresectable group also differed significantly according to the presence of CTCs. Some authors have reported that response to chemotherapy can be evaluated in several cancers with distant metastasis. Monitoring the number of CTCs may be more useful for evaluating chemotherapy.[22,23] It is an advantage that the measurement of CTCs using the CellSearch system is available at any time and is easily and noninvasively performed. An increase in the number of CTCs should lead to a change in chemotherapy regimen.

The CellSearch system is based on the enumeration of epithelial cells, which are separated from the blood by EpCAM antibody-coated magnetic beads and identified with the use of fluorescently labeled antibodies against cytokeratin and with a fluorescent nuclear stain. In the detection of CTCs by molecular techniques there is always the question of whether the result could be a false-positive. Although Sensitivity of RT-PCR is very high for CTCs identification, it is impossible to visually confirm cancer cells. Conversely, with the Cell Search system (Janssen Diagnostics, LLC, Raritan, NJ), the false-positive rate is extremely low, because it is possible to morphologically confirm the presence of cells. Conversely, some cases might be missed (false-negative) because some of the CTCs may not express these epithelial markers and may be undetectable by the CellSearch system.[24]

Most reports concerning the prognosis for patients with breast cancer and prostate cancer have used a cutoff of $\geq$5 CTCs to determine a positive test.[12,13] Conversely, some reports of other cancers use different cutoff values.[25] The question remains regarding the significance of the presence of a single CTC. For patients with gastric cancer who have undergone curative resection, this single cell may be consequential. Our criteria defined $\geq$1 CTC as a positive test. It is important to note that CTCs were not detected in healthy volunteers in our series. In fact, several patients in our cohort who had only 1 CTC relapsed, and the presence of any CTCs in peripheral blood was considered an independent prognostic factor for determining the overall survival of patients who underwent gastrectomy. It may become possible to more accurately estimate the prognosis for these patients if the presence of CTCs is added to the staging factors. In this study, many patients who were positive for CTCs had a recurrence, and several patients who did not have a recurrence had received chemotherapy because of up-regulated serum tumor marker levels during follow-up. The detection of CTCs is useful for predicting recurrence and prognosis. We conclude that the evaluation of CTCs in peripheral blood may be a useful tool for predicting tumor progression, prognosis, and the effect of chemotherapy in patients with gastric cancer.

FUNDING SUPPORT

This work was supported in part by a grant-in-aid (no. 22501032) for scientific research from the Ministry of Education, Science, Sports, and Culture of Japan.

CONFLICT OF INTEREST DISCLOSURES

The authors made no disclosures.

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CellBio, 2013, 2, 179-185
Published Online December 2013 (http://www.scirp.org/journal/cellbio)
http://dx.doi.org/10.4236/cellbio.2013.24020

Scientific Research

Immunohistochemical Analysis of the Acid Secretion Potency in Gastric Parietal Cells

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Received July 31, 2013; revised August 31, 2013; accepted September 7, 2013

ABSTRACT

Gastric parietal cells are important in acid secretion, but it is unclear which cells throughout the gastric gland have the highest secretion potency. Here, we used immunohistochemical methods with anti-H^+, K^+-ATPase, phosphoryl ezrin and CD44 antibodies to study the distribution of gastric acid secretion activity. Stomach tissues from freely fed and starved rats were cryofixed for light microscopy or fixed by high-pressure freezing for electron microscopy. Parietal cells from freely fed animals corresponded to the active secretion phase and to the inactive resting phase from starved rats. Anti-H^+, K^+-ATPase and anti-phosphoryl ezrin labeling were observed on the membrane of the intracellular canaliculi and the tubulovesicle from freely fed rats, while cells from starved animals showed weak labeling with anti-phosphoryl ezrin antibody staining. Morphometrical analysis at the electron microscopic level was performed on active and inactive acid secretory phases between the upper and base regions of the gland. H^+, K^+-ATPase and CD44 were distributed on both sites of the microvillous and tubulovesicle membrane in the same cells, but phosphoryl ezrin localized predominantly on the microvillous membrane in active cells of the glandular neck and upper base. Therefore, the highest secreting potency appeared to be in cells of the glandular neck and upper base.

Keywords: Gastric Parietal Cells; Secretory Potency; Phosphoryl Ezrin; Histochemical Morphometry

1. Introduction

Gastric parietal cells play a major role in acid secretion and are widely distributed from the pit to the base of rat gastric glands. They show characteristic aspects of intracellular canaliculi (IC) with numerous microvilli and tubulovesicles (TV) in the cytoplasm, which are thought to be interconvertable structures. Although the conversion mechanism for these structures is unclear, various hypothesizes have been proposed. During the active acid-secreting phase of parietal cells, the IC is markedly expanded, but the cells undergo a morphological transformation during their inactive resting phase when the IC reduces in width and the TV mass increases [1,2]. The secretion activity alternates according to the physiological phases of feeding or starving.

Proton potassium ATPase (H^+, K^+-ATPase; "the proton pump") is an important enzyme for gastric acid secretion and exists as an integral membrane-protein along the IC and TV throughout the parietal cell membrane. We previously used high-pressure freezing followed by freeze-substitution to investigate the histochemistry of gastric gland cells and the ultrastructural alterations that occur in both fed and starved phases [3,4]. Cryofixation using rapid freezing (especially high pressure rapid freezing for capable freezing depth) is believed to be superior to conventional chemical fixation with regard to morphological preservation and retention of soluble components. Using antibodies against the proton potassium ATPase α- and β-subunits, we also showed that the enzyme localized on both IC and TV membranes in almost all parietal cells throughout the length of the gland [3-5].

Parietal cells contain more actin than other glandular cells. Transformation between IC and TV occurs with redistribution of actin in the cell. Filamentous actins are anchored to the plasma membrane via phosphoryl ezrin,

and most actin molecules are thought to form a globular structure in the inactive resting state, which molecules polymerize rapidly to form a filamentous structure upon active acid secretion [2,6-11]. Ezrin is a member of the ERM (ezrin/radixin/moesin) family of proteins that is implicated in linking functional activities of the plasma membrane to the actin cytoskeleton. In addition, actin binds to intramembranous CD44 via phosphoryl ezrin in the plasma membrane [12-14]. It has previously been suggested that the above-mentioned morphological changes are induced and triggered by this cytoskeletal reorganization of β-actin [15-17].

The purpose of the present study was to investigate which parietal cells are more active than others in terms of acid secretion, based on the distribution of phosphoryl ezrin and CD44 throughout the gland using immunohistochemical techniques.

2. Materials and Methods

2.1. Tissue Preparation

Ten male Wistar rats were used in the experiments and divided into two groups of five animals each. One group was fed freely and the other was starved for 48 h with free access to water. The rats were anesthetized with an intraperitoneal injection of sodium pentobarbital, and the pH of the luminal gastric juice was determined. The stomach tissues were cut into small pieces and cryofixed using a rapid freezing device (RF-6, Eiko, Japan) using liquid propane for cryofixing and liquid nitrogen for light microscopy. The specimens were then freeze-substituted with acetone containing 0.2% glutaraldehyde at −79°C for 72 h and embedded in paraffin [17].

For electron microscopy, the specimens underwent high-pressure freezing under a 21×10^5 hPa atmosphere (HPM 010, BAL-TEC, Liechtenstein). The frozen specimens were freeze-substituted with acetone containing 1% osmium tetroxide or 0.2% glutaraldehyde at −79°C for 72 h and were embedded in Epon812 or Lowicryl K4M resin, respectively [3].

2.2. Primary and Secondary Antibodies

A rabbit antibody against the H^+, K^+-ATPase (proton pump) α-subunit (Immunogen; C-terminal synthetic peptide based on the porcine H^+, K^+-ATPase α-subunit sequence) was purchased from Calbiochem-Novabiochem (San Diego, CA). The antibody was used at a dilution of 1:100 in phosphate buffered saline (PBS). A mouse monoclonal antibody against the H^+, K^+-ATPase β-subunit (Immunogen; purified 34-kDa core peptide from deglycosylated hog gastric microsomes) was purchased from Abcam Ltd. (Cambridge, UK) and diluted 1:200 in PBS. A rabbit polyclonal antibody against phosphoryl ezrin (Immunogen: KLH-conjugated, synthetic phosphopeptide corresponding to residues surrounding Thr567 of human ezrin) and an anti-CD44 antibody were purchased from CHEMICON International, Inc. (Temecula, CA). These were used at a dilution of 1: 10 - 20 in PBS. A mouse monoclonal antibody against actin (pan Ab-5; Clone ACTN05) was purchased from LAB VISION Co. (Fremont, CA). This antibody reacts with all six known isoforms of vertebrate actin (MW-42 kD) and also with two highly homologous cytoplasmic actins (β, γ). This antibody was diluted 1: 10 - 80 in PBS. The antibodies were confirmed to show cross-reactivity against the rat. The following were used as secondary antibodies: biotinylated goat anti-mouse immunoglobulin ($F(ab')_2$) or biotinylated swine anti-rabbit immunoglobulin (DAKO Cytomation, Glostrup, Denmark) diluted 1: 100 - 200 in PBS; horseradish peroxidase (HRP)-conjugated streptavidin (DAKO Cytomation) (1:200 in Tris-buffered-saline; TBS); colloidal gold (CG)-conjugated streptavidin (1:1 in PBS) from British BioCell International (Cardiff, UK).

2.3. Immunohistochemical Staining for Light Microscopy

Specimens embedded in paraffin were cut into 4 μm-thick slices with a sliding Jung-model microtome, mounted on silconized glass slides and air-dried. Sections were deparaffinized, rehydrated and immersed in PBS. After blocking endogenous peroxidase activity with 0.3% hydrogen peroxide in methanol, specimens were incubated with primary antibodies against the H^+, K^+-ATPase α- and β-subunits. They were then labeled with biotinylated anti-rabbit or anti-mouse IgG antibodies overnight followed by HRP-conjugated streptavidin for 1 h. Visualization was performed using 3, 3'-diaminobenzidine tetrahydrochloride (DAB; DAKO Cytomation) for 10 min. Finally, sections were rinsed in distilled water, counterstained with Mayer's hematoxylin, dehydrated in a graded ethanol series, cleared in xylene and mounted with Eukitt (O. Kindler, Germany).

2.4. Electron Microscopy

Ultrathin sections from specimens fixed with 1% osmium tetroxide and embedded in epoxy resin were cut with a Reichert Ultracat-N ultramicrotome and stained with uranyl acetate and Reynolds' lead citrate. They were observed using a HITACHI H-7000 electron microscope at an acceleration voltage of 80 kV.

Specimens fixed with 0.2% glutaraldehyde and embedded in Lowicryl K4M resin were stained by the immunogold method (particle size of colloidal gold (CG): 15 nm and 10 nm). Thin sections were incubated with unlabeled-streptavidin (Southern Biotech, Birmingham, AL) for 30 min at room temperature to block endogenous

biotin. Immunogold staining was performed as described previously [4,18]. Briefly, the sections were incubated with anti-H^+, K^+-ATPase α- and β-subunits, anti-phosphoryl ezrin and anti-CD44 antibodies followed by biotinylated anti-rabbit or anti-mouse IgG antibodies and labeled with streptavidin-colloidal gold. Finally, the sections were counterstained with uranyl acetate and Millonig's lead acetate.

2.5. Morphometrical Analysis of Labeling Density with Phosphoryl Ezrin Immunogold Staining

The parietal cell labeling density with the anti-phosphoryl ezrin antibody was analyzed using Image-J NIH software. Thus, the labeling number of gold particles (on IC containing multiple microvilli) was counted on electron microscopic photographs taken at 15,000 × magnification of the neck or base region (n = 20 each) of active phase glands (fed animals) and inactive resting phase glands (starved animals). The labeling density was estimated as the number of gold particles per unit area (μm^2) of IC. For the assessment of the phosphoryl ezrin labeling-density, the results were statistically analyzed by *t*-test using Microsoft Excel software. Statistical comparisons were made between the neck and the base area of the gland, and between active versus inactive glands from starved animals. The differences between sites or feeding/starving were evaluated by *t*-test. $P < 0.01$ or 0.05 was considered significant. The results are expressed as the arithmetic mean ± SE.

3. Results

3.1. Morphological Observation

The average pH in the fed rats was 2.0, compared with 6.4 in the starved rats. We therefore hypothesized that the former corresponds to the active phase and the latter to the inactive resting phase of gastric juice secretion.

The parietal cells showed excellent ultrastructural preservation at the electron microscopic level. The ultrastructure of IC, TV, and other organelles was well preserved for each active and inactive phase of glands when specimens were processed successfully by means of HPF-followed by FS.

3.2. Immunohistochemical Observation with Anti-H^+, K^+-ATPase Antibody

The parietal cells were labeled intensely and clearly by immunohistochemical staining with the H^+, K^+-ATPase anti-α- and -β-subunit antibodies. Cells in the neck and upper base were labeled particularly strongly in active phase animals. Staining was evenly distributed from the deep pit to the glandular base of the cells (**Figures 1(A)** and **(B)**), and the staining pattern was similar between the anti-β-subunit antibody and α-subunit antibody (data not shown). In the active phase, the microvillous membrane and apical cell membrane of the IC were labeled with the anti-α- and -β-H+, K+-ATPase subunit antibodies and with the anti-phosphorylated-ezrin antibody (corresponding to residues surrounding Thr566 and 567), while TV membranes were hardly stained. In the inactive phase, IC microvilli were labeled weakly with this antibody. The anti-CD44 antibody staining pattern was similar to that of anti-α- (and -β-) H^+, K^+-ATPase subunit antibodies in inactive phase animals (**Figures 2, 3(A)** and **(B)**). A regional labeling difference was evident from the neck to the upper base and lower base.

3.3. Morphometric Analysis with Anti-Phosphoryl Ezrin Antibody and Immunogold Labeling

Immunogold staining was performed to examine the intracellular distribution and the labeling density of the

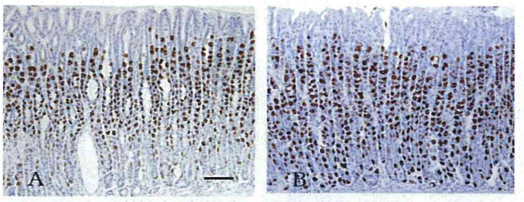

Figure 1. Active phase rat gastric gland immunostained with the anti-H^+, K^+-ATPase α-subunit antibody. (A) Parietal cells throughout the gland are stained strongly. Cells are large and plump and become smaller and more slender as they migrate downwards. Reaction products are thread-like in shape; (B) Inactive resting phase gland with similar staining. Parietal cells scattered throughout the gland are also stained positively and reaction products were observed diffusely in the cytoplasm. Scale bar = 100 μm.

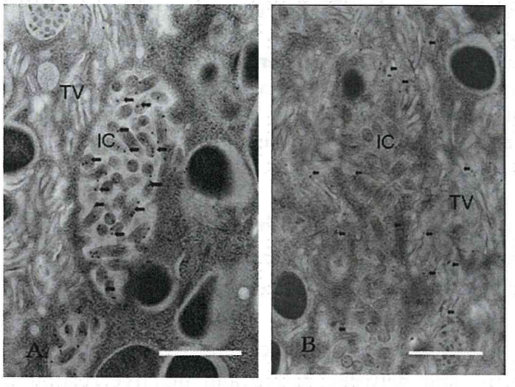

Figure 2. Section of parietal cells stained with immunogold method. (A) Anti-phosphoryl ezrin antibody staining. The IC membrane and its microvilli were stained with anti-phosphoryl ezrin antibody, but little staining was visible on the TV membrane; (B) Anti-CD44 ant-ibody staining. The two organelles (IC and TV) were labeled with this antibody. Scale bar = 1 μm.

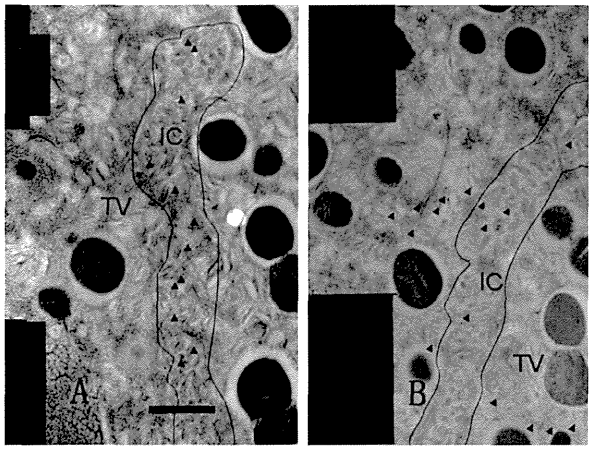

Figure 3. Adjacent serial sections immunostaining. Each photograph is composed of several distinct pictures (montaged pictures) and serially sectioned. Labeled gold particles are shown with arrowheads. The anti-phosphoryl ezrin antibody bound only to the IC microvilli (A), while the anti-CD44 antibody labeled both the IC and TV (B). Scale bar = 1 μm.

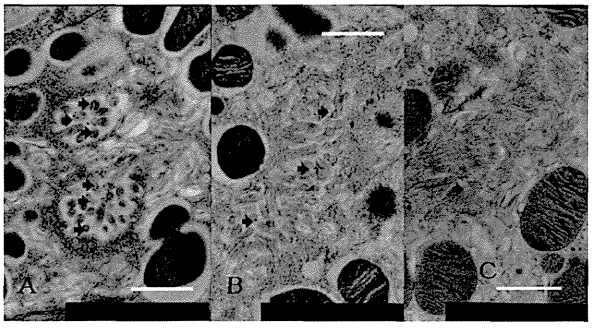

Figure 4. Labeling differences in each level of gland of parietal cell stained with immunogold using anti-phosphoryl ezrin antibody. (A) Neck region, adjoining mucous neck cell in active animals; (B) Lower region of base, neighboring chief cell; (C) Neck region from starved rats. Anti-phosphoryl ezrin antibody labeling is strong on IC membrane of parietal cell from fed (active secreting) rats (A), and moderate to weak in lower half of base (B) and through gland from starved (inactive resting or inactive secreting) rats (C). Scale bar = 1 μm.

anti-phosphoryl ezrin antibody in each cell between the gland segments. Parietal cells adjacent to mucous neck cells or chief cells were deemed to be in the neck or base region, respectively. The gold particle numbers were compared between the neck and the base region of the glands, and between active and inactive resting glands (**Figure 4**). The number of labeled gold particles was divided by the IC area to give the labeling density (per μm^2). Labeling density zonation was clear from the neck to the base, with a significantly higher density in parietal cells located in the isthmus to neck region (mean ± SE; 25.501 ± 3.736 μm^2) compared with the glandular lower base (17.082 ± 7.275 μm^2) or from inactive starved rats (1.926 ± 0.465 μm^2) (**Figures 5(A)** and **(B)**).

Statistical analysis using IMAGE-J revealed that phosphoryl ezrin expression in the neck and upper base was significantly higher than that in lower base (25.501 ± 3.736 vs 17.082 ± 7.275, $p < 0.05$) and than that in starved gland (25.501 ± 3.736 vs 1.926 ± 0.465, $p < 0.01$). These findings suggest that the phosphoryl ezrin assemble in the membrane of active parietal microvilli at neck to upper base.

4. Discussion

The component cells of gastric glands include pit mucous cells, progenitor cells, parietal cells, mucous neck cells, chief cells and endocrine cells and have previously been studied in rodents. These cells undergo mitosis in the isthmus, from where they migrate and differentiate along the longitudinal axis of the gland in an upward or downward direction [19-21]. The parietal cells migrate upwards and downwards then mature, while chief cells derive from the mucous neck cell through an intermediate cell type to the mature chief cell in a downwards migration [17]. Parietal cells adjoining the mucous neck cell are considered to be in the neck region and those next to the chief cell are in the base region of the gland.

Gastric juice is very acidic, with a pH of around 1.5. The average pH value measured in this study was pH 2.0 in fed rats and pH 6.4 in starved animals, indicating that the parietal cells of fed rats correspond to cells in the active secretory-phase, while those of starved animals correspond to cells in the inactive resting phase. The pa-

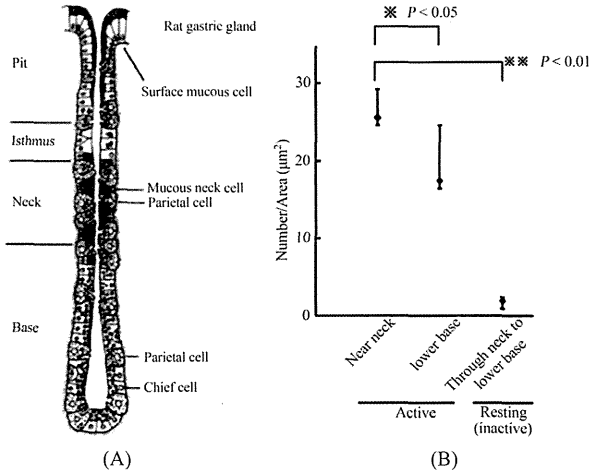

Figure 5. (A) Schematic drawing of rat gastric gland. After proliferation in the glandular isthmus, the parietal cell migrates and differentiate through neck to base of gland; (B) Statistical analysis of phosphoryl-ezrin plotting. The labeling of the cell in the near neck site was significantly higher than that in the lower base, or whole site of the gland in the resting (the inactive).

rietal cells are distributed broadly through the gland from the isthmus to the base. The cells are large and plump from the isthmus to the upper base, although they become smaller and more slender in the lower base as they migrate downwards [19-22].

Routine light microscopy revealed parietal cells of an acidophilic nature with numerous mitochondria in the cytoplasm. The cells were stained with immunolabeling using an anti-H^+, K^+-ATPase antibody, and the reaction products had a thread-like appearance, especially in the isthmus to the neck region [5,18]. The expression pattern followed the contour line of the stained apical-cell membrane. In previous studies, we used high pressure-frozen, freeze-substituted and resin-embedded tissue samples to demonstrate the intracellular localization of H^+, K^+-ATPase [3,23]. This antibody clearly stained the IC containing many microvilli in the active phase, while TV was stained in the inactive resting phase. Diffuse cytoplasmic staining was observed in cells scattered widely from the isthmus to the glandular base. This aspect is thought to derive from TV membrane staining at the light microscopy level.

Yao *et al.* [15] revealed that most actin in the gastric gland is present in parietal cells, which are largely globular during the inactive resting secretion phase. However, during the active phase, actin forms a filamentous structure. Jöns *et al.* [24] reported that the binding of actin to the plasma membrane is dependent on phosphoryl ezrin molecules, and the initiation of ultrastructural changes in parietal cells is thought to be induced by the polymerization of cytoskeletal actin [2,7,15] followed by binding of the actin molecule to the C-terminal of phosphoryl ezrin and intramembranous CD44 to the N-terminus [8-10, 16,25,26]. Non-phosphoryl ezrin molecules are distributed throughout the cytoplasm without binding actin in the inactive resting phase [16,29-29], while localization of the ezrin-actin linkage in the cytoplasm occurs in the active phase during the formation of phosphorylated ezrin molecules and filamentous actin-molecule binding. This indicates that phosphoryl ezrin and actin are related to the cell surface distribution of the H^+, K^+-ATPase proton pump.

In the present study, immunostaining with the phosphoryl ezrin antibody resulted in heavy labeling in the neck to the upper base region (**Figures 3** and **4**), revealing that the labeled cells are in the active phase [5]. A statistical morphometric data comparison of neck and base cells showed that phosphoryl ezrin and H^+, K^+-ATPase were present in similar sites within the same cell [18]. The apical membrane of IC containing microvilli in the active phase was labeled by immunogold staining with the anti-phosphoryl ezrin antibody. On the other hand, labeling of these structures was weak in the inactive resting phase (**Figures 4** and **5**).

These findings suggest that the parietal cells in the neck and upper base are more active than those in the lower base. Karam *et al.* [20] described the intracellular mitochondrial distribution of parietal cells at various levels of the mouse gastric gland and revealed a high number in the isthmus and neck. Moreover, the integral H^+, K^+-ATPase is exposed on the luminal surface when IC is enlarged, and the enzyme is activated by a successive K^+ ion supply. On the other hand, the increasing TV volume results in a decreased surface area of the canaliculi membrane as the IC and TV derive from similar membrane systems [12]. The TV is transformed into the apical plasma membrane during acid secretion [2]. H^+, K^+-ATPase then becomes an intravesicular membrane protein and acid secretion is halted because of an interruption in the K^+ ion supply. This transformation is limited at sites with small amounts of phosphoryl ezrin, such as the middle to the bottom region of the gland [18,22] where parietal cells are small and slender. Here, it is thought that the acid secretory capacity is limited and unresponsive to physiological or feeding conditions.

The purpose of this work was to decide at which level parietal cells are most active. Acid secretion activity in the gland appears to be higher in the segment from the isthmus to the upper glandular base, which agrees with the findings of Fykse *et al.* [30] who reported that parietal cells in the second part of four segments in the gland were activated by histamine treatment. Jiang *et al.* [5] reported that the acid-secreting potency of individual parietal cells was higher in the upper third of the gland (containing the superficial part). Further experiments are required to clarify the secretion system of gastric acid in parietal cells.

5. Acknowledgements

We would like to thank Mr. S. Nonaka for technical assistance and Professor K. Kosai and Professor emeritus S. Nakagawa for helpful comments. This work was supported in part by a Grant-in-Aid for Scientific Research (No. 15590164 to S. Tsuyama) from the Ministry of Education, Culture, Sports, Science and Technology of Japan and the Kodama Memorial Fund for Medical Research.

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