Rectal and Intranasal Immunizations with Recombinant Urease Induce Distinct Local and Serum Immune Responses in Mice and Protect against Helicobacter pylori Infection

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Infection with the gastroduodenal pathogen Helicobacter pylori is now established as the etiologic agent of chronic gastritis and most cases of peptic ulcer disease worldwide (23). Mounting evidence has also linked this chronic infection with gastric adenocarcinoma of the distal stomach and with gastric lymphoma (7, 26), which has resulted in the World Health Organization’s classification of this bacterium as a class I carcinogen (27). The risk of developing gastric cancer has been estimated to be three- to sixfold greater for H. pylori-infected individuals than for uninfected age-matched controls (18, 22), and this bacterium is considered to be the second leading cause of cancer deaths in many developing countries. Prevention of this disease by means of an effective vaccine against H. pylori is thus a high priority. An additional indication of the need for a vaccine strategy is peptic ulcer disease. Treatment of patients presenting with peptic ulcer disease consists of acid suppression and antimicrobial therapy. Although current treatment regimens are effective and the incidence of reinfection (16) is low in industrialized countries, reinfection and recrudescence in the developing world are significant problems (20). The emergence of antibiotic-resistant strains (14), poor patient compliance, and the high cost of therapy and patient management represent additional problems for management of H. pylori-infected individuals, especially in the developing world, where antimicrobial treatment has not been very effective.

Prevention of H. pylori infection by active immunization has been demonstrated with several animal models (2, 3, 5, 11, 13, 15, 17, 21). These studies have evaluated both whole-cell Helicobacter sonicates and recombinant subunit vaccines, such as those whose active component is urease apoenzyme, heat shock protein A (HspA), vaculolating cytotoxin A (VacA), or catalase. Significant protection against challenge with different species of Helicobacter has been demonstrated when these antigenic compositions were coadministered by a mucosal route with a suitable adjuvant such as cholera toxin (CT) or heat-labile toxin (LT) from Escherichia coli. In those studies, vaccine antigens were administered by the intragastric (3) or oral (13) route, both of which were determined to induce protection against challenge. Although its role was not clearly defined, those studies suggested that antigen-specific secretory immunoglobulin A (sIgA) helps protect against infection (3, 13, 21). A role for sIgA in protection against infection with H. pylori in humans has been suggested in a study of passive immunity (24). In that study, human breast milk IgA titers were shown to correlate with a delay in the onset of H. pylori infection in infants.

More recently, we have demonstrated that administration of antigen with LT adjuvant by the intranasal (i.n.) route generated protective immunity against infection with Helicobacter felis (25). However, this study demonstrated that animals immunized by the i.n. route, in the absence of a mucosal adjuvant, were not protected from challenge, even in the presence of elevated levels of sIgA in saliva and fecal extracts. This result suggested that sIgA was not a mediator of protection or that i.n. immunization did not elicit local antibody production in the gastric compartment. The existence of a common mucosal immune system and the induction of mucosal antibody at distant sites is well documented, but there is also evidence for preferential specific sIgA induction at the site of administration (9). Rectal immunization with CT as the candidate antigen was determined to elicit higher levels of specific sIgA in duodenal, colonic-rectal, and vaginal secretions than in saliva (9).
The rectum is an inductive site for the generation of specific sIgA in gastric secretions and has not yet been evaluated in a model of Helicobacter infection.

In all immunization studies of infection with Helicobacter, protection has primarily been defined by using either a qualitative or a quantitative assessment of gastric urease activity in intact stomach tissue or by histology. The recent development of a murine model of H. pylori infection (10, 12, 15) has allowed efficacy studies of other antigens conserved in H. pylori (11, 15) and more-sensitive determinations of the protective efficacies of these candidate antigens after direct quantitation of the number of colonizing bacteria in the stomach by culture.

In the present study we used recombinant urease (rUre) with LT as the vaccine to compare and contrast results of inoculation by the oral (p.o.), i.n., and rectal routes separately to determine a suitable means for inducing protective immunity against infection with H. pylori. In the absence of complete protection (sterilizing immunity) by single-site immunization against H. pylori challenge, we also evaluated a role for priming at one mucosal site followed by three booster doses at one of the other mucosal sites investigated as part of a prime-boost strategy. The level of protection was then compared to that obtained by single-site immunization by either the p.o., i.n., or rectal route. Protection was evaluated by quantitative determination of antibody responses to rUre in sera, saliva, and gastric secretions after immunization and following challenge with H. pylori. Induction of immune cells in gastric tissue was examined by quantitating IgA+ B cells, recombinant-urease-specific-antibody-containing cells (rUre-ACC), and CD4+ and CD8+ T cells.

MATERIALS AND METHODS

Bacterial growth conditions. H. pylori X47-2 AL (ORV2001), originally isolated from a domestic cat, was kindly provided by J. Fox, Massachusetts Institute of Technology, and was adapted to Swiss-Webster mice by sequential in vivo passages (10). A natural streptomycin-resistant mutant of H. pylori X47-2 AL was isolated and used for all challenge experiments. A frozen vial was plated on Mueller-Hinton agar containing 10% whole sheep blood, 5 μg of amphotericin B/ml (Sigma Chemical Co., St. Louis, Mo.) per ml, TVP (5 μg of trimethoprim per ml, 10 μg of vancomycin per ml, 10 U of polymixin B sulfate per ml; Sigma), and 50 μg of streptomycin per ml and grown statically overnight at 37°C in a 7% CO2 atmosphere. Cells were harvested and phosphate-buffered saline (PBS; pH 7.0), containing 0.05% Tween 20, was added to resuspend in PBS to an optical density of 0.600 (OD600) of 1.0, and used as a starter inoculum. Cells were diluted to a final OD600 of 0.05 in 100 ml of brucella broth (Difco Laboratories, Detroit, Mich.) containing 5% fetal bovine serum (JRH Biosciences, Lenexa, Kans.) with helicobacter-selective antibiotics and grown statically overnight at 37°C in a 7% CO2 atmosphere. Bacteria were viewed by phase-contrast microscopy for viability and motility as wet mounts and in inoculation by the oral (p.o.), i.n., and rectal routes separately to determine a suitable means for inducing protective immunity against infection with H. pylori.
FIG. 1. Urease activities of gastric tissues from mice immunized with rUre plus LT by either the p.o., i.n., or rectal (R) route. Mice were immunized with 25 μg of rUre by the p.o. and rectal routes and with 10 μg by the i.n. route. Animals were challenged with _H. pylori_ 2 weeks postimmunization and euthanized 2 weeks postchallenge. Infection was determined by incubating one-fourth of the antrum from each animal in urea broth and measuring the gastric urease activity spectrophotometrically at an _A_260 after a 4-h incubation at room temperature. Mice were considered protected from infection if the urease activity was within 2 standard deviations of the mean value for unchallenged control mice. Mice were significantly protected by all routes compared to LT sham-immunized controls (P < 0.0005; Wilcoxon rank sum test). As no significant differences between results for control groups were apparent, all results for LT sham-immunized animals were pooled for this analysis. Solid lines represent the arithmetic mean for each group studied.

In the same study, groups of mice were primed by either the p.o., i.n., or rectal route and boosted three times, according to the same weekly schedule, by either the p.o., i.n., or rectal route. Each combination regimen afforded protection, as was demonstrated by a significant reduction in the number of colonizing bacteria, but there was no increase in the level of protection when compared to that produced by single-site immunization (Table 1).

**RESULTS**

**Protection against infection with _H. pylori._** Mice immunized p.o., i.n., and rectally with rUre plus LT were significantly protected against challenge with _H. pylori_, as determined by a urea broth assay (P < 0.0005), in comparison to sham-immunized controls (Fig. 1). A statistically significant reduction in the bacterial burden was also observed by all three routes (P < 0.05), as assessed by quantitative _H. pylori_ culture of gastric tissue (Fig. 2). No statistically significant differences in results were observed between groups immunized by the three different routes. The gastric bacterial density in each immunized mouse was reduced by >97%, compared to those of controls. These results confirm the suitability of all three inductive sites for the generation of protective immunity against _H. pylori_ infection.

In the same study, groups of mice were primed by either the p.o., i.n., or rectal route and boosted three times, according to the same weekly schedule, by either the p.o., i.n., or rectal route. Each combination regimen afforded protection, as was demonstrated by a significant reduction in the number of colonizing bacteria, but there was no increase in the level of protection when compared to that produced by single-site immunization (Table 1).

**Serum antibody responses to urease by route of immunization.** Primary immunization with rUre and LT by the p.o., i.n., or rectal route elicited elevated levels in sera of both IgG and IgA against native _H. pylori_ urease (Table 2). Significantly higher levels of IgG1 and IgG2a antibodies were found in the sera of all immunized groups than in the sera of sham-immunized controls. Differences were observed in the IgG1/IgG2a ratios that were specific to the site of immunization and dependent upon challenge with _H. pylori_. Oral immunization resulted in a greater IgG2a response, as was indicated by an IgG1/IgG2a ratio of 0.16, and levels of IgG2a remained unaltered after challenge, indicative of a type 1 helper T-cell (Th1) response. Rectal immunization with the same formulation and antigen dose resulted in a markedly different serum IgG response than that induced by the p.o. route. IgG1 predominated, with an IgG1/IgG2a ratio of 2.5. Challenge again shifted the response towards Th1, resulting in a more balanced Th1/Th2 response (IgG1/IgG2a ratio of 0.88) after infection with _H. pylori_. Immunization by the i.n. route resulted in elevated levels of IgG2a (indicative of a Th1 response; P = 0.04 by the Wilcoxon rank sum test), with an IgG1/IgG2a ratio of 0.29. Challenge with _H. pylori_ further increased the IgG2a response (IgG1/IgG2a ratio of 0.88; P = 0.04 by the Wilcoxon rank sum test, comparing ratios pre- and postchallenge). A shift towards a Th1 response after challenge with _H. pylori_ was observed for all animals within each immunization group.
TABLE 1. Protection against *H. pylori* challenge by a combination prime-boost strategy for mucosal immunization

<table>
<thead>
<tr>
<th>First, second route of immunization</th>
<th>Mean from quantitative <em>H. pylori</em> culture (CFU/ml)</th>
<th><em>P</em> value&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>p.o., p.o.</td>
<td>377</td>
<td>0.0017</td>
</tr>
<tr>
<td>p.o., i.n.</td>
<td>858</td>
<td>0.0065</td>
</tr>
<tr>
<td>p.o., r.</td>
<td>1,590</td>
<td>0.0049</td>
</tr>
<tr>
<td>r., i.n.</td>
<td>79</td>
<td>0.0003</td>
</tr>
<tr>
<td>i.n., i.p.o.</td>
<td>1,293</td>
<td>0.0017</td>
</tr>
<tr>
<td>i.n., r.</td>
<td>650</td>
<td>0.0007</td>
</tr>
<tr>
<td>r., r.</td>
<td>394</td>
<td>0.0014</td>
</tr>
<tr>
<td>r., i.p.o.</td>
<td>428</td>
<td>0.0027</td>
</tr>
<tr>
<td>r., i.n.</td>
<td>233</td>
<td>0.0037</td>
</tr>
<tr>
<td>All</td>
<td>14,217</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Weekly immunizations were given on days 0, 7, 14, and 21 by either the p.o. (50 μl of soluble antigen delivered by pipette into the buccal cavity), the i.n. (5 μl of soluble antigen delivered to each external naris of unanesthetized mice), or the rectal (r.) (25 μl of soluble antigen delivered with an olive-tipped catheter directly into the rectum) route. The number of booster doses given by the second route specified was 3 (does not apply to sham-immunized controls). Sham-immunized control animals (n = 5) received LT alone by either the p.o., i.n., or rectal route (n = 5/route), and results were pooled for this analysis (“All”).
<sup>b</sup> Quantitative *H. pylori* culture was performed on homogenized stomach tissue (one-fourth of the antral tissue specimen) harvested at the time of termination (2 weeks postchallenge). Results are expressed as geometric means of CFU per milliliter per biopsy section for each of 10 mice immunized with rUre plus LT and each of 15 control mice sham-immunized with LT.
<sup>c</sup> By the Wilcoxon rank sum test. Values are relative to those for the LT sham-immunized control group.

Serum IgG responses to rUre were lower than those observed for IgG and were highest after rectal immunization. IgA levels increased only slightly after challenge with *H. pylori* (Table 2). Infection with *H. pylori* in control (sham-immunized) mice given LT induced only much lower levels of both IgG and IgA in sera compared to levels in animals receiving vaccine. Serum responses to infection alone were indicative of a Th1 cell response.

TABLE 2. Serum antibody responses induced by rUre immunization

<table>
<thead>
<tr>
<th>Route&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Vaccine&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Challenge&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Mean level&lt;sup&gt;d&lt;/sup&gt; (μg/ml) in serum of:</th>
<th>IgG1/IgG2a ratio</th>
<th>Mean level of IgA&lt;sup&gt;e&lt;/sup&gt; (ng/ml) in serum</th>
</tr>
</thead>
<tbody>
<tr>
<td>p.o.</td>
<td>rUre + LT</td>
<td></td>
<td>30.57</td>
<td>183.70</td>
<td>0.16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+</td>
<td>20.72</td>
<td>83.51</td>
<td>0.25</td>
</tr>
<tr>
<td>r.</td>
<td>rUre + LT</td>
<td></td>
<td>220.60</td>
<td>88.04</td>
<td>2.51</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+</td>
<td>121.92</td>
<td>139.09</td>
<td>0.88</td>
</tr>
<tr>
<td>i.n.</td>
<td>rUre + LT</td>
<td></td>
<td>120.40</td>
<td>416.50&lt;sup&gt;f&lt;/sup&gt;</td>
<td>0.29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+</td>
<td>85.06</td>
<td>1,017.87&lt;sup&gt;f&lt;/sup&gt;</td>
<td>0.08&lt;sup&gt;f&lt;/sup&gt;</td>
</tr>
<tr>
<td>All</td>
<td>LT</td>
<td></td>
<td>0.42</td>
<td>0.92</td>
<td>0.45</td>
</tr>
</tbody>
</table>

<sup>a</sup> Weekly immunizations were given on days 0, 7, 14, and 21 by either the p.o. (50 μl of soluble antigen delivered by pipette into the buccal cavity), the i.n. (5 μl of soluble antigen delivered to each external naris of unanesthetized mice), or the rectal (r.) (25 μl of soluble antigen delivered with an olive-tipped catheter directly into the rectum) route. Sham-immunized control animals (n = 15) received LT alone by either the p.o., i.n., or rectal route, and results were pooled for this analysis (“All”).
<sup>b</sup> By the p.o. or rectal route, animals were administered 25-μg doses of rUre plus LT (5 μg p.o. and 25 μg rectally), and by the i.n. route, animals were administered 10-μg doses of rUre plus LT (5 μg) (n = 10/group).
<sup>c</sup> Animals were challenged once with 100 μl of a 10<sup>6</sup>-CFU/ml suspension of streptomycin-resistant *H. pylori* X472AL.
<sup>d</sup> By the p.o. or rectal route, animals were administered 25-μg doses of rUre plus LT (5 μg p.o. and 25 μg rectally), and by the i.n. route, animals were administered 10-μg doses of rUre plus LT (5 μg) (n = 10/group).
<sup>e</sup> Animals were challenged once with 100 μl of a 10<sup>6</sup>-CFU/ml suspension of streptomycin-resistant *H. pylori* X472AL.
<sup>f</sup> Serum antibody measurements are presented as geometric means.
<sup>g</sup> Statistical significance (P < 0.05) was determined by the Wilcoxon rank sum test by comparing levels of IgG1 to those of IgG2a.

Urease-specific gastric and salivary antibody responses by route of immunization. Mucosal immunization with rUre plus LT induced gastric IgA responses against the vaccine that appeared to be dependent upon both the route of administration and challenge with *H. pylori* (Table 3). p.o. immunization

TABLE 3. Mucosal antibody responses induced by rUre immunization

<table>
<thead>
<tr>
<th>Route&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Vaccine&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Challenge&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Gastric secretions</th>
<th>Saliva</th>
</tr>
</thead>
<tbody>
<tr>
<td>p.o.</td>
<td>rUre + LT</td>
<td></td>
<td>0.31</td>
<td>798.56</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+</td>
<td>6.00&lt;sup&gt;g&lt;/sup&gt;</td>
<td>832.12</td>
</tr>
<tr>
<td>r.</td>
<td>rUre + LT</td>
<td></td>
<td>40.89&lt;sup&gt;g&lt;/sup&gt;</td>
<td>82.16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+</td>
<td>72.40&lt;sup&gt;g&lt;/sup&gt;</td>
<td>176.65</td>
</tr>
<tr>
<td>i.n.</td>
<td>rUre + LT</td>
<td></td>
<td>0.25</td>
<td>439.23</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+</td>
<td>1.02&lt;sup&gt;g&lt;/sup&gt;</td>
<td>1,258.72&lt;sup&gt;g&lt;/sup&gt;</td>
</tr>
<tr>
<td>All</td>
<td>LT</td>
<td></td>
<td>0.12</td>
<td>0.10</td>
</tr>
</tbody>
</table>

<sup>a</sup> Weekly immunizations were given on days 0, 7, 14, and 21 by either the p.o. (50 μl of soluble antigen delivered by pipette into the buccal cavity), the i.n. (5 μl of soluble antigen delivered to each external naris of unanesthetized mice), or the rectal (r.) (25 μl of soluble antigen delivered with an olive-tipped catheter directly into the rectum) route. Sham-immunized control animals (n = 15) received LT alone by either the p.o., i.n., or rectal route, and results were pooled for this analysis (“All”).
<sup>b</sup> By the p.o. or rectal route, animals were administered 25-μg doses of rUre plus LT (5 μg p.o. and 25 μg rectally), and by the i.n. route, animals were administered 10-μg doses of rUre plus LT (5 μg) (n = 10/group).
<sup>c</sup> Animals were challenged once with 100 μl of a 10<sup>6</sup>-CFU/ml suspension of streptomycin-resistant *H. pylori* X472AL.
<sup>d</sup> By the p.o. or rectal route, animals were administered 25-μg doses of rUre plus LT (5 μg p.o. and 25 μg rectally), and by the i.n. route, animals were administered 10-μg doses of rUre plus LT (5 μg) (n = 10/group).
<sup>e</sup> Animals were challenged once with 100 μl of a 10<sup>6</sup>-CFU/ml suspension of streptomycin-resistant *H. pylori* X472AL.
<sup>f</sup> Gastric and salivary IgA antibody responses are presented as geometric means.
<sup>g</sup> Statistical significance (P < 0.05) was determined by the Wilcoxon rank sum test by comparing results for similarly treated animals.
<sup>h</sup> Statistical significance (P < 0.05) was determined by the Wilcoxon rank sum test by comparing results for similarly treated challenged animals.
TABLE 4. Urease-specific serum and gastric IgG subclass responses

<table>
<thead>
<tr>
<th>Route of immunization</th>
<th>Antiserum IgG1/IgG2a antibody ratio in indicated fluid</th>
<th>Prechallenge with H. pylori</th>
<th>Postchallenge with H. pylori</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Serum</td>
<td>Gastric juice</td>
<td>Serum</td>
</tr>
<tr>
<td>p.o.</td>
<td>0.16</td>
<td>0.35</td>
<td>0.25</td>
</tr>
<tr>
<td>r.</td>
<td>2.51</td>
<td>1.65</td>
<td>0.88</td>
</tr>
<tr>
<td>i.n.</td>
<td>0.29</td>
<td>0.18</td>
<td>0.08</td>
</tr>
</tbody>
</table>

* Weekly immunizations with rUre plus LT were given on days 0, 7, 14, and 21 by either the p.o. (50 μl of soluble antigen delivered by pipette into the buccal cavity), the i.n. (5 μl of soluble antigen delivered to each external naris of unanesthetized mice), or the rectal (r.) (25 μl of soluble antigen delivered with an olive-tipped catheter directly into the rectum) route.

resulted in production of urease-specific gastric IgA, which was detectable only after challenge with H. pylori. Primary rectal immunization resulted in an elevated urease-specific gastric IgA response prior to challenge, and the response was boosted further after challenge. Levels of gastric IgA after rectal immunization were significantly higher than those observed in p.o. immunized, challenged animals (P = 0.014; Wilcoxon rank sum test) but might also reflect the fivefold increase in LT concentration given by this route. i.n. immunization gave rise to the lowest level of urease-specific gastric IgA, which was not significantly boosted after challenge with H. pylori.

Urease-specific salivary IgA was induced by all routes, with levels after p.o. and i.n. immunization exceeding those after rectal immunization (Table 3). After challenge with H. pylori, antiserum salivary IgA was significantly boosted only in those animals immunized by the i.n. route (P = 0.007; Wilcoxon rank sum test). The presence of high levels of salivary IgA but low levels of gastric IgA in those animals immunized by the i.n. route indicated that gastric IgA measured after p.o. or rectal immunization was unlikely to be due to contaminating salivary IgA. This conclusion is in agreement with previous findings, where the level of salivary IgA directed against urease did not correlate with protection (19). The lower salivary IgA response in rectally immunized animals also suggests that IgA detected in gastric wicks is unlikely to come from saliva. Neither gastric nor salivary IgA against native urease was detected in sham-immunized, infected animals.

IgG against H. pylori urease was also detected in the gastric compartments of animals immunized by all routes, although at levels 1,000-fold lower than those found in sera (results not shown). Analysis of the IgG subclass response identified an IgG1/IgG2a ratio in stomachs similar to that observed in sera, with similar boosting and subclass switching after challenge with H. pylori (Table 4). This result suggested that the presence of IgG in gastric secretions may have been the result of transudation of serum into the gastric compartment. If serum IgG transudate is present in gastric secretions, then serum-derived (monomeric) IgA may also contribute to IgA found in gastric secretions. However, immunization by the p.o. route resulted in serum IgA levels that were unaffected by challenge, whereas gastric IgA levels were significantly increased. The minimal increase observed upon challenge in salivary IgA is also unlikely to account for the increase in IgA detected in gastric secretions. In addition, challenge of animals immunized by the rectal route showed a boost in serum IgA that was not reflected in gastric secretions. Thus, while serum cannot account entirely for the IgA response measured in gastric secretions, gastric IgA may be considered to result from both local production and transudation of serum IgA. Immunohistochemical evidence for local IgA production (data presented below) supports this hypothesis.

Recruitment of immune cells to the gastric mucosa. Gastric tissues from both rUre-LT-immunized and LT sham-immunized mice identified IgA+ B cells and rUre-ACC to be dependent upon immunization and challenge. IgA+ B cells were found at their highest frequency at the junction between the antrum and corpus, whereas rUre-ACC were found only in this region. Prior to challenge with H. pylori, there were few IgA+ cells and no rUre-ACC in the gastric mucosae of mice immunized with rUre plus LT by all routes of immunization (Fig. 3A). This result was in agreement with the low levels of urease-specific gastric IgA identified in wick-harvested secretions from animals immunized by the p.o. and i.n. routes, but it did reflect the results for urease-specific gastric IgA in secretions from animals immunized by the rectal route (Table 3). After challenge with H. pylori, mice immunized by all routes with rUre plus LT showed an elevated B-cell response in gastric tissue (Fig. 3A). Of the IgA+ B cells recruited, between 5 and 10% could be attributed to rUre-ACC. This finding is in contrast to results with infected animals immunized with LT alone, where a reduced B-cell response and no urease-specific response was observed after challenge (Fig. 3A, bottom; only results for the rectal LT control group are shown).

An evaluation of T-cell subsets identified CD4+ and CD8+ cells in the gastric mucosae (Fig. 3B). Levels of T cells induced were comparable by each route of immunization and were clearly dependent upon challenge with H. pylori. CD4+ cells outnumbered both IgA+ B cells and CD8+ cells by 5- to 10-fold and were found throughout the antrum and corpus regions of the stomach. In contrast, CD8+ cells were predominantly found in regions adjacent to the junction of the antrum and corpus. The strongest CD4+ cell responses were observed after immunization by the rectal and i.n. routes, and the strongest CD8+ cell responses were observed after immunization by the i.n. route, although there were no statistically significant differences between groups. In the gastric mucosae of sham-immunized, infected animals, CD4+ cells were greatly reduced in number relative to levels in rUre-immunized, protected animals, and CD8+ cells appeared to be absent.

DISCUSSION

We have developed a murine model of H. pylori infection (10) that provides quantitative determinations of the levels of protection afforded by vaccine formulations and that permits us to evaluate novel H. pylori antigens and delivery systems. In this study, mucosal immunization by the p.o., i.n., and rectal routes with rUre plus LT elicited significant protection against colonization with H. pylori. In previous studies, the gastric urease assay has suggested complete protection against infection in the heterologous H. felis challenge model. We showed that the urease assay is relatively insensitive in detecting H. pylori in gastric tissue below approximately 10^3 CFU and thus does not indicate complete protection (sterilizing immunity).

In the present study, a more sensitive quantitative culture approach was used to determine H. pylori colonization of gastric tissue. Immunization by all three mucosal routes gave significant protection, with >97% reduction in bacterial burden relative to that of unimmunized controls. Although immunization by the i.n. route appeared to result in the lowest level of colonization, we observed no significant differences between the levels of protection of the routes investigated. Complex immunization regimens wherein mice were immunized by one mucosal route and boosted (three times) by another route afforded no greater protection than immunization by a single route.
mucosal route. No significant differences between single-site and prime-boost immunization strategies were observed. Complete protection, demonstrated by the absence of bacteria by culture, was achieved for only 10 to 20% of animals immunized mucosally with rUre plus LT adjuvant, all remaining animals showing significant decreases in their bacterial densities. Whether sterilizing immunity is indeed achievable through mucosal immunization is currently being addressed by evaluating synergy of novel protective antigens with rUre.

The residual infection (incomplete protection) in our model may have been due to one of the following: (i) the high challenge inoculum (1,000 90% infective doses) may have resulted in a breakthrough of the level of immunity achieved by vaccination; (ii) urease shed from the bacterial surface may have acted as a decoy for antibody; (iii) residual \textit{H. pylori} organisms may have occupied an immunologically privileged site that is inaccessible to antibody or the effector function of T cells; (iv) there may have been a need for alternate antigens and/or adjuvants to stimulate a more effective response; or (v) there may have been reduced levels of urease on the surface of \textit{H. pylori} cells as the bacterial density decreased. Regardless of the reason for residual infection, the increased sensitivity and reproducibility of the results of the \textit{H. pylori} model and quantitative culture assay provide a means for investigating alternate methods for improving efficacy.

An evaluation of the immune responses induced by rUre immunization at different inductive sites revealed both qualitative and quantitative differences that appeared to shift upon challenge with \textit{H. pylori}. Immunization by all routes elicited elevated levels of antiurease IgA and IgG in serum compared to levels in infected, unimmunized controls. Analysis of the serum IgG subclass responses revealed that each route of immunization induced a characteristic IgG1/IgG2a ratio. p.o. and i.n. immunization resulted predominantly in an IgG2a response, whereas rectal immunization resulted in a stronger IgG1 response. Regardless of the orientation of the primary immune response to p.o., i.n., or rectal immunization, challenge with \textit{H. pylori} shifted the immune response to one that favors IgG2a (Th1), particularly with p.o. and i.n. immunization. This was consistent with the predominance of Th1 responses in sera from unimmunized animals infected with \textit{H. pylori}. IgG subclass responses in the gastric compartments identified similar IgG1/IgG2a ratios prior to challenge with \textit{H. pylori} and corresponding shifts in the direction of an IgG2a response after challenge. These findings suggest that the IgG detected in gastric secretions may result from serum, presumably through transudation into the gastric compartment. In a previous study, we had demonstrated elevated levels of both IgG1 and IgG2a in the sera of animals immunized with rUre, in the absence of adjuvant, by the i.n. route, with no detectable

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**FIG. 3.** Gastric immune responses induced to rUre immunization by route of immunization. (A and B) Recruitment of IgA$^+$ B cells (top) and rUre-specific ACC (bottom) and of CD4$^+$ (top) and CD8$^+$ (bottom) T cells, respectively, into the gastric mucosae of mice immunized with rUre plus LT is dependent upon challenge with \textit{H. pylori}. Results for LT controls are shown for rectally immunized animals only. P-I, postimmunization (only results for the rectally immunized group are shown); P-C, postchallenge. Results for sham-immunized control mice are represented with closed circles.
protection observed against *H. felis* challenge, which indicates that IgG in serum is unlikely to play a role in mediating protection (25). In contrast, Ferrero et al. have presented evidence for local generation of IgG antibodies and have suggested that IgG may play a role in protection (6). These discrepant results may be due to differences in mouse strains, immunization regimens, or analytical methods used to determine local immune responses.

Both p.o. and rectal immunization with rUre induced IgA antibody in gastric secretions. These findings are consistent with other reports that have identified IgA as a marker of protection against *Helicobacter* infection (3, 13, 21). In the present study, a clear difference between routes of administration was the induction of IgA in the gastric compartment prior to challenge after rectal but not p.o. immunization (Table 3). Even though the LT dose administered rectally was fivefold that administered p.o., the magnitude of the sIgA responses in the gastric compartment appears unlikely to be a result of the increase in LT concentration alone. Similar findings were reported from a study where elevated levels of IgA against CT were detected in colonic-rectal secretions harvested from mice immunized by the rectal route (9). It has previously been suggested that p.o. immunization primes the mucosal compartment and that upon challenge with *H. felis*, a boosting of sIgA in the gastric compartment, as measured in fecal extracts, occurs, possibly as a result of reexposure to urease presented by the challenge inoculum (21). In our study, challenge with *H. pylori* resulted in a modest increase in gastric IgA in animals immunized by both the p.o. and rectal routes. The lack of complete protection (sterilizing immunity) even in those animals with preexisting sIgA in the gastric compartment was an unexpected finding and may indicate that sIgA is not the sole effector molecule. We have recently completed a study demonstrating protective immunity against novel *H. pylori* challenge strains and demonstrated that complete protection (sterilizing immunity) is achievable through rectal immunization with rUre, but only against strains that infect at significantly lower levels (unpublished findings). In every case a 2- to 3-log reduction in bacterial density was observed regardless of the challenge strain, indicating that sterilizing immunity may be dependent upon host-pathogen interaction.

Evaluation of IgA-1B cells and urease-specific ACC in situ revealed that these cells were absent in the antral mucosae prior to challenge with *H. pylori*. These findings reflected the low specific-antibody determinations for mice immunized by the i.n. and p.o. routes but did not reflect data for the rectal route. After challenge, there was significant recruitment of 1B cells observed only several weeks after challenge, indicating distinctly different kinetics for T-cell induction between *H. pylori* and *H. felis* (4). Current studies are focusing on (i) determining the antigen specificity of the T-cell population apparent after challenge with *H. pylori* and (ii) using reverse transcription-PCR as a means to monitor regulation of both Th1- and Th2-oriented cytokines and T-cell recruitment as a function of challenge.

In conclusion, we have shown that the rectal and i.n. routes, in addition to the p.o. route, are suitable mucosal routes for inducing protective immunity against infection with *H. pylori*. Each route appeared unique in the generation of both urease-specific serum and mucosal antibody, with no significant difference observed in the levels of protection afforded by the different routes, either by urease activity determinations or quantitative *H. pylori* culture. The immunological basis for protection observed in mice after active immunization with rUre remains uncertain, although our results suggest a role for sIgA and CD4+ T cells as a result of immunization by any of the routes examined.

Although sterilizing immunity was not achieved for all animals, a previous study of immunological longevity as a result of mucosal immunization demonstrated significant protection with rUre up to 1 year after immunization (19). The association of clinical symptoms with bacterial density (1) and the greatly reduced levels of infection observed in this study as a direct result of mucosal immunization may therefore be sufficient to significantly alter the kinetics of induction of gastrointestinal pathologies associated with this chronic infection.

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