Serological Studies of Actinomyces israelii by Crossed Immunoelectrophoresis: Taxonomic and Diagnostic Applications

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Crossed immunoelectrophoresis (CIE) with intermediate gel was applied to the serological analysis of Actinomyces israelii to develop a test with high efficiency in the laboratory diagnosis of human actinomycosis and classification of A. israelii. Recently developed standard antigen-antibody systems for A. israelii by CIE were used as reference. The reference systems were based on standard preparations of cytoplasmic and whole cell-associated antigens of A. israelii and a standard immunoglobulin G pool purified from rabbit antisera to formalin-treated whole cells and cell lysates of A. israelii. The specificity of the standard antigens for A. israelii was evaluated in CIE studies by screening for antibodies to components of the antigens in rabbit antisera raised against related bacteria. The standard system for A. israelii based on cytoplasmic antigens formed species-specific precipitins, whereas antisera raised against A. naeslundii and/or Propionibacterium acnes precipitated components of the other standard antigens. As a result of these analyses, the standard system for A. israelii based on 10 cytoplasmic antigens was used as reference for CIE studies to detect humoral antibodies to A. israelii in sera from nine patients with actinomycosis. All the sera from the patients formed at the time of diagnosis one or more precipitins in terms of the 10 reference precipitins. Up to five precipitins were found in single sera. Follow-up studies covering a period of one-half year after treatment showed a gradually decreased precipitin response in the course of time. In control sera from patients with newly diagnosed tuberculosis, nocardiosis, deep Candida infection, and aspergillosis, and in sera from healthy blood donors, no antibodies were detected with specificity for the reference antigens.

Actinomyces israelii is the most common etiological agent of actinomycosis in man (9, 14, 21), although other species of the genus Actinomyces and Arachnia propionica have also been implicated (7, 10). Actinomycosis is probably often missed in humans, since the laboratory diagnosis of this disease depends on the demonstration of A. israelii in exudates and/or the isolation of this organism in culture (9). Diagnostic problems include the requirement of special arrangements for sample taking and for culture conditions. In many cases antibiotic therapy is started before the true identity of the causative organism is established. A reliable serological test would therefore be a useful adjunct in the diagnosis and prediction of the prognosis of the disease. Moreover, it may often be the only criterion of current or previous actinomycosis.

Antisera raised in rabbits against strains of A. israelii have in immunofluorescence, precipitin tests, and cell wall agglutination tests allowed differentiation of a distinct serogroup of A. israelii, as well as two serotypes (4, 6, 7, 8, 20, 24).

Even though considerable work has been done on the production of specific antisera to identify and classify A. israelii, conflicting results are to be found in the literature concerning serum titers against A. israelii in patients with proved actinomycotic infections and concerning cross-reacting antibodies against antigens of A. israelii formed in other diseases (11, 15). However, little basic work has been done on the characterization of antigen preparations of A. israelii and the development of generally acceptable techniques for the conduct of serological tests to diagnose actinomycosis. The immunodiffusion tests, hemagglutination tests, and complement fixation tests have been the basic serological methods for studies on the serological diagnosis of actinomycosis.
Crossed immunoelectrophoresis (CIE) with intermediate gel (1) proved to be a powerful method in combination with a reference precipitation system for characterization of antibodies in mucocutaneous candidiasis (3), *Pseudomonas aeruginosa* infections (18), and *Mycobacterium leprae* infections (2). The objectives of this study were to apply CIE with intermediate gel technique to the serological diagnosis of human actinomycosis and classification of *A. israelii*, using recently developed standard antigen-antibody systems as reference (17).

**MATERIALS AND METHODS**

**Strains.** For immunization of rabbits the following type strains were used: *A. israelii*, serotype 1, ATCC 12103; SBL 225/74; *A. israelii*, serotype 2, ATCC 23036; WVU 307; *A. viscosus*, serotype 1, ATCC 15987; *A. viscosus*, serotype 2, ATCC 19246; *A. naeslundii*, ATCC 12104; *A. odontolyticus*, serotype 1, ATCC 17382; *A. odontolyticus*, serotype 2, WVU 482; *Arachnia propionica*, serotype 1, ATCC 14157; *A. propionica*, serotype 2, WVU 346; *P. acnes*, serotype 1, NCTC 737; *P. acnes*, serotype 2, ATCC 11828; *P. avidum*, ATCC 25277; *P. granulomatis*, ATCC 25264; *Nocardia asteroides*, ATCC 19247, obtained from American Type Culture Collection (ATCC), West Virginia University (WVU), and National Collection of Type Cultures (NCTC).

**Antisera.** Rabbit antiserum against *Actinomyces* spp., *A. propionica*, *Propionibacterium* spp., and *N. asteroides* were prepared by intravenous injections of formalin-killed whole cells by an immunization schedule previously described (16). Two antiserum against each strain from different rabbits were pooled, and the immunoglobulin fraction was purified by salting out with ammonium sulfate at 37% saturation. The antibody content of each pool was concentrated to 10 mg/ml. Also included in the study were commercial rabbit antiserum to *Candida albicans* (obtained from Dakopatts A/S, Copenhagen, Denmark), rabbit antiserum to *Aspergillus fumigatus* (prepared in this laboratory), and rabbit antiserum to *Aspergillus fumigatus*, *Thermoaclionomyces vulgaris*, and *Micro polyspora faeni* (kindly supplied by D. W. R. MacKenzie, Mycological Reference Laboratory, Public Health Laboratory Service, Colindale, England).

Human sera were obtained from nine patients with actinomycosis diagnosed on the basis of clinical and laboratory findings. Five patients suffered from a cervicofacial form and four from thoracic actinomycosis. In each case the clinical diagnosis was obtained from the attending physician. The infecting organisms were identified as *A. israelii* by the criteria of K. Holmberg and C.-E. Nord (J. Gen. Microbiol., in press). Six patients were followed through remission with consecutive serum specimens. Serum specimens were collected at the time of diagnosis, at 2 months, at 4 months, at 6 months, and at 1 year after establishment of the diagnosis.

Sera and pooled sera from 20 children aged 1 to 10 years were included as controls. Serum specimens from 10 newly diagnosed tuberculosis patients, two nocardiosis patients, two patients with deep candidosis, and three patients with pulmonary aspergillosis were tested for precipitating antibodies to *A. israelii*. The diagnosis of tuberculosis and nocardiosis were proven by isolation of *Mycobacterium tuberculosis* and *N. asteroides*, respectively. Candidosis was diagnosed on the basis of isolation of *C. albicans* and positive precipitation reaction in double immunodiffusion tests. Aspergillosis was proven by isolation of *A. fumigatus* and positive immunodiffusion tests. In addition, sera from two patients with chronic acnes vulgaris from which *P. acnes* was isolated and ten patients with chronic periodontal disease from which *A. israelii* was isolated (Holmberg, Arch. Oral Biol., in press) were included for tests. All sera were stored at −20°C with 15 mM NaN₃, as preservative.

**Standard antigen-antibody systems with *A. israelii*.** Reference antigen-antibody systems for *A. israelii* were prepared from antigen/water extracts on standard preparations of sonic lysates, STAgSL, and chemical extracts from whole cells by 0.2 M hydrochloric acid (STAgHCl), 4 M urea (STAgurea), and 10% (vol/vol) trichloroacetic acid (STAgTCA), and standard rabbit antiserum to formalin-treated whole cells (StAbI) and cell lysates (StAbII) of *A. israelii* (ATCC 12103 and WVU 307). The procedure for preparing standard antigens, standard antiserum, and the immunochromatic characteristics of the systems have been described elsewhere (17).

The standard system based on STAgSL and StAbII comprised six reference precipitins, coded SL1 to SL6, the system based on STAgHCl comprised five reference precipitins, coded HC1 to HC5, the system based on STAgurea comprised five reference precipitins, coded urea1 to urea5, and the system based on STAgTCA comprised one reference precipitin, coded TCA1. The reference precipitins coded SL1, SL2, SL4, SL5, HC1, HC2, HC3, urea1, urea2, and urea4 were specific for their respective systems, whereas the other reference precipitins of the systems showed reactions of partial or total identity to each other in CIE analysis (17). The system based on STAgSL and StAbII comprised 10 reference precipitins, coded 1 to 10, of which six were identical to those revealed in the system based on STAgSL and StAb1. None of the remaining precipitins was identical to any of the precipitins in the other systems employed.

**CIE with intermediate gel.** These immunoelectrophoreses were run by the procedures devised by Axelsen (1), using the same basic reagents as described previously (17). Antigen (5 µl) was submitted to the first-dimension electrophoretic run (9 to 10 V/cm) for 50 min. The second-dimension electrophoresis was run overnight, applying 2 V/cm. The reference gel contained 5 µl of the standard preparations of anti-*A. israelii* serum StAbII per cm². The intermediate gels contained 15 µl of the test serum per cm². A negative control plate, containing the same amount of saline instead of antiserum in the intermediate gel, and a positive control plate, containing the reference antiserum, were always run with each set of six electrophoreses. First- and second-dimension
RESULTS

By means of CIE with intermediate gel using the standard antigen-antibody systems for A. israelii as a reference, the serological relationship between A. israelii and taxonomically related bacteria was studied. Screening was performed for antibodies with specificities for the antigenic components of the different reference systems for A. israelii in concentrated rabbit antibody pools to formalin-treated whole cells of the related bacteria (A. viscosus, serotype 1 [ATCC 15987]; A. viscosus, serotype 2 [ATCC 19246]; A. naeslundii [ATCC 12104]; A. odontolyticus, serotype 1 [ATCC 17982]; A. odontolyticus, serotype 2 [WVU 482]; A. propionica, serotype 1 [ATCC 14157]; A. propionica, serotype 2 [WVU 346]; P. acnes, serotype 1 [NCTC 737] and serotype 2 [ATCC 11828]; P. avidum [ATCC 25577]; P. granulosum [ATCC 25564]; and N. asteroides [ATCC 19247]). By comparison with the control plates, no reference antigens of A. israelii StAgSL were retained by immunoprecipitation in the intermediate gel by these test sera. Antibodies with specificities for components of the standard preparations of the chemical extracts, StAgHCl and StAgurea of A. israelii, were detected in antisera raised against A. naeslundii by deflections of the reference precipitins coded HCl1 and urea4 compared to the control plates. Antibodies against the antigenic components urea4 of the antigen standard StAgurea were also revealed in sera raised against P. acnes, serotypes 1 and 2. No precipitins were detected in these experiments that indicated the presence of antibodies with specificities to other antigenic components of the standard antigens than the reference antigens. No antibodies with specificity for the components of the different standard antigens of A. israelii were detected in rabbit antisera to C. albicans, A. fumigatus, Thermoactinomyces vulgaris, and Micropolyspora faeni.

The identification of antibodies in the sera of patients to A. israelii was conducted by means of CIE with intermediate gel containing these sera by the standard antigen-antibody system for A. israelii based on StAgSL and StAbII as reference.

In sera from nine patients with actinomycosis, precipitating antibodies were detected against this reference standard antigen. The precipitin response varied from patient to patient. The number of retained reference antigens in the intermediate gel containing the serum of the patient ranged from one to four at the time of diagnosis (Table 1). All precipitins were identified in terms of the reference system for A. israelii. Antibodies specific for one of the cytoplasmic antigen components of A. israelii were present in sera from four patients. Two of these patients exhibited thoracic actinomycosis, and two patients exhibited a cervicofacial form of actinomycosis. This precipitin was identified as antigen coded 7 or 10 (17). The sera from two patients with cervicofacial actinomycosis had antibodies to two of the reference antigens, identified as precipitin coded numbers 7 and 10 and numbers 8 and 10, respectively. Antibodies to four reference antigens, identified as precipitins 6, 7, 8, and 10, were detected in sera from one patient with cervicofacial actinomycosis (Fig. 1). No attempts were made to quantitate the immune responses. No immunoprecipitation reactions were obtained that indicated the presence of free antigens of A. israelii in these sera.

Follow-up studies of the sera from six patients revealed that the precipitin responses demon-

Table 1. Serological follow-up of patients with proven actinomycosis

<table>
<thead>
<tr>
<th>Patient</th>
<th>Time of diagnosis</th>
<th>Precipitins at time of testing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 months</td>
<td>4 months</td>
</tr>
<tr>
<td>No.</td>
<td>Identified as:</td>
<td>No.</td>
</tr>
<tr>
<td>GP</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>GH</td>
<td>2</td>
<td>8, 10</td>
</tr>
<tr>
<td>MF</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>AA</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>SK</td>
<td>2</td>
<td>7, 10</td>
</tr>
<tr>
<td>NZ</td>
<td>4</td>
<td>6, 7, 8, 10</td>
</tr>
</tbody>
</table>

* Precipitin codes, see text.
* ND, Not done.
strable at the time of diagnosis were gradually lost in the course of time after substantial clinical improvement following treatment. Six months after establishment of the diagnosis, the sera which initially contained antibodies to one of the reference antigens had lost their precipitating reactivity. The two patients with antibody specificities to two reference antigens had lost antibodies with specificity for antigens coded 7 and 8, respectively. The sera from the remaining patient maintained the initial precipitin pattern. A follow-up study of consecutive sera from this patient during exacerbations, covering a period of 1.5 years, showed an increased number of precipitating antibodies to A. israelii. After 1 year, antibodies with specificity for the reference antigen component coded 9 were also demonstrable.

In control experiments, neither the sera from blood donors nor from patients with tuberculosis, nocardiosis, deep candidosis, chronic acnes vulgaris, or chronic periodontal disease precipitated the reference standard antigen.

**DISCUSSION**

CIE with intermediate gel (1) in conjunction with a reference antigen-antibody system for A. israelii (17) appeared to be useful for serological taxonomic studies of A. israelii and for the study of circulating antibodies to A. israelii in human actinomycosis.

Analysis of the precipitin reactions, obtained by CIE against standard antigens of A. israelii with antisera to some related bacteria, supported current classification of a separate serological group of A. israelii (5, 16, 22–24). The serological reaction of the components of the cytoplasmic standard antigen of A. israelii displayed species specificity. The distinction of a species-specific serogroup of A. israelii by precipitation tests seems to be less apparent with other antigenic materials of A. israelii. In the present study, this was indicated by the cross-reactivities found between antisera produced against whole cells of type strains of A. naeslundii and P. acnes and some components of the whole cell-associated antigens of A. israelii, obtained by hydrochloric acid, trichloroacetic acid, and urea extractions. The findings of common antigens between A. israelii and A. naeslundii are in agreement with those found previously in agar gel diffusion studies with supernatant culture fluid as the antigen. Precipitating antigens, derived by acid extraction of cells of A. israelii, include species-specific antigens and cross-reacting components.

Werner et al. (25) recently found that rabbit antisera against Propionibacterium (Corynebacterium) acnes strains in double immunodiffusion tests formed one or two precipitation lines with A. israelii polysaccharide antigens, obtained by formamide extraction, and the clear supernatant of autoclaved whole cell suspensions of A. israelii. These findings are in agreement with the cross-reactions found in the present study between anti-P. acnes sera and one component of the standard preparation of urea extract, StAgurea.

The precipitating components of the cytoplasmic standard antigen of A. israelii appeared specifically diagnostic for A. israelii. They also possessed immunochemical properties which made them more suitable for CIE studies (17) than the components of the standards extracted from whole cells of A. israelii. The antigen-antibody system for A. israelii, based on the cytoplasmic antigen standard and the standard antiserum, raised against crude cell lysates of A.
israelii, was therefore employed as reference in assays to estimate the humoral immunoreponse to A. israelii in sera of patients with actinomycosis caused by this organism.

Using the technique of CIE with sera from patients in the intermediate gel, it was possible to detect antibodies to the reference antigens of A. israelii in sera from patients with actinomycosis at the time of diagnosis. Analysis of the immunoprecipitation patterns obtained indicated that there appeared to be a correlation between the time of active disease and the humoral immune response to the reference antigens. Thus, in one patient with rapidly fulminating thoracic actinomycosis with a known history of disease for about 2 months and a short period of remission after successful treatment, the immune response was surprisingly weak at the time of diagnosis, with antibodies to only one component of the reference antigens of A. israelii compared to that evoked in sera from a patient with a persistent active cervicofacial actinomycosis covering a period of 1.5 years, which during that time developed antibodies to six components of the reference system.

Although significant differences in the immunoresponse of individual patients may occur, these observations provide evidence for an increased humoral immunoresponse to the reference antigens of A. israelii in chronic actinomycotic infections. The presence of one or two precipitins could indicate any form of actinomycosis. The examination of serial serum specimens provided information about the clinical course of the disease. After successful treatment there was a reduction in the number of precipitins.

No titration of the positive sera with A. israelii precipitins was made in the present study. Titration might be useful in following the clinical course of the disease. It would be expected that titration would reveal a lower level of antibody prior to the time of disappearance of the precipitin reaction and, therefore, would provide an earlier guide for response to therapy.

The role of the humoral antibodies in actinomycosis is still unclear. It is assumed that infections with A. israelii raise protective humoral antibodies to prevent dissemination of the infection to parietal organs. Mere colonization with A. israelii, which is a common commensal of tonsillar crypts in chronic tonsillitis (13) or of periodontal pockets in chronic periodontal disease (K. Holmberg, Arch. Oral Biol., in press), does not seem to evoke detectable humoral responses to the reference antigens of A. israelii as indicated by the absence of precipitating antibodies in sera from patients with advanced periodontal lesions from which A. israelii had been isolated and in sera from healthy blood donors.

Although extensive studies were carried out, cross-reacting antibodies with specificity for the reference antigens were not detectable in serum specimens from patients with other diseases than actinomycosis. This contrasts with the considerable cross-reactions with A. israelii found with heterogeneous sera from other diseases, such as tuberculosis, nocardiosis, streptococcal infections, and some fungal infections, and also in sera from healthy blood donors in previous serological surveys of actinomycosis (11, 15). However, these studies used as antigen chemical fractions of A. israelii (15) and crude antigens of A. israelii prepared by sonic treatment, formamide extraction of cells or acetone precipitation of supernatant fluids from broth cultures (17) in conventional complement fixation, hemagglutination, and gel diffusion tests.

CIE with intermediate gel using a monospecific standard antigen-antibody system for A. israelii as reference permitted the serodiagnosis of actinomycosis. The value of the test rests on the monospecificity of the reference antigens of A. israelii and the fact that the primary production of antibodies is directed to these antigens in the course of natural infections. The high sensitivity and the resolving power of CIE permits the determination of antibody specificities in complex sera to the reference antigens of the crude antigen mixtures. The test seems to be a promising method for routine laboratory practice, with a major advantage being that antigen production is easy and purification of the reference antigens is unnecessary. The test fulfills the need for efficiency of a laboratory test with regard to sensitivity and specificity. The possibility for standardization would be introduced by the test. A standardized test used in prospective clinical trials would yield comparable information from different laboratories and, in turn, clarify the problem concerning the effectiveness of the test in diagnostic A. israelii serology.

**LITERATURE CITED**


