Antinuclear antibodies in the relatives and spouses of patients with systemic sclerosis

P J MADDISON,1 R P SKINNER,1 R S PEREIRA,2 CAROL M BLACK,2 BM ANSELL,3 MALCOLM IV JAYSON,4 NR ROWELL,5 AND KI WELSH6

From the 1Royal National Hospital for Rheumatic Diseases, Bath; the 2Department of Rheumatology, West Middlesex University Hospital, Isleworth; the 3Clinical Research Centre, Harrow; the 4Rheumatic Diseases Centre, University of Manchester, Hope Hospital, Salford; the 5Leeds General Infirmary, Leeds; and the 6Department of Tissue Typing, Guy’s Hospital Medical School, London

SUMMARY  The families of 65 patients with systemic sclerosis were examined clinically and serum samples from each subject were tested for antinuclear antibodies (ANA) by immunofluorescence on HEp2 cells and for precipitating antibodies to soluble cellular antigens including Scl-70. Of 217 blood relatives, 58 (27%) had ANA (42 speckled, 13 nucleolar, one centromere, two homogeneous); 22 (10%) had precipitins, one anti-Scl-70, one anti-PM-Scl, one anti-nRNP, two anti-Ro(SSA), the remainder unidentified. Family members tended to share ANA patterns. Of 38 spouses, nine (24%) had ANA (all speckled) and two showed unidentified precipitins. This compares with an incidence of ANA and precipitins in a control population of 8% and 1% respectively. Antibodies were more common in female than male relatives (particularly in mothers and sisters of probands). Twenty one of the 58 family members with ANA had clinical features of connective tissue disease; the remainder were asymptomatic.

The presence of genetic factors influencing autoimmunity is suggested by the incidence of autoantibodies in first degree relatives. Similar observations in spouses, however, indicate that environmental factors may also have a role in these immune abnormalities.

Systemic sclerosis (SS) is a chronic disease characterised by prominent vascular involvement and progressive fibrosis of various organ systems of the body. The aetiology of SS is unknown, but the disease is characterised by a variety of abnormal serological and cellular immune reactions.1 The presence of antinuclear antibodies (ANA) is particularly common, and when cultured cells are used as the substrate for immunofluorescence tests ANA are found in over 90% of cases.2 Certain antibodies are particularly characteristic of SS, such as antinucleolar and anticentromere antibodies and antibodies to the soluble nuclear antigen Scl-70.2-5

Systemic sclerosis and related connective tissue diseases in family members have been reported,6-20 and in the majority of such kindreds affected members have been first degree relatives of the

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Correspondence to Dr P J Maddison, Consultant Rheumatologist, Royal National Hospital for Rheumatic Diseases, Upper Borough Walls, Bath BA1 1RL.
and spouses were investigated as part of a multicentre family study of systemic sclerosis organised by the UK Systemic Sclerosis Study Group. Patients fulfilled the American Rheumatism Association criteria for SS and were selected only on the basis of having sufficient blood relatives to allow genetic haplotype assignment.

Serum samples were collected at the time of examination of the subject and stored at \(-70^\circ C\) until testing. They were examined without knowledge of the clinical data, together with serum from healthy blood donor controls.

**IMMUNOFUOERESCENCE**
Antinuclear antibodies were examined on a substrate of HEP_2_ cells fixed in acetone using serum diluted in phosphate buffered saline and fluorescein isothiocyanate conjugated goat antihuman polyclonal immunoglobulins (Sigma). The presence of immunofluorescence at a serum dilution of 1:40 was considered to be positive.

**IMMUNODIFFUSION**
Precipitating antibodies to soluble nuclear and cytoplasmic antigens were detected by the Ouchterlony technique as described previously. Reference serum standards were used to detect antibodies to nRNP, Sm, Ro(SSA), La(SSB), Scl-70, Jo-1, and PM-Scl.

**IMMUNOGENETIC STUDIES**
HLA-A, B, C, DR typing was performed by a standard microlymphocytotoxicity method.

Gm allotyping was carried out by red cell agglutination inhibition, using human group O erythrocytes sensitised with anti-rhesus antiserum as indicator cells, except for Gm23, for which a modified method involving direct coupling of myeloma IgG to the erythrocytes was used.

**COMPLEMENT ALLOTYPES**
C4 alleles were established by high voltage electrophoresis of desialated plasma according to the method of Bruun-Petersen et al using both immunofixation and functional testing of electrophoresed samples.

Bf alleles were determined by immunofixation with electrophoresed untreated plasma by a modification of the method of Alper et al, in which the same tris-glycine buffers were used except for the addition of 0.4 g/l calcium lactate in the tank buffer and 0.2 g/l calcium lactate in the gel buffer. The running times for the C4 and Bf electrophoreses were 2.5 h and 1.5 h respectively. The demonstration of a null allele at either the C4A or C4B locus was designated C4Q0.

### Results

**OCCURRENCE OF ANTINUCLEAR ANTIBODIES**
The family members of 65 probands with SS were studied. These included 217 blood relatives and 38 spouses. The demographic features of these subjects are summarised in Table 1.

With HEP_2_ cells as substrate ANA were detected in 93% of sera from probands, 27% from blood relatives, and in 24% from spouses (Fig. 1). This compares with 8% in the healthy controls. Fig. 2 shows that the ANA titres were highest in the patients, intermediate in the relatives, and generally

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**Table 1 Demographic features of 65 probands with SS, 217 blood relatives, and 38 spouses**

<table>
<thead>
<tr>
<th>Subjects studied</th>
<th>Age in years (mean and range)</th>
<th>Nos female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with systemic sclerosis (n=65):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34% with diffuse scleroderma</td>
<td>43 (13–73)</td>
<td>58</td>
</tr>
<tr>
<td>40% with acrodermatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26% with CREST*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relatives (n=217):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 mothers</td>
<td>63 (37–81)</td>
<td></td>
</tr>
<tr>
<td>45 sisters</td>
<td>38 (6–69)</td>
<td></td>
</tr>
<tr>
<td>34 daughters</td>
<td>27 (9–51)</td>
<td></td>
</tr>
<tr>
<td>107 other relatives</td>
<td>38 (4–82)</td>
<td>4</td>
</tr>
<tr>
<td>Spouses (n=38)</td>
<td>49 (29–73)</td>
<td>3</td>
</tr>
</tbody>
</table>

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*CREST = calcinosis, Raynaud’s phenomenon, oesophageal dysmotility, sclerodactyly, telangiectasia.

Fig. 1 Frequency of ANA in patients, relatives, spouses, and controls using HEP_2_ cells.
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Fig. 2. ANA titres in the ANA positive serum samples.

Table 2. Patterns of nuclear immunofluorescence on HEp2 cells observed in patients with SS, relatives, and spouses and in ANA positive healthy controls

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Probands (n=60)</th>
<th>Relatives (n=58)</th>
<th>Spouses (n=9)</th>
<th>Controls (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diffuse speckled</td>
<td>29 (48%)</td>
<td>42 (72%)</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Nucleolar</td>
<td>18 (30%)</td>
<td>13 (22%)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Centromere</td>
<td>12 (20%)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homogeneous</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Frequency of precipitating antibodies to soluble cellular antigens in patients with SS, relatives, spouses, and healthy controls using immunodiffusion

<table>
<thead>
<tr>
<th></th>
<th>Total (%)</th>
<th>Anti-Scl-70 (%)</th>
<th>Anti-PM-Scl (%)</th>
<th>Anti-nRNP (%)</th>
<th>Anti-Ro(SSA) (%)</th>
<th>Unidentified antibodies (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probands</td>
<td>57</td>
<td>17</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>29</td>
</tr>
<tr>
<td>Relatives</td>
<td>10</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>1</td>
<td>7.5</td>
</tr>
<tr>
<td>Spouses</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Controls</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

low in the ANA positive spouses and healthy controls. Table 2 summarises the patterns of immunofluorescence in the ANA positive sera. Antibodies characteristically found in systemic sclerosis were identified in the sera of blood relatives, especially antinucleolar antibodies, which were present in 22%. In one case anticentromere antibodies were present. Although ANA were more commonly found in spouses of patients than in healthy controls, they were generally of low titre and showed a non-specific speckled pattern of fluorescence.

The frequency and specificity of antibodies to soluble non-histone tissue antigens are summarised in Table 3. Antibodies were detected by immunodiffusion in 57% of the probands, 10% of the blood relatives, and 5% of the spouses, which compares with the incidence of 1% in the healthy controls. These antibodies were detected to a variety of cellular constituents in the tissue extracts, and in many cases they did not correspond to the reference sera and still remain uncharacterised. As expected, antibodies to Scl-70 represented the most commonly identified precipitin system in the probands and were present in 17% of cases. In two instances antibodies with a high degree of specificity for systemic sclerosis were detected in relatives, anti-
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Scl-70 in one case who also developed SS, and antibodies to the PM-Scl system in the other.

ANTINUCLEAR ANTIBODIES IN FAMILY MEMBERS
As shown in Table 4 ANA were more commonly found in female than in male relatives \( (\chi^2=5.26; p<0.02) \) and were most commonly found in the mothers and sisters of the probands \( (\chi^2=8.53; p<0.005) \). In female relatives the frequency of ANA was uninfluenced by age (Fig. 3), but in men the highest frequency was found in relatives older than 60 years.

In 23 of the 35 families where there were ANA positive cases among relatives the ANA specificity was shared among the family members. Two examples are shown in Fig. 4. In family A father and daughter shared antibodies to Scl-70 and both had SS with diffuse scleroderma. This was the only example of a multiple case family seen in this study. In family B two relatives and the proband had antinucleolar antibodies. In the remaining families probands and ANA positive relatives showed different ANA specificities, and two examples are illustrated in Fig. 5.

Family members were screened clinically at the time the blood samples were taken. Details of this clinical examination will be reported in detail elsewhere. Table 5 shows that ANA positive

Table 4 Frequency of ANA in relatives of patients with SS

<table>
<thead>
<tr>
<th>Relation</th>
<th>Positive ANA (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother (n=31)</td>
<td>39</td>
</tr>
<tr>
<td>Sister (n=45)</td>
<td>38</td>
</tr>
<tr>
<td>Daughter (n=34)</td>
<td>20</td>
</tr>
<tr>
<td>Other female (n=4)</td>
<td>25</td>
</tr>
<tr>
<td>Male (n=103)</td>
<td>21</td>
</tr>
</tbody>
</table>

Table 5 Features of connective tissue disease in relatives of patients with SS

<table>
<thead>
<tr>
<th>Relation</th>
<th>Number with diagnosed CTD</th>
<th>Number with symptoms of CTD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives with positive ANA (n=58)</td>
<td>4*</td>
<td>17</td>
<td>21 (36%)</td>
</tr>
<tr>
<td>Relatives with negative ANA (n=159)</td>
<td>2†</td>
<td>18</td>
<td>20 (12%)</td>
</tr>
</tbody>
</table>

*Two with RA; one with SLE; one with progressive systemic sclerosis. †Two with RA.

Fig. 3 Frequency of ANA in male and female relatives of different age groups. Those with positive ANA are indicated by the cross hatching.
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relatives more commonly had either a full blown connective tissue disease or clinical features of a connective tissue disease (CTD), predominantly arthralgias or arthritis and Raynaud's phenomenon.

**Antinuclear antibodies in spouses**
ANA were detected in the serum of nine of the 38 spouses. All were men with a mean age of 49. Information concerning the duration of marriage was available in 26 cases, and in the great majority marriage took place before the onset of disease in the proband and the couple had lived together throughout the course of the disease. In this respect there were no obvious differences between those spouses who had ANA (six cases) and those who did not (20 cases). Information of this sort was not obtained from the other 12 cases.

**Immunogenetic associations**
Twenty one patients and 120 blood relatives have so

![Diagram](http://ard.bmj.com/)

**Fig. 4** Two families showing concordance of ANA specificity among family members.

![Diagram](http://ard.bmj.com/)

**Fig. 5** Two families in which family members show different ANA specificities.
Table 6  Association of ANA in first degree relatives with HLA-DRS and C4Q0

<table>
<thead>
<tr>
<th>Subjects</th>
<th>No with DR5 or C4Q0, or both</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANA positive relatives</td>
<td>34 (94%)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>(n=36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANA negative relatives</td>
<td>56 (67%)</td>
<td></td>
</tr>
<tr>
<td>(n=84)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

far been fully HLA typed. The results will be reported in detail elsewhere. ANA positivity was shown to have a significant association with C4Q0 and DR5 (Table 6). Of 36 relatives with a positive ANA, 34 were either DR5 or had a null allele at the C4 locus. When compared with the incidence of these markers in the ANA negative relatives (56 out of 84) this result is significant at the p<0.01 level.

Discussion

Although families with multiple cases of systemic sclerosis are uncommon, genetic factors have been implicated in this disease by a number of studies of immunogenetic markers in patients with SS. 24-27 There appears to be an association with the HLA haplotype A1, B8, DR3 and more particularly with the linked complement allele C4A*Q0 (unpublished data). Furthermore, the HLA antigens DR1 and DR5 seem to be associated with the CREST variant of the disease. 27, 34

In this study an increased frequency of ANA was shown in the sera from relatives of patients with SS. This finding supports the concept that a familial background of immunological abnormalities may contribute to the development of SS. Fennell et al were the first to describe this observation, 22 which has now been repeated on a number of occasions, 9, 19, 20, 23 though in most reports numbers of individuals studied have been small or families selected with multiple SS cases. Using a sensitive ANA test with HEp2 cells as substrate we found the frequency of ANA in relatives to be 27%. Furthermore we also took the opportunity to study ANA specificity. Antinucleolar antibodies, characteristically found in high titre in patients with SS, were quite commonly found in blood relatives but usually in moderate or low titres. Other autoantibodies with a high degree of specificity for SS were only rarely found in family members. The only relative with anti-Scl-70 in fact developed SS with diffuse scleroderma, but the two relatives with anticientromere antibodies and anti-PM-Scl respectively are as yet asymptomatic. Since it is our impression from this study that these antibodies are closely linked to the development of SS, time will tell whether or not these two relatives will develop symptoms.

The increased frequency of ANA in female relatives may be linked to the female preponderance in SS and other CTD. A role for constitutional factors in influencing the development of autoimmune abnormalities and in the disease itself is strengthened by the preliminary findings of HLA analysis in this family study.

The demonstration of familial aggregation of clinical and serological features of CTD helps to support the concept of genetic influences but in no way excludes the importance of environmental factors. In SS the influence of environmental factors is quite unknown, with the exception of scleroderma-like disorders induced by vinyl chloride 35 and contaminated rape seed oil. 36 A recent report of PSS in husband and wife 37 reopens the question of the relative contribution of genetic and environmental factors in this disease. Our observation of an increased frequency of ANA in spouses, albeit of low titre, suggests that environmental factors may indeed have a role in this autoimmune response. It must be noted that the controls for this study were blood donor controls and details of age and sex are not available. It is probable that the controls are younger than the spouses (mean age 49) and although it is unlikely that this accounts for the increased frequency of positive ANA tests, this possibility needs to be considered. Similar findings are well known in non-consanguineous relatives of patients with SLE, who show an increased frequency of ANA, antibodies to polynucleotides, and antilymphocytic antibodies, 38-40 suggesting the possibility of a transmissible agent. Further prospective studies of spouses of patients with SS may furnish clues to the presence of a similarly transmissible agent in this disease.

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References

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