Metabolic Diseases and Crystal Induced Arthropathies Technic of Non-Staining Histologic Sections - A Comparative Study of Standard Stains and Histochemical Reactions

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Abstract

Arthropathy induced by monosodium salt of uric acid [C5H4N4O3] (MSU) (gout), by calcium pyrophosphate dihydrate [Ca3P2O7.2H2O] (CPPD) crystals (chondrocalcinosis, pseudogout, pyrophosphate arthropathy) and arthropathy induced by hydroxyapatite [Ca10(PO4)6(OH)2] (HA) crystals (apatite rheumatism, hydroxyapatite arthritis, calcifying tenosynovitis, Milwaukee syndrome, calcific tendinitis, calcific periartthritis) are regarded as distinct clinical entities. The solubility of MSU, CPPD and HA crystals in conventional fixatives (aqueous formaldehyde solution), in alcohol, acetone, and xylene or in solutions of dyes vary. The crystals in tissues may dissolve during fixation in aqueous formaldehyde solution, embedding in paraffin or during staining. Only those minerals or crystals can be detected microscopically with stains or histochemical reactions which remain in tissue sections after fixation, paraffin embedding or during staining. The probability of identification of crystals is much higher in unstained sections viewed under polarized light than in traditionally stained ones. The aim of this study was to compare the “non-staining” technique according to Bély and Apáthy (2013) with worldwide accepted stains and histochemical methods: hematoxylin-eosin (H-E) staining, Gomori’s methenamine silver method, Schultz staining, Alizarin red S staining, and von Kossa’s reaction in tissue samples of patients with clinically diagnosed gout, chondrocalcinosis and apatite rheumatism in order to demonstrate the effectiveness of crystal detections by these standard methods in comparison with the non-staining technique.

Patients and methods: One hundred and five (105) tissue samples of 47 patients with clinically diagnosed gout, 25 tissue samples of 16 patients with clinically diagnosed chondrocalcinosis, and 19 tissue samples of 4 patients with clinically diagnosed apatite rheumatism were studied. The tissue blocks were fixed in an 8% aqueous solution of formaldehyde [CH2(OH)2] at pH 7.6 for > 24 hours at room temperature (20 °C) and embedded in paraffin. Serial tissue sections (5 microns thin) were cut. Using Bély and Apáthy’s “non-staining” technique, the fixation of tissue blocks, and embedding were the same as with the standard stainings and reactions. Unstained tissue sections were deparaffinized, mounted and cover slipped with Canada balsam. The standard and unstained sections were examined with a professional polarizing light microscope (Olympus BX51).

Results and conclusions: Bély and Apáthy’s non-staining technic was more effective: MSU was demonstrated in 83 (79.05% of 105) tissue samples of 37 (78.72% of 47) patients; CPPD in 15 (60.00% of 25) tissue samples of 10 (62.50% of 16) patients. HA crystals were detected exclusively with this method: in all tissue samples (in 19 of 19; 100.0%) of all patients (in 4 of 4; 100.0%) none with the traditional stains and reactions. The non-staining technique is a simple and very effective method to demonstrate crystal deposits in tissue samples. Handbooks of histologic methods and histochemistry do not mention this simple technique. In case of clinically or histologically suspected metabolic or crystal-induced diseases it is advisable to analyze unstained tissue sections as well, supplemented with the traditional hematoxylin-eosin stained tissues. This approach may also be useful in other crystal deposition induced diseases or identification of foreign bodies and refractile artefacts.

Keywords

Non-staining technique, Traditional stainings and histochemical methods, Gout, Chondrocalcinosis, Apatite rheumatism

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out foreign bodies and/or refractile artefacts) may exist simultaneously in synovial fluid, synovium or adjacent bone and cartilage. Most common crystals and foreign bodies are summarized in Table 1 [1-3].

Arthropathy induced by monosodium salt of uric acid [C₅H₄N₄O₃] (MSU) (gout), by calcium pyrophosphate dihydrate [Ca₅P₃O₉·2H₂O] (CPPD) crystals (chondrocalcinosis, pseudogout, pyrophosphate arthropathy) and arthropathy induced by hydroxyapatite [Ca₅(PO₄)₃(OH)] (HA) crystals (apatite rheumatism, hydroxyapatite arthritis, calcifying tenosynovitis, Milwaukee syndrome, calcific tendinitis, calcific periarthritis) are regarded as distinct clinical entities [4-14].

The solubility of MSU, CPPD and HA crystals in conventional fixatives (aqueous formaldehyde solution),

### Table 1: Characteristics of most common crystals and foreign bodies in synovial fluid or synovium.

<table>
<thead>
<tr>
<th>Crystal [Chemical formule]</th>
<th>Breaking direction (Elongation)</th>
<th>Breaking intensity</th>
<th>Shape</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monosodium urate (MSU)-[C₅H₄N₄O₃]- Figure 2</td>
<td>negative</td>
<td>intensive</td>
<td>needle, rod, sperule</td>
<td>Submicroscopic -40 μm 5-25 μm</td>
</tr>
<tr>
<td>Calcium pyrophosphate dihydrate (CPPD) [Ca₅P₃O₉·2H₂O]- Figure 3</td>
<td>positive</td>
<td>strong</td>
<td>rod, rhomboid</td>
<td>&lt; 40 μm</td>
</tr>
<tr>
<td>Calcium hydroxyapatite - HA [Ca₅(PO₄)₃(OH)], [Ca₁₀(PO₄)₆OH₂] or [Ca₅(PO₄)₃OH·2H₂O]- Figure 4</td>
<td>positive</td>
<td>weak</td>
<td>rod, clusters: shiny coins</td>
<td>Individual crystals: submicroscopic [1] 50-500 nm [2] clusters of crystals: 1-5 μm [2] 1.9-15.6 μm [3]</td>
</tr>
<tr>
<td>Octocalcium phosphate- [Ca₈H₂(PO₄)₆·5H₂O]</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Tricalcium phosphate-[Ca₃(PO₄)₂] (whitelockite)</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Dicalcium phosphate dehydrate [Ca₂(PO₄)·2H₂O]</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Calcium hydrogen phosphate dihydrate-[Ca₅H₂(PO₄)₃·2H₂O] (orthophosphate, brushite)</td>
<td>positive</td>
<td>moderate</td>
<td>rod</td>
<td>1-2 μm</td>
</tr>
<tr>
<td>Calcium oxalate [CaC₂O₄·H₂O]</td>
<td>positive</td>
<td>variable</td>
<td>tetrahedron, rod</td>
<td>1-2 μm</td>
</tr>
<tr>
<td>Cholesterol- [C₂₇H₄₆O]- Figure 5</td>
<td>negative and/or positive</td>
<td>variable</td>
<td>rhomboidal, notched, needle-shaped cloven -separate or clusters</td>
<td>5-40 μm [3]</td>
</tr>
<tr>
<td>Liquid lipid crystals- Figure 5</td>
<td>Maltese cross, positive</td>
<td>variable</td>
<td>spherules</td>
<td>0.5-30 μm [3]</td>
</tr>
<tr>
<td>Lithium heparin</td>
<td>positive</td>
<td>weak</td>
<td>polymorphous</td>
<td>2-5 μm</td>
</tr>
<tr>
<td>Corticosteroid</td>
<td>variable</td>
<td>mostly strong</td>
<td>polymorphous</td>
<td>1-40 μm</td>
</tr>
<tr>
<td>Talc</td>
<td>Maltese cross, negative</td>
<td>strong</td>
<td>ovoid</td>
<td>1-40 μm</td>
</tr>
<tr>
<td>Glass fiber</td>
<td>positive</td>
<td>strong</td>
<td>orbited-oval</td>
<td>variable</td>
</tr>
<tr>
<td>Surgical sutures</td>
<td>negative</td>
<td>strong</td>
<td>clusters</td>
<td>variable</td>
</tr>
<tr>
<td>Methylmetacrylate</td>
<td></td>
<td>intensive</td>
<td>fragments</td>
<td>variable</td>
</tr>
<tr>
<td>Metallosis (swarf)</td>
<td>none</td>
<td>none</td>
<td>spotty deposits</td>
<td>variable</td>
</tr>
<tr>
<td>Hemosiderin crystals</td>
<td>Maltese cross, positive</td>
<td>weak</td>
<td>groups</td>
<td>5-40 μm</td>
</tr>
<tr>
<td>Osmium</td>
<td>none</td>
<td>none</td>
<td>spotty deposits</td>
<td>variable</td>
</tr>
<tr>
<td>Ochronosis (artifact) colored refractile collagen fragments</td>
<td>positive</td>
<td>none</td>
<td>fragments</td>
<td>variable</td>
</tr>
</tbody>
</table>

Remark to Table 1: "Modified from Gatter and Schumacher [3] and from Gardner and McClure [4]."
in alcohol, acetone, and xylene or in solutions of dyes vary. The crystals in tissues may dissolve during fixation in aqueous formaldehyde solution, embedding in paraffin or during staining [15,16]. Only those minerals or crystals can be detected microscopically by staining or histochemical reactions which remain in tissue sections after fixation, paraffin embedding and staining [17-21]. The probability of identification of crystals is much higher in unstained sections viewed under polarized light than in traditionally stained ones [22-25,26].

The aim of this study was to compare the “non-staining” technique according to Bély and Apáthy (2013) [22] with worldwide accepted stains and histochemical methods such as hematoxylin-eosin (H-E) staining, Gömöri’s methenamine silver method, Schultz staining, Alizarin red S staining, and von Kossa’s reaction [17-21] in tissue samples of patients with clinically diagnosed gout, chondrocalcinosis and apatite rheumatism in order to demonstrate the effectiveness of crystal detection with these standard methods in comparison with non-staining technique [22].

Patients and Methods

One hundred and five (105) tissue samples of 47 patients with clinically diagnosed gout, 25 tissue samples of 16 patients with clinically diagnosed chondrocalcinosis, and 19 tissue samples of 4 patients with clinically diagnosed apatite rheumatism were studied. Demographics are summarized in Table 2.

<table>
<thead>
<tr>
<th>Clinical diagnosis</th>
<th>Number of patients</th>
<th>Average age in years at biopsy</th>
<th>Range (in years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gout</td>
<td>47</td>
<td>52.59</td>
<td>85-36</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>57.67</td>
<td>62-51</td>
</tr>
<tr>
<td>Male</td>
<td>41</td>
<td>52.17</td>
<td>85-36</td>
</tr>
<tr>
<td>Chondrocalcinosis</td>
<td>16</td>
<td>61.86</td>
<td>81-39</td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>61.00</td>
<td>81-39</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>73.00</td>
<td>-</td>
</tr>
<tr>
<td>Apatite rheumatism</td>
<td>4</td>
<td>71.33</td>
<td>79-66</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>74.00</td>
<td>79-69</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>66.00</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 2: Sex, average age (range) of patients with gout, chondrocalcinosis and apatite rheumatism.

Using Bély and Apáthy’s “non-staining” technique, the fixation of tissue blocks in 8% aqueous solution of formaldehyde at pH 7.6 for > 24 hours at room temperature (20 °C) and embedding in paraffin were the same as with the standard stainings and reactions. Unstained tissue sections were deparaffinized, mounted and cover slipped with Canada balsam.

Serial sections (5 micron thin) were stained: in case of gout with H-E [20], according to Gömöri [18,20], and Schultz [17], and in case of chondrocalcinosis, and apatite rheumatism with H-E [20], Alizarin red S [19,21], and von Kossa’s reaction [17,21]. The results with these standard stainings and reactions were compared in serial sections with the unstained ones [22,25].

The standard and unstained sections were examined with a professional polarizing light microscope (Olympus BX51). In selected cases the nature of crystals was confirmed by a JEM 100CX electron microscope and electron diffraction as well (Figure 1a, Figure 1b, Figure 1c and Figure 1d).

Results

The average age of patients with gout was significantly lower than the average age of patients with chondrocalcinosis (p < 0.050). There was no significant difference between the average age of patients with chondrocalcinosis and with apatite rheumatism (p < 0.129).

Prevalence of MSU, CPPD, HA and cholesterol crystals or crystal aggregates in tissue samples with standard stainings and reactions (H-E, Gömöri, Schultz, Alizarin red S, and von Kossa) compared with Bély and Apáthy’s non-staining technique

In sections stained with H-E: MSU crystals were present in 24 (22.86% of 105) tissue samples of 16 (34.04% of 47) patients; CPPD in 11 (44.00% of 25) tissue samples of 8 (50.00% of 16) patients; HA crystals were not detected. In sections with Gömöri’s methenamine silver method: MSU was present in 59 (56.19% of 105) tissue samples of 25 (34.19% of 47) patients; CPPD or HA crystals were not detected. In sections stained according to Schultz: MSU was present in 66 (62.86% of 105) tissue samples of 27 (57.45% of 47) patients; CPPD or HA crystals were not detected. CPPD crystals were detected in sections stained with Alizarin Red S in 7 (29.17% of 24) tissue samples of 4 (25.00% of 16) patients; with von Kossa reaction in 2 (8.33% of 24) tissue samples of 2 (12.50% of 16) patients; with these methods HA crystals were not detected.
Detection of monosodium salt of uric acid \([C_5H_4N_4O_3]\) (MSU) crystals

In contrast with these classic stains and reactions Bély and Apáthy’s non-staining technic was more effective: MSU was demonstrated in 83 (79.05% of 105) tissue samples of 37 (78.72% of 47) patients; CPPD in 15 (60.00% of 25) tissue samples of 10 (62.50% of 16) patients. HA crystals were detected exclusively with this method: in all tissue samples (in 19 of 19; 100.0%) of all patients (in 4 of 4; 100.0%).

The prevalence of MSU, CPPD and HA crystals in tissue samples (Ts) of patients (Pts) with gout, chondrocalcinosis and hydroxyapatite arthritis (in case of standard stains and reaction in comparison with Bély and Apáthy’s “non-staining” technique) is summarized in Table 3.

**Figure 1:** a) Urate crystals, surface electron micrograph, x1600; b) Urate crystals, transmission electron micrograph, x6000; c) CPPD crystals, surface electron micrograph, x10000; d) Hydroxy apatite crystals, surface electron micrograph, x50000; e) Cholesterol crystals, surface electron micrograph, x13000. Original magnifications correspond to the 600 × 900 mm negative. The printed size may be different; therefore, it is necessary to indicate the original magnifications corresponding to a fixed size (in case of electron micrographs this is the 6 × 9 cm analogue negative).
Table 3: The prevalence of MSU, CPPD, HA crystals or crystal aggregates in tissue samples of patients with gout, chondrocalcinosis or with apatite rheumatism.

<table>
<thead>
<tr>
<th>Presence of crystals</th>
<th>MSU</th>
<th>CPPD</th>
<th>HA</th>
</tr>
</thead>
<tbody>
<tr>
<td>(under polarized light)</td>
<td>Pts-n</td>
<td>Ts-n</td>
<td>Pts-n</td>
</tr>
<tr>
<td>H-E [20]</td>
<td>47 (%)</td>
<td>105 (%)</td>
<td>16 (%)</td>
</tr>
<tr>
<td>Gömöri [18,20]</td>
<td>25 (53.19)</td>
<td>59 (56.19)</td>
<td>NA</td>
</tr>
<tr>
<td>Schultz [17]</td>
<td>27 (57.45)</td>
<td>66 (62.86)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Alizarin red S [19,21]</td>
<td>NA</td>
<td>NA</td>
<td>4 (25.0)</td>
</tr>
<tr>
<td>von Kossa [17,21]</td>
<td>NA</td>
<td>NA</td>
<td>2 (12.5)</td>
</tr>
<tr>
<td>Bély and Apáthy [22,25]</td>
<td>37 (78.72)</td>
<td>83 (79.05)</td>
<td>10 (62.5)</td>
</tr>
</tbody>
</table>

Remark to Table 3: Only the presence of crystals was registered in Pts and Ts (yes or no); the amount of crystal deposits was not evaluated.

Pts-Patients; Ts-Tissue samples.

Table 4: The statistical correlations (“p” values of significance) are summarized.

Detection of MSU according to

<table>
<thead>
<tr>
<th>Level of significance p &lt; 0.05</th>
<th>Pts - n = 47</th>
<th>Ts - n = 105</th>
<th>Pts - n = 47</th>
<th>Ts - n = 105</th>
<th>Pts - n = 47</th>
<th>Ts - n = 105</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-E [20]</td>
<td>χ² = 18.592</td>
<td>p &lt; 0.0000</td>
<td>χ² = 22.004 p &lt; 0.0000</td>
<td>χ² = 4.023 p &lt; 0.0448</td>
<td>χ² = 7.614 p &lt; 0.0057</td>
<td>χ² = 4.717 p &lt; 0.0289</td>
</tr>
<tr>
<td>Gömöri [18,20]</td>
<td>χ² = 8.532 p &lt; 0.0034</td>
<td>χ² = 36.999 p &lt; 0.0000</td>
<td>χ² = 11.848 p &lt; 0.0005</td>
<td>χ² = 32.867 p &lt; 0.0000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schultz [17]</td>
<td>χ² = 0.280 p &lt; 0.596 - NS</td>
<td>χ² = 15.849 p &lt; 0.0000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remark to Table 4: Pts - Patients; Ts - Tissue samples.

Table 5: The statistical correlations (“p” values of significance) are summarized.

Detection of CPPD according to

<table>
<thead>
<tr>
<th>Level of significance p &lt; 0.05</th>
<th>Pts - n = 47</th>
<th>Ts - n = 105</th>
<th>Pts - n = 47</th>
<th>Ts - n = 105</th>
<th>Pts - n = 47</th>
<th>Ts - n = 105</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-E [20]</td>
<td>χ² = 7.921 p &lt; 0.0048</td>
<td>χ² = 8.802 p &lt; 0.0030</td>
<td>χ² = 0.571 p &lt; 0.4496 - NS</td>
<td>χ² = 0.3782 -NS</td>
<td>χ² = 1.422 p &lt; 0.2330 - NS</td>
<td>χ² = 3.885 p &lt; 0.0486</td>
</tr>
<tr>
<td>Alizarin red S [19,21]</td>
<td>χ² = 3.047 p &lt; 0.0808 -NS</td>
<td>χ² = 2.218 p &lt; 0.1363 -NS</td>
<td>χ² = 1.422 p &lt; 0.2330 -NS</td>
<td>χ² = 3.885 p &lt; 0.0486</td>
<td></td>
<td></td>
</tr>
<tr>
<td>von Kossa [17,21]</td>
<td>χ² = 0.1523 p &lt; 0.696 - NS</td>
<td>χ² = 0.1454 p &lt; 0.702 - NS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remark to Table 5: Pts - Patients; Ts - Tissue samples.

Detection of calcium pyrophosphate dihydrate [Ca₅P₂O₇.2H₂O] (CPPD) crystals

CPPD crystals were not detected in combination with MSU crystals in our patient cohort’s. The HE staining was more effective in detection of CPPD crystals than Alizarin red S staining or von Kossa reaction, and Bély and Apáthy’s non-staining technique detected many more CPPD crystals than HE staining (Table 5). Using these methods there was a difference in the number of detected crystals, but regarding the effectivity (sensitiv-
clusters were not detected in combination with MSU crystals.

Detection of cholesterol \([C_{27}H_{46}O]\) crystals

Cholesterol \([C_{27}H_{46}O]\) crystals were present only in tissue sections stained according to Schultz, and in unstained sections according to Bély and Apáthy; cholesterol crystals were not detected with H-E, Gőmöri, and Alizarin Red S staining or with von Kossa’s reaction. In tissue sections stained according to Schultz, cholesterol was detected in case of gout in 10 (21.27%) of 47 patients (with or without MSU) and in case of chondrocalcinosis or apatite rheumatism, in 14 (77.77%) of 18 patients without CPPD or HA crystals. These differences were not significant statistically in most cases (Table 5). The statistical correlations (“p” values of significance) are summarized in Table 5, comparing tissue samples and involved patients with chondrocalcinosis with different stains and techniques.

Detection of hydroxyapatite \([Ca_6(PO_4)_3(OH)]\) (HA) crystals

Clusters of HA crystals and aggregates were detected only in unstained sections according to Bély and Apáthy in combination with more or less CPPD crystals together (significance was not calculated; there were no comparable values). Clusters of HA crystals and aggregates of clusters were not detected in combination with MSU crystals.
Discussion

The histological diagnosis of metabolic disorders is based on the presence of crystals in tissue sections with or without non-crystalline (amorphous), calcium phosphate and/or carbonate containing mineral deposits. There is a difference in the shape, size, intensity of birefringence, and optical breaking direction of MSU, CPPD, HA and cholesterol crystals. The solubility of these crystals in conventional fixatives (aqueous formaldehyde solution), in alcohol, acetone, and xylene or in solutions of dyes is also different. The crystals in tissues may dissolve during fixation in aqueous formaldehyde solution (formalin), embedding in paraffin or during staining.

In clinically known or suspected cases of gout the surgical tissue specimens should be fixed in absolute ethyl alcohol, because urate crystals are soluble in 8% form-
Figure 3: Chondrocalcinosis (pseudogout, pyrophosphate arthropathy, calcium pyrophosphate dihydrate \([\text{Ca}_2\text{P}_2\text{O}_7.2\text{H}_2\text{O}]\) (CPPD) crystal induced arthropathy), viewed with the light microscope and under polarized light, respectively.

(a) H-E viewed with the light microscope x100; (b) same as (a) x200

CPPD crystals and crystal fragments are accompanied by amorphous calcium phosphate, or calcium carbonate deposits of blue-violet colour; (c) H-E, viewed under polarized light, same as (a) x100; (d) same as (c) x200; (e) Unstained section, viewed under polarized light, same field as (a) x100; (f) same as (e) x200; (g) Unstained section, Red I compensator, viewed under polarized light, same field as (a) x100; (h) same as (g) x200

Under polarized light CPPD crystals show positive birefringence (parallel to the long axis of the crystals analogous to the birefringence of collagen fibers, see: Figure 3c and Figure 3g).

(i) Alizarin red S, viewed with the light microscope, same as (a) x100; (j) same as (c) x200

Non-crystalline calcium containing mineral deposits are staining with calcium specific Alizarin red S. Alizarin red S does not stain the CPPD crystals, and the masses of amorphous calcium phosphate and carbonate may mask the crystals, with no detectable birefringence; (k) von Kossa’s reaction, viewed with the light microscope, same as (a) x100; (l) same as (c) x200

Non-crystalline phosphate or carbonate containing mineral deposits show a positive reaction according to von Kossa. The CPPD crystals are negative with von Kossa’s reaction, and the masses of amorphous calcium phosphate and carbonate may mask the crystals, with no detectable birefringence.

(m) Intact CPPD crystals and fragments, unstained section, viewed under polarized light, same field as (e-f) x600

The intact CPPD crystals have a rhomboid shape, they range in size is from 5 to 40μm and show a strong birefringence; (n) Unstained section, Red I compensator, viewed under polarized light, same field as (g-h and m) x600

Axis parallel direction of birefringence of CPPD crystals is positive.
The HA (and CPPD) crystals are accompanied by amorphous calcium phosphate, or calcium carbonate deposits of blue-violet colour. The absence of an inflammatory reaction is characteristic [27].

In traditionally fixed tissue specimens the HA crystals (crystal clusters and aggregates of clusters) dissolved and are not demonstrable (the sporadic CPPD crystals or fragments are also not visible).

Our results indicate that the very simple “not-staining” technique is a most effective method to demonstrate crystal deposits in tissue samples [15,16,22,25]. Theoretically the largest amounts of crystals may be best preserved in unstained frozen sections. Indeed, large amounts of cholesterol or fatty acid crystals may be visualized in frozen sections under polarized light [35]. The frozen sections are not suggested for diagnosis of metabolic disorders in everyday practice, because large amounts of cholesterol crystals may conceal other crystals.

A disadvantage of unstained sections is that parallel (serial) tissue sections have to be stained traditionally, since detailed histology cannot be studied adequately in unstained sections with the light microscope or under polarized light. Another disadvantage (or advantage) is that in unstained sections other crystals can be found which differ in shape, size, arrangement or quality of birefringence from the well-known crystals, and their

aldehyde solution [17,18,20,21]. To quote McManus and Mowry “since urates are slightly soluble in water, alcohol fixation is preferable” [21], but we found that in gout most urate crystals dissolve during the hematoxylin-eosin staining procedure [15,16,32-34]. In present study the alcohol fixed cases of gout were excluded, in order to compare the traditional staining and reaction with Bély and Apáthy’s non-staining technique under the same circumstances.

CCPD crystals are less soluble than urate and are likely to be detected in traditionally processed tissue sections. The small and soluble HA or the highly soluble cholesterol crystals are not detected in traditionally fixed, embedded and stained tissue samples. In case of cholesterol deposition, the absence of crystals and characteristic empty spaces accompanied by a typical inflammatory reaction of macrophages and multinucleated giant cells are a reminder of the dissolved crystal deposits.

Our results indicate that the very simple “not-staining” technique is a most effective method to demonstrate crystal deposits in tissue samples [15,16,22,25]. Theoretically the largest amounts of crystals may be best preserved in unstained frozen sections. Indeed, large amounts of cholesterol or fatty acid crystals may be visualized in frozen sections under polarized light [35]. The frozen sections are not suggested for diagnosis of metabolic disorders in everyday practice, because large amounts of cholesterol crystals may conceal other crystals.

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Figure 5: Same tissue samples of a patient with clinical diagnosis of apatite rheumatism demonstrated on Figure 4a-n, stained according to Schultz or Bély and Apáthy’s non-staining technique.

Cholesterol \([\text{C}_27\text{H}_{46}\text{O}]\) and lipid crystals stained according to Schultz and viewed under polarized light. The cholesterol \([\text{C}_27\text{H}_{46}\text{O}]\) and lipid crystals were associated in this patient with HA and CPPD crystals. The HA and CPPD crystals are not visible in tissue sections stained according to Schultz. The size of cholesterol crystals is 5-40 μm [3], rhomboidal, notched, needle-shaped cloven and are present as separate sheets or typically arranged in clusters. A “semi-liquid” appearance is also characteristic. The birefringence of cholesterol crystals is positive or negative; the needle-shaped or cloven crystal fragments rotating around the axis may show in the same position (direction) positive or negative birefringence. The lipid crystals are small 0.5-30 μm spherules, with positive Maltese cross birefringence.

Identification would require further specific (electron microscopic, electron diffraction, etc.) studies.

Major textbooks of histochemistry discuss many techniques and staining methods to demonstrate preserved crystals and mineral deposits in tissue, but none mention the simplest method, namely viewing of unstained tissue sections with polarized light [17-21].

In his book Mohr demonstrated crystals in unstained tissue sections (independent of us) but does not mention the advantage of this method in comparison with traditional stainings [9]. According to our best knowledge a detailed analysis or comparative study of our non-staining technique and its comparison with traditional stainings and reactions has not been available in the literature.

In case of suspected metabolic or crystal induced disorders, we suggest analyzing the tissue samples with unstained tissue sections as well, supplemented with traditional stainings and reactions. Crystals remain detectable in unstained sections viewed under polarized light in the great majority of cases which appear negative with H-E staining [22-24,32-34].

Conclusions

Bély and Apáthy’s non-staining technique is a simple and sensitive method and may help in the microscopic demonstration and analysis of crystalline deposits.

The probability of identifying crystals is much higher in unstained sections viewed under polarized light than in haematoxylin-eosin stained ones. Textbooks of histologic methods and histochemistry do not mention this simple technique.

In case of clinically or histologically suspected metabolic or crystal induced diseases the analysis of tissue samples is suggested with unstained tissue sections as well, supplemented with the traditional haematoxylin-eosin staining. This approach may also be useful in other crystal deposition induced diseases or identification of foreign bodies and refractile artefacts.

Disclosure/Conflict of Interest

There is no conflict of interest.

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