Gm allotypes and HLA in rheumatoid arthritis patients with circulating antibodies to native type II collagen

P A SANDERS,1 D M GRENNAN,1 P S KLIMIUK,1 R B CLAGUE,2 G G deLANGE,3 I COLLINS,2 P A DYER4

From the 1University of Manchester Rheumatic Diseases Centre, Hope Hospital, Salford; the 2Department of Rheumatology, Withington Hospital, Manchester; the 3Central Laboratory of the Netherlands Red Cross Blood Transfusion Service, Amsterdam; and the 4Tissue Typing Laboratory, St Mary’s Hospital, Manchester

SUMMARY  HLA antigens and immunoglobulin heavy chain allotypes (Gm) were determined in 166 unrelated patients with rheumatoid arthritis (RA), 44 of whom had circulating antibodies to native type II collagen. Collagen antibody positive patients showed an association with HLA-DR3 and DR7 (68% compared with 39% of collagen antibody negative RA, p<0.005), and with the Gm phenotype, Gm(zafngb). This contrasted with the collagen antibody negative RA patients where there was an association with HLA-DR4 and, in DR4 positive disease only, with the Gm allotype, G1m(x). The Gm(zafngb) phenotype was found in 26% of DR3 or DR7 positive patients overall and only 9% of RA patients negative for these DR antigens (p<0.005), suggesting an interaction between HLA-DR3/7 and Gm(zafngb). The differing Gm associations for collagen antibody positive and negative RA provide further evidence for genetic heterogeneity in susceptibility to RA.

Key words: immunoglobulin heavy chain genes, interaction, immunogenetics, heterogeneity of rheumatoid arthritis.

RA is thought to be caused by a combination of genetic and environmental factors. There is a well recorded association between RA and HLA-DR4 in most populations studied and a weaker association between RA and the immunoglobulin heavy chain constant region allotype, G1m(x), in DR4 positive disease only, suggesting that genes linked to HLA on chromosome 6 and to Gm on chromosome 14 may interact in disease predisposition.

A subgroup of patients with RA accounting for about 11% of RA patients seen in hospital has been shown to have circulating antibodies to native type II collagen and shows an association with HLA-DR3 or DR7 rather than DR4. Apart from a decreased frequency of seropositivity for rheumatoid factor and a later age of disease onset these patients are clinically indistinguishable from those with collagen antibody negative RA. It is uncertain what part the collagen antibodies play in the pathogenesis of this form of RA. Native type II collagen is the major type of collagen in articular cartilage, and immunisation of rats and mice with native type II collagen induces a polyarthritis and an immune response. The results of a single study suggest that the Gm as well as the HLA associations may differ in collagen antibody positive and negative RA.

The aim of this study therefore was to reinvestigate the relation between RA and Gm in a larger group of patients who had been tested for the presence of circulating antibodies to native type II collagen and to look for evidence of an interaction between HLA and Gm in this disease subset.

Patients and methods

One hundred and sixty six patients with classical or definite RA (by American Rheumatism Association criteria) were studied. These were all unrelated Caucasians and were attending rheumatology outpatient clinics at Manchester Royal Infirmary.
were measured either by radioimmunoassay or an enzyme method of each antibody. Significant deviations from normal were considered to be positive.

Laboratory Methods
Serum antibody levels to native type II collagen were measured either by a specific solid phase radioimmunoassay (MRI patients) or by an enzyme linked immunosorbent assay method (Hope patients) developed from this technique. The normal range was calculated using 15 normal sera with each batch tested (these results did not differ significantly from those obtained using a larger group of 100 normal sera). Results greater than two standard deviations above the mean were considered to be positive.

HLA typing was carried out for A and B antigens using standard National Institute of Health methods. HLA-DR typing was carried out using B lymphocytes isolated by their adherence to nylon wool columns. All antisera were obtained locally or through mutual exchange with other laboratories and characterised using cell panels typed with international histocompatibility antisera.

Gm and Km allotyping was performed by the technique of haemagglutination inhibition. The following allotypes were recognised: G1m(z, a, x, f), G2m(n), G3m(b0, b1, b3, b5, g, s, t, c3, c5), Km(1) and (3). G3m (b0, b1, b3, and b5) always occurred together and are henceforth referred to simply as G3m(b).

Statistics
Results were analysed using a \( \chi^2 \) test or Fisher’s exact test.

<table>
<thead>
<tr>
<th>Gm phenotype</th>
<th>Collagen antibody positive RA (n=44)</th>
<th>Collagen antibody negative RA (n=122)</th>
<th>Controls (n=101)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
</tr>
<tr>
<td>fnb</td>
<td>11</td>
<td>25.0</td>
<td>46</td>
</tr>
<tr>
<td>fb</td>
<td>3</td>
<td>6.8</td>
<td>10</td>
</tr>
<tr>
<td>zaxg</td>
<td>1</td>
<td>2.3</td>
<td>8</td>
</tr>
<tr>
<td>zaxgfnb</td>
<td>5</td>
<td>11.4</td>
<td>11</td>
</tr>
<tr>
<td>zaxfb</td>
<td>2</td>
<td>4.5</td>
<td>6</td>
</tr>
<tr>
<td>zafngb</td>
<td>14*</td>
<td>31.8</td>
<td>17*</td>
</tr>
<tr>
<td>zafgb</td>
<td>5</td>
<td>11.4</td>
<td>15</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>2.9</td>
<td>4</td>
</tr>
</tbody>
</table>

*\( \chi^2 = 6.810, p=0.0093 \) (see text).

Results
Table 1 shows the distribution of Gm phenotypes in collagen antibody positive and negative patient groups and in controls. The Gm(zafngb) phenotype was increased in the collagen antibody positive RA patients compared with collagen antibody negative RA (\( p=0.0093 \)). As the phenotype Gm([z]afgb) has been previously reported to be associated with collagen antibody positive RA in a study in which the G2m(n) allotype was not tested for, there is a priori evidence to suggest that phenotypes Gm(zafngb) or Gm(zafgb) may be implicated in this type of RA so that the p value need not be corrected for the total number of phenotypes compared. Table 2 shows the distribution of Gm and Km allotypes in the two patient groups and controls. There were no significant differences in frequency between the groups for Gm allotypes. Km(1) was increased in the collagen antibody negative RA group compared with the controls, but the difference did not reach statistical significance after correction of the p value (which is necessary as there

<table>
<thead>
<tr>
<th>Gm/Km allotype</th>
<th>Collagen antibody positive RA (%) (n=44)</th>
<th>Collagen antibody negative RA (%) (n=122)</th>
<th>Controls (%) (n=101)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1m(f)</td>
<td>90-9</td>
<td>88-5</td>
<td>89-1</td>
</tr>
<tr>
<td>G1m(z)</td>
<td>68-2</td>
<td>54-1</td>
<td>60-4</td>
</tr>
<tr>
<td>G1m(x)</td>
<td>18-2</td>
<td>22-1</td>
<td>21-8</td>
</tr>
<tr>
<td>G2m(n)</td>
<td>68-2</td>
<td>63-1</td>
<td>65-3</td>
</tr>
<tr>
<td>Km(1)</td>
<td>13-6</td>
<td>20-5*</td>
<td>9-9*</td>
</tr>
</tbody>
</table>

*\( \chi^2 = 4.681, p=0.031, p_c = 0.062 \) (see text).
Table 3  HLA-DR4, HLA-DR3/7, and Gm(zafngb) in patients with RA and controls

<table>
<thead>
<tr>
<th>HLA/Gm</th>
<th>Collagen antibody positive RA</th>
<th>Collagen antibody negative RA</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
</tr>
<tr>
<td>DR3 or DR7*</td>
<td>28/41</td>
<td>68.3</td>
<td>44/113</td>
</tr>
<tr>
<td>DR4*</td>
<td>19/41</td>
<td>46.3</td>
<td>71/113</td>
</tr>
<tr>
<td>Gm(zafngb)</td>
<td>14/44</td>
<td>31.8</td>
<td>17/113</td>
</tr>
<tr>
<td>DR3/7+Gm(zafngb)†</td>
<td>10/41</td>
<td>24.4</td>
<td>9/113</td>
</tr>
<tr>
<td>DR4+G1m(x)§</td>
<td>3/41</td>
<td>7.3</td>
<td>19/113</td>
</tr>
</tbody>
</table>

*Collagen antibody positive RA v antibody negative RA, \( \chi^2 = 10.411, p < 0.005 \).
†Collagen antibody negative RA v controls, \( \chi^2 = 21.084, p < 0.005 \).
‡Collagen antibody positive RA v antibody negative RA, \( \chi^2 = 7.50, p < 0.01 \).
§Collagen antibody positive RA v controls, \( \chi^2 = 5.98, p < 0.025 \).

is no a priori association of RA with Km allotypes.

In Table 3 we examine the possibility of an interaction between HLA and Gm in collagen antibody positive RA and show the relative frequencies of HLA-DR4, DR3, and DR7 in the patient groups. As expected there was a strong association between collagen antibody negative RA and HLA-DR4 and as previously shown an association between RA and Gm(zafngb) bearing haplotypes in DR4 positive disease only. 3 The collagen antibody positive subgroup was significantly associated with HLA-DR3 or 7, or both. The combination of DR3 or 7 with the Gm(zafngb) phenotype was significantly increased in the collagen antibody positive compared with collagen antibody negative patients and controls.

In Table 4 we consider the relative risks for HLA and Gm linked markers found in association with the respective patient groups. The relative risks for HLA-DR3/7, Gm(zafngb), and the combination of these markers were significantly higher in the collagen antibody positive than in the collagen antibody negative RA group. Although there are trends with this method of analysis for interactions between HLA-DR3/7 and the Gm(zafngb) phenotype or G1m(x) allotype in collagen antibody positive and negative RA groups respectively, the 95% confidence limits for the combinations of markers overlapped with those for HLA and Gm linked markers alone.

In the above search for an interaction between HLA and Gm the numbers of collagen antibody positive patients were relatively small. In Table 5, therefore, we have looked for evidence of an interaction between HLA-DR3/7 and the Gm(zafngb) phenotype in the RA population overall and irrespective of collagen antibody status. As shown there was a statistically significant increase in frequency of this Gm phenotype in DR3 and DR7 positive RA patients.

Discussion

In previous studies a subgroup of patients with RA characterised by persisting antibodies to native type II collagen was shown to have an HLA association with HLA-DR3 or DR7 rather than with HLA-DR4, the DR antigen associated with RA patients overall. 4, 5 The antigens HLA-DR3 and DR7 are in very strong linkage disequilibrium with DQw2. It is

\[ \chi^2 = 8.706, p < 0.005. \]
therefore possible that DQw2 is a better HLA marker for this subset of rheumatoid patients rather than the DR antigens themselves. In the present study we have shown that collagen antibody positive and negative RA subgroups also have different Gm associations, and these findings are in keeping with those of a previous study of Gm in collagen antibody positive RA. These differing associations for HLA and Gm markers in different RA subgroups add further evidence to a growing concept of genetic heterogeneity in susceptibility to RA (unpublished data).

Previous evidence for an interaction between HLA and Gm linked genes has been provided by the demonstration of an increased frequency of the Gm allotype, G1m(x), in DR4 positive but not DR4 negative RA. In the present study there is a trend for a comparable interaction between genes in linkage disequilibrium with HLA-DR3/7 and Gm in the collagen antibody positive RA subgroup, and this interaction appears statistically significant irrespective of collagen antibody status when the 154 patients typed for HLA and Gm overall are analysed. (This group, however, contained a high percentage of collagen antibody positive patients, and we would not expect to find evidence for an interaction between these HLA and Gm markers in an unselected RA population.) The evidence for an interaction between HLA and Gm linked genes predisposing to RA is in keeping with the findings of previous studies showing that HLA and Gm may interact in influencing humoral responsiveness to bacterial antigens as well as in predisposing to other autoimmune disorders such as chronic active hepatitis and systemic lupus erythematosus.

How 14th and 6th chromosomal genes interact is unknown. One mechanism suggested by a study of collagen induced arthritis in mice is that major histocompatibility complex (MHC) linked genes may regulate the level of overall immunoglobulin synthesis but that non-MHC linked genes (possibly immunoglobulin heavy chain genes) may determine the proportion of this response devoted to a particular autoantibody. The site of the RA susceptibility gene(s) on the 14th chromosome is similarly uncertain and could be accounted for by immunoglobulin heavy chain constant region genes themselves or by linked V region genes which map telomeric to those for the immunoglobulin constant region on chromosome 14.

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References


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