

## Plasma pentraxin-3 level in acute appendicitis

Pentraxin 3 levels in acute appendicitis

Ayetullah Temiz<sup>1</sup>, Yavuz Albayrak<sup>2</sup>, Konca Altınkaynak<sup>3</sup>, Adem Aslan<sup>4</sup>, Yılmaz Özdemir<sup>5</sup><sup>1</sup>Department of General Surgery, Erzurum Regional Training and Research Hospital, Erzurum,<sup>2</sup>Department of General Surgery, Atatürk University School Of Medicine, Erzurum,<sup>3</sup>Department of Biochemistry, Erzurum Regional Training and Research Hospital, Erzurum,<sup>4</sup>Department of General Surgery, İstanbul Sultan Abdülhamid Han Sample Training and research Hospital, İstanbul,<sup>5</sup>Department of Gastroenterology Surgery, Erzurum Regional Training and Research Hospital, Erzurum, Turkey

### Abstract

**Aim:** In recent years, it has been found that plasma levels of Pentraxin-3 (PTX3) are elevated in systemic inflammatory conditions. In this study, we aimed to demonstrate the diagnostic value of PTX3 in patients with Acute Appendicitis (AA). **Material and Method:** This study was carried out in the general surgery clinic of Erzurum Regional Training and Research Hospital between 1st December 2015 and 31st March 2016 and included 56 patients who were diagnosed with acute appendicitis and 28 healthy controls. **Results:** In a comparison of the groups, mean PTX3 level in control group was  $3.08 \pm 1.49$  ng/mL, whereas in acute suppurative appendicitis or perforated appendicitis it was  $7.96 \pm 4.29$  ng/mL, indicating a significant between-group difference ( $P < 0.0001$ ). PTX3 level differed significantly between the control group and acute suppurative appendicitis and between the control group and perforated appendicitis ( $P < 0.0001$ ). However, there was no significant difference in the PTX3 levels between acute suppurative appendicitis and perforated appendicitis ( $P > 0.05$ ). The area under the ROC curve (AUC) for the diagnosis of acute appendicitis using PTX3 was 0.883. **Discussion:** PTX3 may be a potential new marker for the diagnosis of acute appendicitis because the PTX3 level is significantly higher in patients with AA.

### Keywords

Acute Appendicitis; Pentraxin- 3; Inflammation

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Corresponding Author: Ayetullah Temiz, Department of General Surgery, Erzurum Area Training and Research Hospital, 25100, Erzurum, Turkey.

T.: +90 4422325248 E-Mail: temiz-49@hotmail.com

ORCID ID: 0000-0003-2178-3369

## Introduction:

Acute appendicitis (AA) is the most common surgical disease affecting approximately 7 % of the population that can present at any time throughout life and at all ages [1,2]. AA is usually diagnosed by a combination of physical examination findings such as a clinical information from patients, conventional biomarkers like white blood cell count (WBC), mean platelet volume (MPV), absolute neutrophil count (ANC) and C-reactive protein (CRP); and imaging methods such as ultrasound imaging and computed tomography [3-6]. Clinical diagnosis of AA is often difficult even for experienced surgeons, and the rate of negative explorations can approach 20–30% [7,8]. Delays in the diagnosis of AA can cause perforation and other complications. Therefore, there is a need for simple and economic novel laboratory methods for diagnosis of AA.

Pentraxin 3 (PTX3) is a member of the pentraxin family and is also called the tumor necrosis factor-inducible protein that is located on gene 14 (TSGF 14) [9]. PTX3 is secreted by macrophages and various other cells when induced by primary inflammatory mediators such as tumor necrosis factor alpha, interleukin-1, and lipopolysaccharide [10]. Plasma levels of PTX3 are very low (2 ng/mL). In recent years, it has been found that plasma levels of PTX3 are elevated in systemic inflammatory conditions. In this study, we aimed to investigate the diagnostic value of PTX3 in patients with AA.

## Material and Method

This study was carried out in the general surgery clinic of Erzurum Regional Training and Research Hospital between 1st December 2015 and 31st March 2016 and included 56 patients who were diagnosed with acute appendicitis and 28 healthy controls. Study subjects were classified into four subgroups for analysis.

1. Group 1 (control; n = 28): A control group was selected from healthy individuals who visited the hospital for routine health check-up in the Infectious Diseases Clinics and did not fulfill any of the exclusion criteria.
2. Group 2: There were 31 patients who underwent pathologic examination and were diagnosed with acute suppurative appendicitis.
3. Group 3: There were 25 patients diagnosed, clinically and pathologically, with perforated appendicitis.
4. Group 4: There were 56 patients with acute suppurative appendicitis or perforated appendicitis.

## Inclusion and exclusion criteria

All patients who underwent surgery for appendicitis on the basis of history, physical findings and relevant clinical data were eligible for study inclusion. Postoperatively, the resected appendix was sent for histopathological examination. Cases, where the histopathology was not consistent with appendicitis, were excluded from the study. Exclusion criteria included heart failure, peripheral vascular disease, hematological disorders, acute or chronic infection, cancer, prior antibiotic therapy, age <10 years, pregnancy, hepatic diseases, and other known inflammatory conditions. None of the patients had received prior anticoagulants, nonsteroidal anti-inflammatory drugs, or oral contraceptives.

## Biochemical Analysis

Blood samples collected into EDTA tubes from all participants were centrifuged at 4000 rpm for 10 min at 4°C. The obtained

plasma samples were stored in a deep freezer at –80°C until analysis. Levels of PTX3 in plasma samples were measured by the enzyme-linked immunosorbent assay (ELISA) method using the Human Pentraxin 3 ELISA Kit (Abcam, UK) according to the manufacturer's instruction, and the assay was analyzed on a Bio-Tek Power Wave ST microplate spectrophotometer (USA). Statistical Analysis

All data analyses were conducted with SPSS 16.0 for Windows, and results are presented as mean ± standard deviation (SD). For continuous variables, the independent samples test was used to analyze variance among groups. P-values less than 0.05 were considered statistically significant. Plasma PTX3 (ng/mL) values are given as mean ± SD for normal dispersion. We applied the unpaired t-test for 2-group comparison, ANOVA for multi-group comparisons, Tukey's test for subgroup analysis in homogeneous groups, and Tamhane's test when homogeneous distribution was not observed. A receiver operating characteristics (ROC) curve was plotted to demonstrate the diagnostic value of PTX3 in acute appendicitis. A written informed consent from the patients was waived because the present study was performed prospectively.

## Results

Characteristics of the study subjects, including patient age and levels of WBC, CRP, and PTX3, are shown in Table 1. Of the 56 patients who underwent appendectomies, 30 were male and 26 female; in the control group, 6 subjects were male and 22 female. There was a significant difference between WBC counts of the patient and control groups ( $P < 0.0001$ ), but no difference between the group of subjects with perforated appendicitis and that of subjects with suppurative appendicitis ( $P > 0.05$ ). WBC distribution of the patient and control groups is shown in Figure 1. In a comparison of the 2 groups, mean PTX3 level in Group 1 was  $3.08 \pm 1.49$  ng/mL, whereas in Group 4 it was  $7.96 \pm 4.29$  ng/mL, indicating a significant between-group difference ( $P < 0.0001$ ). PTX3 level differed significantly between Group 1 and Group 2 and between Group 1 and Group 3 ( $P < 0.0001$ ). However, there was no significant difference in the PTX3 levels between Group 2 and Group 3 ( $P > 0.05$ ). The distribution of PTX3 levels of the patient and control groups are shown in Figure 2. The area under the ROC curve (AUC) for the diagnosis of acute appendicitis using PTX3 is shown in Figure 3.

## Discussion

Pentraxins are a family of multimeric proteins divided into short and long pentraxins, based on their primary structure; CRP is the prototype of the short pentraxin subfamily, and PTX3 is a prototypic long pentraxin. [11]. PTX3 is an inflammatory me-

Table 1. Age, Plasma pentraxin 3, white blood cells and C-reactive protein in patients and control subjects

	Groups			
	Control subjects (Group I), n:28	Acute suppurative appendicitis (Group II), n :31	Acute perforated appendicitis (Group III), n: 25	Acute suppurative and perforated appendicitis (Group IV), n: 56
Age (Year)	34.0±10.7	35.7±17.1	33.8±16.1	34.8±16.6
WBC, (x10 <sup>9</sup> /L)	7397±1135	13067±4633	14712±4926	13801±4794
CRP, (mg/dl)	0,66±1.12	3.12±4.43	3.78±6.14	3.41±5.22
Pentraxin (ng/ml)	3.08±1.49	7.91±4.55	8.03±4.04	7.96±4.29

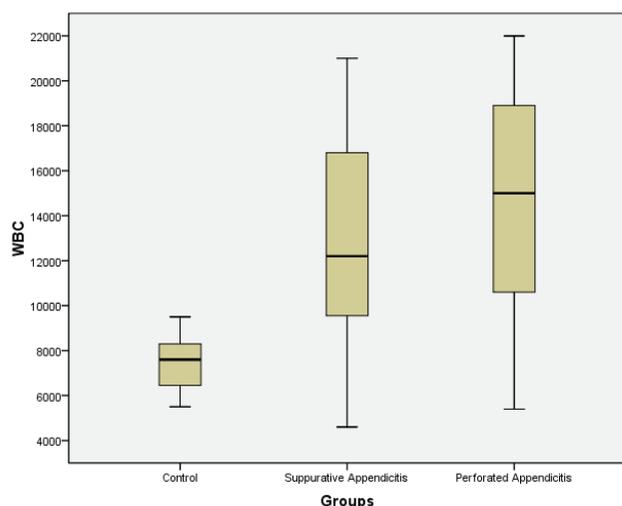


Figure 1. Absolute white blood cell (WBC) counts by category of groups. WBC X 10<sup>6</sup>/L, Acute suppurative appendicitis: A. Suppurative app, Acute perforated appendicitis: A.perforated app.

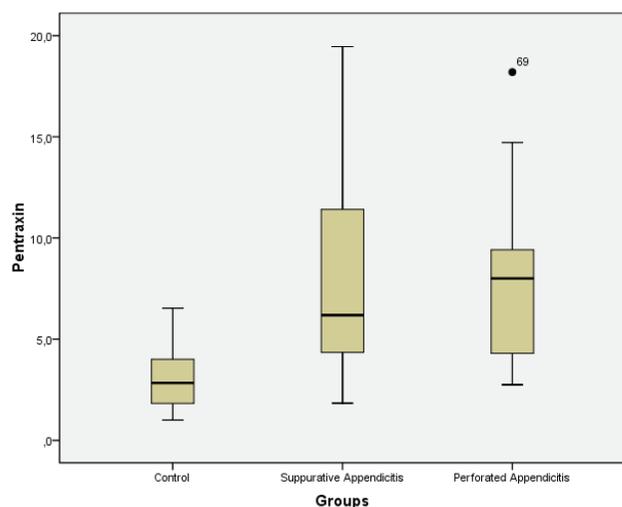


Figure 2. Pentraxin 3 counts by category of groups. (Pentraxin 3 ng/mL. Suppurative app.: Acute suppurative appendicitis, A. Perforated app.: Acute perforated appendicitis).

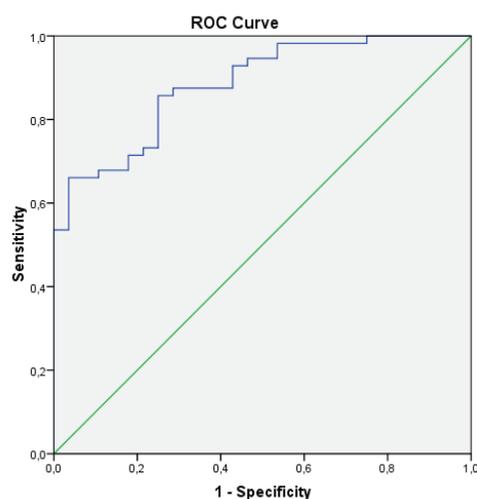


Figure 3. Receiver operating characteristic (ROC) curve of pentraxin 3.

diator secreted from mononuclear phagocytes, dendritic cells, fibroblasts and endothelial cells within the long pentraxin family [12]. PTX3 is found in human serum and plasma, urine [13], cerebrospinal fluid [14], pleura [15], amniotic fluid [16] and in

synovial fluid [17]. Although plasma levels of PTX3 are very low (2 ng/mL) normally, these dramatically and rapidly increase to 200–800 ng/mL in 6–8 hours in the pathological state [18]. Elevated PTX3 levels have been reported in many types of cardiovascular diseases including acute coronary syndrome, congestive heart failure and heart failure with normal ejection fraction [19–21]. In addition, recent reports have shown that PTX3 may have potential to be used as a vascular inflammatory marker to differentiate the activity of Takayasu aortitis [22,23]. Previous clinical trials have shown that PTX3 levels increased in tumors such as liposarcoma, glioma, lung and prostate cancers, or benign hyperplasia when compared to healthy humans [24–27]. In a study of patients with pancreatic cancer, elevated levels of pentraxin were associated with worse prognosis [28]. It has been detected that PTX3 levels increased in systemic immune diseases such as systemic inflammatory response syndrome (SIRS), rheumatoid arthritis, progressive systemic sclerosis, Chug–Strauss syndrome, Wegener’s granulomatosis and microscopic polyangiitis [17, 29–32]. Moreover, PTX3 levels increase in chronic renal failure [33,34]. Therefore, it was of interest to determine PTX3 expression patterns in inflammatory bowel diseases such as Crohn’s disease and ulcerative colitis. As IL-6 was found to have increased expression in active Crohn’s disease, but not in ulcerative colitis, it is not surprising that plasma PTX3 levels were found to be increased only in patients with ulcerative colitis (because IL-1, but not IL-6, induces PTX3 expression). Therefore, PTX3 can be used as a marker of exacerbation in people with inflammatory bowel disease [35,36]. PTX3 levels rise rapidly in response to inflammation and infection, whereas PTX3 concentration is less than 2 ng/mL in healthy individuals [37,38]. Mauri et al. [39] conducted a study showing that elevated PTX3 level is useful as a predictive factor of severe sepsis and death. PTX3 can be evaluated in patients with a suspected infection on admission, and may be used to predict many variables indicating severe sepsis i.e. need for ICU stay, hypotension, acute renal insufficiency and need for mechanical ventilation in the emergency room setting. Thus, PTX3 may help to stratify patients to ensure effective resource utilization [40]. In a previous study, PTX3 level peaked within the first hour of admission to the hospital and was found to be an early indicator of shock in severe meningococcal disease [41]. Elevated plasma PTX3 concentrations are also present in a variety of inflammatory conditions. High PTX3 levels are important for determining the severity of Dengue virus infection, leptospirosis and epidemic nephropathic disease [42–44]. Aksungur et al. [45] reported that PTX3 levels were high in patients with cholecystitis, especially in patients with gangrenous cholecystitis. In our study, PTX3 levels were elevated both in patients with acute suppurative appendicitis and perforated appendicitis, without any significant between-group difference. PTX3 may be a potential new marker for the diagnosis of acute appendicitis. In our study, we found that PTX3 levels were significantly elevated in patients with acute appendicitis compared with the control group. The AUC value of PTX3 was found to be highly elevated, up to 0.883, in the ROC curve for sensitivity and specificity in the diagnosis of acute appendicitis. Therefore, the value of PTX3 in the diagnosis of acute appendicitis may be considered to be high.

Worldwide, AA is the most common surgical pathology. Negative surgical explorations are undertaken from time to time for misdiagnosis. There is a need for additional laboratory tests to support a diagnosis of AA and to reduce negative explorations.

Therefore, negative explorations, unnecessary investigations and invasive procedures can be reduced through an increase in the number of tests and methods that will improve a specific diagnosis of AA. Because the PTX3 level is significantly higher in patients with AA, PTX3 can be used as a supporting marker of AA.

### Scientific Responsibility Statement

*The authors declare that they are responsible for the article's scientific content including study design, data collection, analysis and interpretation, writing, some of the main line, or all of the preparation and scientific review of the contents and approval of the final version of the article.*

### Animal and human rights statement

*All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. No animal or human studies were carried out by the authors for this article.*

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### Conflict of interest

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