Linkage of Pemphigus Vulgaris Antibody to the Major Histocompatibility Complex in Healthy Relatives of Patients

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Summary

Pemphigus vulgaris (PV) is an autoimmune disease caused by high concentrations of antibody to an epidermal cadherin. The disease is associated with two kinds of HLA-DR4, DQ8 haplotypes dominantly distributed among Jewish patients, and these plus DR6, DQ5 haplotypes in non-Jewish patients. Low levels of the PV antibody were found in 48% of a total of 120 asymptomatic parents, children, and siblings of 31 patients, thus exhibiting dominant inheritance. The inheritance of these low levels of antibody in asymptomatic relatives was linked to the major histocompatibility complex with a highly significant logarithm of the odds score of 9.07, almost always to a DR4 or DR6 haplotype of the patient. Disease appears to occur in susceptible individuals with low levels of antibody when a second factor, either environmental or genetic, induces high levels, sufficient to produce blisters.

In contrast to diseases like sickle cell anemia, where all genetically susceptible individuals have the disease and carriers are easily detected, the genetics of autoimmune diseases are far less clear. Although many autoimmune diseases show MHC associations, genetically susceptible persons may not have the disease and carriers are usually not detectable. This phenomenon has been called incomplete penetrance. Another problem is extensive linkage disequilibrium within the human MHC. In our experience, and that of others, many MHC-associated diseases are marked by fixed or extended haplotypes with conserved DNA in independent examples, over at least the HLA-B-DR, DQ interval, that form the basis of the linkage disequilibrium, making localization of a specific susceptibility gene particularly difficult (1).

Our previous studies demonstrated that in patients with the rare autoimmune blistering skin disease pemphigus vulgaris (PV), caused by an antibody to a skin cadherin (2-4), three conserved or extended MHC haplotypes or their class II segments are disease associated (5, 6). We found that susceptibility in Ashkenazi Jewish patients was associated with the extended haplotype [HLA-B38, SC21, DR4, DQ8], and the possible extended haplotype HLA-B35, SC31, DR4, DQ8, or (unusually) DR4, DQ9-containing segments of these haplotypes with a variety of other HLA-B and complotype markers. These findings helped explain the DR4 increase (7) and the DR4, DQ8 association among Jewish PV patients (8). Of non-Jewish PV patients (6), some had HLA-DR4, DQ8 haplotypes, as in the Jewish patients, but also, consistent with the known increase in HLA-B55 (22) and HLA-DK6, DQ1 (10), many had HLA-B55, SB45, DK14(6), DQ5(1) or its presumed DR14, DQ5 segment.

Clues to the mode of inheritance of these disorders are the distribution of MHC alleles in populations (11) or among multiple affected siblings (12). Thus, the inheritance of MHC-associated susceptibility to type I diabetes is essentially recessive (13, 14), whereas that for ankylosing spondylitis is dominant (11). From the analysis of the distribution of DR4, DQ8 on MHC haplotypes among Jewish patients with PV, we inferred that the MHC susceptibility gene operated in a dominant fashion (5).

If there is a dominantly expressed gene specifying autoantibody production in PV patients, autoantibody might also be present, although at low levels, insufficient to cause symptoms, in relatives of patients who share the susceptibility haplotype. Furthermore, a fraction of normal persons from such populations who carry one of these haplotypes might also have the PV antibody.

In the present study, we have approached the problem directly and tested the serum of close relatives of PV patients.
for the presence of low levels of antibody, using a recently
developed sensitive Western blotting procedure. We found
that about half of the healthy immediate relatives of patients
carry low levels of this antibody and that the presence of
antibody is genetically linked to one of the HLA-DR4 or DR6
haplotypes, the same as occur in patients.

Materials and Methods

We studied 174 members of 31 families of patients with PV.
The criteria for diagnosis and MHC types of most of these were
published earlier (5, 6). For the present study, serum was obtained
from clotted venous blood by centrifugation and analyzed for anti-
body to skin epithelial surface antigens.

Serological typing of PBL for HLA-A, B, C, DR, and DQ was
by microlymphocytotoxicity (15). Fresh frozen EDTA plasma was
used to type the MHC-encoded complement proteins C4 (16), BF
(17), and C2 (18). Complotypes are given as BF, C2, C4A, C4B
types, for example, SC31 is BF*S, C2*C, C4A*3, C4B*1.

Serum samples from the study and control subjects were tested
for antibody to the 130-kD (keratinocytes) (4) and 105-kD (COLO
16 tumor cell line) (19) antigens characteristic of PV by a Western
blot method (20). Immunoblots were produced by incubating sub-
ject serum with detergent-solubilized normal skin cells or squa-
mous carcinoma cells after electrophoresis in polyacrylamide gel
in the presence of SDS. Two modifications of the method described
previously (20) were introduced to increase sensitivity. Cell extracts
were passed through a Sepharose 4B column previously coupled
to normal human serum to avoid nonspecific binding by serum
proteins and transferred after electrophoresis to PVDF membranes
(Bio-Rad Laboratories, Richmond, CA). The membranes were over-
laid with an IBI enzygraphic web (Eastman Kodak, New Haven,
CT) to detect bound antibody by the peroxidase reaction. Immu-
nobLOTS were performed and interpreted blindly. PV antibody levels
were estimated in all available members of 10 families by 1:5 and
then doubling dilution, and the titer was assigned as the last
immunoblot-positive dilution.

Sera from 74 control healthy individuals who carried [HLA-B38,
SC21, DR4] (n = 8); HLA-B35, SC31, DR4 (n = 10); DR4 in
general (n = 21); HLA-B55, SB45, DR6 (n = 10); DR6 in general
(n = 2); or none of these markers (n = 23) were studied by immu-
noblot in addition to 29 spouses of patients for a total of 103 con-
trol subjects.

Serum samples were also tested for PV antibody by immunoflu-
orescence using rhesus monkey esophagus as substrate (2). By
immunofluorescence, 30 of 31 patient samples were positive. Of 29
spouses of patients or carriers of antibody, three (10%) were posi-
tive for the autoantibody by immunoblot and 2 of 13 (15%) by
immunofluorescence (one of these was also positive by immuno-
blot). Only 7 of 62 (11%) of first-degree relatives' sera were posi-
tive by immunofluorescence, but, of these, six were positive by im-
munoblot. This, coupled with the negativity of one patient sample
by this technique, suggested that immunofluorescence, although
useful for detecting the high levels of antibody in PV patient sera,
was not sensitive enough to regularly detect low levels of antibody
in relatives. On blind specific testing of patients' sera diluted seri-
ally, it appeared that samples with titers below ~700 were some-
times negative and below 200 were usually negative by im-
munofluorescence. Thus, immunofluorescence was one to two
orders of magnitude less sensitive than the immunoblot assay. There-
fore, the presence or absence of PV antibody was assigned by im-
munoblot.

To determine formally whether the presence of the antibody was
MHC linked, linkage analysis (21) was carried out between the
presence of antibody detected by immunoblot and the MHC. One
family, with two antibody-positive spouses, was considered to be
uninformative for linkage. If a patient was heterozygous for HLA-
DR4 or DR6 and some other HLA-DR, the assumption was made
that the antibody was linked to the DR4 or DR6 haplotype and
the family was treated as phase known. Families of patients homozy-

Figure 1. Four families with a proband with PV (filled symbols). Males are shown as squares, females as circles. The two MHC haplotypes of each
person and the presence (positive) or absence (negative) of PV antibody are shown below each symbol. The haplotypes linked to the presence of antibody
are shown in bold. To the right of each family are shown the immunoblots for PV antibody.
analyzed by standard linkage analysis.

Table 1 gives the haplotypes clearly segregating with the presence of antibody in each of 30 families with a PV patient. These are virtually exclusively those with HLA-DR4, DQ8 and DR6, DQ5 that were assumed earlier to be the dominantly expressed susceptibility haplotypes (5, 6). There were four exceptions. Patients 1699 and 1727 carried SC31, HLA-DR4, DQ8 haplotypes on their other chromosomes, and patient 1689 carried HLA-B55, SB45, DR6, DQ5, making the identification of the susceptibility haplotype ambiguous from class II genes or extended haplotypes alone. Only in patient 1749, in whom the antibody-linked haplotype was with DR5 and the guessed susceptibility haplotype was HLA-A26, B35, SC31, DR4, DQ8, was the guess truly incorrect. All the other 24 patient's haplotypes were correctly guessed, and the haplotypes in common listed here are the same as shown previously (5, 6).

Of 29 spouses of patients or carriers of antibody, three (10%) were positive for the autoantibody by immunoblot. One of these was a 91-yr-old man with myasthenia gravis, a condition known to be associated in some patients with the presence of PV antibody (22), and two were in family 1797. Of the latter, one carried HLA-B35, SC31, DR4, and the other carried [HLA-B38, SC21, DR4]. Serum from the latter was also positive for the pemphigus antibody by immunofluorescence assay, as was that of another spouse with no DP-,4 or DR6 haplotype in family 1719. These results suggested that some normal individuals with these haplotypes (and even perhaps some without the haplotypes) but no family history of PV might carry low levels of the PV antibody. However, of the remaining 74 serum samples, including seven with [HLA-B38, SC21, DR4] and nine with HLA-B35, SC31, DR4 from healthy controls, none were positive by immunoblot.

Discussion

In autoimmune diseases characterized by autoantibodies, several genetic factors, including the MHC, in addition to environmental factors, may be important in pathogenesis. However, since the methods for detection of autoantibodies have been neither very sensitive nor highly specific, it had not been possible to study the genetics of autoantibodies and their relationship to the MHC. We have used a very sensitive and specific Western blot assay that can detect 10–100 pg of the anticadherin (pemphigus) autoantibody. By these means,
Table 1. MHC Haplotypes Linked to Antibody in Families

<table>
<thead>
<tr>
<th>Family no.</th>
<th>HLA A</th>
<th>HLA B</th>
<th>HLA Comp.</th>
<th>HLA DR</th>
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Elements of known PV susceptibility haplotypes are underlined. Patients 2006 and 2406 were not reported earlier; all others were reported (5, 6).

* These haplotypes were incorrectly guessed previously (5, 6) to be nonsusceptibility haplotypes; see text.

we found many individuals within families of PV patients who were positive for low levels of the autoantibody. The study demonstrates that the inheritance of this autoantibody is consistent with dominant Mendelian genetics. It has been known from work done by others and by us that there are MHC class II genes that are associated with PV (5, 6, 10, 23–25), but the relationship of these alleles or extended haplotypes to the presence or absence of autoantibody was unknown. The distribution of homozygotes and heterozygotes for HLA-DR4 in Jewish patients with PV was consistent with dominant but not recessive inheritance (5, 6).

Formal linkage analysis provides strong evidence for linkage between the MHC and the presence of PV antibody in relatives’ families with odds of >10^9 to 1 for linkage (10^7 is evidence for linkage at p = 0.05). Supposed recombinants were of two kinds, those in which a bearer of a suspected susceptibility haplotype or an arbitrarily assigned MHC haplotype failed to have the antibody (11/17 of instances), and those in which an offspring who did not inherit that haplotype nevertheless had antibody (6/17). Although both situations could have arisen from recombination between the MHC and the putative immune response gene, other explanations are at least as likely. The first kind of “recombinant” could be due to a failure of penetrance, or to lack of sensitivity of the autoantibody detection method. The unexpected presence of the antibody could be due to lack of specificity of the detection assay (false positivity) or to inheritance of a susceptibility haplotype from the unaffected parent whose antibody response is impenetrant. Nonparenthood (for which we had no evidence) could also confuse the picture.

The current findings redefine the concept of penetrance, at least as it is applied to PV. In the sense of specifying the presence of antibody, penetrance of the MHC susceptibility gene is nearly complete even though penetrance for the disease is much lower. Since multiple cases of PV in the same family are rare, neither the presence of the PV-associated MHC nor low levels of antibody suggest impending disease in an unaffected relative.

There was a significant difference between the amounts or titers of the autoantibody (anticadherin) in the patients and the unaffected relatives. Although PV is a rare disease, the asymptomatic presence of low levels of nondisease-producing PV antibody could be several-fold more common, particularly in subjects who carry the specific MHC haplotypes known to be PV associated. Our findings are consistent with these predictions. Of 103 control subjects enriched in specific susceptibility-type MHC haplotypes, only three individuals who were unrelated members of the nuclear families of PV patients were found to carry low levels of PV antibody. Other individuals with the same extended haplotype without disease, who were from other households, did not have detectable anticadherin autoantibody. One positive elderly man without a specific susceptibility-type haplotype had myasthenia gravis, known to be occasionally associated with PV.
antibody (22). The other two positive individuals were spouses of PV patients or PV antibody carriers and both carried susceptibility-type MHC haplotypes. This raises the question of a common household environmental factor such as a virus being involved in the production of low levels of PV antibody in MHC-susceptible persons. We postulate that either a non-MHC gene or an environmental factor acts occasionally in the individual with low levels of pemphigus antibody to increase production and this results in disease.

Thus, our results suggest that the production of high levels of PV antibody, and thus the disease PV, is a two-step process. The first involves the MHC with or without an environmental factor and leads to the presence of low levels of antibody. The second involves either an environmental factor and/or a non-MHC gene and results in high levels of the antibody.

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