Autoimmune cholangitis/cholangiopathy (AIC) is a recently described disease characterized by chronic cholangitis resembling primary biliary cirrhosis (PBC) with a high frequency of antinuclear antibodies (ANA) and with sero-negativity for antimitochondrial antibodies (AMA). Whether AIC is a disease entity distinct from PBC and autoimmune hepatitis (AIH) or whether it is an AMA-negative variant of PBC or a cholangiopathic variant of AIH have so far been controversial. We recently examined the specificities of AMA and ANA in Japanese patients with AIC, PBC and AIH by immunofluorescence, immunoblotting and enzyme inhibition assays using various mitochondrial and nuclear autoantigens including 2-oxo-acid dehydrogenase complex, Sp100, gp210, and p62, and found that AIC and PBC had similar patterns of immunoreactivity. However, this duo is of interest because, usually, among sets of autoimmune syndromes, differences in serological targeting are matched by differences in clinical presentation: AIC and PBC seem to be an exception to this rule. While it is true that a single etiological agent can produce a wide range of disease expression, it is possible that seemingly similar clinicopathological features can be induced by pathogenetic mechanisms caused by a diversity of etiological agents.

Key Words: autoimmune cholangitis, primary biliary cirrhosis, autoimmune hepatitis, antimitochondrial antibody, antinuclear antibody

Introduction

Autoimmune hepatitis (AIH), primary biliary cirrhosis (PBC), and primary sclerosing cholangitis (PSC) are regarded as autoimmune liver diseases. AIH is a chronic necroinflammatory liver disease of unknown etiology and characterized by immunological features, including hypergamma-globulinemia and circulating autoantibodies such as antinuclear antibodies (ANA). On the other hand, PBC is a chronic, progressive cholestatic liver disease of unknown cause that usually affects middle-aged woman. Antimitochondrial antibodies (AMA) are found in 95% of patients with PBC, and they have a specificity of more than 98% for this disease. The distinction between AIH and PBC is in general based on above characteristic clinical, histologic, and immunologic features. However, there have been several reports on liver diseases marked by coexisting features of PBC and AIH.

In this context, considerable interest has been generated in a novel chronic liver disease recognized as autoimmune cholangitis/cholangiopathy (AIC) since the first report of this disease in 1987. In that report and subsequent studies, the clinical and histopathological features of AIC were characterized as an inflammatory intrahepatic cholangitis with sero-negativity for AMA and a high frequency of ANA. The disease resembles PBC in many respects including survival experience, although early reports cited a more favorable response to treatment with corticosteroids. Thus, it is unclear at present whether AIC is distinct from PBC or whether AIC is considered as an AMA sero-negative variant of PBC or a cholangiopathic variant of AIH. Detailed serological specificities of AMA and ANA, tested using recently developed assays, have not been described hitherto in AIC although the study of a single case of AIC led us to surmise that the disease resembled PBC since the serum reacted by immunoblotting with an E2 subunit (50-52 kDa) of one of the lower molecular weight 2-oxo-acid dehydrogenase complexes (2-OADC), antigenic components specific for PBC serum, and
The term "immunocholangitis" was introduced first by Brünner and Klinge\(^6\) in 1987. The authors described a condition seen in three women who had clinical, histological and biochemical liver abnormalities fulfilling the criteria of PBC but were sero-positive for ANA and sero-negative for AMA. The three patients responded well to immunosuppressive treatment with azathioprine and prednisolone. Carrougher et al.\(^5\) also reported a relatively young woman with clinical, pathologic, and serologic features of both AIH and PBC. The positive ANA, negative AMA, and favorable response to corticosteroid therapy were similar to the cases reported by Brünner and Klinge.\(^6\) Ben-Ari et al.\(^9\) described four such patients who were also sero-positive for smooth muscle antibody (SMA).

Subsequent to the above three reports, attention has focused on a subgroup of patients with clinically and histologically diagnosed PBC who are sero-negative for the classical immunofluorescence pattern of AMA but sero-positive for ANA. The subgroup is termed "immunocholangitis",\(^{12,14}\) "autoimmune cholangitis",\(^{12,14,16,17}\) "autoimmune cholangiopathy",\(^{12,14,16,17}\) "primary autoimmune cholangitis",\(^9,10\) or "immune cholangiopathy".\(^9,10\) Ben-Ari et al.\(^9\) suggested that AIC probably represented a subgroup of type 1 AIH with predominant bile duct damage because the patients responded well to prednisolone therapy, in contrast to those with classical PBC. However, some other reports indicated that AIC can be considered to be the same as AMA-negative PBC since an only consistently distinguishing feature between the two disease entities was the autoantibody (AMA and ANA) profile as both had otherwise virtually identical clinical and histopathologic features.\(^{12,13}\) Moreover, Sherlock indicated only a partial response to prednisolone therapy in their subsequent study;\(^13\) inflammation was reduced but serum gamma-glutamyl transpeptidase level remained at the high levels and bile duct lesions persisted. Furthermore, Colombato et al.\(^6\) reported a patient with AIC in whom this entity was the result of consecutive typical PBC followed by typical steroid-dependent AIH. Thus, "sero-conversion" from AMA positivity to negativity by immunofluorescence or immunoblotting, or vice versa,\(^21\) is a rare but recognised clinical situation in PBC,\(^22\) and the clinical entity of AIC is so far unestablished (Table 1). AIC is not very rare since the frequency of this disease was reported in one study to be 11% among 225 patients with various autoimmune liver diseases including PBC, AIH and primary sclerosing cholangitis,\(^23\) and 20% among another group of 200 patients who had morphologically consistent features of PBC.\(^22\)

### Definition of "autoimmune cholangitis/cholangiopathy"

The term "immunocholangitis" was introduced first by Brünner and Klinge\(^6\) in 1987. The authors described a condition seen in three women who had clinical, histological and biochemical liver abnormalities fulfilling the criteria of PBC but were sero-positive for ANA and sero-negative for AMA. Carrougher et al.\(^5\) also reported a relatively young woman with clinical, pathologic, and serologic features of both AIH and PBC. The positive ANA, negative AMA, and favorable response to corticosteroid therapy were similar to the cases reported by Brünner and Klinge.\(^6\) Ben-Ari et al.\(^9\) described four such patients who were also sero-positive for smooth muscle antibody (SMA).

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### Immunologic or serological markers in AIC

**Table 1. Clinical features of various autoimmune liver diseases**

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<thead>
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<tbody>
<tr>
<td>Target</td>
<td>Hepatocyte</td>
<td>Septal and intra-hepatic bile duct</td>
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<td>Sex</td>
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Hitherto, no specific immunologic or serological pattern of reactivity in AIC have been described, except the presence of an antibody to human carbonic anhydrase II (CA-II), one of a family of zinc metal enzymes, reported by Gordon et al.\(^{13}\) However, Muratori et al.\(^{29}\) reported that the antibody to CA-II seemed to be commonly found in a variety of pathological and normal conditions and was therefore unlikely to be a serological marker specific to AIC. On the other hand, Michieletti et al.\(^{29}\) reported that 3 of 20 patients diagnosed as PBC who were AMA-negative and ANA-positive by immunofluorescence showed the positive results of antibodies to 2-OADC enzymes by immunoblotting and ELISA. Of these 3 sera, 2 reacted with pyruvate dehydrogenase complex (PDC), which has been characterized as the immunodominant autoantigen in PBC, and 1 with branched-chain oxo-acid dehydrogenase complex (BCOADC) by immunoblotting. Thus, if AIC is, in fact, a part of the spectrum of PBC, detailed studies on the profile of immunoreactivities with 2-OADC enzymes can be informative. We examined the specificities of AMA and ANA in 21 Japanese patients with AIC, 37 with classical PBC and 16 with AIH by immunofluorescence, immunoblotting and enzyme inhibition assays using various mitochondrial and nuclear
autoantigens including 2-OADC, Sp100, gp210, and p62. By immunoblotting, in which the sensitivity, specificity, positive predictive value, negative predictive value, and accuracy in our assay condition were 99%, 86%, 89%, 99%, and 93%, respectively, and notwithstanding the negative result for AMA by immunofluorescence, 5 (24%) of the 21 sera from AIC reacted with the 74kDa component of bovine heart mitochondria (PDC-E2), and 9 (43%) with the lower molecular weight E2 subunits of 2-OADC enzymes (Figure 1). The antinuclear autoantibodies in AIC reacted with centromere, Sp100 and nuclear pore complex proteins as in PBC, but preferentially with the nuclear pore complex. Our results have demonstrated that AIC and PBC are virtually similar diseases.

**Proposed revised categories of "autoimmune cholangitis"**

The term "primary biliary cirrhosis" is clearly a misnomer for a disease that has a long precirrhotic stage and "cirrhosis" is a relatively late feature of the disease. "Chronic nonsuppurative destructive cholangitis" or "(primary) autoimmune cholangitis" would be a more appropriate description, however, "primary biliary cirrhosis" is too entrenched a term to be supplanted. Goodman et al. and Dhillon have proposed revised categories of a group of conditions in which chronic nonsuppurative destructive cholangitis is seen histologically. They tentatively divided so called "autoimmune cholangitis" into four groups (Table 2).

**Future work**

It remains to be determined whether the identification of the mitochondrial and nuclear antigens reacting with PBC- or AIC-specific autoantibodies will help to unravel the pathogenesis of the disease. First, we could direct attention to genetic factors, particularly to human leukocyte antigens (HLA), which may determine the autoantibody response to an etiologic agent, although HLA only weakly predisposes to PBC vis-a-vis other autoimmune diseases. Second, we noted in our previous study that in Japanese patients with PBC there was a relatively high frequency of reactivity with the lower molecular weight components of 2-OADC such as BCOADC-E2, and this same bias was also evident in Japanese patients with AIC. It would be interesting to elucidate whether this same trend is also evident in Caucasian patients with AIC. Third, a longitudinal follow-up studies on serological reactivities of AMA and ANA in patients with PBC,
AIC and AIH will be useful since it is well known that in PBC the AMA titres often fluctuate considerably from a negative result to a positive result, and vice versa, during the course of the disease.\(^9\) If so, the diagnosis of PBC or AIC might depend on the "phase" of the same disease. Such studies are in progress in our laboratory. Again, this duo is of interest because, usually, among sets of autoimmune syndromes, differences in serological targeting are relevant to differences in clinical manifestations: AIC and PBC are an exception to this rule.\(^10\)

**Acknowledgements**

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