Amyloid Typing Mass Spectrometry

Background Information

Systemic amyloidosis is a rare condition characterized by deposits of amorphous material that interfere with the normal structure and function of tissues. Most often amyloid deposits are identified in the heart, kidney and vascular walls, but virtually every organ system can be affected. All amyloid deposits are thought to be composed of proteins forming beta-pleated sheets, structures that render them insoluble and rigid.

Clinical Indications

Investigations leading to the diagnosis of systemic amyloidosis can be triggered by a variety of symptoms induced by heart or kidney failure, neuropathy or coagulation abnormalities. Abnormalities suggestive of cardiac amyloidosis have been described by ultrasonography. Amyloid deposits can be identified during workups for low-grade lymphomas, plasma cell myelomas, familial conditions or renal failure.

There are four major types of systemic amyloidosis: primary amyloidosis, familial amyloidosis, secondary amyloidosis and senile amyloidosis. The most common form of amyloidosis, primary amyloidosis, is the consequence of deposits of immunoglobulin light chains. Primary amyloidosis is usually diagnosed in patients with plasma cell neoplasms, from monoclonal gammopathy to plasma cell myeloma. Familial amyloidosis is a consequence of inherited mutations, most common in the transthyretin gene. Transthyretin, this time in its wild-type form, is the main component of amyloid in senile amyloidosis, a condition most often diagnosed in the heart. With the decrease in the incidence of chronic inflammatory diseases, mainly infectious, and with better management of autoimmune disorders, the incidence of secondary amyloidosis has markedly decreased and is currently a rare disease. The main amyloidogenic protein in secondary amyloidosis is Amyloid A. Overall, at least 28 proteins have been described to be responsible for the formation of amyloid deposits.

In addition to the proteins that are considered amyloidogenic, amyloid deposits in all types of systemic amyloidosis constantly include other proteins: Serum P component (SAP), Apolipoprotein E (ApoE), Apolipoprotein A-I (ApoA-I) and Apolipoprotein A-IV (ApoA-IV).

Methodology and Interpretation

In histologic sections stained with hematoxylin-eosin, amyloid deposits can be difficult to differentiate from serum or dense collagen. Several stains have been developed to assist in the diagnosis of amyloid, with the Congo Red stain currently considered the gold standard. The microfibrillar nature of the amyloid deposits can be confidently identified by electron microscopy, while the beta-pleated sheet structure of the amyloid can only be demonstrated with x-ray diffraction, a technique exclusively used in research.

While from a purely morphologic point of view there are no significant differences between different types of amyloid, the treatment of each type of amyloidosis is different. Immunohistochemical stains show the amyloid deposits to be positive for SAP, but this does not always allow the differentiation of amyloid from serum. In many cases stains for Transthyretin, Amyloid A, kappa or lambda immunoglobulin light chains allow further characterization of the components of the amyloid deposits. However, in a significant number of cases these techniques fail to identify with confidence the amyloidogenic protein. Factors that prevent a confident diagnosis include abnormal protein folding and truncation, as well as the presence of many other endogenous proteins in the amyloid deposits. This results in a significant fraction of cases being inadequately typed and, as a consequence, treated.

Recent studies have shown mass spectrometry (MS) to be a reliable method in the identification of amyloidogenic proteins and it is considered by some groups as the current gold standard. This technique was initially used on fresh or frozen tissue, but recently it has been shown that analysis of formalin-fixed, paraffin-embedded tissue (FFPET) can lead to similar results. The analysis usually begins with visual identification of amyloid deposits, followed by their dissection under the microscope (laser microdissection). The specimen is then digested with trypsin, resulting in the generation of peptide fragments. LC-MS is then used to analyze these peptide fragments, resulting in an m/z spectrum. The specific m/z characteristics of the different peaks are compared to those in several databases, leading to the identification of the peptide...
fragments in the amyloid digested by trypsin. These peptide fragments are quantified and the higher the number of peptide fragments originating from a particular amyloidogenic protein, the higher the degree of confidence that the particular protein is a component of the amyloid. Peptides from the structures of SAP, Transthyretin, ApoE, ApoA1 and ApoA-IV are used as internal controls, indicating the adequate identification of amyloid. When more than one amyloidogenic protein is identified, comparison of the relative abundance of peptide fragments can indicate which protein is the most abundant in the sample.

This amyloid typing test allows typing of the amyloid deposits with a precision superior to the other available techniques. It incorporates multiple internal controls and allows amyloid typing to be performed in archived specimens. When necessary, in addition to the LC-MS, alternative techniques such as immunohistochemical stains can be employed.

Limitations of the Assay
This test is not a substitute for a surgical pathology consult. The diagnosis of amyloidosis should not be made by mass spectrometry, as this method has not been developed as a substitute for a detailed morphologic analysis, Congo Red stain or immunohistochemistry. Amyloid analysis by mass spectrometry requires that a sufficient amount of amyloid is microdissected. In a few cases the assay may fail due to the insufficient amyloid available. In some cases additional immunohistochemical stains are necessary in order to increase the confidence with which the diagnosis is rendered.

References
