p53 protein is absent from the serum of patients with lung cancer

MA Levesque1,2, M D’Costa2,3 and EP Diamandis1,2,4

1Department of Pathology and Laboratory Medicine, Mount Sinai Hospital, Toronto M5G 1X5; 2Department of Clinical Biochemistry, University of Toronto, Toronto M5G 1L5; and 3Department of Laboratory Medicine, St Joseph’s Health Centre, Toronto M6R 1B5, Canada.

Summary p53 protein, which accumulates intracellularly in over half of all human tumours, has also been reported to be present in the sera of patients with various malignancies, including lung cancer. Using a quantitative immunoassay, we measured p53 protein concentrations in 216 sera from 114 lung cancer patients of whom 75 provided matched lung tumour tissues, which were also assayed for p53 protein. p53 protein levels above the detection limit of 0.04 ng ml\(^{-1}\) were detected in only two sera from lung cancer patients (0.14 ng ml\(^{-1}\) and 0.27 ng ml\(^{-1}\)), but not in any of 13 sera from non-malignant lung disease patients or in 100 sera from normal non-diseased individuals. The presence of these apparent traces of serum p53 protein concentrations could not be related either to the p53 protein expression status of the primary lung tumours or to the tumour stage, grade or histological type. By pretreating these two sera with anti-p53 antibody linked to solid phase, and by the addition of mouse serum to neutralise possible heterophile antibodies, the signals arising from these sera were shown to be non-specific and possibly caused by heterophile antibodies. We conclude that our data do not support previous reports of p53 protein in the sera of lung cancer patients. Since immunooassays are subject to numerous sources of interference in serum, including heterophile antibodies, we suggest that the results of p53 protein analysis of serum specimens should be interpreted with caution.

Keywords: p53 protein; lung neoplasm; enzyme-linked immunosorbent assay; tumour marker

Wild-type p53 protein is a nuclear transcription factor with multiple functions, including the induction of a G1/S cell cycle checkpoint, DNA repair and programmed cell death, following genomic damage (Kuerbitz et al., 1992; Lowe et al., 1993; Smith et al., 1994). Deletion of one p53 allele, on the short arm of chromosome 17, accompanied by the missense point mutation of the other p53 allele is the most common genetic feature of almost every human malignancy (Levine et al., 1991; Hollstein et al., 1992), strongly suggesting that p53 inactivation plays a key role in tumorigenesis. Missense mutation in most cases leads to the expression of a conformationally altered, non-functional mutant p53 protein which accumulates in the nucleus of affected cells and can be demonstrated by immunochemical techniques. Levels of wild-type p53 protein in normal cells, in contrast, are typically undetectable. Of clinical relevance are reports of p53 genetic abnormalities and the closely correlated p53 protein overexpression, in neoplasms of breast (Thor et al., 1992), colon (Remvikos et al., 1992), ovary (Levesque et al., 1995a) and bladder (Esgir et al., 1994). Overexpression of mutant p53 may identify more aggressive tumours and hence patients with unfavourable prognoses.

p53 mutation (Miller et al., 1992; Gazzeri et al., 1994; Ryberg et al., 1994) and protein accumulation (Caaman et al., 1991; Brambilla et al., 1993) also frequently occur in primary lung carcinoma, which is the leading cause of cancer mortality in North America (Boring et al., 1993). Prognosis for these patients is largely dependent on the stage of the tumour presenting at clinical diagnosis, although other factors, including p53 overexpression in tumour tissue, have also been reported to predict reduced patient survival (Quinlan et al., 1992; Mitsudomi et al., 1993a). There is strong evidence implicating the p53 gene as a target for genotoxic agents in tobacco smoke (Suzuki et al., 1992; Dosaka-Akita et al., 1994), supporting observations that p53 mutations are an early event in lung cancer progression (Bennett et al., 1993; Walker et al., 1994). In addition to immunohistochemistry, which has been extensively used in clinical studies, enzyme-linked immunosorbent assay (ELISA) methods have also been developed to detect both mutant and wild-type p53 protein overexpression in tumour tissues (Midgley et al., 1992; Vojeesk et al., 1992; Hassapoglidou et al., 1993). The application of ELISA for the measurement of p53 protein in lung neoplasms has recently been reported (Pappot et al., 1996).

Whether tumour cells which overexpress p53 protein may release it into the bloodstream has been the subject of only a few investigations to date. A screen of 800 serum specimens collected from patients with a wide range of malignancies was unable to detect p53 protein in any specimen using an immunofluorometric assay (Hassapoglidou et al., 1993). This finding is consistent with those of other workers (Winter et al., 1992) employing a commercially available p53 ELISA method (Oncogene Science, Uniondale, NY, USA) on lung cancer patient sera. More recently, however, elevated levels of p53 protein have been reported in the sera of patients with lung cancer (Luo et al., 1994; Braun et al., 1995) and colon adenomas and carcinomas (Greco et al., 1994; Luo et al., 1995), relative to the sera of control subjects, as well as in the sera of patients with Hodgkin’s disease (Trumper et al., 1994), malignant lymphomas (Lehtinen et al., 1993; Lababdio et al., 1993), breast cancer (Rosanelli et al., 1993) and asbestosis with and without lung cancer (Partanen et al., 1995). In all of these recent studies, p53 protein was quantified in sera by the same or similar ELISA procedure. We report here the use of a recently developed highly sensitive immunoassay of p53 protein (Levesque et al., 1995b), which is suitable for all sample matrices including serum. Because our initial inability to detect p53 protein in the serum of cancer patients (Hassapoglidou et al., 1993) was in conflict with the findings of other groups, we sought to determine if the p53 immunooassay signals arising in serum were truly p53-specific. This study, however, comparing p53 protein concentrations in sera and tumour tissue extracts of patients with primary lung cancer, as well as reporting the measurements of p53 protein levels in sera from non-malignant lung disease patients and from normal individuals, suggests that p53 protein is not present in the sera of patients with lung cancer.

Correspondence: EP Diamandis, Department of Pathology and Laboratory Medicine, Room 600-16, Mount Sinai Hospital, 600 University Avenue, Toronto M5G 1X5, Canada.

Received 1 March 1996; revised 7 May 1996; accepted 15 May 1996.
Materials and methods

Cancer patients

Matched tumour and serum specimens were obtained from 75 patients who were operated on at St Joseph’s Health Centre in Toronto, Ontario, Canada between June 1993 and August 1995 for resectable primary lung carcinoma. This group consisted of 23 males and 52 females, and included 16 individuals less than 59 years of age, 32 between 60 and 69 years, 23 between 70 and 79 years, and four more than 80 years of age at the time of surgery. Only four patients lacked a history of tobacco smoking. All but three patients were staged at surgery according to the TNM classification system (Beahrs et al., 1992): 46 were found to have stage I disease, 12 were in stage II, 12 had stage IIIA, one patient had stage IIIB, and one patient had stage IV cancer.

Lung tumour specimens

All lung tumour specimens were obtained during routine surgery for the treatment of primary lung cancer. This study was approved by the ethics and research committee at St Joseph’s Health Centre, Toronto, Ontario, Canada. Immediately after surgery, a representative portion of each primary lung tumour was selected during quick-section procedures in the operating theatre, snap frozen and stored at −80°C for subsequent p53 immunohistoassay (see below). Formalin-fixed, paraffin-embedded sections of adjacent tumour tissue were used routinely to establish the grade and histological type in 72 cases following World Health Organization guidelines (WHO, 1982). Well-differentiated (G1) tumours were found in six patients, 43 had moderately differentiated (G2) tumours, 22 were poorly differentiated (G3) and one was not differentiated (G4). Adenocarcinoma and squamous cell carcinoma, represented by 32 and 34 cases, respectively, accounted for the majority of specimens, while the remainder consisted of carcinoid tumours (n = 3), small-cell carcinoma (n = 2), large-cell carcinoma (n = 2), and one each of adenosquamous and carcinoid sarcoma histologies. Further histological examination classified the tumour cellularity of 26 lung tumours as high (n = 10), intermediate (n = 12), or low (n = 4).

Approximately 200 mg of the frozen tumour tissue was pulverised and subjected to cell lysis by incubation on ice for 30 min with 1 ml of a buffer containing 50 mM Tris, 150 mM sodium chloride, 5 mM EDTA, 10 mm 1-1 NP-40 surfactant, 10 mg l-1 phenylmethylsulphonyl fluoride and 1 mg l-1 each of aprotnin and leupeptin. The soluble extracts were obtained following centrifugation at 14 000 g for 30 min at 4°C and collection of the supernatant fractions. Extracts were then assayed immediately for p53 protein as described below, and for total protein content by the bicinchoninic acid (BCA) method (Pierce Chemical, Rockford, IL, USA). In order to determine the degree of heterogeneity for p53 protein accumulation within individual tumour specimens, ten tumour specimens were each further sampled at three different surfaces, and the equivalent masses of tissue were extracted and assayed for p53 protein. Normal lung tissue, free of overt malignant infiltration, was cut from seven surgical specimens at the margins of resection and subsequently pulverised, extracted and assayed for both p53 protein and total protein as described above. These were designated as control or ‘normal’ tissues.

Serum specimens

For each of the 75 lung cancer patients, preoperative and/or post-operative aliquots of serum specimens were obtained from the routine biochemistry laboratory. A preoperative serum specimen was obtained from 54 patients: 17 on the same day as surgery, 19 one day before and 18 two to nine days before surgery. At least one post-operative serum was obtained from 64 patients. Multiple post-operative samples were collected from 12 patients up to 12 days after surgery: four patients provided two specimens, four patients had three sera, and one patient each provided four, five, six and seven specimens, respectively, after surgery. A preoperative serum and at least one post-operative serum were collected from 43 patients. Sixty-eight sera were also collected from 39 lung cancer patients for whom no matched tumour tissues were available. For these latter specimens, the dates of collection relative to the date of surgery in each case were not known. All sera were stored at −80°C until analysis.

Control sera from 100 individuals from the general population without symptomatic disease were stored for no longer than 6 months at −40°C. Further controls were provided by 13 sera obtained from patients assessed at St Joseph’s Health Centre for non-malignant lung diseases, including chronic obstructive lung disease (n = 5), pulmonary embolism (n = 2), sarcoidosis (n = 2) or respiratory failure due to other causes (n = 5). These specimens were frozen after venipuncture and stored at −40°C before immunohistoassay.

p53 immunofluorometric assay

Lung tumour extracts and undiluted sera were assayed for p53 protein in duplicate using a ‘sandwich-type’ immunofluorometric assay (Levesque et al., 1995b). Briefly, this method involves the capture of soluble p53 by DO-1 monoclonal antibody (Vojtesek et al., 1992) (gift from Dr David P Lane, University of Dundee, Scotland) immobilised in microtitre wells and probing with polyclonal CM-1 anti-p53 rabbit antiserum (Middley et al., 1992). Following addition of an alkaline phosphatase-conjugated goat anti-rabbit secondary antibody, detection of bound immunocomplexes was achieved by addition of the substrate fluorophosphate; the dephosphorylated product then enters into a complex with terbium and EDTA emitting long-lasting fluorescence at 615 nm measured by a time-resolved fluorometer (Cyberfluor, Toronto, Canada). Both mutant and wild-type p53 are measured by this assay as DO-1 and CM-1 each recognise both molecular forms of p53 (Middley et al., 1992; Vojtesek et al., 1992). Concentrations of p53 were interpolated from a standard curve generated by the simultaneous assay of a dilution series of an extract of Sf9 insect cells infected with a baculoviral p53 expression vector (gift from Dr Thierry Sousi, INSERM, Institut de Génétique Moléculaire, France) as detailed elsewhere (Levesque et al., 1995b). Values of these standards were established in turn by the assay of lyophilised recombinant human p53 protein standards (Oncogene Science, Uniondale, NY, USA) and extended from 0 to 75 ng ml-1, containing the range of p53 concentrations (~0.15–75 ng ml-1) within which the assay response was linear. The detection limit of the assay was approximately 0.04 ng ml-1. Interassay precision at a p53 protein concentration equal to the first p53 protein standard (0.15 ng ml-1) was calculated to be 15%. In lung tumour extracts, p53 levels were expressed relative to the amount of total protein in the cell lysates.

Serum specimens with p53 concentrations consistently exceeding the detection limit on repeated analyses were reassayed after incubation for 1 h at room temperature with 30% (v/v) DO-1 Sepharose (to immunoabsorb p53 protein), anti-digoxin Sepharose (control) or uncoupled Sepharose (control), used as 50% slurries, followed by centrifugation at 14 000 g for 30 min to collect the supernatants. The solid phase Sepharose–antibody conjugates were prepared from high titre ascites fluids collected from mice injected with monoclonal DO-1 or anti-digoxin-producing hybridomas using standard procedures (Harlow and Lane, 1988), and from CNBr-activated Sepharose 4B (Pharmacia, Uppsala, Sweden) used according to the manufacturer’s instructions. A lung tumour extract prepared as above, and a serum specimen from a hospitalised patient without evidence of malignancy which was supplemented with 10% (v/v) lung tumour extract, were also treated as above and then assayed for p53 protein. Serum specimens containing detectable levels of p53 protein were also tested for the presence of
heterophilic antibodies, a potential source of spurious background signals in two-site immunoassays (Nahm and Hoffmann, 1990). The fluorescence counts yielded by the reassembly of specimens 30 min after the addition of mouse serum (50% v/v), with agitation at room temperature, were compared with the counts elicited by assay of the same specimens to which equivalent volumes of 6% bovine serum albumin (BSA) (50 mM Tris, pH 7.80, 60 g l⁻¹ BSA and 0.5 g l⁻¹ sodium azide) had been added.

Results

All 75 lung tumour extracts had p53 protein concentrations that exceeded the p53 detection limit of ~0.04 ng ml⁻¹; values ranged from 0.06 to 70.7 ng ml⁻¹ with a median p53 concentration of 0.52 ng ml⁻¹. Because of variations in the extraction efficiency, the levels of p53 protein were adjusted for the total protein concentrations in the extracts. The distribution of these adjusted p53 concentrations in the tumour tissues was positively skewed (minimum, 8 ng g⁻¹; maximum, 10,967 ng g⁻¹; median, 133 ng g⁻¹; mean, 1,100 ng g⁻¹; standard deviation, 2,198 ng g⁻¹). In order to categorise tumour specimens as either p53-negative or p53-positive, the median value of 133 ng per gram of total protein was selected as the arbitrary cut-off point, shown in relation to the histogram of the logarithmically transformed p53 values in Figure 1. Tumour tissues were roughly homogeneous for p53 protein overexpression, since three independent extractions of tissue cut from different surfaces of a small number of p53-positive (n = 5) and p53-negative (n = 5) specimens yielded p53 concentrations, adjusted for total protein, which did not vary by more than 10% for each tumour (data not shown). Normal lung tissue cut from the resection margins of seven tumour-containing specimens revealed much lower p53 concentrations which ranged from 10 ng g⁻¹ to 70 ng g⁻¹ with a median of 30 ng g⁻¹.

Of all the sera collected from the lung cancer patients, only two had p53 protein levels which consistently exceeded the assay detection limit on repeated analyses, necessary for the measurement of p53 protein levels in serum specimens because of the random fluctuations of the assay at the beginning of the calibration curve. One of these sera, having a p53 protein concentration of 0.27 ng ml⁻¹ (which exceeds the first p53 protein standard in the linear portion of the calibration curve) and denoted as patient serum 1, was identified from a screen of 68 sera collected from patients while they were in hospital for surgical removal of their primary lung carcinomas. The other serum specimen, henceforth referred to as patient serum 2, had a p53 protein level of 0.14 ng ml⁻¹ and was collected from a lung cancer patient before surgery. Although it was known that this patient had a poorly differentiated squamous cell carcinoma which had invaded the visceral pleura but did not involve any of the regional lymph nodes (stage I), correlation between the appearance of detectable p53 protein in serum and any clinical pathological feature was obviously not possible. The relationship between p53 protein expression status by the primary tumour and its detection in serum could similarly not be addressed; the p53 protein concentration in the extract prepared from this patient’s lung tumour was 15 ng g⁻¹, below the median cut-off point for p53 positivity. None of the 100 sera from asymptomatic members of the general population or the 13 sera from patients with lung diseases other than malignancy had p53 protein concentrations exceeding the assay detection limit.

To provide evidence that the fluorescence signals in apparently ‘p53-positive’ sera were related to p53 protein concentrations, patient sera 1 and 2 were further investigated by a simple immunoabsorption procedure in which specimens were incubated with Sepharose beads conjugated to DO-1 antibody to clear them of soluble p53 protein before assay. The high capacity of DO-1 Sepharose to specifically immunoabsorb p53 protein from a lung tumour extract is shown in Figure 2a; the assay of the tumour extract after treatment with DO-1 Sepharose yielded only 8% of the fluorescence counts generated by the assay of the same extract after incubation with uncoupled Sepharose, used as a dilution control since the conjugates were added as aqueous slurries. The tumour extract, which had a p53 protein concentration of approximately 10 ng ml⁻¹, was completely cleared of detectable p53 protein as the signal after Sepharose treatment did not exceed background. Treatment with Sepharose, conjugated to an antibody against the irrelevant antigen digoxin, resulted in a much smaller reduction of the fluorescence signal. As shown in Figure 2b, DO-1 Sepharose was also able to remove p53 protein from control sera which was supplemented, to a p53 protein level of 0.8 ng ml⁻¹, with p53-containing lung tumour extract. Again, background fluorescence counts were achieved in these sera following DO-1 Sepharose treatment. The high recoverability of p53 protein from serum (Levesque et al., 1995b) was confirmed by the observation that dilution of the lung tumour extract 10-fold by the control sera yielded fluorescence signals less than seven times lower than that of the undiluted tumour extract (data not shown). Given these results, the reduction in p53-associated fluorescence after incubation of patient serum 1 with DO-1 Sepharose to 58% of the signal produced in the same serum treated with uncoupled Sepharose (Figure 2c), was suggestive that this serum specimen contained p53 protein. In contrast, no reduction in fluorescence counts resulted from the treatment of patient serum 2 with DO-1 Sepharose (Figure 2d).

Because treatment of patient serum 1 with DO-1 Sepharose did not reduce the fluorescence signal to a background level, as was the case when DO-1 Sepharose was added to both the tumour extract-spiked control sera and to the extract itself, we investigated the possibility that the signals in these specimens were caused by the presence of human antibodies with broad anti-species specificities which might have cross-linked the solid phase DO-1, polyclonal CM-1 or alkaline phosphatase-conjugated antibodies in our immunoassay leading to false-positive results. A common practice to neutralise these heterophilic antibodies, which have been reported in the sera of up to 40% of normal subjects (Boscofo and Stuart, 1986), is the inclusion of non-immune serum from a species used to raise one of the analyte-specific antibodies to the sample assay buffer (Nahm and Hoffmann, 1990). The large excess of mouse immunoglobulins in mouse serum, added to human serum specimens, would be expected to saturate the binding of any heterophilic antibodies with anti-mouse specificity. Figure 2c shows that when added to patient serum 1, mouse serum (added as 30% of the total volume) was able to suppress completely the fluorescence signal, unlike equivalent dilution of this serum by the addition of immunoglobulin-free 6% BSA. The same amount of mouse serum added to patient serum 2 (Figure 2d) or to either the tumour extract or the spiked control sera.
(data not shown) were without similar effect. These results strongly suggest that patient serum 1 contained non-specific reactants with the sandwich immunoassay.

Discussion

Loss of p53 function is believed to impair a regulatory pathway whereby DNA damage may trigger cell cycle arrest or apoptosis in order to limit the propagation of harmful mutations to daughter cells. The accumulation of mutations leading to increased rates of cell division, the ability to invade locally and to metastasise, and the general escape from cellular social controls governing cell behaviour provide the molecular basis for neoplasia. Alterations to the p53 gene are the most frequent genetic changes revealed so far in human cancer and occur in 43–75% of non-small-cell lung cancers (NSCLC) (Marchetti et al., 1993; Mitsudomi et al., 1993a; Gazzieri et al., 1994) and 32–70% of small-cell lung cancers (SCLC) (Miller et al., 1992; Lohmann et al., 1993; Ryberg et al., 1994), demonstrating its importance in the pathogenesis of these malignancies. Determination of the functional status of p53 in cell lines, normal tissues and in tumours is most often inferred by sequence analysis of p53 coding regions, indirect methods of revealing the genotype, or by the detection of p53 protein in the nuclei of tumour cells by standard immunohistochemical techniques (Soussi et al., 1994). Quantitative immunoassays for p53 protein, however, may offer a number of advantages (Diamandis and Levesque, 1995) and have been applied to soluble cell extracts prepared from breast (Bartkova et al., 1993; Vojtesek et al., 1993; Levesque et al., 1995c), ovarian (Levesque et al., 1995a), gastrointestinal (Bartek et al., 1991; Bartkova et al., 1993; Joyeux et al., 1993), vulval (Bartkova et al., 1993), muscle (Bartek et al., 1991), and more recently, in lung tumours (Pappot et al., 1996). For tumours of three anatomic sites, breast (Vojtesek et al., 1993), stomach (Joyeux et al., 1993) and colon (Joyeux et al., 1993), parallel determinations of p53 protein expression status by immunohistochemistry and immunoassay have revealed that these methods yield concordant findings.

Procedures less invasive than thoracotomy to remove structures affected by lung cancer have also been shown to indicate p53 mutational events directly or indirectly. Single strand conformation polymorphism (SSCP) analysis of p53 exons 5 to 8 (Mitsudomi et al., 1993b), where the majority of mutations occur in lung and other cancers (Hollstein et al., 1991; Levine et al., 1991), and immunostaining for p53 protein (Bennett et al., 1993; Walker et al., 1994) in bronchial biopsy specimens have demonstrated the potential for the early diagnosis of lung cancer. In addition, sputum specimens not cytologically diagnostic for cancer from patients who later developed adenocarcinoma have been shown to contain the same mutations identified in the primary lung lesion up to a year before clinical diagnosis (Mao et al., 1994). Circulating antibodies recognising p53 protein have been detected in the sera of a proportion of both SCLC and NSCLC patients by immunoblotting (Winter et al., 1992; Schlichting et al., 1994) and by enzyme immunoassay (Angelopoulos et al., 1994; Lubin et al., 1995). Patients expressing these antibodies have
been shown to possess tumours harbouring p53 mutations and to be highly positive for p53 protein (Winter et al., 1992). Because the appearance of anti-p53 antibodies is likely to be an early event in lung cancer (Lubin et al., 1995), and the antibody titre may reflect the clinical course of the disease (Angelopoulou et al., 1994; Lubin et al., 1995), measurement of serum antibodies against p53 has been proposed for both diagnosis and monitoring of lung cancer.

Attempts to detect in serum the p53 antigen which elicited this antibody response were initially unsuccessful (Winter et al., 1992; Hassapoglidou et al., 1993). A number of subsequent studies however, have reported the presence of p53 protein in serum. Over 30% of sera from patients with malignant lymphomas were found to be positive for p53 protein in two Finnish studies correlating serum levels of p53 with either thymidine kinase (Lehtinen et al., 1993) or antibodies directed against the adenosirus 12 Elb protein (Lahdeaho et al., 1994). A 64% p53-positivity rate in the sera of Hodkin's lymphoma patients was also reported (Trumper et al., 1994). In another study, pre- and post-operative serum specimens collected from 60 cases of primary breast carcinoma and assayed for p53 protein were found to exceed 1 ng ml⁻¹ in five cases but did not correlate with immunohistochemical p53-positivity in the matched breast tumours (Rosanelli et al., 1993). Two groups have provided evidence that serum p53 protein may be measurable in patients with neoplasms of the colon. One of these (Greco et al., 1994) has shown statistically significant differences in median serum p53 values between patients with colon adenoma (0.06 ng ml⁻¹) and adenocarcinoma (0.10 ng ml⁻¹), although, again, associations between serum p53 and tumour stage, grade or site could not be demonstrated. Another group (Luo et al., 1995) additionally collected normal plasma controls, which were shown to differ with respect to p53 concentrations from sera obtained from patients with colon adenoma (mean, 0.44 ng ml⁻¹), with a 20% p53-positivity rate, and from patients with colon carcinoma (mean, 0.55 ng ml⁻¹), 32% of which were positive for p53 protein. These same authors have also examined serum levels of p53 protein in 23 cases of lung cancer, an equal number of matched hospital controls, 58 members of the general population and four people with non-malignant lung disease (Luo et al., 1994). The mean p53 level in lung cancer patients (0.55 ng ml⁻¹) was in fact higher than those of non-malignant lung disease (0.42 ng ml⁻¹) or of the other control subjects (approximately 0.32 ng ml⁻¹) for both groups, but these differences did not achieve statistical significance. Even more recently, we reported the presence in the sera of patients with asbestos, some of whom also have lung cancer. While one group (Partanen et al., 1995) was unable to find significant differences in mean serum p53 protein levels between asbestos patients with (0.33 ng ml⁻¹) or without (0.29 ng ml⁻¹) cancer and control subjects (0.61 ng ml⁻¹), another group (Braun et al., 1995) revealed that uranium miners with lung cancer had higher serum concentrations of p53 (median, 0.23 ng ml⁻¹) than control subjects, including non-smokers (median, 0.06 ng ml⁻¹) and individuals without malignancy (median, 0.03 ng ml⁻¹), possibly signalling exposure to radioactive radon. Unlike all of the above investigations, which used commercial p53 ELISA methods, was a study reporting levels of p53 protein in colon cancer patient sera up to 10⁴ ng ml⁻¹, determined by a chromatographic procedure to extract tumour-associated antigens from sera (Zusman et al., 1995). This latter finding deviates tremendously from data obtained by ELISAs and should be interpreted with caution.

In this report we have used a new immunoassay (Levesque et al., 1995b) to measure p53 protein in both tumour tissue and sera. Compared with our original assay configuration, the new assay incorporated modifications, including the use of microtitre plates coated directly with an anti-p53 monoclonal antibody, a detergent and mouse serum containing sample diluent, and a labelled secondary antibody diluent containing goat serum, which greatly reduced the non-specific background signals arising in many serum specimens from hospitalised patients without cancer. Freedom from such interference, the high recovery (range 72–131%, mean 90%) of p53 protein from serum, and the generation of p53 results concordant with the original method when applied to extracts of non-diseased and malignant breast tissues, all indicated that the new immunoassay was equally suited for the analysis of p53 protein in both tissue extracts and serum specimens. This, to our knowledge, is one other group (Pappot et al., 1996) has used a quantitative ELISA-type method to detect p53 protein in malignant lung tissue, rather than the more widely used p53 immunostaining techniques. However, ours is the first report of the use of an immunoassay for the concomitant measurement of p53 protein in both tumours and matched serum specimens. To classify tumour specimens as either p53-negative or p53-positive, we used the median p53 concentration of 133 ng g⁻¹ rather than the preferred receiver operator characteristic analysis (Zweig and Campbell, 1993), since a reference method for unequivocally establishing p53 status has not been universally accepted. This practice had also been adopted in work recently reported (Pappot et al., 1996), in which a median p53 concentration of 100 ng g⁻¹ was found by the immunoassay of 214 NSCLC extracts whose p53 values ranged from 0 to 700 ng g⁻¹. The use of the median p53 concentration value provides a more objective determination of p53 expression status than the variety of immunohistochemical scoring schemes used in other studies (Caamano et al., 1991; Quinlan et al., 1992; Brambilla et al., 1993).

Given these findings by a number of groups of p53 protein in the sera of patients with lung (Luo et al., 1994; Braun et al., 1995; Partanan et al., 1995) and other (Lehtinen et al., 1993; Greco et al., 1994; Lahdeaho et al., 1994; Luo et al., 1994) malignancies, our failure to detect p53 in the sera from over 100 lung cancer patients was surprising. In those specimens in which p53 concentrations were found to exceed the assay detection limit, subsequent reassyling following either immunoperoxidase by solid phase anti-p53 antibody or addition of immunoglobulins to neutralise possible crosslinking heterophile antibodies, provided strong evidence that even these serum specimens were devoid of p53-specific immunoreactivity. Confidence in our findings rests on several attributes of our study design. Most importantly, for the measurement of p53 protein concentrations we have used a sensitive, well-characterised immunoassay (Levesque et al., 1995b) yielding minimal background signals in serum, a method containing neither immunoperoxidase nor p53-negative tumour tissue was associated with detectable serum p53 protein. Consequently, we could not determine if p53 levels declined following surgery.

The most likely explanations for the discrepancy between our findings and that of all those other reporting p53 protein in patient sera invoke potential differences between the immunoassay methods used to quantitate serum p53 protein. The estimated analytical sensitivity of our method, 0.04 ng ml⁻¹, is superior to that of either the mutant p53 selective (0.25 ng ml⁻¹) ELISA assays (Oncogene Science, Uniondale, NY, USA) commonly employed in studies measuring p53 in serum. Therefore, the relatively low p53 protein concentrations reported in these studies would easily have been detected by our immunoassay. Whether p53 protein is complexed by serum components, masking its detection by the combination of monoclonal CM-1 and monoclonal DO-1 immunoreagents
used in our assay yet allowing its detection by polyclonal CM-1 and the monoclonal antibodies used in the other assays, cannot be determined at present.

The potential of the measurement of p53 protein levels in serum for the diagnosis and monitoring of a variety of malignant conditions in which p53 is overexpressed is of obvious clinical interest. The success of such an approach might be limited, however, by three major biological considerations: (1) not all tumour tissues, even those in which the p53 gene has been mutated, show accumulation of the p53 protein; (2) in many patients, the generation of autoantibodies against p53 might mask epitopes of the protein necessary for its detection by ELISA-type immunoassays; and (3) since p53 is a transcription factor thought to function primarily in the nucleus and is not targeted for extracellular release, it could probably enter the blood circulation only by cell death within the tumour.

Investigators concerned with the measurement of p53 protein in biological fluids should also be aware of possible analytical difficulties. p53 immunoassay designs which use anti-species antibodies (e.g. an anti-serum raised in a goat host against mouse IgG) to coat the solid phase are not suitable for serum analysis since they are susceptible to non-specific interference by heterophilic antibodies, which may be present in up to 30% of normal individuals. These assays will therefore yield false-positive results in a large proportion of the patient sera tested. In addition, since all current ELISA-type methods for p53 quantification include rabbit polyclonal anti-p53 detection antibodies and subsequently added enzyme-labelled anti-rabbit antibodies, it is imperative that the anti-rabbit antibody used in each assay has been treated, such as by adsorption to human IgG columns, in order to eliminate any cross-reactivity with human IgG present in serum specimens. Otherwise, in our experience, approximately 30% of human serum assayed will be apparently positive for p53 protein. Once ‘p53-positive’ specimens are identified, it is highly recommended to check for the presence of heterophilic antibodies by treating the sera with mouse IgG and then reasaying them. Since the ability to confirm the molecular weight of the immunoreactive species in serum by Western blotting is impaired by the relatively low sensitivity of this procedure, other methods to demonstrate the dependence of the assay response upon p53 protein, such as the immunoabsorption experiment described here, are required. Further indirect evidence for the existence of p53 protein in the sera of cancer patients may also be provided by the demonstration that p53 levels in the sera are compatible with those found in the tumour tissues and that serum p53 concentrations decline following surgical removal of the tumour. When all of these stringent criteria were applied, none of the serum specimens assayed for p53 protein in this study were found to have measurable p53 protein levels. The presence of p53 protein in the sera of patients with lung cancer is therefore not supported by the results of this study.

In the light of our finding, we strongly recommend that before it is concluded that p53 protein is present in the sera of patients with lung or other malignancies, stringent criteria such as those outlined above should be used to identify p53-specific assay responses. Immunological assays for p53 protein based only on monoclonal antibodies will probably prove more successful for the assay of serum specimens but as yet await development.

Acknowledgements

The authors wish to thank Dr Latif Tadross for providing the tumour cellularity of the malignant lung tissues, and Drs David Lane and Thierry Soussi for the gifts of the DO-1 hybridoma cell line and baculovirus p53 expression vector respectively. This work was supported by St Joseph’s Health Centre Foundation.

References


