Analysis of T cell receptor V alpha polymorphisms in rheumatoid arthritis

Mark Iberson, Véronique Péclat, Pierre-Andre Guerne, Jean-Marie Tiercy, Paul Wordsworth, Jerry Lanchbury, Jeremy Camilleri, Alex K So

Abstract

Objective—To test for association of T cell receptor (TCR) V alpha polymorphisms and rheumatoid arthritis (RA) in British and Swiss white populations.

Methods—TCRAV polymorphisms were analysed in RA patients and controls by single strand conformational polymorphism (SSCP) analysis. Associations were sought between defined genotypes and RA, and the effect of HLA-DR4 status analysed. Putative associations were then retested further in new groups of patients and controls. Overall, 360 RA patients and 197 controls were studied.

Results—No association between TCRAV5S1, 6S1, 8S1, 17S1 or 21S1 polymorphisms and RA were observed in the initial population screened. Stratification for DR4 status showed an increase of V5S1*01/*01 in DR4 positive RA, and none of which showed significant increase of V5S1*01/*01 in DR4 positive patients, although an overall trend towards an increase in V5S1*01/*01 was observed.

Conclusion—No evidence was found for a strong association of TCRAV genes and RA in a white population. However, these results suggest a weak association of V5S1*01/*01 with DR4 positive RA, although this requires confirmation using larger groups of patients and controls.

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Both environmental and genetic factors contribute to the pathogenesis of rheumatoid arthritis (RA). Multiple genes are probably involved in determining susceptibility, the most clearly established being genes on chromosome 6, in the major histocompatibility complex HLA-DR region.1 Data from family and twin studies have estimated that the HLA component of heritability is approximately 40%, whereas the remaining 60% is caused by as yet unidentified genes.2 Efforts to identify these other genes can broadly be grouped into three approaches: by looking for linkage with candidate genes, by seeking genetic linkage on a genome wide basis, or by seeking association with candidate genes in a population study.

Using the candidate gene approach, associations between RA and genes encoded by the TCR loci is conceptually attractive, as the products of TCR genes function as receptors for peptide antigens bound to MHC molecules. The V regions of the TCR molecules interact directly with peptide fragments bound to the MHC, and variations in the V sequence can affect T cell specificity.3 Although the major source of variation of the TCR repertoire resides in recombinatorial diversity, differences in germ line TCR genes can also influence the repertoire.4–7

Recent studies of the TCR A locus have indicated that a number of the V gene subgroups are polymorphic,8–9 and may be useful markers for disease studies. We have investigated the genetic contribution of TCRAV genes to RA by examining the distribution of five known TCRAV polymorphisms in north European white RA patients and controls using single strand conformational polymorphism (SSCP) analysis. Association between genotype distribution and RA was studied initially in a British group of patients and controls, and subsequently tested in Swiss patients and controls, as well as further UK patients.

Methods

PATIENTS AND CONTROLS

The UK RA patient groups consisted of patients attending rheumatology clinics in South Wales (UKRA1), Hammersmith Hospital, London (UKRA2), and Guy's Hospital, London (UKRA3). Control subjects were healthy hospital volunteers. All British subjects were from a white population.

Swiss RA patients were recruited from the rheumatology clinics of the University hospitals of Geneva and Lausanne. All Swiss patients were of white origin. Swiss controls were consecutive white blood donors.

All patients fulfilled the ACR criteria for the diagnosis of RA.10 Table 1 shows the characteristics of the patient groups.

SINGLE STRAND CONFORMATIONAL POLYMORPHISM (SSCP) ANALYSIS

SSCPs were performed for TCRAV5S1, 6S1, 8S1, 17S1, and 21S1 polymorphisms as described previously.4

DR4 TYPING

Genotyping for DR4 was performed by PCR-SSCP using DR4-specific primers or by a microtitre plate oligotyping assay.11–12 Table 1 shows the percentage of DR4 positive subjects in RA groups.

References

The data were analysed using contingency tables. Odds ratios were calculated as described.13

**Results**

V5S1, V6S1, V8S1, V17S1, and V21S1 genotypes were determined by SSCP on a cohort of British white RA patients and normal subjects (UKRA1). No significant association was found for V5S1, V6S1, V8S1, V17S1, or V21S1 with RA (data not shown).

To investigate the possibility of interaction with HLA-DR4, the control and patient groups were stratified according to DR4 status. No significant differences were observed in the genotype distribution of V6S1, V8S1, V17S1, and V21S1 polymorphisms (data not shown).

An increase in V5S1*01/*01 in DR4+ versus DR4− was observed in RA patients but not controls (63% v 45% compared with 48% v 45% in controls, χ²=7.18, p=0.0275 (2df), p=0.14 after correction for multiple comparisons, see table 2: RA1).

To determine if the increase of the V5S1*01/*01 genotype in relation to HLA-DR4 is reproducible and significant, the genotype distribution of TCRAV5S1 was analysed in three additional groups of RA patients, two from the UK (RA2 and RA3) and one from Switzerland.

Table 3 shows the odds ratios for association of V5S1*01/*01 with HLA-DR4 positive RA. The values for the individual groups ranges from 1.2 for UKRA3 (95% CI 0.2, 6.7) to 2.2 (0.7, 6.7) for UKRA2. The overall odds ratio is estimated at 1.7 (0.9, 3.4; table 3).

**Discussion**

The inherited basis of RA is likely to be polygenic. To date, the influence of HLA genes is the best studied and has been consistently confirmed in many different populations.14 TCR genes are candidate susceptibility genes in RA, however analyses of the role of TCR genes in disease have been hampered by suitably polymorphic markers, and the absence of genetic maps of the loci in question.15

Little is known about the genetic contribution of the TCRA locus to RA. Among other autoimmune diseases, associations between a

\[ \chi^2 = 7.18 \]

\[ p = 0.0275 \] (2df)

\[ p = 0.14 \] (2df)

\[ \chi^2 = 6.63 \]

\[ p = 0.036 \] (2df)

\[ \chi^2 = 7.78 \]

\[ p = 0.02 \] (2df)

\[ \chi^2 = 7.19 \]

\[ p = 0.028 \] (2df)

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TCRA constant region RFLP and systemic lupus erythematosus, and an RFLP of the TCRAV1 subgroup and autoimmune thyroid disease have been reported.

In our initial study, we found no associations between TCRAV polymorphisms and RA overall, but an increase in the V5S1*01/*01 genotype in DR4+ subjects was observed. This prompted us to enlarge our study to include RA patients from other centres in the UK and also from Switzerland. Our initial results could not be significantly reproduced, although two of the three further patient groups showed an increase of V5S1*01/*01 in DR4+ subjects. The non-reproducibility of the results may be because of disease heterogeneity between the patient groups studied. However, we believe this is unlikely as all groups are similar in terms of DR4 positivity, sex, and all were recruited from the general population. In addition, from the available clinical data, there seems to be little difference between the characteristics of the UKRA1 group and the Swiss RA patient group, which showed differences in V5S1 genotype distribution (see table 1). Distinct HLA-DRB1 subtypes are associated with RA in white subjects, of which HLA-DRB1*0401 and *0404 show the strongest association. We cannot rule out the possibility that V5S1*01/*01 is associated with a particular DR4–subtype, which may be differentially represented in the patient groups.

Using combined data from all groups we estimate the odds ratio for the putative association of V5S1*01/*01 with DR4 positive RA to be 1.7 (95% CI = 0.9, 3.4), with values for other patient groups, although the differences in V5S1 ratios are not statistically significant. Much rectivity to p-azobenzenearsonate. Cell 1988;54:247–61.


In conclusion, our results do not support strong association of TCRAV genes with RA, however, the existence of a minor genetic influence is suggested.
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