Autoantibodies directed against cytoplasmic antigens of neutrophils (ANCA), especially proteinase 3 (PR-3), have proved to be a useful clinical tool confirming the diagnosis or monitoring disease activity of Wegener’s granulomatosis (WG). Although several concepts concerning the pathophysiologic potentials of ANCA have been discussed, only sparse data about ANCA-endothelium interactions have been available. In this study, we have investigated the expression of PR-3 in cytokine-treated human endothelial cells using purified anti–PR-3 antibodies of patients with WG, murine and human monoclonal anti–PR-3 antibodies as probes. We were able to show that tumor necrosis factor-α, interleukin-1α/β, and interferon-γ led to an increased PR-3 expression in the cytoplasm of endothelial cells by performing polymerase chain reaction analysis, Western blot, cyto–enzyme-linked immunosorbent assays, and confocal laser scanning microscopy. Moreover, PR-3 was also translocated into the cell membrane, becoming accessible to ANCA. Our data suggest a possible direct pathogenic effect of anti–PR-3 antibodies in WG and other vasculitides. Anti–PR-3 antibodies represent an important missing link in ANCA-endothelial interactions.
Fig 2. (A) Indirect immunofluorescence of fixed HEC (no cytokine treatment; original magnification X 450). Only weak reaction of a purified anti–PR-3 antibody [F(ab)₂ fragments]. (B) Reaction of monoclonal anti–PR-3 antibody WGM2 on fixed HEC after 30 minutes of treatment with TNF-α (immunogold staining; original magnification X 1,000). Diffuse cytoplasmic reaction. (C) Indirect immunofluorescence of fixed HEC after 30 minutes of treatment with TNF-α (original magnification X 450). Reaction of a purified anti–PR-3 antibody [F(ab)₂ fragments] with diffuse cytoplasmic staining.
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We were recently able to detect PR-3 in cytokine-treated human tumor cells, therefore refuting the exclusivity of neutrophils and monocytes as the sole source for this antigen. These findings were the impetus to investigate a possible expression of PR-3 in human endothelial cells, which could represent one important prerequisite of ANCA-endothelium interactions.

PATIENTS AND METHODS

Serum samples. Serum samples were obtained from 150 donors. Fifty donors suffered from clinically active WG. The diagnosis was established on the basis of classical symptoms and the typical histologic findings in biopsy specimens, as described earlier. One hundred healthy blood donors (HBD) served as controls.

Antibody testing. All WG sera were tested for anti–PR-3 antibodies by IFT on fixed neutrophils, enzyme-linked immunosorbent assay (ELISA), and Western blot. Several antigen preparations served as antigens: α-extract of human neutrophils, purified PR-3, MPO, cathepsin G, and elastase. ELISAs were performed as described earlier. Polyacrylamide gel electrophoresis (PAGE) and Western blotting were performed as described previously. In addition, all sera were screened with routine methods for other antibodies specificities. Rheumatoid factor (RF) was determined by a latex fixation test (Behring Werke Marburg, Marburg, Germany).

Purification of anti–PR-3 antibodies. IgG was prepared from 10 monospecific anti–PR-3 antibody-positive WG sera by ammonium sulfate precipitation and ion exchange chromatography on diethylaminoethyl (DEAE)-Sephadex (Pharmacia, Uppsala, Sweden). Anti–PR-3 antibodies were affinity-purified as described earlier using purified PR-3. F(ab′)2 fragments were prepared as described earlier. For inhibition experiments, serum antibodies were mixed with affinity-purified antigen and PR-3 purified as described by Kao et al. vol/vol diluted to 0.1 mg/mL protein concentration in phosphate-buffered saline (PBS), and incubated on a rotator for 1 hour at 37°C and 12 hours at 4°C. The mixture was centrifuged at 30,000g for 15 minutes at 4°C and the supernatants kept as absorbed material.

An anti–PR-3–specific B-cell clone (IgG) has been established and characterized earlier. In addition, a murine monoclonal antibody to PR-3 served as control.

Isolation and culture of human endothelium cells. Human umbilical cord endothelial cells (HEC) were isolated according to the method of Jaffe et al. These cells were used for further experiments between passages 4 and 6. Cells of 10 donors were pooled to exclude the influence of blood group antigens. Morphology was confirmed by phase-con-
Fig 5. Confocal laser scanning microscopy of TNF-α-treated fixed HEC (original magnification × 630). Reaction of a purified anti-PR-3 antibody [F(ab')2 fragments]. (A) Binding in the endoplasmic reticulum after 20 minutes of cytokine treatment (n = nucleus). (B) Cytoplasmic distribution of PR-3 after 30 minutes of cytokine treatment.

Fig 6. Visualization of RT-PCR products by chemiluminescence. Lane L, DNA-ladder biotinylated FX174 DNA digested with HinfI. Lane 1, endothelial cells stimulated with TNF-α. Lane 2, endothelial cells unstimulated. Lane 3, HL-60 cells (control). Lane 4, WGH1 cells (control). Lane 5, mouse Ag8 cells (negative control). Lane 6, plasmid DNA PR-3. Lane 7, minus DNA PCR control. Lanes 3, 4, and 6 are positive controls.
Fig 7. Cyto-ELISA with unfixed HEC. Measurements at 0, 1, 2, 4, and 24 hours of treatment of cells with TNF-α. One mark represents the mean of three measurements. WG 1-10, affinity-purified anti–PR-3 antibodies of 10 sera of patients with WG. PR3-EBV, anti–PR-3 antibody Ho3. NS-Pool, pool of 100 healthy blood donors. Peak-surface expression of PR-3 after 2 hours of TNF-α treatment.

According to the manufacturer’s protocol and dissolved in 100 μL DEPC H2O. mRNA was extracted using 50 μL Dynabeads oligo (dT)25 (Dynal A.S., Oslo, Norway) according to the manufacturer’s protocol. The mRNA was used in a 40-μL reverse transcriptase reaction (50 mmol/L Tris-HCl, pH 8.3, 40 mmol/L KCl, 1 mmol/L DTT, 6 mmol/L MgCl2, 1 mmol/L rNTPs, 0.5 μg oligo (dT)12-18, 0.1 mg/mL BSA), 18 U RNAGuard [Pharmacia-LKB, Uppsala, Sweden] with 200 U MMLV reverse transcriptase (GIBCO-BRL, Berlin, Germany). RNA, DEPC-H2O, and oligo (dT)24 were incubated for 95°C for 5 minutes and quickly chilled in ice. All other components were added and incubated at 10 minutes at room temperature and 60 minutes at 37°C. The reaction was terminated by heating to 95°C for 5 minutes and quickly chilling in ice. Twenty micrograms of Glycogen (Boehringer Mannheim) was added and the volume was increased to 100 μL with a final concentration of 0.3 mol/L NaOAc, pH 5.5. cDNA was precipitated with 1 vol 2-propanol and resuspended in 20 μL DEPC-H2O.

Polymerase chain reaction (PCR). Two microliters of the reverse transcriptase reaction was used in a 30-cycle PCR reaction (Perkin-Elmer Cetus Thermal Cycler; Perkin-Elmer Cetus, Norwalk, CT). Each cycle consisted of 95°C for 1 minute, 62°C for 1 minute, and 72°C for 1 minute. The reaction volume consisted of 20 μL (20 mmol/L Tris-HCl, pH 8.3, 25 mmol/L KCl, 2 mmol/L MgCl2, 0.05% Tween 20, 100 mg/mL gelatine, 20 pmol of each primer, 200 μmol/L dNTPs (Biotin-dUTP/TTP in ratio of 1:4), 0.5 U of Taq polymerase (GIBCO-BRL) and was overlayed with 50 μL mineral oil. The reaction was started after preincubation at 80°C for 10 minutes by the addition of the Taq polymerase.
Affinity-purified anti-PR-3 antibodies [F(ab')2 fragments] produced a strong diffuse cytoplasmic staining of cytokine-treated HEC (Fig 2C). Antibodies produced by the PR-3-specific B-cell clone Ho3 and the murine monoclonal antibody WGM2 showed a similar pattern (Fig 2B). In contrast, untreated cells showed only a weak reaction (Fig 2A). Modification of the fixation method had no influence on the binding pattern. A serum of a WG patient, purified PR-3 antibodies, and antibodies produced by Ho3 recognized the affinity-purified antigen (extract of TNF-α-treated HEC) at 29 Kd (Fig 3).

Cytokine treatment of HEC also led to a membrane expression of PR-3. In contrast to cytoplasmic translocation, which has been investigated by IFT with fixed HEC, this was first assessed by cyto-ELISA with unfixed HEC. Figure 7 shows an increased surface expression of PR-3 under the influence of TNF-α in an ELISA with unfixed HEC. Compared with a serum pool of HBD, affinity-purified antibodies reacted rather weakly with untreated HEC (Fig 7), but TNF-α and IL-1α treatment led to a peak of antigen expres-
sion after 2 hours, with a distinct peak of PR-3 expression after 2 hours and a rapid decline during the next 2 hours. In contrast, treatment with IFN-γ led to a slow increase of antigen expression with a maximum after 24 hours and PR-3 remained on the cell surface for 72 hours (data not shown). Membrane expression could be blocked by cycloheximide. The effect of TNF-α could be blocked by a TNF-specific antibody (data not shown). Blocking of Fc-receptors on HEC with heat-aggregated human IgG had no influence on the binding of unfixed anti-PR-3 antibodies on HEC (Fig 8). Membrane expression of PR-3 on HEC could also be visualized by confocal laser scanning microscopy (Fig 9).

**DISCUSSION**

WG and microscopic polyarteritis are forms of systemic vasculitis whose pathogenic mechanisms are still poorly understood. An autoimmune etiology has been implicated in WG by the finding of circulating autoantibodies shown by indirect immunofluorescence techniques to bind to cytoplasmic components of alcohol-fixed normal human neutrophils.28

C-ANCA are seromarkers of WG and evidence exists that both the autoantigen and ANCA participate in the pathogenesis of at least the group “ANCA-associated vasculitides.”29 Until now, concepts of a direct pathogenic effect put the neutrophil in the focus of interest. The infiltration of polymorphonuclear leukocytes has been detected in inflammatory lesions of ANCA-associated vasculitis and glomerulonephritis.30 Several investigators report on the activation of neutrophils as important mechanism of ANCA-induced tissue destruction.31-33 In vitro ANCA can activate neutrophils and monocytes to produce reactive oxygen species, degranulation, and endothelial cell injury.34,35 Recently, two groups have presented a model in which ANCA and their target antigens could be involved as a major pathogenic event in vascular tissue damage.36,37

The first contact with antigen is the luminal surface of the vascular endothelium of the tissue and this unique anatomical location of endothelial cells makes them a major candidate for initial antigen presentation.38 Recently, Abbott et al29 could show by IFT that a monoclonal antibody to neutrophil cytoplasmic antigens and WG sera bound to human cultured glomerular epithelial and endothelial cells as well as to HEC. The investigators concluded that the antigen recognized by the ANCA-positive sera is also expressed on surface vascular structures, suggesting a direct pathogenic role for this antibody specificity.

These findings, together with the knowledge that neutrophils do not represent the exclusive source of PR-3,9 were the impetus behind the investigation of the repertoire of endothelial antigens recognized by ANCA. In this study we have investigated the expression of PR-3 in HEC using purified anti-PR-3 antibodies of WG sera and monoclonal antibodies against PR-3 (murine and human) as probes.

According to our knowledge, this is the first report of PR-3 in HEC. In addition to the identification of PR-3 in untreated HEC using PCR and affinity-purified anti-PR-3 antibodies as probes, we were able to demonstrate time-dependent translocation of this antigen in the cytoplasm of HEC and a transient membrane expression after treatment with cytokines. Different cytokines showed different profiles of membrane expression. Translocation of PR-3 in HEC could be characterized as an active process depending on protein synthesis. Antibody binding does not occur unspecifically via Fc-receptors.

PR-3 under the influence of cytokines is expressed in the membrane of endothelial cells, thereby becoming accessible to circulating C-ANCA, supporting the supposition that the generation of these autoantibodies might be a fundamental process in the development of the systemic vasculitides. Thus, the ANCA antigen is present in the sites affected by the disease (ie, WG and other ANCA-related diseases).

Furthermore, our data confirm the putative key role of cytokines in ANCA-associated vasculitic syndromes. In this context, we recently have measured TNF and IL-6 levels in
WG sera. TNF levels were elevated during active phases and not detectable in remission.37 These findings are supported by reports of enhanced transcription of TNF-α gene in peripheral blood mononuclear cells of patients with systemic vasculitis and WG compared to HBD performing RNA-dot blot or Northern blot analysis.40

In summary, our data give a hint at a possible direct pathogenic effect of anti-PR-3 antibodies in WG and represent an important missing link in ANCA-endothelial interactions. Further investigations are currently in progress to evaluate the effect of other cytokine specificities on the expression of PR-3 and to characterize cytotoxic effects of anti-PR-3 antibodies on HEC.

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Human endothelial cells express proteinase 3, the target antigen of anticytoplasmic antibodies in Wegener’s granulomatosis

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