The regulation of mineral absorption in the gastrointestinal tract

J. J. Powell*, R. Jugdaohsingh and R. P. H. Thompson
Gastrointestinal Laboratory, The Rayne Institute, St Thomas’ Hospital, London SE1 7EH, UK

The absorption of metal ions in the mammalian single-stomached gut is fortunately highly selective, and both luminal and tissue regulation occur. Initially, assimilation of metal ions in an available form is facilitated by the intestinal secretions, chiefly soluble mucus (mucin) that retards hydrolysis of ions such as Cu, Fe and Zn. Metal ions then bind and traverse the mucosally-adherent mucus layer with an efficiency \( M^+ > M^{2+} > M^{3+} \). At the mucosa Fe\(^{3+}\) is probably uniquely reduced to Fe\(^{2+}\), and all divalent cations (including Fe\(^{2+}\)) are transported by a membrane protein (such as divalent cation transporter 1) into the cell. This minimizes absorption of toxic trivalent metals (e.g. Al\(^{3+}\)). Intracellular metal-binding molecules (such as mobilferrin) may be present at the intracellular side of the apical membrane, anchored to a transmembrane protein such as an integrin complex. This mobilferrin would receive the metal ion from divalent cation transporter 1 and, with part of the integrin molecule, transport the metal to the cytosol for safe sequestration in a larger complex such as ferritin or ‘paraferritin’. \( \beta_2 \)-Microglobulin and HFE (previously termed human leucocyte antigen H) may be involved in stabilizing metal mobilferrin-integrin to form this latter complex. Finally, a systemic metal-binding protein such as transferrin may enter the antiluminal (basolateral) side of the cell for binding of the sequestered metal ion and delivery to the circulation. Regulatory proteins, such as HFE, may determine the degree of ion transport from intestinal cells to the circulation. Gradients in pH and perhaps pCa or even pNa could allow the switching of ions between the different transporters throughout this mechanism.

Metal ion absorption: Gastrointestinal tract: Aluminium: Iron: Zinc

The absorption of metal ions in the mammalian single-stomached gut is fortunately highly selective. Thus, essential dietary cations, such as Cu, Zn and Fe are generally absorbed 10–100-fold more efficiently than toxic dietary ions such as Al. In previous reviews (Powell et al. 1994; Whitehead et al. 1996) we have discussed the relationship between the anatomy, biochemistry and physiology of the gastrointestinal lumen and the regulation of mineral absorption. Here we concentrate on the absorptive role of the most important luminal metal-binding species, i.e. mucus, and explore mechanisms for the subsequent transmucosal uptake of metal ions.

Background

Ingested metals may be considered in two categories: those soluble throughout the potential pH range of the gastrointestinal lumen (approximately pH 1–8), such as Na, Mg and Ca, and those susceptible to hydroxy-polymerization, such as Al, Cu, Fe, Mn and Zn. This latter group, termed ‘hydrolytic metals’, are acid-soluble, but as the pH is raised in the absence of soluble binding ligands, they readily form insoluble hydroxide precipitates. This sometimes led, incorrectly, to the belief that hydrolytic metal ions were absorbed from the ‘soluble’ acidic gastric environment and not from the ‘insoluble’ peri-neutral intestinal environment (Stewart, 1989). In fact, the stomach has little absorptive capacity, with a small surface area and a thick protective layer of pH-buffered gelatinous mucus (Fig. 1), and is remarkably impermeable to the absorption of nutrients, including metal ions (Whitehead et al. 1997). Nonetheless, the stomach plays an important role in the ‘preparation’ of ingested metals for later absorption. A marked reduction in gastric acid output (hypochlorhydria) may be ineffective in dissociating a metal ion from its ingested matrix (e.g. Fe in food (Champagne, 1989) or Al in an antacid), leading to a reduced luminal concentration of solubilized and potentially-available metal. Furthermore,
secreted gastric juice, which mixes with the luminal contents, contains solubilized mucin (once termed ‘gastroferrin’, see p. 148) that helps hydrolytic metals to remain soluble at near-neutral pH such as that occurring with transient gastric acid buffering by food or following gastric emptying into the small bowel (Powell et al. 1994). Indeed, it is the small intestine, which also secretes numerous endogenous ligands and again most notably mucin, that is the predominant site of mineral absorption (Whitehead et al. 1996).

**Luminal mucin: gastroferrin**

The large glycoprotein mucin is secreted throughout the gastrointestinal tract which provides both the mucosally-adherent gelatinous layer (mucus, see p. 150) and a soluble luminal form (Hunter et al. 1989). Much of the soluble form occurs as a degradation product of the mucus layer, and its role in metal binding has been well demonstrated (Crowther, 1982; Crowther & Marriott, 1984; Conrad et al. 1991). Between 1963 and 1973 a number of authors demonstrated an Fe-binding glycoprotein in human gastric juice that was
termed ‘gastroferrin’ (Davis et al. 1969; Rudzki et al. 1973; Rudzki & Deller, 1973). This isolated glycoprotein maintained Fe$^{3+}$ in solution at neutral pH, suggesting that it played a role in facilitating intestinal Fe absorption, although it was present in gastric juice at similar levels in healthy individuals and in those with Fe-related disorders (Rudzki et al. 1973). Significant characterization of gastroferrin was carried out by Rudzki et al. (1973) and Rudzki & Deller (1973), who demonstrated its carbohydrate and amino acid content, homology with blood-group antigens, and interactions with metal ions. These findings, in particular the blood-group antigen activity, identify gastroferrin as gastric mucin, and indeed, information on the role of gastroferrin in promoting intestinal Fe absorption is identical to that from recent work with intestinal mucin and Fe (Conrad et al. 1991; Fig. 2). Interestingly, much of the Fe is bound non-stoichiometrically by mucin (Rudzki et al. 1973), with the glycoprotein stabilizing colloidal poly-hydroxy ion cores and preventing their further polymerization (Rudzki et al. 1973; Fig. 2). In vitro, these aggregates varied in size from 2 to 20 nm diameters (Rudzki et al. 1973) and, by comparison with the similar poly-hydroxyferric fructose system (Bates et al. 1972; Bates, 1973), are expected to be easily dissociable, thus maintaining Fe in a readily-available form. Indeed, instillation of the Fe(OH)$_3$-mucin complex into the rat gastrointestinal tract yields effective absorption that is clearly not seen with Fe(OH)$_3$ alone or even with ‘uncomplexed’ Fe(OH)$_3$ + mucin (Rudzki et al. 1973; Conrad et al. 1991; Fig. 2). Soluble mucins from the stomach and intestinal tract behave similarly, not only in their Fe-binding capacity, but also in their binding to other metals. Combining data from a number of papers (Rudzki et al. 1973; Crowther, 1982; Crowther & Marriott, 1984; Conrad et al. 1991) suggests that the affinity of gastrointestinal mucin for metals follows the pattern: Fe$^{3+}$ > Al$^{3+}$, Cr$^{3+}$ > Pb$^{2+}$ > Zn$^{2+}$ > Co$^{2+}$ > Ca$^{2+}$ > Na$^+$, Cs$^+$ (i.e. M$^{3+}$ > M$^{2+}$ > M$^+$. Although initially this appears to hold few surprises, given the nature of metal binding to polyelectrolytes, metal–mucin interactions are not so simple. First, although poly-hydroxy Fe clearly interacts with mucin, it also appears that monomeric ionic Fe presented to mucin by low-molecular-mass ligands also binds to mucin (Conrad et al. 1991). Indeed, we have shown that potential ligands of low molecular mass are secreted in the gastrointestinal fluids (such as lactate, pyruvate, histidine and bicarbonate; Powell et al. 1990; Whitehead et al. 1996); these may transiently stabilize metal hydroxy-polymerization, and could allow stoichiometric donation to mucin.

Second, there may be more than one binding site on mucin, since the molecule contains both sulfated groups (sulfated mucins) and carboxylate groups (sialomucins; Rhodes, 1989). Metal ions are anticipated to bind preferentially to one site or another, with covalent-type binding by ‘soft’ metals (e.g. Pb$^{2+}$, Cd$^{2+}$) to sulfated groups and ionic-type binding by ‘hard’ metals (e.g. Al$^{3+}$, Fe$^{3+}$) to carboxylate groups. However, some previously unpublished findings (J Quarterman, unpublished results; Fig. 3) suggest that Zn has two pH-dependent binding sites on mucin. Such

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**Fig. 2.** A solution of ferric chloride at pH 2 has a characteristic u.v. spectrum (a in inset) and, although unphysiologically acidic for the small intestine, it is fully soluble, allowing some absorption of iron when directly introduced to the bowel (A). In contrast, at neutral pH, the solution forms poly-hydroxy iron species that yield a light-scattering spectrum (c in inset) and, although now at physiological pH, are unavailable for absorption in the bowel (C). However, iron bound to gastroferrin (or mucin) maintains its characteristic poly-hydroxy spectrum at neutral pH (b in inset) but is also available for absorption in the bowel (B). Values are means and standard deviations represented by vertical bars. (Data combined from Rudzki et al. 1973 and Conrad et al. 1991, with permission.)

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**Fig. 3.** Dialysis results showing zinc binding to isolated porcine mucus with increasing pH (●) and decreasing pH (○). The data suggest that two pH-sensitive binding sites exist on mucus for zinc (and possibly other metal ions), and that a pH of 5.5–6 may facilitate dissociation of the metal–mucus complex. (Data provided by Dr J. Quarterman, Aberdeen, UK; formerly of The Rowett Institute, Aberdeen.)

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observations on the complex interaction between metal ions and mucins make it difficult to interpret competition studies between different metals for mucin, or between mucin and different ligands for metals. For example, Rudzki et al. (1973) showed that in the presence of a tenfold molar excess of ascorbate or citrate Fe would not bind to mucin. However, with identical concentrations mucin-bound Fe could not be released by citrate or ascorbate (Rudzki et al. 1973). Thermodynamic measurements require the reverse reaction to equilibrate similarly to the forward reaction, but kinetic effects, particularly marked in colloidal and/or polyelectrolyte-containing systems, often preclude the simple generation of thermodynamic data. Hence, the proposed Fe–mucin dissociation constant of $10^{-4}$ M (Conrad et al. 1991) may not be reliable or even relevant in vivo during transit of the (non-equilibrium) gastrointestinal tract. Nevertheless, we have demonstrated in situ the marked luminal interaction of ingested metal (Al) and intestinal mucin (Powell, 1994; Whitehead et al. 1995; Fig. 4), which is favoured by the large concentration of mucin in the intestinal lumen and its overall high capacity for metal ions and/or their polyhydroxy species. Further work will be required to delineate the exact in vivo nature of the soluble metal–mucin interactions, the influence of endogenous or dietary ligands, and how mucin promotes the availability of dietary metals to the mucosally-adherent mucus layer for the next phase of absorption.

**Mucosally-adherent mucus layer**

Some remarkable work from Katsuyama’s group (Ota & Katsuyama, 1992; Shimizu et al. 1996) has recently demonstrated the in situ structure of the gastrointestinal mucosally-adherent mucus layer. This leaves little doubt that not only is this a continuous thick layer in constant contact with the mucosa, but it is an alternating laminated array of distinct glycoproteins, rather than an amorphous gel (Fig. 1). Within this layer is a pH gradient influenced only at its surface by the luminal pH and otherwise controlled by the mucosal microclimate pH at the tissue–mucus interface (Powell et al. 1994). This again allows order (acid–base control) in the mucus layer, compared with the variable pH of the gastrointestinal lumen. Although the contribution to metal binding and transport by the individual components in mucus has not yet been demonstrated, we have shown using snap-frozen sections that Al is avidly bound in situ by the intestinal mucus layer (Powell, 1994; Whitehead et al. 1995, 1996). There is clear delineation of the mucus, which stains well for Al, and the mucosa, which lacks any detectable staining (Fig. 4), in keeping with the poor absorption (approximately 0.1 %) of the metal (Powell & Thompson, 1993). In contrast, Quarterman (1987), using an elegant agar cast technique, was able to demonstrate both mucous uptake and subsequent mucosal transfer of the much better-absorbed element Zn (Fig. 5). These findings provide strong evidence for the assimilation of metal ions from the luminal milieu by the intestinal mucus layer, and suggest that those ions easily absorbed traverse the layer, whereas those poorly absorbed remain bound and are shed with the mucus back into the lumen, and excreted. Indeed, binding to mucus appears to follow the pattern $M^{3+} > M^{2+} > M^+$ (see p. 149), and for metal absorption the pattern is $M^+ > M^{2+} > M^{3+}$ (Whitehead et al. 1996). Thus, the mucus barrier may act initially as a ‘coarse filter’ in regulating metal uptake. As we have discussed elsewhere (Whitehead et al. 1996), the extent of luminal hydroxy-polymerization, rates of metal–ligand exchange, and mucosal transport systems (see p. 150) will all additionally act to control the degree of metal absorption. In addition, pH (and perhaps pCa or pNa) gradients may play an important role in regulating uptake, and it is interesting to note that the pH at which there is least interaction of mucus and Zn (approximately pH 6.0) appears to be the mammalian mucosal microclimate pH of the proximal small bowel (Lucas & Blair, 1978). This may thereby facilitate cellular uptake of ions by dissociation of the metal–mucous complex and promotion of the final step, i.e. the metal–epithelial cell interaction.

**Fig. 4.** Solochrome azurine stain showing association of aluminium with rat intestinal tissue following oral administration of aluminium sulfate in deionized water. Aluminium (shown as dark areas) is localized with the mucus layer at the villi surfaces and with soluble mucin in the lumen.

**Fig. 5.** Uptake of $^{65}$Zn (counts/min per cm gut) into the mucus layer (C) and mucosa (O) of rats following an oral dose of zinc sulfate. (Data modified from Quarterman, 1987, with permission.)
Mucosal regulation

Absorption from the mucus layer and into the intestinal mucosa may occur either through the enterocyte (transcellular) or between enterocyte junctions (paracellular; Powell et al. 1994). The latter route is inefficient (usually <1%) and likely, therefore, only to be important in the absorption of non-essential polyvalent metals (M>2+, e.g. Bi and Al) that lack a transport system. Efficiency of this route ("paracellular leakage") may be increased by the ingestion, or mucosal application of penetration enhancers. Such substances either chelate intercellular Ca2+ (e.g. citrate), since Ca2+ is important in normal maintenance of the tight junctional integrity, or undergo rapid enterocyte metabolism (e.g. glucose) causing cytoskeletal contraction and an increase in junctional space (Powell et al. 1994). However, for the absorption of most essential metals a transcellular route facilitated by a mucosal transport system is likely to operate. Until recently, direct evidence was lacking on the role of these routes in the intestinal absorption of Fe and Zn.

It is well recognized that in the absence of genetic haemochromatosis body Fe stores influence inversely the efficiency of Fe absorption. However, there is a complex sequence of factors controlling this Fe homeostasis at the intestinal mucosa. Advances in molecular techniques have generated much new information, chiefly on the acquisition of Fe and Zn, underlying their physiological importance, but the broad concepts are likely to be applicable to other essential elements such as Cu and Mn. The following section outlines some of this newer information and speculates how it may be pieced together, rather than providing a comprehensive review.

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In some tissues such as the liver, Fe-responsive proteins appear integral to the regulation of Fe homeostasis at the intestinal mucosa. However, there is a complex sequence of factors controlling this Fe homeostasis at the intestinal mucosa. Advances in molecular techniques have generated much new information, chiefly on the acquisition of Fe and Zn, underlying their physiological importance, but the broad concepts are likely to be applicable to other essential elements such as Cu and Mn. The following section outlines some of this newer information and speculates how it may be pieced together, rather than providing a comprehensive review.

Arguably, transmembrane shuttles are not required for the passage of divalent ions across the intestinal mucosa, as facilitated transfer could be achieved through intracellular chelating agents providing the necessary gradient (Whitehead et al. 1996). However, recent findings strongly support the presence of transmembrane transporters. A transferrin-like protein (melanotransferrin) linked to a cell-surface glycosyl-phosphatidylinositol has been described in fetal porcine intestinal cells, but its role in adult mammals was not demonstrated, and further information is required to assess its role in neonatal Fe absorption (Danielsen & Deurs, 1995). The transmembrane dimeric integrin complex with an α chain of 150 kDa and β chain of 90 kDa has been strongly supported by Conrad and colleagues (Conrad et al. 1993b; Umbreit et al. 1998) for a role in apical Fe transportation. Typically, the α chain has several cation-binding sites often occupied by Ca, but as discussed by Umbreit et al. (1998) integrins lack normal transport-protein properties. Integrins are transmembrane molecules and their extracellular domains function as adhesion sites for cell–cell or cell–matrix interactions, while their intracellular cytoplasmic tail provides linkage for internal cytoskeletal proteins. Thus, it is proposed that these integrins are involved in the ‘docking’ of intracellular Fe carriers such as mobilferin (see p. 151), facilitating the uptake of ions by enterocytes without themselves undertaking transport (Umbreit et al. 1998). Indeed, the actual transmembrane transport of Fe may involve a ferrireductase enzyme that has been demonstrated at the mucosal surface and uniquely reduces Fe3+ to Fe2+ (Riedal et al. 1995; Pountney et al. 1996). This would allow subsequent Fe absorption through a common divalent cation transporter, and protect against inadvertent uptake of the highly toxic Al3+ ion and other trivalent metal ions that do not have redox potential. A divalent cation transporter (divalent cation transporter 1) has recently been cloned that is expressed at high levels in enterocytes of the proximal small bowel and appears to have many transmembrane domains, making its expression at the cell surface likely (Gunshin et al. 1997). This protein shows significant homology with the natural resistance-associated macrophage protein family, and while it avidly binds Fe2+, it also has a broad substrate range of other divalent cations, including Cu2+, Mn2+ and Zn2+ (Gunshin et al. 1997). This binding of metal ions, which is a proton-coupled process, is favoured at the mildly acidic pH typically found in the micro-environment of the gastrointestinal mucus layer. As discussed previously, the pH gradient of the mucus layer may serve to de-couple metal–mucus interactions (Fig. 4) at the mucosal surface and promote the coupling of apical transporter and metal ion. Internalization of the metal ion (with or without its binding protein) has not been directly demonstrated, although findings with fetal melanotransferrin suggest this mechanism (Danielsen & Deurs, 1995).

In some tissues such as the liver, Fe-responsive proteins appear integral to the regulation of cellular Fe concentrations acting as Fe sensors in the cell cytosol, but there is little evidence for an action of Fe-responsive proteins in intestinal epithelial cells (Chrichton & Ward, 1998). Instead, the recently-identified HFE gene (previously termed HLA-H due to the similarity with the human leucocyte antigen family), that generally carries a point mutation in genetic haemochromatosis, may be involved in controlling Fe levels in the absorptive intestinal cells (Feder et al. 1996). This gene encodes for a protein (HFE; previously termed human leucocyte antigen H) that is related to the major histocompatibility complex class I and, similarly, associates with β2-microglobulin and is expressed at the cell surface (Feder et al. 1998). Thus, HFE has only a short cytoplasmic tail and a single membrane-spanning region that is inconsistent with a role as an ion transporter (Gunshin et al. 1997). More recent findings suggest that the role of HFE is in regulation of Fe transfer from epithelial cells to the circulation by regulated interaction with the basolateral transferrin receptors (Feder et al. 1998; Lebron et al. 1998; see p. 152).

Intracellular metal-binding proteins have been reported, most notably mobilferin (Conrad et al. 1990; Conrad et al. 1990, 1994, 1996; Umbreit et al. 1998). Mobilferin is a 56 kDa intracellular protein that has been isolated from both rat and human small intestine and is homologous with the Ca-binding protein calreticulin (Conrad et al. 1993a). Interestingly, calreticulin has chaperone activity in the formation of major histocompatibility complex class I...
complexes (Umbreit et al. 1998), so perhaps it has similar activity for the putative Fe-regulating protein HFE (which is major histocompatibility complex class I-like). Mobilferrin binds metal ions such as Ca, Cu and Zn with relatively high affinity, and is a particularly strong binder of Fe (Conrad et al. 1990). These interactions are acid-sensitive, again suggesting pH gradients as a means to associate and dissociate metal–mobilferrin complexes. As we have previously noted (Whitehead et al. 1996), it remains to be established if trace-metal–mobilferrin complexes are sufficiently stable in the presence of the relatively high levels of intracellular Ca. Nonetheless, a number of papers from Conrad’s group (Conrad 1990, 1993a,b, 1994; Umbreit et al. 1996, 1998) point to a key role for this molecule, at least in intracellular Fe regulation. In fact this work goes further, suggesting that following acquisition of the Fe, mobilferrin binds into a large protein complex termed ‘paraferritin’ containing solubilized integrin, mobilferrin, metal ion, β2-microglobulin and ‘unidentified polypeptides’ (Umbreit et al. 1996, 1998). Since β2-microglobulin normally stabilizes major histocompatibility complex class I–peptide complexes (Song & Harding, 1996), it may be that the major histocompatibility complex class I-like putative Fe-regulating protein HFE is also involved in this complex. Similarly, for Fe, ferritin sequesters excessive levels of the metal, possibly providing a short-term depot of Fe before the cell is sloughed into the lumen, while preventing Fe-related free-radical damage to the cell, but a significant role in Fe transport has not been shown. Indeed, a number of molecules, such as metallothioneins, exist in the cell cytosol that are likely to be involved in the transient sequestering of absorbed metal ions, particularly when the influx of metal ions is high (Davis et al. 1998).

Finally, a basolateral transporter, such as transferrin for Fe, appears to shuttle ions from the cell through the basolateral membrane to the circulation. A lack of mRNA for transferrin in the enterocyte suggests that there is no constitutive expression of the protein in intestinal cells (Chrichton & Ward, 1998). However, basolateral transferrin receptors (there is normally no apical expression) may allow influx of transferrin and efflux of Fe–transferrin (Chrichton & Ward, 1998). This flux of transferrin appears to be one major regulatory mechanism in Fe homeostasis, because in genetic haemochromatosis there is inefficient interaction of the transferrin receptor with the (abnormal) Fe-regulatory HFE protein (Fedet et al. 1998) and hence upregulation of the receptor (Chrichton & Ward, 1998). Similarly, for Zn, a basolateral Zn transporter (Zn transporter-1) partly regulates flux from intestinal cells (McMahon & Cousins, 1998).

Hence, in summary, assimilation of metal ions in an available form is facilitated by the intestinal secretions, chiefly soluble mucus (mucin). Metal ions then bind and traverse the mucosally-adherent mucus layer with an efficiency M+ > M2+ > M3+. At the mucosa, Fe3+ is uniquely reduced to Fe2+. Divalent cations (including Fe2+) are transported by a membrane protein (such as divalent cation transporter 1) into the cell. Intracellular metal-binding molecules (such as mobilferrin) may be present at the intracellular side of the apical membrane, anchored to a transmembrane protein such as an integrin complex. This mobilferrin would receive the metal ion from divalent cation transporter 1 and, with part of the integrin molecule, transport the metal to the cytosol for safe sequestration in a larger complex such as ferritin or ‘paraferritin’. Finally, a systemic ion-binding protein such as transferrin may enter the antiluminal (basolateral) side of the cell for binding of the sequestered metal ion and delivery to the circulation. This would allow some external regulation, by the liver, of the release of Fe from the enterocytes to the circulation, perhaps determined by the extent of liver Fe stores. Regulatory proteins, such as HFE, may determine degree of ion transport from intestinal cells to the circulation. Gradients in pH and perhaps pCa or even pNa could allow the switching of ions between the different transporters throughout this mechanism.

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Bioavailability of micronutrients


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