p53 expression in the gastric mucosa of patients infected with *Helicobacter pylori* 

G.A. Morales-Fuentes\(^a,\)*, A. Zarate-Osorno\(^b\), E.E. Quiñónez-Urrego\(^c\), M. Antonio-Manrique\(^d\), C.L. Martínez-García\(^a\), P. Figueroa-Barojas\(^e\), Y. Zamorano-Orozco\(^a\), S.E. Leal-Osuna\(^f\), C. Martínez-Camacho\(^a\), L.A. Mejía-Cuán\(^a\), C.A. Rivera-Nava\(^a\), X. Sánchez-Chávez\(^a\), M.A. Ramírez-Ramírez\(^a\)

\(^a\)Gastrointestinal Endoscopy Service, Hospital General Regional No. 1 “Dr. Carlos MacGregor Sánchez Navarro”, IMS, Mexico City, Mexico
\(^b\)Pathology Department, Hospital Español de México, Mexico City, Mexico
\(^c\)Pathology Department, Centro Médico Nacional La Raza, Hospital de Especialidades, IMSS, Mexico City, Mexico
\(^d\)Gastrointestinal Endoscopy Service, Hospital Juárez de México, SSA, Mexico City, Mexico
\(^e\)Gastrointestinal Endoscopy Service, Hospital Ángeles Lindavista, Mexico City, Mexico
\(^f\)Internal Medicine Department, Hospital General de Atizapán, SSA, State of Mexico, Mexico

Received 6 September 2012; accepted 26 November 2012
Available online 29 January 2013

**KEYWORDS**
p53; Helicobacter pylori; Immunohistochemistry; Gastritis; Mexico

**Abstract**

**Background:** Helicobacter pylori (Hp) is recognized as a type 1 carcinogen for gastric cancer associated with pre-neoplastic lesions (atrophy and intestinal metaplasia [IM]). Its relation with p53, which intervenes in the cell cycle, has had contradictory results.

**Aims:** To analyze p53 expression in gastric mucosa and its relation with Hp infection.

**Methods:** A 3-month prospective, observational, cross-sectional study was conducted. Patients that had no evidence of acute or clinically significant gastric pathology had biopsies taken according to the Sydney system at the Hospital Juárez de México and the histopathologic studies were done at the Hospital Español de México.

**Results:** Hp prevalence was 32.7% in 104 patients. There were no cases of atrophy or dysplasia. A total of 91% of the infected patients were positive for p53. Of the non-infected patients, 14% were positive for p53 and 60% of them had IM. Of the IM patients, 75% presented with positive p53. Of the patients without IM, 31 presented with positive p53, and Hp was positive in 85% of...
Introduction

Gastritis is defined as an inflammatory response of the gastric mucosa to a harmful stimulus and is a problem of considerable magnitude worldwide. Its global prevalence has increased through the use of endoscopy and the possibility of taking directed biopsies. Infection from Helicobacter pylori (Hp) is a major cause of chronic inflammation of the human gastric antral mucosa.

The development of atrophy is due to the disappearance of glands, and its final stage is atrophic chronic gastritis (CG). Antral CG with or without atrophy is clearly related to the presence of Hp. In contrast, if CG presents exclusively in the corpus, it is unlikely that it is due to Hp, given that the presence of the microorganism diminishes parallel to the development of mucosal atrophy. Populations with elevated CG prevalence show an earlier age of Hp infection. Some areas of the stomach, such as the lesser curvature and the incisura angularis are more prone to develop CG and intestinal metaplasia (IM), and the pre-pyloric zone is the best site for Hp detection.

There are multiple gastritis classifications, each one with its own terminology, which produces difficulty and confusion for referring to the same type of gastritis. Therefore, in 1990 the Sydney system (SS) was created in order to have a single classification. In the present study, the section on biopsy specifications is particularly important. It states that a minimum of 2 biopsies should be taken at each site, as well as from all identified suspicious lesions, taking biopsies from the anterior and posterior wall, from the antrum between 2 and 5 cm from the pylorus, and from the gastric corpus at approximately 10 cm from the cardia. The SS was re-evaluated in Houston in 1994, and among other things, it was concluded that biopsies from the corpus are especially useful, because that is where Hp is located after proton pump inhibitor use. However, the maximum grade of atrophy and IM is found in the incisura angularis, which is also where the greatest prevalence of dysplasia is found, and so it has been proposed as the fifth biopsy site to be included in the protocol.

Infection occurs in the antrum in at least 85% of the cases, but up to 15% will only infect the corpus, which explains the reasoning behind the SS biopsy proposals.
Routine staining should be carried out with the hema-
toxylin and eosin (H&E), Giemsa, and periodic acid-Schiff
(PAS)/alcian blue (AB) methods. Each one of these staining
methods is necessary to assess the SS as it is described.\textsuperscript{2}

To determine the presence of Hp when IM is found,
other samples where there is no IM have to be evaluated,
because Hp does not colonize this mucosa.\textsuperscript{1} IM is recognized
morphologically and it has been subclassified as complete or
incomplete.\textsuperscript{1} The risk for progression to gastric cancer (GC)
in the complete type is low; it is higher in the incomplete
type.

Hp is a Gram-negative bacterium that colonizes the
human stomach, causing antral gastritis. It is the main cause
of peptic ulcer, gastric lymphoma, and adenocarcinoma.\textsuperscript{3} Hp
colonizes the stomach at infancy and persists throughout life
if left untreated. Its spiral shape and its flagella enable it to
cross the mucus barrier of the mucosa and attach itself to
the cells.\textsuperscript{1} Despite evading the immune response of the host,
it manages to trigger a reaction that produces inflammation
in the gastric mucosa, thus inducing gastritis.\textsuperscript{1}

Hp possesses genetic factors whose functions and
interactions with the host are important to point out:

− One of them is CagA, which can be present, absent,
or non-functioning; most commonly it is present and
functioning.\textsuperscript{3,4} In the United States, at least 60% of the
isolated strains are of this type, and the figure goes up
to 90% in other countries.\textsuperscript{4} This strain is also found
more often in patients that develop GC,\textsuperscript{4} and it causes
greater inflammation of the gastric mucosa and higher
proliferation levels. Some studies have shown that it
functions as an oncprotein, promoting gastric epithelial
cell growth.\textsuperscript{5} It also induces cytokine production.\textsuperscript{3} The
induced transcription factors produce gene p53 mutation.

− Vacuolating protein, or VacA, is found in practically all bacilli. It is an exotoxin that is resistant to degradation
by pepsin. It inhibits the activation of T lymphocyte
transcription, inducing cell cycle arrest,\textsuperscript{3} and thus is
regarded as being associated with precancerous lesions.

− At times it modifies and repairs its genetic composition
itself, creating mutant CagA and VacA strains.

Hp infection is associated with structural alterations,\textsuperscript{1} such
as the loss of intercellular union between gastric mucosal
cells, loss of form and uniformity of the mucosal cells, loss of
the cytoskeleton, loss of mucus content, strong adherence
of Hp to epithelial cells, and intracellular edema. After
treatment, all these alterations disappear and the mucosa
returns to normality.\textsuperscript{1}

Gastric carcinogenesis is thought to be a multistep
and multifactorial process that affects the expression of oncopgenes, suppressor genes, intercellular adhesion
molecules, and microsatellite instability, producing a chain
going from gastritis of the corpus or pangastritis,\textsuperscript{1,6} to atrophic
carcinoma (CG), to IM, to dysplasia, and finally to GC;\textsuperscript{1} this chain can
take decades to complete. In the majority of cases, tumor
presents in the stomach with severe atrophy and IM. The
crucial step is atrophy; Hp appears to lead to its induction.
One hypothesis as to how atrophy progresses to GC is that
hypochlorhydria allows for an increase in Hp colonization,
which results in greater damage to DNA;\textsuperscript{6} another theory
is that the free radicals produced by the inflammatory
response may act as carcinogens;\textsuperscript{1} and finally, it has been
suggested that hypergastrinemia produces such an increase
in cellular proliferation that control over it is lost.\textsuperscript{1}

Hp is the main causal factor that has been identified
for the development of gastropathy, including CG, ulcer
disease, intestinal GC, and MALT lymphoma. Only a small
number of infected patients will develop clinical disease.
Approximately 1 in every 5 or 6 cases will develop ulcer
disease in an entire lifetime and fewer than 1% will develop
GC.\textsuperscript{6} A 50 to 60% risk for GC\textsuperscript{7} has been attributed to Hp and
the International Agency for Research on Cancer defined it
as a definitive carcinogen in GC, listing it in group 1 of the
carcinogens recognized by the World Health Organization.\textsuperscript{7,8}

Reports in the literature have been inconsistent in relation
to the effects of Hp on gastric cell proliferation, and to a
certain point, the findings have been contradictory, and
have shown that many signals and signaling cascades can be
affected by the presence of Hp.

It has been demonstrated that Hp eradication implies a
reduction in GC incidence, as long as there are no existing
premalignant lesions.\textsuperscript{8}

The results of studies indicate that Hp inhibits the G1 cell
cycle, preventing it from entering into the S phase. This
inhibition is associated with genetic alterations, such as that
of p53, and finally with apoptosis.\textsuperscript{9}

Since 1979, p53 has been called a tumor antigen,
an oncogene, or a tumor suppressor gene. Certain
immunohistochemistry studies have shown an increase in
p53 levels in patients infected with Hp. However, other
studies have reported that there is no difference in the levels
or in associated p53 activity. Currently, p53 is regarded
as a transcription factor whose increase in expression or
whose mutation is associated with cell cycle inhibition,
primarily with the arrested G0 or G1 phase of the cell
cycle,\textsuperscript{3} which does not let it enter into the S phase, and in
a secondary manner, does not allow for the repair of the
damaged genome. Cycle arrest and consequent apoptosis
induction may be a result of the same p53 activation and
stabilization that inhibits cellular proliferation.\textsuperscript{4}

Many studies have shown that p53 expression is altered in
premalignant gastric lesions such as atrophy or metaplasia,
which can be produced in an attempt to stop the cycle of the
damaged cell,\textsuperscript{10} and its accumulation indicates suppressor
function loss. Similar changes have been reported in
Barrett’s esophagus.

The increase in p53 expression may be a protective
mechanism on the part of the host that results in cell
cycle arrest in order to enable genome repair. The lack of
this protective mechanism would increase the risk for GC
in infected subjects. The absence of p53 activation may
reduce gastric epithelial cell sensitivity to Hp-induced
apoptosis.

In the study by Unger et al.,\textsuperscript{11} they found that there was
p53 overexpression in the cases of gastritis that were related
to Hp with no IM. There was less overexpression in the cases
with IM. However, there was an elevated apoptosis rate in
the cases with no IM, whereas in the patients with IM this
rate was not different from that of the control group. It was
confirmed that Hp infection increased p53 expression and
the apoptosis rate when there was no IM. This is due to the
fact that Hp cannot colonize the IM, and so its effects on
apoptosis disappear, as would happen if it were eradicated.
Hp can alter the cycle at various steps and in various manners. Apoptosis is a normal component of the cell cycle, but the effects of Hp are not uniform in all of the gastric mucosa. Specific Hp strains may contribute to the heterogeneity of the results.

It is particularly important to recognize and define the characteristics of benign lesions and premalignant ones. It is not possible at this time to conclude whether p53 expression is produced by an inflammatory reaction or if it will persist through time as part of the carcinogenesis chain.

**Methods**

A 13-week observational, prospective, comparative, cross-sectional study was conducted.

Patients sent to the Endoscopy Service of the Hospital Júarez for upper endoscopy were fit to the inclusion criteria (above 18 years of age, both sexes undergoing upper endoscopy and signing letters of informed consent, patients whose study indications included gastroesophageal reflux disease, acid peptic disease, dyspepsia, dysphagia, or GC screening) and for the exclusion criteria (patients with a history of GC, active hemorrhage, portal hypertension, patients that did not cooperate during biopsy, that did not authorize biopsy, or that presented with gastropathy of another etiology that merited routine biopsy). Clinical and demographic data were gathered and biopsies were taken according to the guidelines established by the SS. The biopsies were labeled and transported to the Pathology and Immunohistochemistry Service of the Hospital Español, where they were processed and stained using the following methods: H&E, PAS/AB, Giemsa, and p53 immunohistochemistry. The 2 participating pathologists did not have access to the clinical and demographic data.

**Definition of the variables**

- **p53 expression**: the brown coloring in the cell nucleus was immunohistochemically measured and expressed as positive (present) or negative (absent).
- **Presence of Hp**: measured with the Giemsa stain and expressed as positive or negative.
- **Presence of IM**: measured with H&E and PAS/AB staining, expressed as positive or negative, and specified as complete or incomplete.

**Statistical analysis**

Sample size calculation: This is the first study in Mexico showing the relation of p53 expression in patients infected by Hp. Therefore no previous information was available and due to the contradictory results of the studies reviewed in the literature, a difference in proportion with a $\Delta$ of 0.4 was taken into account to obtain an $\alpha$ error of 0.5 and a $\beta$ error of 0.2. The calculated total was 50 patients.
The Fisher exact test was used for nominal variables with a statistical significance of \( p < 0.05 \).

**Results**

Within the study time frame, 104 patients were enrolled that fit the protocol inclusion criteria.

Of that total, 70 patients (67.3%) were women and 34 patients (32.7%) were men, with a 2:1 ratio. The mean age ± standard deviation was 47.6 years ± 13 years, with a range of 18 to 80 years. The general results are summarized in Table 1.

No cases of atrophy of the gastric mucosa or evidence of dysplasia were found and all the cases of IM were classified as complete.

Of the 34 patients with Giemsa stain that was positive for Hp infection, 31 (91%) also had positive p53 immunohistochemistry. Only 3 patients (9%) had negative p53 results (Fig. 1). Of the 70 patients with negative Giemsa stain, 10 (14%) had positive p53 and 60 (86%) had negative p53 (Fig. 2).

Regarding the 20 PAS/AB+ patients, in other words, those with IM, 15 of them (75%) had positive p53 and 5 (25%) had negative p53 (Fig. 3). Of the 84 PAS/AB- patients, 26 (31%) had positive p53 and 58 (69%) had negative p53 (Fig. 4).

The three stains were positive in 9 of the 20 PAS/AB+ patients, resulting in Hp infection, complete IM, and p53 nuclear expression. Of the remaining 11 PAS/AB+ patients, 5 were not infected with Hp and did not have p53 expression, and the other 6 patients had p53 expression but Hp presence was not confirmed through positive Giemsa stain.

The Fisher exact test was used when the Giemsa stain was positive for Hp and the immunohistochemistry stain showed nuclear p53 expression, and it produced a statistically significant result of \( p<0.0001 \) (OR = 62, 95% CI, 15.8-241.8). The test was also used for analyzing the association between p53 expression and PAS positivity, that is to say, patients with IM, and produced the statistically significant results of \( p<0.0006 \) (OR = 6.69, 95% CI, 2.1-20.3) (Table 2).

Figure 5 shows the PAS/AB stain in which the goblet cells with acid mucins are stained blue/purple with the AB, indicating the presence of IM. The magenta-colored stain indicates the presence of pseudo-goblet cells that are characteristic of the gastric epithelium and are base mucin producers.

Figure 6 is a 40× microscopic photo of an H&E stain that shows bacilli suggestive of Hp on the epithelium of the gastric glandular surface that was confirmed by the Giemsa stain.

Figure 7 is a 40× microscopic photo of an immunohistochemistry stain for the p53 protein in which positivity is manifested through the staining of the nucleus, indicating gene expression. The presence of the stain in the cell’s cytoplasm is what is known as “deep staining” and it does not have diagnostic value.
p53 expression in the gastric mucosa of patients infected with *Helicobacter pylori*

### Discussion

The patients making up the greater portion of our population were women; 62% of them were taking, or had recently taken, proton pump inhibitors either of their own accord or prescribed medically.

The endoscopic findings in the order of frequency were CG in 44%, acute gastritis in 17%, reactive gastritis in 12%, and nodular gastritis in 12%. Other findings, such as superficial gastritis, atrophic gastritis, and normal study presented less frequently. We observed that CG was found in almost half of our patients that did not present with the specific characteristics proposed by the SS. The finding of nodular gastritis is noteworthy because it implicates a high endoscopic suspicion of Hp in the patient.

Histopathologic diagnoses were made according to the SS proposals and moderate CG was the most predominant, representing 31% of the cases. It was followed by histologically normal mucosa, with 13% of the cases, superficial CG with 12%, active CG with 10%, and active follicular CG with 10%. The remaining diagnoses included superficial CG with a reactive component, moderate CG with a reactive component, reactive CG, mild CG, active follicular CG with a reactive component, and moderate follicular CG. CG was found in 87% of the cases and its subdivisions were dependent on the grade of activity and penetration into the mucosa, with the characteristic that in some patients, reactive gastritis data were found. The presence of lymphoid follicles, or follicular CG, was highly suggestive of Hp and was not a predominating diagnosis. Not one case of mucosal atrophy or dysplasia was found.

It should be kept in mind that the biopsies were taken from mucosa that had no macroscopic lesions that were apparent using conventional endoscopy.

In regard to the use of staining methods, PAS/AB was positive in 19% of the patients, all of them presenting with complete metaplasia. Within the SS criteria, biopsy is taken from the incisura angularis, which is where the greatest prevalence of this pre-neoplastic lesion is found, and it is highly unlikely to be identified endoscopically with conventional endoscopy.

Hp infection was confirmed by Giemsa stain in 32.7% of the patients, which is below that reported in the Mexican medical literature. It is noteworthy that the majority of patients were taking, or had recently been taking, a proton pump inhibitor, which produces Hp migration to the corpus and gastric fundus from its habitual location in the antrum and pre-pyloric region, which is why biopsy was not taken at those sites.

In relation to p53 immunohistochemistry, it was positive in 39.4% of the study patients. As mentioned before, p53 is an oncogene that is expressed once it has been mutated. Also called the «wild gene», it alters the cell cycle, in turn producing altered cell proliferation and apoptosis rates that condition the accumulation of mutations and DNA damage, initiating a chain of events that leads to GC. In some in vivo

### Table 2  Relation between the parameters studied and p53 expression.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Positive p53</th>
<th>Negative p53</th>
<th>p value/ OR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Giemsa (Helicobacter pylori)</strong></td>
<td>31</td>
<td>3</td>
<td>&lt; 0.0001 OR = 62; 95% CI, 15.8-241.8</td>
</tr>
<tr>
<td>Positive</td>
<td>10</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PAS/AB (intestinal metaplasia)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>15</td>
<td>5</td>
<td>&lt; 0.0006 OR = 6.69; 95% CI, 2.1-20.3</td>
</tr>
<tr>
<td>Negative</td>
<td>26</td>
<td>58</td>
<td></td>
</tr>
</tbody>
</table>
studies, p53 expression has been related to Hp infection, and in vitro studies have confirmed that acute Hp infection produces p53 expression.

Concerning the relation between variables, it was demonstrated that in 91% of the patients with Giemsa+, meaning Hp infection, there was mutated p53 expression. This was not the case in the remaining 9% of Giemsa+ patients, because p53 expression was negative.

However, of the Giemsa- patients, that is to say, patients in whom Hp infection could not be confirmed, 14% (10 patients) presented with p53 expression; 60% of those patients (6 patients) had positive PAS/AB, that is to say, complete IM diagnosis. And as was mentioned before, Hp does not colonize IM. Other elements that could influence this result would be the possibility of genetic or environmental factors causing p53 mutation in the patient. Among the latter, the

**Figure 5** Staining with PAS/AB. A) Alcian blue positive intestinal metaplasia B) PAS/AB positive. C) PAS/AB positive with evidence of intestinal metaplasia. PAS/AB: Periodic acid-Schiff/Alcian blue stain.

**Figure 6** A) H&E stain with suspicion of Hp on the surface epithelium. B) Giemsa stain highlighting the Hp on the surface epithelium. C) Another example of positive Giemsa stain for Hp bacilli. H&E: Hematoxylin/Eosin stain, Hp: Helicobacter pylori.

**Figure 7** A) Immunohistochemistry stain with positive p53 in the nucleus and cytoplasm, making it inadequate for evaluation. B) Positive and negative for p53 in the nucleus. C) Nuclear positivity for p53.
reactive gastritis that was found could be a factor worth investigating in this area in later studies.

There was a statistically significant relation between the Giemsa stain and the p53 immunohistochemistry.

Of the patients with confirmed IM, 75% had positive p53, which according to the rest of the results, suggests that Hp infection could be a predisposing factor for p53 mutation. By changing the epithelium toward IM, Hp was no longer able to colonize it, but the induced genetic damage would remain and continue in the oncogene chain leading to GC, given that IM is regarded as a pre-neoplastic lesion. However, 25% of the patients with IM did not present with p53 reactivity.

Finally, of the PAS/AB- patients, 31% (26 patients) had p53 expression, and Giemsa was positive in 85% (22 patients) of them, meaning that the p53 expression could be explained by the presence of Hp; in the remaining 15% p53 expression could again be due to other genetic or external factors. Of the PAS/AB- patients, 69% (58 patients) did not present with p53 reactivity, and of those patients, 95% (55 patients) were regarded as having no findings, due to the fact that in the remaining 5% (3 patients) Hp was found in the Giemsa stain and p53 expression was absent.

The relation between the PAS/AB stain and p53 immunohistochemistry also has a statistically significant association, and taking into account the abovementioned, that relation is confirmed by the Giemsa stain.

It should be underlined that the majority of the analyses that have been conducted are in vitro or animal model studies in which both the amount of time of Hp infection and its specific strain have been controlled. Until now, no epidemiologic studies have been carried out that indicate the true incidence of p53 mutations in asymptomatic patients or in those that do not present with macroscopic lesions during the endoscopy. The study was conducted, for the first time, on a Mexican population presenting with high Hp prevalence rates that are dependent on the geographic zone, providing a good opportunity for studying the chain of origin of gastric cancer. And to the best of our knowledge, this study is a first step in such an analysis. Our study design was a limitation because it did not allow for clinical follow-up in relation to the presence or absence of p53 expression and its progression to cancer; another limitation was the size of the study sample. Genetic studies for the confirmed detection of p53 mutations were not conducted in this study, only its expression was considered positive.

Conclusions

The study presents a strong association between the presence of Hp and the immunohistochemically visible expression of the p53 gene. The expression of this gene was even detected in patients that already presented with pre-neoplastic infections as a consequence of Hp infection, as occurs in IM, with the bacillus no longer present.

As with any other oncogene, p53 overexpression may be due to genetic factors or to external ones, such as infectious factors. The latter was found in this study in relation to Hp infection. Reactive gastritis as a possible cause of p53 alteration is an interesting finding; in patients with gastric surgery, biliary reflux in anastomosis has been related to a greater probability of cancer, but the possible role played by the p53 gene in this gastric cancer chain has not been studied.

The early identification of GC is of vital importance for its adequate treatment and cure. Gastric atrophy and IM have currently been identified as pre-neoplastic lesions and should be under surveillance for their potential to become malignant. In addition to routine biopsy taken during upper endoscopy for Hp detection by means of Giemsa staining, the complementary use of p53 immunohistochemistry can identify the population presenting its expression, which in its role as oncogene signifies cell cycle alteration.

Follow-up of the patients that present with p53 is necessary in order to fully understand the effect of the expression or mutation and its actual predisposition for GC. It is a known fact that all stomach cancers present genetic alterations, but it is not known which of them is the first to occur, the time that elapses between each event, and how they are produced by Hp. Due to the high prevalence of p53 expression in these patients, and taking into account that in Mexico Hp prevalence is variable but constantly elevated, there would be many detected patients with this test. Therefore it is necessary to know which other factors lead to the development of cancer, possibly starting from a first step, such as p53 expression.

For now, p53 expression must be thought of as a marker for cell cycle alteration in patients with active or past Hp infection, the same as in patients with histologic consequences of that infection.

Financial disclosure

Internal: the Endoscopy Service of the Hospital Juárez de México provided the necessary endoscopic equipment.

External: the Pathology Service of the Hospital Español de México covered the costs of the biopsy processing.

Conflict of interests

The authors declare that there is no conflict of interest.

Acknowledgements

The authors wish to thank the Endoscopy Service of the Hospital Juárez for collecting the samples and the Pathology Service of the Hospital Español de México for processing the biopsies.

References