Autoimmunity in Man

Autoimmune diseases are MHC-linked

MHC genes are immune response genes
Indicates a role for T cells in these diseases

How might autoimmunity emerge?

• Crossreactivity/Molecular Mimicry
• Inflammation (IFN-γ) induced neo-expression of class II MHC and the presentation of novel MHC-peptide complexes to which the system is not tolerant
• Breaking tolerance by the induction of co-stimulator activity or by interfering with normal suppressor or regulatory mechanisms
• Imbalance of Th1/Th2 cells
• Not autoimmunity (really a viral or bacterial disease)

Autoimmunity in Man

In most organ specific autoimmune syndromes, there is neo-class II MHC expression

IFN-γ and TNF secreted during immune and inflammatory responses induces upregulation of class II MHC.
This permits presentation of new self antigens to the immune system

Autoimmunity in Man

In most organ specific autoimmune syndromes, the T cell response is pauci-clonal

• T cells infiltrating the target organ use only a few related TCR genes
• Indicates that these diseases are due to particular peptide antigen(s) presented by MHC

The Control of Activated CD4+ T Cells by Regulatory T cells

NKT cells/CD4+CD25+ T regs

peptide/antigen

Th1 CD4+ cells

Th2 CD4+ cells

CD4 suppressor effector

CD8 suppressor precursor

Regulatory immunity CD4/CD8 interactions

T cell activation is regulated by signals derived from the TCR/CD3/CD4 complex and the CD40L and CD80/CD86 co-stimulatory molecules

TH1 CD4+ cells

IL-12

IFN-γ

IL-4

Th2 CD4+ cells

Apoptosis

Resting CD4 T cells

Activated CD4 T cells

IL-12

IFN-γ

IL-4
## Functions of Th1 and Th2 cells

<table>
<thead>
<tr>
<th>Type</th>
<th>Function</th>
<th>Helpful</th>
<th>Harmful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Th1</td>
<td>Activate macrophages, dendritic cells</td>
<td>DTH, Tb, fungi, Leishmania and other intracellular bacteria</td>
<td>Thyroiditis, RA, IDDM, Scleroderma, poison ivy</td>
</tr>
<tr>
<td>Th2</td>
<td>B cell help</td>
<td>Clearance of antigens/toxins</td>
<td>Allergy, Autoantibody, SLE</td>
</tr>
</tbody>
</table>

## Clinical Aspects of Multiple Sclerosis

1. The clinical symptoms of the disease are entirely attributable to immune-mediated injury of myelin and subsequent demyelination in the CNS.
2. Clinical problems may include disturbances in visual acuity and blindness; double vision; motor disturbances affecting walking and use of the hands; bowel and bladder incontinence; spasticity; and sensory disturbances including loss of touch, pain, and proprioception. Cognitive function is generally not impaired in MS.
3. A typical presentation of MS involves episodes of relapse followed by remission. Relapses often follow an episode of a viral infection of the upper respiratory system or gastrointestinal tract. In many MS cases the disease progresses to a more chronic phase.

## Induction of CD4+ TH1 mediated autoimmunity:

A paradigm for the pathogenesis of rheumatoid arthritis, multiple sclerosis and type 1 diabetes

1. Expansion of CD4+, autoreactive TH1 cells specific for autoantigens
2. Migration and infiltration of these self-reactive CD4+ TH1 cells into tissues and induction of inflammation and autoimmunity
3. Induction of regulatory cells which control the growth and activation of the pathogenic autoreactive CD4+ T cells

## Multiple sclerosis (MS) Overview

1. Multiple sclerosis (MS) is the most common autoimmune disease involving the central nervous system (CNS). In the United States ~250,000 individuals suffer from MS.
2. The first clinical signs of MS typically begin in young adulthood, and women with the disease outnumber men 2:1. The cause of the disease is unknown, but genetic factors including MHC class II genes are important with HLA DR2 carrying a 4-fold relative risk for northern European Caucasoids.
3. The pathology of the disease lies entirely in the central nervous system and is characterized by a classic picture of inflammation surrounding venules and extending into the myelin sheath.

## Immunopathology of MS

- CD4+ T cells and dying, MHC class II+ oligodendrocytes (microglia, DCs)
- Perivascular infiltrate of CD4+ T cells and APCs
- Myelin
- Oligodendrocytes
- Naked axon (plaque)
Pathophysiology of MS: 1

(1) Genetic and environmental factors (including viral and bacterial infection) facilitate the movement of autoreactive T cells from the systemic circulation into the central nervous system (CNS) through disruption of the blood-brain barrier.

(2) In the CNS, local factors up-regulate the expression of endothelial adhesion molecules, such as ICAM-1, VCAM-1 and E-selectin, further facilitating the entry of T cells into the CNS.

(3) Proinflammatory cytokines like IFN-\(\gamma\) and TNF up-regulate the expression of surface MHC molecules on neighboring tissue and antigen-presenting cells. Binding and presentation of putative multiple sclerosis (MS) antigens, including myelin basic protein (MBP), myelin oligodendrocyte glycoprotein (MOG), and potential to CD4+ T cells of complex on APCs triggers an autoreactive immune response.

Pathophysiology of MS: 2

(4) Proinflammatory cytokines (e.g., interleukin-12) trigger a cascade of events, resulting in the proliferation of proinflammatory CD4+ Th1 cells, release of IFN-\(\gamma\), activation of macrophages and ultimately in immune-mediated injury to myelin and oligodendrocytes.

(5) Multiple mechanisms of immune-mediated injury of myelin have been postulated: cytokine-mediated injury of oligodendrocytes and myelin; direct injury of oligodendrocytes by CD4+ and CD8+ T cells; antibody-dependent cytotoxicity and complement-mediated injury; phagocytosis by macrophages.

(6) This injury to the myelin membrane results in denuded axons that are no longer able to transmit action potentials efficiently within the central nervous system resulting in neurologic symptoms.

(7) This Th1 mediated injury may be controlled both by cytokines released from Th2 T cells or alternatively by regulatory CD4+ or CD8+ T cells which down regulate the Th1 response.

Immunopathophysiology of Multiple Sclerosis

- Antibody-mediated injury
- Dendritic cell/APC
- CD40L
- CD40
- \(\alpha,\beta\), TCR
- IL-4

Overview of insulin dependent diabetes mellitus (IDDM)

- IDDM is an autoimmune disease that affects 0.3% of the world’s population. In the United States, the prevalence of IDDM by the age of 20 years is about 0.26 percent, and the lifetime prevalence approaches 0.4 percent.
- IDDM is mediated by autoreactive CD4+ and CD8+ T cells that infiltrate the pancreas, induce islet \(\beta\) cell insulinitis eventually leading to death or damage to the insulin-producing \(\beta\)-islet cells.
- The cause of the disease is unknown, but genetic factors including HLA class II genes exert an influence manifest as a complex interplay between alleles of the two major MHC class II molecules, HLA DR and DQ. In particular, particular alleles of DR3, DR4 and DQ2 and DQ8 confer the highest risk for IDDM.
Prior to the onset of clinically apparent disease, children at risk for IDDM produce antibodies to putative islet cell autoantigens including glutamic acid decarboxylase (GAD), insulin and the tyrosine phosphatase, IA-2. T cell responses to self-peptides derived from these autoantigens are also made.

Clinically, the T cell mediated destruction of islet cells results in an increase in glucose levels, which are normally kept in check by insulin.

Autoimmune diabetes usually affects young people, who are then dependent on an artificial source of insulin for life. With time severe diffuse vascular abnormalities effecting multiple organs including the heart, kidney, retina and skin occur. In addition, patients are prone to develop the premature onset of atherosclerosis.


Inflammatory infiltrate of mononuclear cells in an islet from a 2-year-old patient with type 1 diabetes of short duration

Autoantigenic Targets of the Autoimmune Response in IDDM

<table>
<thead>
<tr>
<th>Autoantigen</th>
<th>Antibody</th>
<th>T Cell Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAD65/67</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>ICA10 (IA-2)</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Peripherin</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>HSP60</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

Histologic Appearance of Pancreatic Specimens from Patients with IDDM of Recent Onset

Later stage of IDDM with clinical signs
Panel A shows a section of pancreas stained for glucagon, somatostatin, and pancreatic polypeptide with a method involving alkaline phosphatase (x1150). All endocrine cells are stained, confirming the lack of insulin-containing beta-cells.

Very early stage of IDDM-no clinical IDDM
Panel B shows an islet infiltrated with inflammatory cells, a condition often referred to as insulitis (hematoxylin and eosin, x700).

Insulin Peptide bound to HLA-DQB in IDDM
Scleroderma: Progressive Systemic Sclerosis

**Definition:** Scleroderma is a multi-systemic disease characterized by the excessive accumulation of collagen in skin, GI tract and various other internal organs.

**Histopathology:** Early there is lymphocytic infiltration and fibroblast proliferation, later there is fibrosis.

**Clinical manifestations:** Sclerodactyly, dermal swelling and/or ulceration, esophageal dysfunction, small bowel infection and distention, renal dysfunction, arthritis and in a systemic form "Crest" is associated with calcinosis, Raynauds phenomenon and telangiectasia, also associated with pulmonary, and/or renal hypertension.

**Serology:** Scl 70 (DNA Topoisomerase)
**Antibodies Associated With Scleroderma**

- Scl-70 (DNA Topoisomerase I)
- 70% Diffuse Scleroderma
- Centromere
- 70-80% in CREST
- 25% Raynaud’s Phenomenon
- Nuclear Antigens
- 1-6% Scleroderma
- PM-Scl
- Polymyositis-Scleroderma Overlap

**Pathophysiology of Scleroderma**

- CD4+ T Cell
- Activated CD4+ T Cell
- TCR α,β
- CD4
- Dermal fibroblast
- IFNγ
- IL-2, IL-4, IL-5, IL-6
- Fibroblast proliferation
- PGE-2, collagen
- Fibrosis
- Anti-scl 70, Ro, La and RF’s

**Physiology of the DTH Response in Contact Hypersensitivity**

- Sensitization to Poison Ivy and DTH response
- Blistering skin lesions on the hand of patient with poison ivy contact dermatitis