Distribution of the HindIII restriction fragment length polymorphism among patients with systemic lupus erythematosus with different concentrations of CR1

Hironobu Satoh, Eisuke Yokota, Kunihiro Tokiyama, Tatsuo Kawaguchi, Yoshiyuki Niho

Abstract
Sixty six patients with systemic lupus erythematosus (SLE) were genotyped using a HindIII restriction fragment length polymorphism (RFLP) identified by CR1 C DNA, then were followed up for an average of 50 months to evaluate the stability of their CR1 activities. The gene frequencies for the two alleles which correlate with the numeric expression of CR1 on the erythrocytes were not significantly different between 66 patients with SLE and 52 normal controls. A discrepancy between homozygosity for a high allele and a negative CR1 activity was found in many patients. These patients, however, had significantly lower concentrations of serum complement than did patients with a positive CR1, and some were in an active state of the disease. Furthermore, there were several patients in whom the CR1 activities changed from negative to positive together with an increase in serum complement. Our results suggest that the decreased expression of CR1 on erythrocytes in patients with SLE is not inherited, rather it is a consequence of the disease processes.

The human receptor for complement fragments C3b and C4b (complement receptor type 1: CR1, CD35) is expressed on a variety of blood and tissue cells.1-5 Despite the low number of CR1 per erythrocyte, these cells carry on their surfaces more than 90% of the circulation pool, because they are present in large numbers compared with other circulating cells.1 Recent evidence suggests that CR1 plays an important role in the processing and clearance of circulating immune complexes.6-8 Thus CR1 on the erythrocytes may protect against diseases mediated by deposition of circulating immune complexes.

Patients with systemic lupus erythematosus (SLE) were found to have reduced numbers of CR1 on erythrocytes. It remains controversial, however, whether the decreased expression is linked to inherited9-13 or to acquired factors.14-20 A quantitative polymorphism of CR1 on erythrocytes was also noted in a normal group, and initial family studies suggested that this event was controlled by an autosomal locus with two codominant alleles.10 Wilson et al22 discovered a HindIII restriction fragment length polymorphism (RFLP) identified by a partial complementary DNA (cDNA) of the CR1 molecule (called CR1.1), which correlates with the number of CR1 on normal erythrocytes—the 7.4 kb and 6.9 kb bands corresponding to high and low expression respectively. This approach makes feasible determination of whether or not the CR1 deficiency in patients with SLE is linked to these genotypes.

In a previous study we discussed the defective CR1 in patients with SLE as the genetic factor because of their stability during over two years' follow up.22 We have followed up these same patients for an additional three to five years and, using Southern blot analysis, examined the relation between genotype and phenotypic data.

Patients and methods
STUDY GROUP
Sixty six unselected Japanese patients with SLE, from a previous study,22 who were receiving continuous care in the clinic of the first department of internal medicine of Kyushu University, were studied between July 1984 and March 1989. The diagnosis of SLE was based on the revised criteria of the American Rheumatism Association.23 They were classified as having active disease if one or more of the following were present: rash, fever, arthritis, alopecia, serositis, glomerulonephritis, and central nervous system lupus, and/or two or more laboratory test results were abnormal, such as blood cell count, serum complement, anti-DNA antibody, immune complex, and erythrocyte sedimentation rate. Hypocomplementaemia was defined as a decrease in CH50 and either C3 or C4.

IMMUNE-ADHERENCE HAEMAGGLUTINATION
The CR1 concentrations were measured every month by immune adherence haemagglutination.22 Erythrocytes obtained from EDTA treated blood were suspended in gelatin-veronal buffer. Human IgG was prepared from pooled serum samples by salt precipitation and chromatography on diethylaminoethyl-cellulose. A solution of IgG in phosphate buffered saline (10 mg/ml) was heated at 65°C for 30 minutes. After centrifugation at 15 000 g for 15 minutes the supernatant was used as the aggregated human γ globulin. Serial twofold dilutions of aggregated human γ globulin starting from 100 μg/ml were prepared in gelatin-veronal buffer in a polystyrene U bottomed microtitre plate. Complement was prepared by dilution of guinea pig serum in gelatin-veronal buffer containing 3
CH50 U/ml, 25 μl of which was added to each well. The plate was incubated at 37°C for 45 minutes. Thereafter, 25 μl of dithiothreitol solution (3 mg/ml) was added to protect the generated C3b sites from decay. Subsequently, 25 μl of erythrocytes (2×10⁶ cells/ml in EDTA-gelatin-veronal buffer) suspension was transferred to each well and the plate was incubated at 24°C for a further 60 minutes. When the haemagglutination exceeded 25 dilution a positive value was recorded.

SOUTHERN BLOT ANALYSIS OF GENOMIC DNA DNA was obtained from peripheral white blood cells by sodium dodecyl sulphate-protease K digestion, followed by phenol-chloroform extraction. Then the DNA was digested with HindIII restriction enzyme (Nippon Gene, Tokyo) at a concentration of 3 U/μg DNA. The DNA fragments were separated according to size by electrophoresis in 0.7% agarose gels and transferred to a nylon membrane (Zeta-probe: Bio-rad, Richmond, CA), by the method of Southern. Prehybridisation and hybridisation were carried out, at 42°C in the presence of 50% formamide, according to the manufacturer's instructions. A 0.79 kb EcoRI insert from pBR327 plasmid called CR1.1, which is related to the CR1 gene, was used as the probe and was labelled with α-(32P)-dCTP by multiprime DNA labelling systems (Amersham Japan, Tokyo). After hybridisation the filters were washed under stringent conditions at 65°C. Autoradiography was performed at ~70°C with a Kodak XAR-5 film.

LABORATORY ASSESSMENT Complement activity (CH50) was assessed by a modification of Mayer's method. Serum C3 and C4 were determined by single radial immunodiffusion until August 1987, and after that by laser nephelometry. Anti-DNA antibody was measured by radioimmunoassay and immune complex was measured by a C1q binding enzyme linked immunosorbent assay (ELISA).

STATISTICAL ANALYSIS Variables were compared by χ² test or Student's t test.

Results HindIII RFLP PATTERN IN PATIENTS WITH SLE AND CONTROLS A CR1 cDNA probe was used to study the HindIII RFLP in 66 patients with SLE and in 52 normal controls. As reported previously, 21 polymorphic bands at 7-4 kb and 6-9 kb were obtained. Among 66 patients with SLE, 40 had only the 7-4 kb band, three had only the 6-9 kb band, and 23 patients were heterozygous for the 7-4 kb and 6-9 kb bands. The gene frequencies were 0.78 for the 7-4 kb and 0.22 for the 6-9 kb band and did not differ significantly from findings in the unselected control group (table 1).

CHANGES IN CR1 CONCENTRATIONS IN PATIENTS WITH SLE DURING LONG TERM FOLLOW UP CR1 concentrations on erythrocytes from 66 patients with SLE were examined by immune-adherence haemagglutination for 35 to 55 months. At the initial study no CR1 activity was evident in 56 patients. Among these 56 patients, 38 were persistently negative. The CR1 activity varied in 18 patients during the follow up and eight became constantly positive. On the other hand, among 10 patients with positive CR1 at the initial study, three became negative, but seven patients were persistently positive.

Table 1 Distribution of the HindIII restriction fragment length polymorphism (RFLP) among patients with systemic lupus erythematosus (SLE) and normal subjects

<table>
<thead>
<tr>
<th>Subjects</th>
<th>HindIII RFLP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7-4/7-4 kb</td>
<td>7-4/6-9 kb</td>
</tr>
<tr>
<td>SLE</td>
<td>40</td>
<td>25</td>
</tr>
<tr>
<td>Normal</td>
<td>34</td>
<td>15</td>
</tr>
</tbody>
</table>

Gene frequencies did not differ significantly (p>0.5).

DISTRIBUTION OF HindIII RFLP AMONG PATIENTS WITH SLE WITH DIFFERENT CR1 CONCENTRATIONS Table 2 shows the relation between CR1 concentrations and the HindIII RFLP patterns in the patients with SLE. Three patients with only the 6-9 kb band showed a persistently negative CR1 and the seven with a persistently positive CR1 were all homozygous for the 7-4 kb band. For the other 56 patients, however, there was a discrepancy between CR1 concentrations and RFLP patterns.

RELATION BETWEEN CR1 CONCENTRATIONS AND DISEASE ACTIVITIES To evaluate the existence of acquired factors which influence CR1 concentrations we examined the patients with SLE who only had the 7-4 kb bands and separated them into three groups based on CR1 activity (group I: persistently negative, group II: varied, group III: persistently positive). Eight patients in group II with frequently changing CR1 concentrations were excluded from analysis.

In group I 13 patients had episodes of active disease, but they had a negative CR1 even during the inactive state. The other five were inactive during follow up. In group II changes in CR1 concentrations accompanied by remission were evident in only one patient. The other six were inactive and the CR1 changed from negative to positive but with no change in the disease activities. All seven patients in group III were inactive during follow up.

Table 2 Distribution of the HindIII restriction fragment length polymorphism (RFLP) among patients with systemic lupus erythematosus with different CR1 activity

<table>
<thead>
<tr>
<th>CR1 activity</th>
<th>HindIII RFLP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7-4/7-4 kb</td>
<td>7-4/6-9 kb</td>
</tr>
<tr>
<td>Persistently negative</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Varied</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>Persistently positive</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>23</td>
</tr>
</tbody>
</table>
RELATION BETWEEN THE CRI CONCENTRATIONS AND SERUM COMPLEMENT

The figure shows serum complement concentrations in these three groups at the initial and follow-up study. At the initial study (A) the mean value of CH50 in group II with a negative CRI at that time was 30 (SD 10) U/ml, a value close to the 29 (9) U/ml in group I and significantly different from the 45 (8) U/ml in group III (p<0.01). Similarly, the mean (SD) value of C4 in group II was 270 (110) mg/l, a value similar to the 260 (150) mg/l in group I and significantly different from the 490 (140) mg/l in group III (p<0.01). In contrast, at the follow-up study (B) the mean value of CH50 in group II with a positive CRI at that time was 36 (4) U/ml—that is, significantly different from the 28 (7) U/ml in group I (p<0.02) but similar to the 40 (10) U/ml in group III. Similarly, the mean value of C4 in group II was 220 (40) mg/l, which significantly differed from the 140 (50) mg/l in group I (p<0.001) and was similar to the 220 (50) mg/l in group III.

The mean value of C3 was significantly different between groups I and III in both studies, but values in group II were not statistically different from those for each group.

Discussion

In this study we investigated the distribution of RFLPs, which correlate with the numeric expression of CRI, on erythrocytes from 66 Japanese patients with SLE, using the CRI1 cDNA probe and HindIII restriction enzyme. Wilson et al first reported a smaller proportion homozygous for the 7-4 kb band among patients with SLE and their relatives than in controls. Moldenhauer et al and Cohen et al, however, reported no difference between them. As table 1 shows that the frequencies of each genotype did not differ significantly between patients with SLE and normal controls.

Cohen et al also suggested that homozygosity of the 6-9 kb band could be a protective genetic factor for SLE. The data pooled from these studies indicate that only one of the 132 patients with SLE showed homozygosity of the 6-9 kb band. Among our patients, however, we found this genotype in three of 66 patients with SLE and in three of 52 normal controls. Although the gene frequencies of each band did not differ among these reports, ethnic differences may play some part.

Correlations between the erythrocyte CRI numbers and immunological indices such as serum complement, antibody to DNA, and circulating immune complex were examined, but these results were also controversial perhaps because the genotype had not been taken into account. In those of our patients homozygous for the 7-4 kb allele it was noteworthy that all subjects with active disease were among those with a negative CRI. There were patients homozygous for the 7-4 kb allele who had negative CRI, however, despite their inactive state. As shown in the figure the concentration of serum complements in patients with a negative CRI was significantly lower than those in patients with a positive CRI, and in group II, the change in CRI from negative to positive was accompanied by an increase in serum complement. The existence of potential complement activation has been described even in patients with SLE in clinical remission.
persistent hypocomplementaemia in patients with inactive SLE. The erythrocyte CR1 may have a functional role in the removal of circulating immune complexes and this process would depend on complement consumption. Therefore, even if the genotypes are homozygous for the 7 kb allele, the CR1 activities may be negative as long as immunological disorders remain and the complement concentrations are low.

In conclusion, our results support the notion that a decreased CR1 expression on erythrocytes in patients with SLE is not inherited, rather it is the consequence of the disease process.

The 0.79 kb EcoRI insert from pBR327 called CR1.1 was a gift from the American Type Culture Collection. We thank Mrs Ohara for her valuable advice on the preparation of this manuscript.


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