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Newly defined aberrant crypt foci as a marker for dysplasia in the rat colon

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Key words

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Dysplasia represents a preneoplastic status in multistep colon carcinogenesis. Whereas laborious preparation of thin sections is required for its diagnosis, we here show that newly defined aberrant crypt foci (ACF) simply mark the majority of the dysplasia on the whole colon. Specifically, decoloring of the azoxymethane-treated rat colon after scoring classical ACF (cACF) resulted in visualization of a subset of aberrant crypts that remained densely stained. They were morphologically classified into three subtypes, of which two with compressed luminal openings proved highly correlated with dysplasia. Accordingly, we designated those foci harboring either of the two crypt subtypes as dysplasia-associated ACF (dACF). By serially applying different detection methods for known preneoplastic lesions to the same colon, we showed that most dACF had already been identified as cACF, and a few newly identified dACF contained an entire population of more advanced lesions, such as flat ACF and mucin-depleted foci. Consequently, integrative scoring of cACF and dACF enabled capture of all early lesions of the colon. Furthermore, 94% of the dACF showed dysplasia and 90% of the dysplastic lesions proved to be dACF. Thus, dACF is a promising marker for dysplasia, likely facilitating precise identification of the early stages of colon carcinogenesis.

Step-wise accumulation of genetic events underlies histological transition in colon carcinogenesis.[1–4] Aberrant crypt foci (ACF), clusters of enlarged thick crypts visualized by methylene blue (MB) staining, can be easily detected under a microscope at low magnification, and are the earliest identifiable lesions.[5,6] As their incidence at an early time point is highly correlated with eventual tumor incidence,[7] they have been widely used in evaluating carcinogenicity of chemicals.[8] However, their specificity as tumor precursors has been questioned, partly due to their predominant location in the proximal colon, where tumors do not develop, and gradual disappearance over time.[9,10] Moreover, ACF frequently harbor mutations in *Kras*, but rarely in adenomatous polyposis coli (*Apc*).[11–13] These findings strongly suggested that the majority of ACF might not be true preneoplastic lesions. Frequent *Apc* inactivation and β-catenin accumulation strongly suggest that dysplastic ACF[4,14–16] or crypts with β-catenin accumulation[17–19] might be specific tumor precursors, but they need histological analysis to be identified.

There are other non-ACF lesions on the whole colon. Flat dysplastic ACF (fACF) are less densely stained foci by brief exposure to MB.[10] Flat dysplastic ACF are likely associated with *Apc* inactivation, as $Apc^{min/+}$ mice spontaneously develop equivalent lesions, but not classical ACF (cACF).[20] Mucin-depleted foci (MDF) are the stain-defect lesions by periodic acid–Schiff (PAS), which readily detects mucin.[9,21] Unlike cACF, these two lesions develop predominantly in the distal colon and exhibit high-grade dysplasia. Moreover, chronological analysis has indicated that foci are likely tumor precursors.[9,10] However, they manifest only a low sensitivity for dysplasia.

Feeding rats with a dietary mutagen, 2-amino-1-methyl-6-phenylimidazo[4,5-*b*]pyridine (PhIP), allows recapitulation of colon carcinogenesis, providing many insights into the molecular mechanisms.[14,22–28] While characterizing PhIP-induced ACF, we noted that addition of a decoloring step could result in selective visualization of some stained foci. These foci tended to be more dysplastic than classical ACF, and the higher staining intensity of the foci could considerably, if not always, predict a higher likelihood of being dysplastic.[29] These findings raised the possibility that dysplasia could be identified as a new type of ACF. In this study, we verified this notion, and showed that the new ACF might be reasonably useful to evaluate the early stages of colon carcinogenesis.

Materials and Methods

Animal studies. Five-week-old F344 male rats were purchased from Clea Japan (Tokyo, Japan). The rats were s.c. treated with azoxymethane (AOM; Nard Institute, Osaka, Japan) at a dose of 15 mg/kg twice at the age of 6 and 7 weeks, and killed 9 weeks after the last treatment. The institutional committee for ethics in animal experimentation approved the protocol for animal experiments. The experiments were carried out in accordance with the guidelines for

animal experiments of the National Cancer Center (Tokyo, Japan).

Identification of cACF and dACF. The formalin-fixed colons were stained with 0.2% MB in PBS for 20 min, and the number of cACF[5] was counted. The colons were further stained with 0.2% MB for 20 min, and soaked in 70% methanol for 6 min for destaining.[29] Stained crypts were classified into three subtypes: crypts larger than surrounding normal ones with proportionally large and narrow openings were designated as *c*-type and *cd*-type, respectively, and crypts smaller than surrounding normal ones with narrower openings were designated as *d*-type. These three subtypes were readily distinguishable under a microscope, but objective evaluation was also carried out. The external diameter of normal (R_N) and aberrant crypts (R), and the internal diameter of aberrant crypts (*r*) were measured on captured images to calculate relative luminal opening size and relative crypt size. Foci containing at least a single crypt of either *cd*-type or *d*-type crypts were diagnosed as dysplasia-associated ACF (dACF). The signal intensity ratio (SIR) of the foci was determined as previously described.[29]

Serial scoring of preneoplastic lesions in a whole mounted colon. The formalin-fixed colons were divided into four segments, which were subject to serial different staining. The mucosal surface was examined under an inverse light microscope, and pictures across the whole colon were taken at each step for later comparison of the images of the same foci. Fragments were first soaked in 1% Alcian blue (AB), pH 2.5, for 30 min, and subsequently in 0.2% MB for 5 s to detect MDF and fACF, respectively. We adopted the staining solely with AB for the detection of MDF,[21] instead of the original high iron diamine–AB staining,[9] to avoid interference of high iron diamine with MB in evaluating ACF. Subsequently, the number of cACF and dACF were counted.

Histological analysis. For vertical sections, the colons were cut into pieces 3 mm long and 6 mm wide, so that each dACF would be located in the center of the fragment. For horizontal sections, the colons were first cut longitudinally into two strips, and subsequently segmented laterally into 8-mm-long pieces. These pieces were embedded in paraffin and cross-sections were prepared in 4 μm. Serial sections were subject to H&E staining without prior knowledge of information on surface examination. Dysplastic lesions were further graded into three classes as previously described.[30] The AB-PAS staining was carried out for the detection of foci that had completely lost mucin, which we designated as mucin-depleted crypts (MDC). Crypts with an accumulation of β-catenin in the cytoplasm or nucleus were diagnosed as β-catenin accumulating crypts (BCAC).[19,29]

Mutation analysis. Genomic DNA was selectively collected from BCAC by microdissection from the unstained serial sections of 20 independent samples. Extracted DNA was sub-

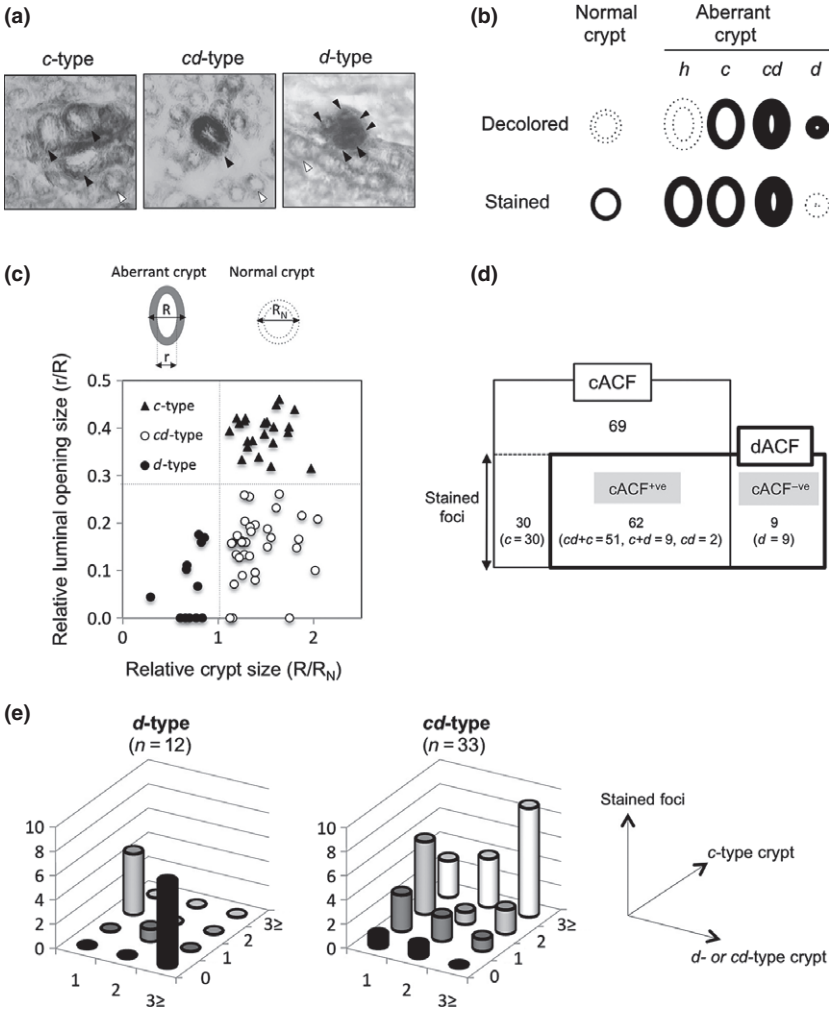

Fig. 1. Crypt-based characterization of azoxymethane-induced dysplasia-associated aberrant crypt foci (dACF). (a) Typical images of the three crypt subtypes (closed arrowheads) constituting dACF: *c*-type, enlarged crypt and broad opening; *cd*-type, enlarged crypt and narrow opening; and *d*-type, small crypt and narrow opening. Each arrowhead points to a single crypt. Note that normal crypts in surrounding mucosa (open arrowheads) could serve as a reference with a diameter of approximately 30 μm. (b) Schematic view of the crypt subtypes. A ring-shaped image represents the morphology of epithelial lining. Dashed lines indicate invisible status. (c) Classification of aberrant crypts by objective and subjective methods. Note that visual judgment and strict quantification gave completely concordant results for randomly selected crypts ($n = 66$). r, internal diameter of aberrant crypts; R, external diameter of aberrant crypts; R_N, external diameter of normal crypts. (d) Venn diagram for classical ACF (cACF) and dACF. Dysplasia-associated ACF (shaded box) was divided into two subgroups, $cACF^{+ve}$ and $cACF^{-ve}$, depending on the presence of overlap with cACF (open box). Composition of crypt subtype in stained foci is indicated in parenthesis. (e) Breakdown of crypt subtypes within stained foci. Each axis of the bar chart depicts the number of aberrant foci, *c*-type crypt and *d*- or *cd*-type crypt.

ject to amplification of exon 3 of the *Ctnnb1* gene by PCR, as previously described.[16] Polymerase chain reaction products were purified and directly sequenced by the standard Sanger method.

Results

Decoloring of MB-stained colon segregated three subtypes of aberrant crypts. We previously showed that more accurate detection of dysplasia might be achieved by destaining of cACF, although with laborious procedures, and found that the narrow opening might suggest the dysplastic nature of the foci.[29] We then hypothesized that stained foci harboring crypts with narrow opening, or dACF as tentatively designated, might be equivalent to dysplasia. To address this issue, we examined a rat colon treated with AOM. Starting with examining 161 induced cACF, we noted that decoloring gave rise to three morphologically distinct subtypes of stained crypts (Fig. 1a). We designated enlarged crypts with large openings, and small crypts with narrow openings as *c*-type and *d*-type, respectively, to emphasize specific features of cACF and dACF (Fig. 1B). Accordingly, enlarged crypts with narrow openings were designated as *cd*-type. Normal crypts and a subset of crypts within cACF turned invisible after decoloring. We designated the latter as *h*-type crypts (Fig. 1B), as such crypts constituted hyperplasia.[29] Thus, various types of crypts were differentially visualized through decoloring. We now redefined dACF as foci harboring at least single *d*- or *cd*-type crypt.

Dysplasia-associated ACF consisted of diverse combinations of crypt subtypes. The three crypt subtypes were morphologically so distinct that the right diagnosis could be made even by visual judgment. In fact, rigorous quantification of the size of both the crypt and its luminal openings for 66 randomly selected crypts gave completely concordant results (Fig. 1c). Direct comparison of the images of 71 dACF before and after

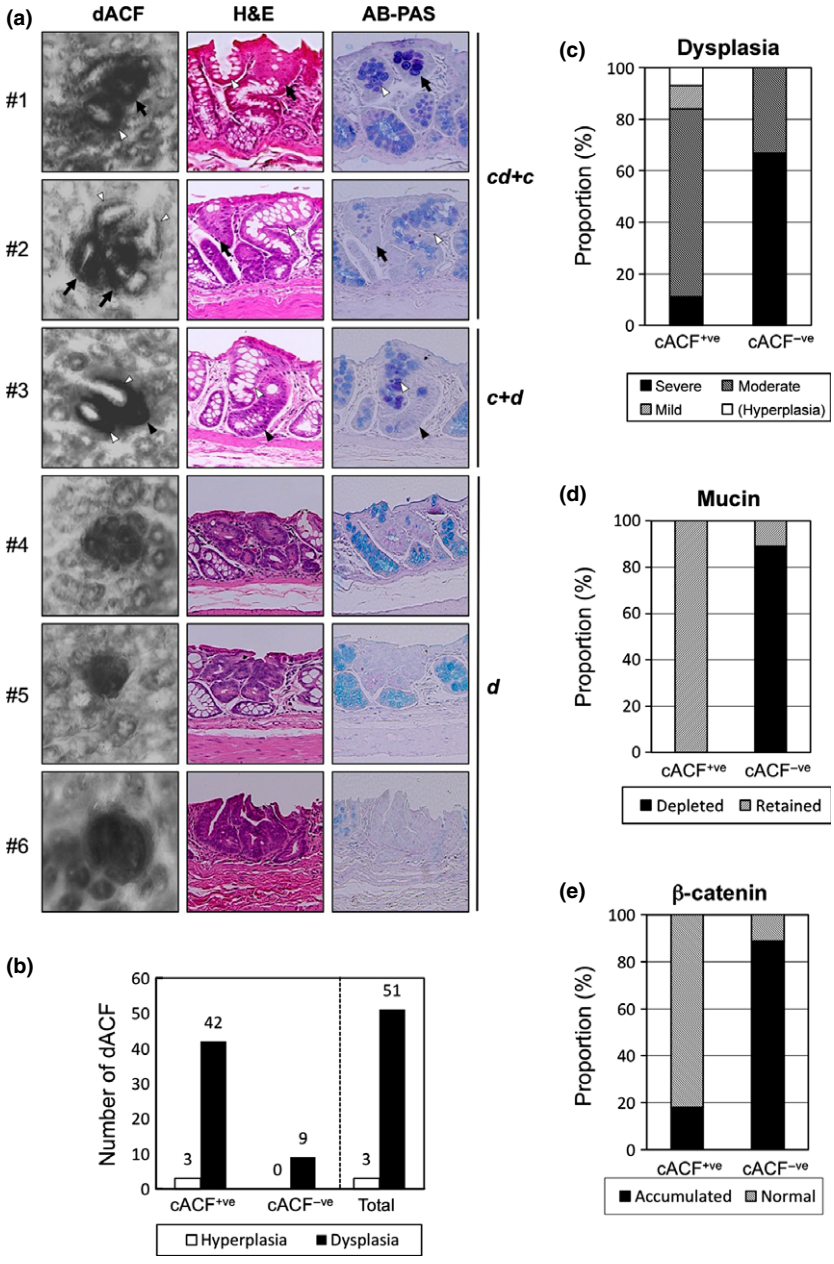

Fig. 2. Histological features of dysplasia-associated aberrant crypt foci (dACF). (a) Representative images of dACF (left panel) and corresponding histological features with H&E (middle panel) and Alcian blue–periodic acid–Schiff (AB-PAS) (right panel) staining. A single crypt of *c*-type (enlarged crypt and broad opening; open arrowheads), *cd*-type (enlarged crypt and narrow opening; arrow), and *d*-type (small crypt and narrow opening; closed arrowheads) is individually indicated for classical ACF (cACF)$^{+ve}$ (#1–3). Classical ACF^{-ve} consisted solely of *d*-type crypts (#4–6). Mucin expression was decreased in *cd*-type crypts (arrow) and completely depleted in *d*-type crypts (closed arrowheads). Accumulation of red granules indicative of Paneth cell differentiation (#4 and #5), consistent with severe dysplasia. (b–e) Comparison of cACF^{+ve} and cACF^{-ve}. The number of lesions with hyperplasia and dysplasia (b), and proportion of dysplastic lesions with each histological grade (c), with mucin depletion (d), and with β-catenin accumulation (e) are shown in the bar charts.

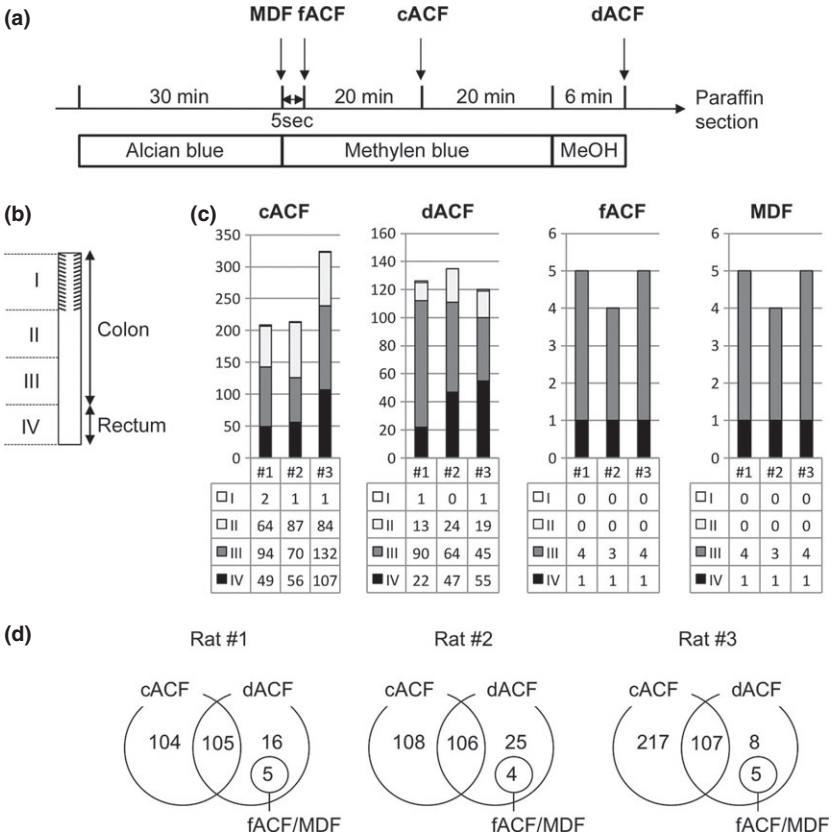

Fig. 3. Serial scoring of multiple preneoplastic lesions on the same colon. (a) A schematic diagram of the serial detection of multiple preneoplastic lesions. The images of mucosal surfaces were captured at the end of each step (arrows) for comparison at a later time point. (b) Colons were cut open longitudinally and separated into four segments (I–IV). (c) Bar chart showing the number of preneoplastic lesions per segment. #1–3 corresponds to the colons of three individual F344 male rats. Note that dysplasia-associated aberrant crypt foci (dACF), flat ACF (fACF), and mucin-depleted foci (MDF) are more enriched in segments III and IV compared to classical ACF (cACF). (d) Venn diagram for the number of cACF, dACF, and fACF/MDF for each rat.

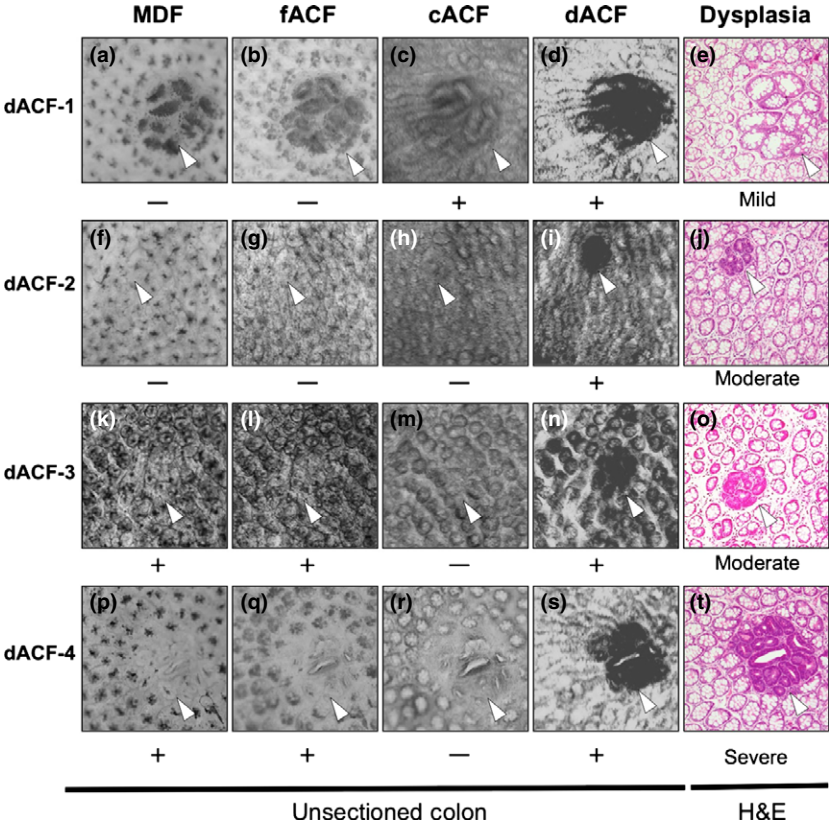

Fig. 4. Direct comparison between images of the same foci visualized by different methods: lesion dysplasia-associated aberrant crypt foci-1 (dACF-1) with mild dysplasia (a–e); lesions dACF-2 (f–j) and dACF-3 (k–o) with moderate dysplasia; and lesion dACF-4 with severe dysplasia (p–t). The left four columns show the images obtained by scoring preneoplastic lesions on the mucosal surface, and the diagnosis is indicated below the images as – (negative) or + (positive). The far right column depicts H&E staining of the corresponding lesions in horizontal sections, where the grade of dysplasia is shown below the images. Open arrowheads point to the area where the dysplastic lesions are supposed to be located in each image.

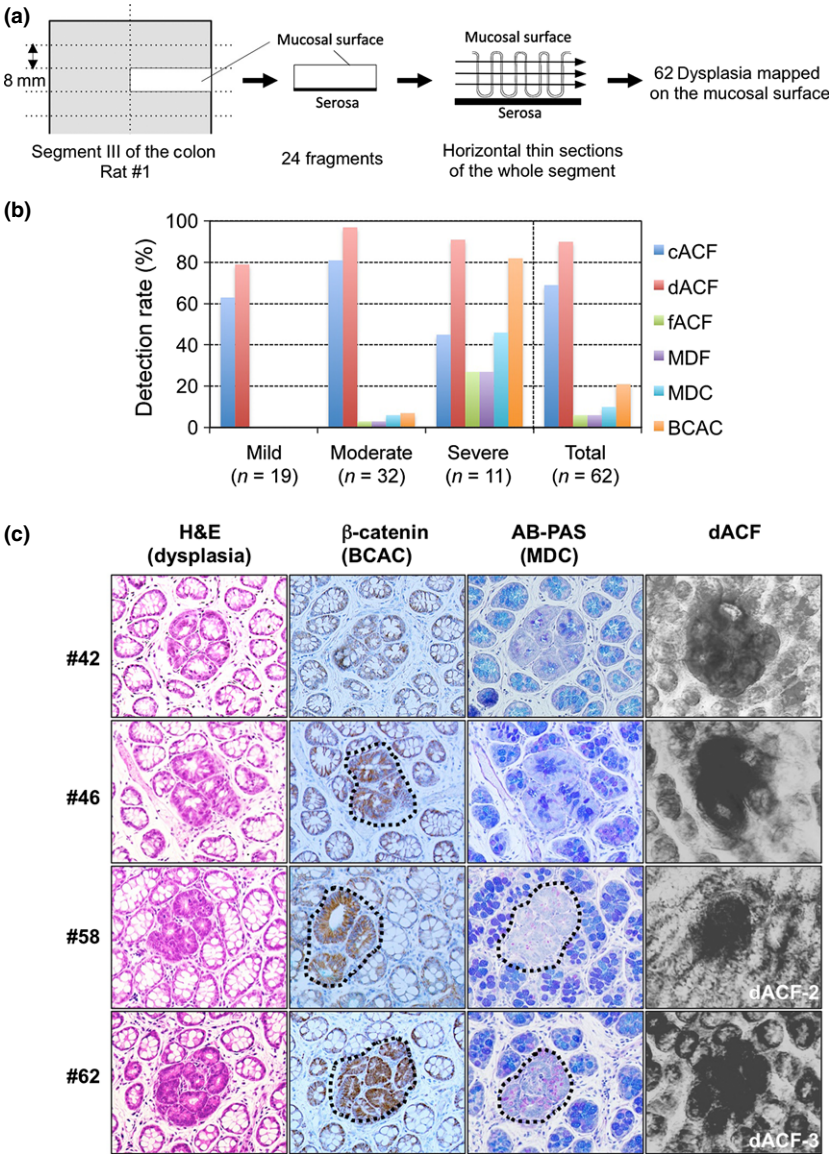

Fig. 5. Robust identification of dysplasia by scoring dysplasia-associated aberrant crypt foci (dACF). (a) Schematic diagram of the comprehensive histological analysis. A fixed colon from rat #1 was longitudinally cut open and segment III (shaded area) was divided into 24 fragments of 8 mm width (open rectangle) to cover the whole area by horizontal sections. (b) Successful detection rate of dysplasia for each preneoplastic lesion. Note that dACF provides the highest sensitivity in all grades of dysplasia. (c) Histological features of four representative dACF. Images of serial sections from the same lesion are shown. Dashed line circles β-catenin accumulating crypts (BCAC) or mucin-depleted crypts (MDC). Note that Paneth differentiation is evident in #58 and #62 (dACF-2 and -3 in Fig. 4, respectively), consistent with severe dysplasia. AB-PAS, Alcian blue–periodic acid–Schiff; cACF, classical ACF; fACF, flat ACF; MDF, mucin-depleted foci.

decolorization revealed that 62 and 9 had been diagnosed as $cACF^{+ve}$ and $cACF^{-ve}$, respectively (Fig. 1d). Nine newly identified $cACF^{-ve}$ consisted solely of *d*-type crypts, whereas 62 $cACF^{+ve}$ had various compositions of crypt subtypes. Most foci contained both *cd*- and *c*-type crypts (51/62), but some foci consisted of *cd*-type crypts alone (2/62), or with both *c*- and *d*-type crypts (9/62) (Figs 1d and 2a). Interestingly, *cd*- and *d*-type crypts never coexisted in the same foci, and the foci with more than two *d*-type crypts tended not to coexist with *c*-type crypts, which was not the case with *c*-type crypts (Fig. 1e). These observations strongly suggested that *cd*- and *d*-type crypts might have evolved independently. The SIR of the foci[29] was in fact more than 1.0 for all the stained lesions and tended to be higher in dACF than in cACF, but failed to completely distinguish between the two (Fig. S1), consistent with our previous study.[29] These observations confirmed the relevance of the size of the luminal opening, but not SIR of the foci, for the right diagnosis of dACF.

Dysplasia-associated ACF histologically manifested dysplasia of all grades. Among 71 dACF, vertical sections were successfully prepared for 54 lesions, 45 $cACF^{+ve}$ and 9 $cACF^{-ve}$ (Fig. 2b). Histological analysis revealed that 51 dACF were dysplastic (94%) and 3 hyperplastic (6%). The $cACF^{+ve}$ lesions predominantly comprised moderate dysplasia and $cACF^{-ve}$ severe dysplasia (Fig. 2c). The SIR did not correlate with histological grades (Fig. S2), further declining its relevance. Notably, dysplastic crypts predominantly below the mucosal surface could be detected as dACF (#3–6 of Fig. 2a). Staining with AB-PAS clarified that mucin depletion was exclusively in $cACF^{-ve}$ lesions (Fig. 2d), and accumulation of red granules, indicative of Paneth cell differentiation due to Wnt activation,[31] only in $cACF^{-ve}$ (Fig. 2a and Fig. S3). Accumulation of β-catenin was observed in only a few $cACF^{+ve}$, but in the majority of $cACF^{-ve}$ (Fig. 2e). These findings implied that dACF could manifest dysplasia of all grades, with $cACF^{-ve}$ representing Wnt-activated more advanced lesions than $cACF^{+ve}$. Sequencing analysis of microdissected BCACs from 10 $cACF^{+ve}$ and 10 $cACF^{-ve}$ for *Ctnnb1* mutation identified only one activating mutation from A to G substituting Asp at codon 32 with Asn in a lesion from $cACF^{+ve}$, but not in any

lesion from $cACF^{-ve}$, implying non-genetic mechanisms for AOM-induced β-catenin accumulation, at least in early stages.

Dysplasia-associated ACF overlapped both cACF and advanced preneoplastic lesions. To relate dACF to other known preneoplastic lesions, the colons from three AOM-treated rats were serially stained to detect these lesions, and images of the same foci were directly compared (Fig. 3a). Staining with AB visualized four to five MDF per rat exclusively in the distal colon (Fig. 3b), as previously reported.[9,21] Subsequent brief exposure to MB visualized fACF, which completely coincided with MDF in a total of 14 lesions from three rats (Fig. 3c). By longer exposure to MB and subsequent destaining, 200–300/rat cACF and ~120/rat dACF were visualized (Fig. 3c). Dysplasia-associated ACF tended to be in the more distal colon than cACF, in line with the dysplastic nature of dACF. Approximately 100 and 20 dACF were diagnosed as $cACF^{+ve}$ and $cACF^{-ve}$, respectively (Fig. 3d), consistent with our pilot experiment. Taken together, dACF had a significant overlap with cACF and contained an entire population of MDF and fACF. Representative cases are shown in Figure 4; dACF-1 is $cACF^{+ve}$ (Fig. 4a–e) and dACF-2,3,4 are $cACF^{-ve}$ (Fig. 4f–q). Unlike dACF, all the other lesions were not constantly positive for these four foci. Of note, dACF-2 could be detected only as dACF, strongly suggesting higher sensitivity of dACF for dysplasia.

Scoring dACF enables robust identification of dysplasia. We next wondered, conversely, if the dysplasia could appear as dACF. To address this issue, we thoroughly examined a defined part of the colon, both by histological analysis on horizontal sections, and by serially scoring preneoplastic lesions on the whole mounted colon. We scrutinized segment III of rat #1 (Fig. 5a) because it harbored the highest number of dACF across the samples (Fig. 3c). Of 64 dysplasia, 62 were successfully related between the images of H&E staining and those of the mucosal surface. It was revealed that 56 (90%) and 43 (69%) dysplasia were previously detected as dACF and cACF, respectively, whereas only 4 (6.5%) were diagnosed as fACF/MDF (Fig. 5b, Table S1). Dysplasia-associated ACF and cACF achieved the highest and second highest detection rate, respectively, but 42 of 43 cACF lesions were also detected as dACF, underscoring the superiority of dACF. The detection rates of fACF/MDF, MDC, and BCAC, were comparable to that of cACF only for severe dysplasia (Fig. 5b, Table S1), but still no higher than that of dACF. Representative cases of dysplasia are shown in Figure 5(c). Whereas all the four lesions were diagnosed as dACF, three and two were also diagnosed as BCAC and MDC, respectively. Notably, #58 and #62, identical to dACF-2 and dACF-3 (Fig. 4), respectively, were both diagnosed as MDC, but only #62/dACF-3 was diagnosed as MDF (Fig. 4), clearly indicating that MDF might be less sensitive for dysplasia below the mucosal surface. There was one lesion with severe dysplasia exceptionally undetectable as either dACF or cACF (Table S1). It turned out to be a single aberrant crypt undetectable as MDF despite obvious mucin depletion and β-catenin accumulation (Fig. S4), illustrating the limitation in detecting too small dysplasia as dACF. Taken together, dACF marked with high sensitivity pan-dysplasia of any depth in the mucosa, whereas the other advanced lesions marked dysplasia with modest sensitivity only when on the surface.

Discussion

An ideal marker should be simply detected and easily diagnosed, let alone manifest high specificity and sensitivity. In terms of a marker for dysplasia, however, none of the known preneoplastic lesions of the colon meet all these criteria. As an extension of our previous study, we developed a more straightforward method that enables more specific and sensitive detection of dysplasia in this study. Indeed, 94% of the dACF showed dysplasia, while 90% of the dysplastic lesions proved to be dACF, obviously overwhelming cACF as a marker. Inter-relationships between dACF and various other lesions are summarized in Figure 6.

We developed the new marker by modifying diagnostic steps of the foci. Specifically, we discontinued strict measurement of foci's signal intensity because it proved dispensable and insufficient for detecting and separating dysplastic foci, respectively. Instead, we introduced crypt-based evaluation of the foci for diagnosis of dACF. The crypt subtypes were so distinct that even visual judgment gave concordant results with those obtained by objective quantification. In contrast, we felt that the right diagnosis might be difficult for fACF and MDF, although the visualizing procedure is simple. We were able to spot only relatively large lesions, which resulted in 100% coincident diagnosis of fACF and MDF in our hands, however, examination of the same samples by two experts resulted in a concordant rate as low as 42%,[32] implying difficulties in diagnosing small lesions for non-experts.

The potential of dACF might extend to a marker for tumorigenicity. Currently, incidence of cACF is widely used as a surrogate marker for eventual tumorigenesis based on their high correlation.[7] We showed that the number of dACF is

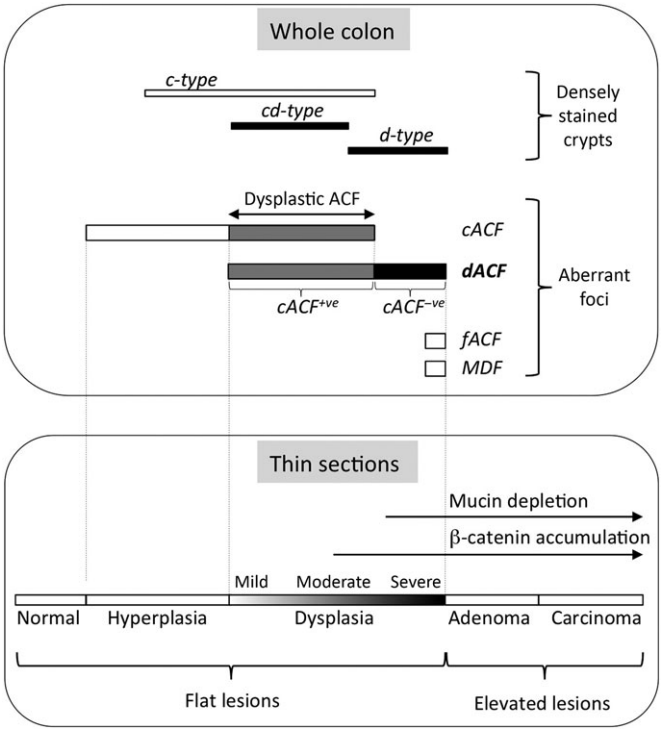

Fig. 6. Dysplasia-associated aberrant crypt foci (dACF) among other preneoplastic lesions of the colon. A summary of the interrelationship between dACF and other preneoplastic lesions, both on unsectioned colon and in thin sections. The spectra of various lesions along multistep colon carcinogenesis clearly indicate that dACF successfully filled in the gap between mucin-depleted foci (MDF)/flat ACF (fACF) and classical ACF (cACF) in detection of dysplasia. *c*-type, enlarged crypt and broad opening; *cd*-type, enlarged crypt and narrow opening; *d*-type, small crypt and narrow opening.

approximately half that of cACF, with a large overlap with the cACF, which is still large enough to yield a proper dynamic range for quantitative evaluation. Given the close association of dACF with dysplasia, it is conceivable that the number of dACF could have more accurately predicted the incidence of eventual tumor development, had it been applied to a case where retinoids decreased the number of cACF, but not that of tumors.[33] It is also tempting to speculate that the relationship between cACF and dACF might account for the long-appreciated correlation between the incidence of cACF and eventual tumorigenesis, presumably through a correlation between the incidence of dACF and dysplasia, justifying the past studies using incidence of cACF as a marker for tumorigenicity.

Crypt-based analysis of dACF also clarified novel aspects of the early stages of colon carcinogenesis. The foci with more than two *d*-type crypts tended not to coexist with *c*-type crypts within the same foci, in line with the previous observation that adenomatous ACF developed from hyperplastic ACF,[34] while it was not the case with *cd*-type crypts. Together with a mutually exclusive relationship within the same foci, *d*- and *cd*-type crypts might constitute a distinct population that follows different pathways toward tumor development. To gain insights into the molecular differences between the two types, we compared $cACF^{-ve}$ and $cACF^{+ve}$ subsets of dACF, which contained exclusively *d*-type and predominantly *cd*-type, respectively. β-catenin accumulation and mucin depletion was significantly more frequent in $cACF^{-ve}$, clearly indicating that $cACF^{-ve}$ are more advanced lesions. However, activating mutation of *Ctnnb1* was rarely found in both subsets, strongly suggesting alternative mechanisms for Wnt activation in early stages, such as *APC* knockdown by *SND1* overexpression.[35] Although *d*- and *cd*-type crypts were stained after decolorization of mucosa, underlying molecular mechanisms are poorly understood. Considering MB's high affinity to an acidic substrate, including phosphate,[36] higher staining intensity might reflect higher amounts of nucleic acids and phosphorylated protein in dysplastic foci. A puzzling feature of *d*-type crypts is that they are invisible before decolorization, although they are supposed to be stained by MB. This observation might be partly due to the fact that *d*-type crypts tend to reside predominantly below the stained normal crypts[22] (Fig. 2a, #3–6; Fig. S3, #7–10; Fig. 4h), consistent with the "bottom-up model" for colon carcinogenesis,[37] thereby requiring complete decolorization of surface mucosa. Taken together, further studies on crypt-based analysis would be warranted to elucidate molecular mechanisms underlying colon carcinogenesis.

In conclusion, we showed that dysplasia could be simply identified on an unsectioned colon as dACF. Based on their unique features, dACF might be established as novel standard preneoplastic lesions of the colon, by complementing or substituting cACF, the current gold standard in this field.

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Disclosure Statement

The authors have no conflict of interest.

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Supporting Information

Additional supporting information may be found in the online version of this article:

Fig. S1. Signal intensity ratio (SIR) of the foci is insufficient for right diagnosis of dysplasia-associated aberrant crypt foci (dACF). A dot represents each lesion.

Fig. S2. Lack of correlation between histological grade and signal intensity of stained foci.

Fig. S3. Classical aberrant crypt foci $(cACF)^{-ve}$ subset of dysplasia-associated ACF (dACF) manifest severe dysplasia.

Fig. S4. Dysplastic crypt exceptionally undetectable by scoring dysplasia-associated aberrant crypt foci (dACF).

Table S1. Characterization of comprehensively determined dysplastic lesions.