INTRODUCTION

Each year, an estimated 50,000 people worldwide will become afflicted with amyloidosis, with more than 3,000 people receiving the diagnosis in North America alone. Its symptoms are vague and nonspecific, often mimicking those of other common conditions. Amyloidosis are a group of disorders in which soluble proteins aggregate and get deposited extracellularly in tissues as insoluble fibril, causing progressive organ dysfunction (1, 2). More than 20 proteins are known to form amyloid fibrils (3, 4). The two most common causes of systemic amyloid deposition are monoclonal immunoglobulin light chains (ALs) and the acute-phase reactant serum amyloid A (AA). AL amyloidosis is associated with plasma cell dyscrasias, including monoclonal gammopathy of undetermined significance, and multiple myeloma. AA amyloidosis is typically secondary to chronic inflammatory conditions, such as rheumatoid arthritis and several other inflammatory diseases. Kidneys are some of the most frequent sites of amyloid deposition in AL, AA, and several hereditary amyloidoses (5).

The diagnosis of renal amyloidosis on kidney biopsies relies on Congo red staining, leading to typical apple-green birefringence under polarized light (5). Once, the potassium permanganate method with Congo red staining, as described by Wright et al. in 1977 (6), had been widely used to discriminate AL and AA amyloidoses. Unfortunately, this method has largely lost the credibility because of false positive results (7). It was recently recommended to use immunohistochemical analysis to detect λ-light chain, κ-light chain and amyloid A for differential diagnosis of AL and AA amyloidosis (8). Nonetheless, this immunohistochemical examination takes a long time and has a problem with reproducibility due to variations in the protocols and conditions of the antibodies. Therefore, simple and reproducible methods are needed to distinguish AL and AA amyloidoses.

In our previous immunofluorescence staining technique for the detection of a set of immunoglobulins and complements factors for diagnosis of 130 renal biopsy samples at Tokushima University Hospital between 2008 and 2010, we performed staining with 4',6-diamidino-2-phenylindole (DAPI) positive areas were clearly consistent with amyloid deposition in AL amyloidosis. In contrast, the overlapping staining was not seen in AA amyloidosis. Therefore, we propose that DAPI staining readily distinguishes AL renal amyloidosis from AA renal amyloidosis as a simple and reproducible histochemical method. J. Med. Invest. 64 : 217-221, August, 2017

Keywords: amyloidosis, DAPI
patients.

Laboratory examination—Creatinine in serum was measured by an enzymatic method. Twenty-four-hour urine protein in g/day was determined to multiply the 24-hour urine volume by the urine protein concentration measured using a pyrocatechol violet molybdate dye-binding method. Serum amyloid A protein (SAA) was measured by a latex agglutination immunooassay method.

Histology—Histopathological studies were performed on human tissues. Kidney specimens (n=14) were obtained from renal biopsies. Kidney tissue blocks for light microscopy examination were fixed with Dubosq-Brazil’s solution and embedded in paraffin. Amyloid staining was performed with Congo-red, exhibited apple-green birefringence on polarizing microscopy, and confirmed the reaction of the potassium permanganate digestion.

Immunohistochemistry—Kidney sections were processed for immunohistochemistry following standard procedures. Dubosq-Brazil’s solution-fixed and paraffin-embedded kidney tissue blocks were used. Before dyeing them, tissue sections (2 µm) were rehydrated and treated with HistoVT One (Nacalai Tesque Inc., Kyoto Japan) for 20 min at 98°C. To perform DAPI-λ-chain double staining, sections were stained with FITC-conjugated anti-human lambda light chains antibody (1:40 dilution) (Dako, Kyoto, Japan) or anti-human kappa light chains antibody (1:40 dilution) (Dako, Kyoto, Japan) for 120 min at room temperature and then incubated with DAPI (1:1000 dilution) (Wako, Osaka, Japan) for 30 min at room temperature. To perform DAPI-amyloid A double staining, sections were stained with anti-human amyloid A antibody (1:100 dilution) overnight at 4°C and then stained with Propidium iodide double staining, sections were stained with DAPI (1:1000 dilution) (Wako, Osaka, Japan) for 30 min at room temperature. To perform DAPI-Propidium iodide double staining, sections were stained with DAPI (1:1000 dilution) overnight at 4°C and then stained with Propidium iodide (1:500 dilution) (RPL, MD, USA) for 5 min at room temperature.

RESULTS

In an attempt to clarify the differential diagnosis of amyloidosis, we conducted histochemical evaluation of amyloid deposition in kidneys. The clinical profile of 14 patients is shown in Table 1. The presence of λ-light chain monoclonal proteins in serum and/or urine was examined by immunoelectrophoresis tests. As a result, λ-light chain monoclonal proteins were detected in patients 1–5, 7, 8, and 10. As for patient 6, these tests were not performed because of sudden death. Monoclonal proteins were not detected by these tests in patient 9. Patients with rheumatoid arthritis (11 to 14) showed high levels of serum amyloid A. Patients 11 and 14 had advanced renal failure.

The pathological profile of the patients is shown in Table 2. All patients had Congo red-positive staining in glomeruli and showed apple-green birefringence under polarized light. In addition, electron microscopic analysis revealed amyloid fibrils in glomeruli in all patients. According to the potassium permanganate method with Congo red staining, kidney slices from patients 1–9 and 10–14 were potassium permanganate-resistant and potassium permanganate-sensitive, respectively. Patients 11–14 had deposition of amyloid A in glomeruli. In patient 3, positive staining of λ-light chain in glomeruli was detected in addition to amyloid A. In patient 10, all staining yield negative results. By bone marrow biopsy, multiple myeloma was ruled out for patients 1–10. As for patient 6, the bone marrow biopsy was not performed due to sudden death. Patient 3 did not have any chronic inflammatory conditions to cause AA amyloidosis. Although patient 10 received a diagnosis of monoclonal gammopathy of undetermined significance, which was close to AL amyloidosis, the deposition of paraproteins in glomeruli could not be detected by immunohistochemical and mass spectrometric analyses.

The results of DAPI staining in these patients are shown in Table 3. Glomerular DAPI-positive areas as accompanied with nuclei were observed in AL amyloidosis, indicating that DAPI-positive staining areas except for nuclei are consistent with amyloid deposition areas (Fig. 1g, h). In contrast, the consistency of overlapping staining patterns was not seen in AA amyloidosis (Fig. 1c, f, i). The overlapping staining patterns with amyloid deposition were not observed with the staining by means of another nuclear staining

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age(years)</th>
<th>Sex</th>
<th>Proteinuria (g/day)</th>
<th>Cr (mg/dl)</th>
<th>Immunelectrophoresis (Blood)</th>
<th>Immunoelectrophoresis (Urine)</th>
<th>SAA (µg/ml)</th>
<th>Underlying disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>69 M</td>
<td></td>
<td>7.3</td>
<td>1.01</td>
<td>neg</td>
<td>BJ-P-λ</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>76 M</td>
<td></td>
<td>4.8</td>
<td>1.61</td>
<td>IgG-λ</td>
<td>IgG-λ</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>39 F</td>
<td></td>
<td>2.5</td>
<td>0.61</td>
<td>neg</td>
<td>BJ-P-λ</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>55 M</td>
<td></td>
<td>3.9</td>
<td>1.68</td>
<td>IgA-λ</td>
<td>IgA-λ</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>83 M</td>
<td></td>
<td>5.2</td>
<td>0.83</td>
<td>IgG-λ</td>
<td>IgG-λ</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>77 F</td>
<td></td>
<td>3.1</td>
<td>0.70</td>
<td>N/P</td>
<td>N/P</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>81 F</td>
<td></td>
<td>2.2</td>
<td>1.05</td>
<td>IgG-λ</td>
<td>BJ-P-λ</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>83 M</td>
<td></td>
<td>4.2</td>
<td>0.98</td>
<td>neg</td>
<td>BJ-P-λ</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>62 M</td>
<td></td>
<td>2.9</td>
<td>1.05</td>
<td>neg</td>
<td>neg</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>67 F</td>
<td></td>
<td>1.1</td>
<td>0.76</td>
<td>IgG-λ</td>
<td>neg</td>
<td>N/P</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>50 F</td>
<td></td>
<td>3.7</td>
<td>4.37</td>
<td>N/P</td>
<td>N/P</td>
<td>276</td>
<td>RA</td>
</tr>
<tr>
<td>12</td>
<td>69 F</td>
<td></td>
<td>1.9</td>
<td>1.59</td>
<td>neg</td>
<td>neg</td>
<td>61.7</td>
<td>RA</td>
</tr>
<tr>
<td>13</td>
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<td></td>
<td>6.0</td>
<td>0.64</td>
<td>N/P</td>
<td>N/P</td>
<td>714.9</td>
<td>RA</td>
</tr>
<tr>
<td>14</td>
<td>34 F</td>
<td></td>
<td>6.5</td>
<td>2.34</td>
<td>N/P</td>
<td>neg</td>
<td>882</td>
<td>RA</td>
</tr>
</tbody>
</table>

M: male; F: female; Cr: serum creatinine; neg: negative result; N/P: not performed; SAA: serum amyloid A protein; RA: rheumatoid arthritis
Thus, DAPI-PI double staining was performed on 13 patients; DAPI and light chain double staining was conducted on five patients with AL amyloidosis; and DAPI-amyloid A double staining, on two patients with AA amyloidosis. Consequently, DAPI-positive areas without nuclei corresponded to the deposition of paraprotein, which was the \( \lambda \)-light chain monoclonal protein in every patient with AL amyloidosis (Fig. 2a-c).

### DISCUSSION

Amyloidosis is defined as pathological accumulation of extracellular proteins that adopt a \( \beta \)-pleated configuration and share histochemical characteristics and fibrillary ultrastructure. These proteins are resistant to degradation. These substances share morphological, ultrastructural, and staining features, but they have different chemical structure. The diagnosis of amyloidosis requires histological demonstration of amyloid deposits. Many pathologists...
use Congo red to make a diagnosis of amyloidosis and state the
common opinion that Congo red-stained amyloid in polarized light
shows apple-green birefringence, sometimes called apple-green
dichroism.

Patients with primary amyloidosis can be classified into two
groups: one with potassium permanganate-sensitive and one with
potassium permanganate-resistant amyloid deposits. These two
groups correlate with the clinical classification of typical organ distri-
bution (presenting with nephropathy) and atypical organ distribution
(presenting with cardiomyopathy, nephropathy, and glossopathy)
and the expected presence of amyloid AA or amyloid AL. This histo-
chemical method for differentiating amyloid AA from AL was intro-
duced by Wright et al. (6). The method is based on the affinity of
 amyloid for Congo red dye after exposure to potassium permanga-
nate and dilute sulfuric acid. Because potassium permanganate
produces Congo red staining has been barely used after 2001 (7), it was
recently recommended to use immunohistochemical analysis to
detect λ-light chain, κ-light chain, and amyloid A as a diagnostic
for the discrimination of AL and AA amyloidoses (8). On the
other hand, this immunohistochemical examination takes a long
time and has a problem with reproducibility due to variations in the
protocols and conditions of antibodies. Therefore, simple and re-
producible methods are needed to distinguish AL and AA amyloi-
doses.

Our study revealed that extracellular and cytoplasmic glomerular
DAPI-positive areas without nuclei are clearly consistent with amy-
loid deposition in AL amyloidosis. In contrast, the overlapping
staining was not seen in AA amyloidosis. These results suggest that
DAPI-staining can be a useful way to discriminate AL and AA
amyloidoses. It is also well known that glomerular amyloid depo-
sition is categorized into several types: 1) a mesangiocapillary type
with diffuse amyloid deposition in the mesangium and along both
sides of the glomerular basement membrane; 2) a perimembrana-
nous type principally involving the subepithelial side of the base-
ment membrane; 3) a mesangial nodular type showing nodular
mesangial deposits; 4) and a hilar type showing amyloid deposits
in hilar arterioles (9-11). We demonstrated here that DAPI-PI
double staining clarifies the difference in amyloid deposition
types more effectively. Moreover, considering the result of patient
10, DAPI might detect tiny amount of amyloid deposition that is
resistant to the potassium permanganate method, the immuno-
histochemistry to detect amyloid paraprotein. DAPI can detect
even a small deposit of amyloid paraprotein for testing of resis-
tance to the potassium permanganate method and to immunohisto-
chemical analysis. Moreover, DAPI staining revealed these deposits
more clearly than Congo red staining did in most patients in this
study. These results suggested that the staining method with
popular dye DAPI may be rapid and easy way to discriminate AL
and AA amyloidoses. It is imperative for clinicians and patholo-
gists to consider amyloidosis as part of their differential diagnosis.

Given the simple and reproducible staining method for amyloid
proteins, testing for the disease becomes easier too. Early accurate
diagnosis is necessary for patients with amyloidosis, and they may
benefit from the new diagnostic procedure that is available to im-
prove and extend life. We cannot deny that this study only shows a
preliminary result because there were only a limited number of
such patients available at our institution. Nonetheless, we believe
that this result represents an interesting finding, and that confirma-
tion on a large sample size should make this conclusion firmer.

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CONFLICT OF INTEREST

The authors declare no competing financial interests.
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AUTHOR CONTRIBUTIONS


REFERENCES