Small intestinal MUC2 synthesis in human preterm infants

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Schaart MW, de Bruijn ACJM, Schierbeek H, Tibboel D, Renes IB, van Goudoever JB. Small intestinal MUC2 synthesis in human preterm infants. Am J Physiol Gastrointest Liver Physiol 296: G1085–G1090, 2009. First published February 26, 2009; doi:10.1152/ajpgi.90444.2008.—Mucin 2 (MUC2) is the structural component of the intestinal protective mucus layer, which contains high amounts of threonine in its peptide backbone. MUC2 synthesis rate might be a potential parameter for intestinal barrier function. In this study, we aimed to determine whether systemic threonine was used for small intestinal MUC2 synthesis and to calculate the MUC2 fractional synthetic rate (FSR) in human preterm infants. Seven preterm infants with an enterostomy following bowel resection for necrotizing enterocolitis received intravenous infusion of [U-13C]threonine to determine incorporation of systemic threonine into secreted MUC2 in intestinal outflow fluid. Small intestinal MUC2 was isolated using cesium chloride gradient ultracentrifugation and gravity gel filtration chromatography. MUC2-containing fractions were identified by SDS-PAGE/periodic acid-Schiff staining and Western blot analysis and were subsequently pooled. Isotopic enrichment of threonine, measured in MUC2 using gas chromatography isotopic ratio mass spectrometry, was used to calculate the FSR of MUC2. Systemically derived threonine was indeed incorporated into small intestinal MUC2. Median FSR of small intestinal MUC2 was 67.2 (44.3–103.9)% per day. Systemic threonine is rapidly incorporated into MUC2 in the small intestine of preterm infants, and thereby MUC2 has a very high synthesis rate.

mucin 2; small intestine; threonine

Disturbances in intestinal barrier function, characterized by inappropriate initial bacterial colonization of the intestine and immature epithelial responses to bacteria and their toxins, are thought to be crucial in the development of necrotizing enterocolitis (NEC) in preterm infants (35). NEC is the most devastating intestinal disease in premature infants and a regular indication for neonatal bowel resection (5). Postoperatively, adequate gut adaptation and recovery of the intestinal barrier function are required to avoid malabsorption and pathogenic bacterial insults. Therefore, patients with NEC receive total parenteral nutrition for a variable period of time after surgical intervention. However, lack of enteral nutrition can induce intestinal atrophy and may reduce digestive, absorptive, and protective capacity (3, 12, 23). In these circumstances, the usage of systemically derived substrates such as threonine might be of vital nutritional importance to maintain and restore an intact mucus layer and thus intestinal barrier function.

We recently developed a tracer method to study small intestinal MUC2 synthesis and to determine the fractional synthetic rate (FSR) of MUC2 in human neonates as a potential parameter for intestinal barrier function (24). We found that dietary threonine is incorporated into small intestinal MUC2. However, because the tracer was administered enteraly, we could not verify whether threonine used for MUC2 synthesis was derived directly from the diet and/or after intestinal absorption and thus from the systemic circulation. As already known, the intestine utilizes amino acids in first pass and/or from the systemic site (20, 28, 32, 36). Hence, threonine incorporated into small intestinal MUC2 may be derived from either the lumen or the basolateral site (systemic circulation). Moreover, our study in piglets demonstrated that two-thirds of threonine utilized by the portal-drained viscera was extracted from the systemic circulation during normal protein feeding (25). Thus, in the present study, our main objective was to determine whether a functional small intestine of preterm human infants after bowel resection for NEC was able to incorporate systemically derived threonine into MUC2. Furthermore, the FSR of MUC2 was calculated to determine the capacity of the small intestine to synthesize and secrete MUC2 from systemically derived threonine.

MATERIALS AND METHODS

Patients

The study was conducted at the Department of Pediatrics, Division of Neonatology and the Department of Pediatric Surgery of the Erasmus Medical Center (MC)-Sophia Children’s Hospital (Rotterdam, the Netherlands) after approval from the Erasmus MC Institutional Review Board. Written, informed consent was obtained from the parents.

Eligible for this study were infants who had had a bowel resection for NEC in the neonatal period and received a temporary enterostomy
during the initial surgery. The diagnosis NEC was made on specific clinical symptoms, namely systemic (e.g., apnea, respiratory failure, lethargy, poor feeding, temperature instability, or hypotension), abdominal signs (e.g., distension, gastric retention, tenderness, vomiting, diarrhea, and hematochezia), and/or characteristic features on an abdominal X-ray according to the Bell staging criteria. NEC was further confirmed at surgery and by histological features characteristic for NEC identified in resected intestinal tissue sent for routine histopathology. We included seven infants in the study. Table 1 lists their main clinical characteristics. All included infants had bowel surgery at the Erasmus MC-Sophia Children’s Hospital and were admitted to the Neonatal Intensive Care Unit (NICU) or the Pediatric Surgical Intensive Care Unit (PSICU) at the Erasmus MC-Sophia Children’s Hospital. Exclusion criterion for this study was cystic fibrosis.

Feeding

Before onset of NEC, feeding regimens adhered to our feeding protocol for newborns, breast milk and/or formula [Nenatal, Nenatal Breast Milk Fortifier, Nutrilon Premium, or Nutrilon Pepti Junior; all from Nutricia, Zoetermeer, the Netherlands] and parenteral nutrition containing glucose, amino acids (Primene 10%; Clinitec Benelux NV, Brussels, Belgium), and lipids (Intralipid 20%; Fresenius Kabi, Den Bosch, the Netherlands). For patients in whom the diagnosis of NEC was considered, enteral feeding was immediately stopped and switched to full parenteral feeding. Patients recovering from NEC received full parenteral feeding during the first 10 postoperative days. Next, minimal enteral feeding was added during 4 days, after which enteral feeding was gradually introduced by continuous nasogastric gavage feeding or bottle feeding under simultaneous diminishing of the parenteral nutrition. All patients included received enteral feeding. Six infants had a much higher dietary threonine intake compared with the parenteral tracer amount administered intravenously and received no parenteral threonine supplementation at the time of the study. One infant received both enteral and parenteral nutrition at the time of the study (Table 1).

Study Design

The study was performed when the infant was clinically stable, i.e., about 4 wk (4 ± 1 wk) following bowel resection. Then, a continuous 12-h infusion (7.43 μmol/kg and 7.43 μmol/kg per h) of [U-13C]threonine (99.47%; Cambridge Isotopes Laboratories, Andover, MA) was administered intravenously. All isotopes were tested and found sterile and pyrogen free. The small intestinal outflow fluid samples were collected in adhesive bags, which were stuck around the enterostomy. At 3-h intervals, adhesive bags including small intestinal outflow fluid were removed by the attending nurse and stored at −80°C for further analysis. Small intestinal outflow fluid samples were collected during 48 h. At time zero (baseline value) and after 9 h and 12 h of tracer administration, blood samples were collected by heelstick. Blood was centrifuged immediately to separate plasma and cells. The plasma was stored at −80°C until further analysis. Figure 1 outlines the tracer-infusion study described.

Analytical Procedure

Isolation of MUC2. MUC2 was isolated from the small intestinal outflow fluid using cesium chloride (CsCl) density gradient ultracentrifugation according to the method previously described combined with gravity gel filtration chromatography (24, 30). Briefly, samples were homogenized in homogenization buffer, pH 7.5 [6 mol/l guanidinium HCl (Sigma), 50 mmol/l Tris(hydroxymethyl)aminomethane (Tris, GIBCO), 5 mmol/l EDTA (Merck), and 1 mmol/l PMSF (Sigma)]. The disulfide bonds of mucins were chemically reduced by adding 100 mmol/l DTT (Sigma) and stirring overnight at 4°C in the dark. The homogenate was centrifuged to remove the fat layer and to isolate the supernatant at 23,700 g for 10 min at 4°C (Mutiufe 3 S-R, Heraeus, Wehrheim, Germany). Sulphydryl groups were carboxymethylated through addition of 250 mmol/l iodoacetamide (Sigma) in the supernatant and stirring for another 24 h at 4°C. Mucins were purified by equilibrium ultracentrifugation on a CsCl (Roche, Uppsala, Sweden) density gradient. The gradient had a guanidinium HCl concentration of 4 mol/l with CsCl added to a density of 1.40 g/ml. Isopycnic density gradient centrifugation was performed in a Beckmann ultracentrifuge, 70 Ti rotor at 250,000 g for 72–88 h at 4°C. One-millilitre fractions were collected, and the mucin-containing fractions were analyzed as described below. Mucin-containing fractions were pooled and further purified by gravity gel filtration chromatography using columns (Econo-columns; Bio-Rad, Veenendaal, the Netherlands) filled with 20 ml of Sepharose CL-2B resin. The resin was equilibrated with 50 mmol/l Tris, 5 mmol/l EDTA, and 1 mmol/l PMSF, pH 7.5, containing 4 mol/l guanidinium HCl. One millilitre of the mucin-containing fractions of each time point was loaded onto the.

Table 1. Patient characteristics

<table>
<thead>
<tr>
<th>Patients</th>
<th>Sex</th>
<th>GA, wk</th>
<th>BW, g</th>
<th>AS, days</th>
<th>Cause</th>
<th>Enterostomy</th>
<th>Residual Small Intestine</th>
<th>Enteral Threonine Intake, μmol/kg per h</th>
<th>Parenteral Threonine Intake, μmol/kg per h</th>
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<tbody>
<tr>
<td>1 M</td>
<td>28</td>
<td>695</td>
<td>11</td>
<td>NEC (small bowel)</td>
<td>ileostomy</td>
<td>Small bowel excluding 7 cm ileum</td>
<td>55</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>2 M</td>
<td>30</td>
<td>930</td>
<td>33</td>
<td>NEC (small bowel)</td>
<td>jejunostomy</td>
<td>Small bowel excluding 5 cm jejunum and 15 cm ileum</td>
<td>90</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>3 M</td>
<td>25</td>
<td>940</td>
<td>15</td>
<td>NEC (small bowel)</td>
<td>ileostomy</td>
<td>Small bowel excluding 24 cm jejunum and ileocecal valve</td>
<td>69</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>4 M</td>
<td>30</td>
<td>885</td>
<td>30</td>
<td>NEC (small bowel)</td>
<td>ileostomy</td>
<td>Small bowel excluding 10 cm ileum and ileocecal valve</td>
<td>55</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>5 M</td>
<td>26</td>
<td>950</td>
<td>44</td>
<td>Intestinal obstruction after conservative treatment for NEC</td>
<td>ileostomy</td>
<td>Total small bowel</td>
<td>10</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>6 M</td>
<td>32</td>
<td>995</td>
<td>11</td>
<td>NEC (small bowel)</td>
<td>ileostomy</td>
<td>Small bowel excluding 10 cm ileum</td>
<td>45</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>7 M</td>
<td>33</td>
<td>1445</td>
<td>5</td>
<td>NEC (colon)</td>
<td>End-Ileostomy</td>
<td>Total small bowel</td>
<td>55</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>30</td>
<td>940</td>
<td>15</td>
<td>NEC (colon)</td>
<td>End-Ileostomy</td>
<td>Total small bowel</td>
<td>Min-Max 25–33</td>
<td>695–1445</td>
<td>5–44</td>
</tr>
</tbody>
</table>

M, Male; GA: gestational age; BW: birth weight; AS: age at surgery; NEC: necrotizing enterocolitis.

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columns. Mucins were eluted in the void volume of the column with 50 mmol/l Tris, 5 mmol/l EDTA, and 1 mmol/l PMSF, pH 7.5, containing 4 M guanidinium HCl. The mucin-containing fractions were extensively dialyzed against distilled water at 4°C and stored at −20°C until further analysis.

**Analysis of MUC2.** Samples of dialyzed fractions were analyzed on reducing polyacrylamide gel electrophoresis in the presence of 0.1% sodium dodecylsulfate (SDS-PAGE) (14). Gels were composed of 3% stacking gel and 4% running gel using a stock solution containing 0.1% (wt/vol) 2-mercaptoethanol (Bio-Rad) and 2% (wt/vol) SDS. Gels were stained with periodic acid-Schiff reagent (PAS, Sigma) according to Konat et al. (13), with Phast Gel Blue R (Coomassie, Amersham, Roosendaal, the Netherlands), and with Silver Staining according to the manufacturer’s protocol. Because mucins have a characteristic buoyant density of ~1.45 g/ml, the density of CsCl gradient fractions was measured by weighing 1 ml of each fraction using a calibrated pipette. Hexose assay was performed using orcinol (Sigma) according to François et al. (10) with D-glucose:fucose [3:2 (wt/wt)] as standard. Quantity of hexose was expressed as the optical density at 540 nm. Mucin-containing fractions, i.e., fractions that contained a high molecular weight PAS-positive band at ~550 kDa after SDS-PAGE, had a buoyant density of ± 1.45 g/ml, contained relatively high hexose levels, were pooled, and stored at −20°C for further analysis.

**Western blot analysis.** The mucin-containing pooled fractions (16 μl) were loaded and run on a SDS-PAGE gel. The separated proteins were transferred to nitrocellulose membranes (Protran BA 83, 0.2 μm) and blocked for 1 h at room temperature in blocking buffer containing 1% (wt/vol) 2-mercaptoethanol (Bio-Rad) and 2% (wt/vol) SDS. Gels were stained with periodic acid-Schiff reagent (PAS, Sigma) according to Konat et al. (13), with Phast Gel Blue R (Coomassie, Amersham, Roosendaal, the Netherlands), and with Silver Staining according to the manufacturer’s protocol. Because mucins have a characteristic buoyant density of ~1.45 g/ml, the density of CsCl gradient fractions was measured by weighing 1 ml of each fraction using a calibrated pipette. Hexose assay was performed using orcinol (Sigma) according to François et al. (10) with D-glucose:fucose [3:2 (wt/wt)] as standard. Quantity of hexose was expressed as the optical density at 540 nm. Mucin-containing fractions, i.e., fractions that contained a high molecular weight PAS-positive band at ~550 kDa after SDS-PAGE, had a buoyant density of ± 1.45 g/ml, contained relatively high hexose levels, were pooled, and stored at −20°C for further analysis.

**Mass Spectrometry**

**Analysis of [U-13C]threonine.** After gravity gel filtration chromatography, aliquots of 3–4 ml of the pooled MUC2 fractions were dialyzed, freeze dried, and prepared for mass spectrometric analysis. The dried samples were hydrolyzed by adding 1 ml of 6 mol/l HCl and incubating at 110°C in sealed tubes for 24 h. The protein hydrolysates (1,000 μl) were dried under a nitrogen stream at 55°C, and the residue was dissolved in 0.5 ml water. The amino acids in the residue were bound to 1 ml AG50 W-X8, H+ cation exchange column (Bio-Rad, Richmond, VA). Amino acids were eluted with 3 ml 6 mol/l NH4OH and dried under nitrogen at 30°C. Threonine was converted to its N-ethoxycarbonylthylethester derivative according to the method used in our previous work (25). The [13C1/13C0] ratio of threonine in isolated MUC2 was measured by a Thermo Electron Delta-XP isotope ratio MS linked online with a trace gas chromatography (GC) (Thermo Electron, Bremen, Germany) and a combustion interface type 3 (Thermo Electron). Aliquots of 1 μl of the ethyl acetate suspension containing the amino acid derivatives were introduced into the GC system by a CTC PAL autosampler (CTC Switzerland). Chromatographic conditions were like those described previously. After separation using capillary GC, amino acids were combusted online at 940°C and introduced as CO2 into the isotope ratio mass spectrometry (MS), where the [13C1/13C0] ratio was measured. Enrichment was expressed in mole percent excess (MPE).

**Analysis of [U-13C]threonine in blood samples.** Small aliquots of plasma (50 μl) were prepared to determine threonine enrichment and concentration by GC-MS. Although aminoacyl-tRNA-bound threonine derived from intestinal biopsies is the best representative to determine the true threonine precursor pool, plasma threonine enrichment is used as a substitute for the true intracellular threonine enrichment of goblet cells. For obvious ethical reasons and the vulnerability of the intestine after surgical intervention, we were not able to sample additional intestinal tissue to determine the true threonine precursor pool.

Briefly, 20 μl of internal standard (1 μmol/ml [15N]threonine) was added to 50 μl plasma and deproteinized with sulfosalicylic acid 6% (wt/vol). After centrifugation for 10 min at 4°C and 20,000 g, the amino acids in the supernatant were isolated by cation exchange separation as described above. The eluate was dried overnight at 30°C under a stream of nitrogen. Finally, t-butyldimethylsilyl derivatives were formed by adding 25 μl of dimethylformamide and 25 μl of N-methyl-N-(tert-butyldimethylsilyl)-trifluoroacetamide (MTBSTFA) to the dried residue and heated at 60°C for 1 h. Standard curves were prepared by mixing aqueous solutions of natural and labeled threonine for both enrichment and concentration determination. GC-MS analyses were performed in selective ion-monitoring mode on a Carlo Erba GC8000 gas chromatograph connected to a Fisons MD-800 mass spectrometer (Interscience BV, Breda, the Netherlands). One micro-liter of the derivative was injected in split mode (1:20) on a DB-17, 30 m × 0.25 mm capillary column (Agilent). Selective ion monitoring was carried out at m/z 404.3, 405.3, and 408.3. Enrichment was expressed in MPE.
**Calculations**

**MUC2 secretion time.** MUC2 secretion time was defined as the time interval between start of intravenous [U-13C]-threonine administration and the appearance of enriched MUC2 in small intestinal outflow fluid.

**FSR.** The FSR of MUC2 is expressed as percentage of the total MUC2 pool synthesized per day. Plasma threonine enrichment is used as precursor.

FSR was calculated by the equation [(slope of the linear hourly increase of [U-13C]threonine enrichment of MUC2)/(U-13C]threonine enrichment in plasma)] × 24 h.

**Statistics**

Data are presented as the means ± SD or as medians (minimum-maximum).

**RESULTS**

**Patients**

The seven infants studied had median gestational age of 30 (25–33) wk and median birth weight of 940 (695–1445) g (Table 1). Surgery was performed at median 15 (5–44) days after birth, with creation of a jejunostomy (n = 1) or ileostomy (n = 6). At the time of the study (mean 4 ± 1 wk following bowel resection) patients had mean enteral protein intake of 2.6 ± 1.2 g/kg per day. Enteral nutrition consisted of a combination of breast milk and/or formula feeding (Nenatal or Nutrilon Pepti Junior). Median dietary threonine intake was 55 (10–90) µmol/kg per hour. Moreover, two infants had a glucose infusion, and one infant received both enteral and parenteral nutrition during the study (Table 1).

**Isolation and Characterization of Mucins**

MUC2 was isolated from the intestinal outflow fluid using CsCl density gradient ultracentrifugation and was characterized by PAS staining, hexose assay, buoyant density, and Western blot analysis as described previously (24, 30). The mucin-containing fractions were pooled and further purified by gravity gel filtration chromatography. The fractions 5–8 contained the purified mucin MUC2. These fractions contained a high molecular mass band of ≈ 550 kDa, which was PAS positive on SDS-PAGE (Fig. 2A). Moreover, this high molecular weight band corresponded with a peak in hexose assay (Fig. 2C). Each mucin fraction was free of contaminating proteins detected by Coomassie Blue staining as well as silver staining (data not shown). Furthermore, Western blot analysis using anti-HCM-1, an antibody specific for MUC2, revealed that the pooled fractions 5–8 after Sepharose CL-2B gravity gel filtration contained MUC2 (Fig. 2B).

**Threonine Enrichment**

The [U-13C]enrichment of plasma threonine reached a steady state of 3.63 ± 0.56 MPE in all patients between t = 9 and t = 12 h, seeing that slopes of enrichment between these time points did not significantly differ from zero. Figure 3 shows the values of MUC2-bound threonine enrichment and the time course of systemic tracer incorporation into MUC2 for two representative patients. Threonine enrichment rose almost linearly in isolated MUC2 [maximal threonine enrichment (1.06 ± 0.50 MPE)] and gradually decreased after mean 21 ± 2 h. Time needed to absorb systemic threonine and to synthesize and secrete MUC2 into the small intestinal lumen was within 3 h in four patients, between 3–6 h and between 9–12 h in the other two patients (Table 2). Median FSR of small intestinal MUC2 was 67.2 (44.3 - 103.9)% per day (Table 2).

**DISCUSSION**

Tracer studies in mammals showed that amino acids in the intestine derived from both dietary and arterial sources and are used for mucosal protein synthesis and energy generation (20, 26–28, 31, 32, 36). Because MUC2 is the predominant secretory mucin in the intestine and its peptide backbone is rich in threonine, we speculated that absorbed threonine is mainly used for MUC2 synthesis to maintain the protective mucus layer and thus gut barrier function. Because threonine cannot be synthesized de novo, the epithelial cells are offered high quantities of threonine from both the intestinal lumen [i.e., the diet or proteolysis (recycling of threonine)] and the systemic circulation during enteral nutrition. The question arises whether threonine is utilized differently when presented to epithelial cells via the lumen or via the circulation. In piglets, we previously showed that two-thirds of threonine utilized by the intestine derived from the systemic circulation during normal protein feeding (25). However, dietary, rather than systemic threonine was preferentially utilized for constitutive protein synthesis in the small intestinal mucosa of these piglets. The present study demonstrated that even during enteral feeding the intestine utilizes systemically derived threonine for MUC2 synthesis. We therefore suggest that dietary threonine is preferentially taken up by enterocytes and is used for constitutive protein synthesis, whereas goblet cells might extract threonine from...
the systemic site and use it for intestinal MUC2 synthesis. Hence, we assumed that goblet cells, which secrete MUC2 and trefoil peptides, are not capable to absorb threonine directly from the intestinal lumen in contrast to enterocytes (16). That intestinal channeling of amino acids to specific metabolic products occurs dependent on the site of absorption during enteral feeding was also suggested by Reeds et al. (21) for the mucosal glutamate pool in enterally fed piglets. Our previous study showed that dietary threonine was incorporated into small intestinal MUC2, and, thereby MUC2 entres within the gastrointestinal tract might be important. Otherwise, the intestinal threonine requirement of parenterally fed piglets is significantly lower than that of piglets fed enterally, which might suggest diminished MUC2 synthesis during parenteral feeding (2). Our present study showed that systemic threonine is utilized for intestinal MUC2 synthesis in preterm infants who were predominantly fed enteral nutrition. However, it is yet unknown whether systemic threonine is utilized similarly in infants fed full parenteral nutrition since other factors such as bowel movements, enteric nerve stimulation, or hormone production related to the presence of nutrients within the gastrointestinal tract might be important.

In conclusion, systemically derived threonine is rapidly incorporated into small intestinal MUC2, and, thereby MUC2 synthesis rate of the small intestine is high.

ACKNOWLEDGMENTS

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GRANTS

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Table 2. Kinetic parameters of small intestinal MUC2

<table>
<thead>
<tr>
<th>Patients</th>
<th>MUC2 Secretion Time, h</th>
<th>FSR, %/day</th>
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<tr>
<td>1</td>
<td>3–6</td>
<td>103.9</td>
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<tr>
<td>2</td>
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<td>Min-Max</td>
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<td>44.3–103.9</td>
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MUC2, mucin 2; FSR: fractional synthetic rate; *not determined.


