

Ankylosing spondylitis and HLA-B27: restriction fragment length polymorphism and sequencing of an HLA-B27 allele from a patient with ankylosing spondylitis

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Abstract

Two groups of patients with ankylosing spondylitis (AS) from England and Poland were examined for restriction fragment length polymorphisms (RFLPs) associated with the disease. No preferential association was found between the 9.2 kb *PvuII* fragment in HLA-B27 positive patients with AS compared with HLA-B27 healthy subjects as had been previously reported. In the English group, however, a 14 kb *PvuII* fragment was more common in HLA-B27 positive subjects with AS than in normal controls. Also 4.6 and 3.7 kb *PvuII* fragments were more prevalent in subjects without AS than in the group with AS, but these results were confined to the English group. Furthermore, the sequence of an HLA-B*2705 gene isolated from a patient with AS was examined, and no significant differences were found compared with the sequence isolated from a healthy subject. There do not seem to be significant genetic differences in the coding or in the regulatory region in HLA-B27 alleles, in subjects with or without AS.

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Ankylosing spondylitis (AS) is an inflammatory disease affecting the sacroiliac joints, spine, and peripheral joints. Patients with reactive arthritis associated with HLA-B27 often have a history of antecedent infection with microorganisms such as salmonella, shigella, and yersinia,¹ whereas in patients with AS klebsiella has been implicated as a possible cause.^{2,3} A strong association exists between AS and the major histocompatibility complex (MHC) class I antigen HLA-B27,^{4,5} with over 90% of patients with AS carrying this HLA antigen compared with a prevalence of HLA-B27 of less than 8% in the white population. The relative risk for subjects carrying HLA-B27 has been shown to be greater than 70.⁶ HLA-B27 is present in 50% of American black subjects with AS, whereas only 2% of the American black population have the HLA-B27 allele.⁷

Despite the close association between AS and HLA-B27 the mechanism underlying it remains unclear. It has been suggested that HLA-B27 is linked directly to the pathology of AS through the mechanism of molecular mimicry by means of immunological cross reactivity between antigens on the associated bacteria and the

HLA-B27 molecule.⁸ Alternatively, it may not be HLA-B27 itself which plays a part in the disease development but a gene in linkage disequilibrium with HLA-B27. There is reported to be no difference between the amino acid sequence of the extracellular domains of HLA-B27 antigen in patients with AS and in non-diseased subjects.⁹

Restriction fragment length polymorphism (RFLP) analysis has been used to examine the possibility of linking a particular allelic form of HLA-B27 with AS. Using an HLA-B7 cDNA probe, McDaniel *et al* showed that a polymorphic 9.2 kb *PvuII* DNA fragment was present in 72.9% of HLA-B27 positive patients with AS but in only 22% of HLA-B27 positive normal white subjects from Alabama, USA.¹⁰ Segregation studies in families showed that the 9.2 kb *PvuII* polymorphic DNA fragment is not a polymorphism of the HLA-B27 allele. A number of more recent RFLP studies have failed to confirm an association between the 9.2 kb *PvuII* fragment and AS.¹¹⁻¹³

We report here our studies of two groups of European patients with AS, usually genetically more homogeneous than American patients, who were investigated to determine a possible association between RFLPs and AS.

Materials and methods

SUBJECTS

Thirty four unrelated English patients with AS (seven women, 27 men), all with classical AS according to the New York criteria,¹⁴ were studied. Thirty two of the 34 patients were white. Thirty two patients had peripheral joint disease and 14 had had uveitis. Only one HLA-B27 negative patient was included, who had peripheral joint disease but not uveitis. Thirty two healthy English subjects with no previous history of AS in the family, including seven who were positive for HLA-B27, served as controls.

Twenty Polish white patients with AS were also studied, of whom 10 had peripheral joint disease. The incidence of uveitis among these patients was not known. Thirteen healthy, white Polish subjects, of whom seven were HLA-B27 positive without any history of arthritis or spondylitis, served as controls.

PROBES

Full length HLA-B27 cDNA probe pB1¹⁵ was kindly provided by Dr E Weiss. HLA-B27 5'

and 3' cDNA probes were derived from pB1. The 5' cDNA probe was a 415 bp *PstI-PvuII* fragment containing the sequences encoded in the leader sequence, the presequence, the $\alpha 1$ domain, and 194 bp of the $\alpha 2$ domain. The 3' cDNA probe consisted of the 550 bp *PvuII-PstI* fragment containing the 3' untranslated region of pB1 cDNA. The HLA-B27 3' flanking probe was a 1650 bp *PstI-BamHI* fragment from an HLA-B27 gene isolated from a subject without AS¹⁶ and was also kindly provided by Dr E Weiss. The probe contains sequences immediately downstream from the poly-A addition signal.

SOUTHERN BLOTTING

The peripheral lymphocytes from 10 ml of whole EDTA blood were lysed in 90 ml of lysis buffer containing 0.32 M sucrose (BDH), 10 mM TRIS-HCl pH 7.5 (Sigma), 5 mM MgCl₂ (BDH), and 1% (v/v) Triton-X100 (Sigma). The nuclei were pelleted by centrifugation at 2000 g for 20 minutes and then resuspended in 5 ml 75 mM NaCl (BDH), 24 mM EDTA (BDH) pH 8.0. The nuclear membranes were lysed by addition of sodium dodecyl sulphate (Sigma) to a final concentration of 0.5% and 0.2 mg/ml proteinase K (Boehringer Mannheim) and incubated at 37°C for two to 12 hours. The DNA was then purified by extraction with an equal volume of phenol (BDH) followed by two extractions with chloroform (BDH). The DNA was further purified by addition of 11 ml ethanol (BDH) after addition of sodium acetate pH 5.2 (BDH) to a final concentration of 0.3 mol/l. The precipitated DNA was dissolved in 0.5 ml TE buffer.

DNA (10 μ g) was digested to completion with 25–50 units of the restriction enzymes *EcoRI*, *HindIII*, or *PvuII* (BRL/Gibco) as recommended by the manufacturers. The DNA fragments were separated through a 0.8% agarose (Sigma) gel at 60 V for 17 to 20 hours in 40 mM TRIS (Sigma), 20 mM acetic acid (BDH), 10 mM EDTA (BDH). The DNA fragments were denatured, neutralised, and transferred to Hybond-N membranes (Amersham, UK) followed by cross linking of the DNA to the nylon membrane by ultraviolet irradiation (305 nm) for three minutes.

Blots were prehybridised for a minimum of four hours at 65°C in 6 \times SSC (900 mM NaCl, 90 mM sodium citrate pH 6.15), 0.01% BSA (ICN Immunobiochemicals), 0.1% (w/v) polyvinylpyrrolidone (Sigma), 0.1% Ficoll 600 (Pharmacia), 10% dextran sulphate (Pharmacia), 0.1% sodium dodecyl sulphate, and 0.1 mg/ml denatured sonicated herring sperm DNA (Sigma). Fresh hybridisation buffer containing 0.1 M EDTA was used for overnight hybridisation at 65°C. Denatured probe labelled with [³²P]dCTP (NEN) to a specific activity of at least 10⁸ cpm/ μ g according to Feinberg and Vogelstein¹⁷ was also added to the hybridisation buffer at a final concentration of 1–2 \times 10⁶ cpm/ml. After hybridisation the membranes were washed twice in 2 \times SSC/0.5% sodium dodecyl sulphate at 65°C for 30 minutes followed by two 30 minute washes in 0.1 \times SSC/

0.5% sodium dodecyl sulphate at 65°C. Autoradiography was carried out using screened x ray cassettes at –70°C with Kodak XAR–5 film.

CLONING OF THE HLA-B27 GENE FROM A PATIENT WITH AS

Lymphocytic DNA isolated from a patient with AS heterozygous for the HLA-B27 gene was digested to completion with *EcoRI* and selected according to size by agarose gel electrophoresis. DNA fragments of about 6.5 kb containing the HLA-B27 gene were electroeluted and cloned into λ gt10 phages (Amersham, UK). Recombinant phages (7 \times 10⁴) were screened with the 3' flanking probe, and one strongly cross hybridising clone was purified. The 6.5 kb genomic insert was subcloned into pBluescript SK+ (Stratagene) for further characterisation. The DNA sequence was determined with Sequenase after subcloning of suitable DNA fragments into M13 mp18 or M13 mp19 bacteriophages.

Results

RFLP ANALYSIS

Genomic DNA from English and Polish patients with AS and healthy normal subjects was analysed for RFLPs by hybridisation with

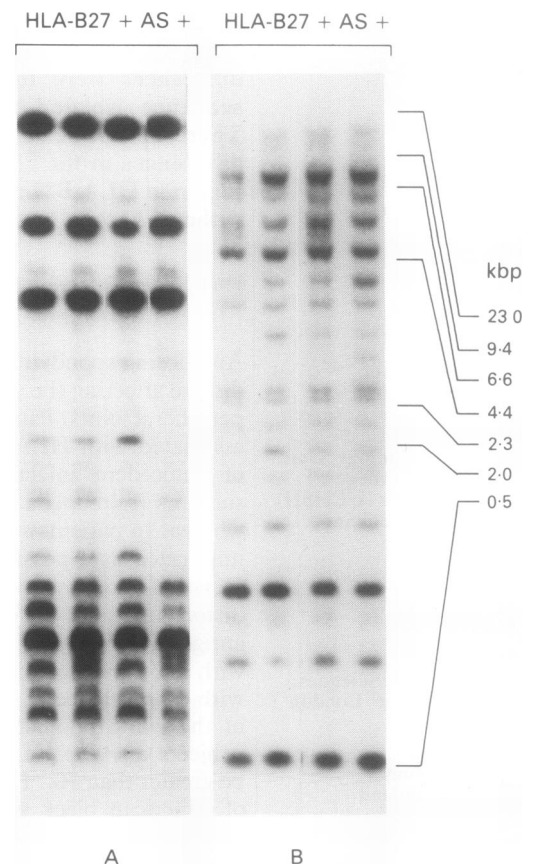


Figure 1 Autoradiograph of *PvuII* digested genomic DNA from four HLA-B27 positive Polish subjects with AS hybridised with full length HLA-cDNA probe. After hybridisation the blot was washed with 2 \times SSC, 0.1% sodium dodecyl sulphate (SDS) at 65°C and exposed against x ray film for three days (A) after which the stringency of the wash was increased to 0.2 \times SSC, 0.1% SDS and the Southern blot was re-exposed to x ray films for seven days (B).

a number of probes derived from different regions of the HLA-B27 gene or the corresponding cDNA. Hybridisation to Southern blots of *EcoRI* and *HindIII* digested DNA showed that the HLA-B27 cDNA probe detected several DNA fragments. Some of these were polymorphic, but none showed any association with the disease (data not shown).

In the light of this a more detailed analysis was performed on Southern blots of *PvuII* digested DNA. Hybridisation at low stringency of a full length cDNA (fig 1) as well as a 5' cDNA probe (fig 2) showed about 20 DNA fragments. Most of these are derived from other MHC class I genes which have DNA sequence homology with the HLA-B27 gene. The two probes detect virtually the same fragments, except that the 5' probe detects no fragments below 2.6 kb. The table lists the frequencies of all fragments detected with the 5' cDNA probe. A 14 kb *PvuII* fragment was found in 82% (28/34) of English HLA-B27 positive patients with AS, whereas it appeared in only 29% (2/7) of the English control subjects with HLA-B27. The 14 kb *PvuII* fragment, however, occurred

with the same frequency in the HLA-B27 negative control group as seen among HLA-B27 positive healthy subjects. The 14 kb *PvuII* fragment was not an AS susceptibility polymorphism among HLA-B27 positive Polish patients.

The prevalence of the 9.2 kb *PvuII* fragment, described by McDaniel and coworkers,¹⁰ was low among HLA-B27 positive English and Polish patients with AS (28% and 15% respectively). In contrast, this 9.2 kb fragment was significantly more prevalent in both English and Polish HLA-B27 positive controls (86% and 50% respectively). This suggests a negative association between the disease and the 9.2 kb fragment among HLA-B27 positive subjects.

The 4.6 and 3.7 kb fragments were more prevalent in HLA-B27 negative healthy subjects (70% and 67% respectively) than in HLA-B27 positive English subjects (35% and 23% respectively). The 3.7 kb fragment was also seen more commonly in healthy subjects (64%) than in patients with AS (16%), irrespective of the presence of the HLA-B27 allele. Among the English patients it was found that the 3.7 kb

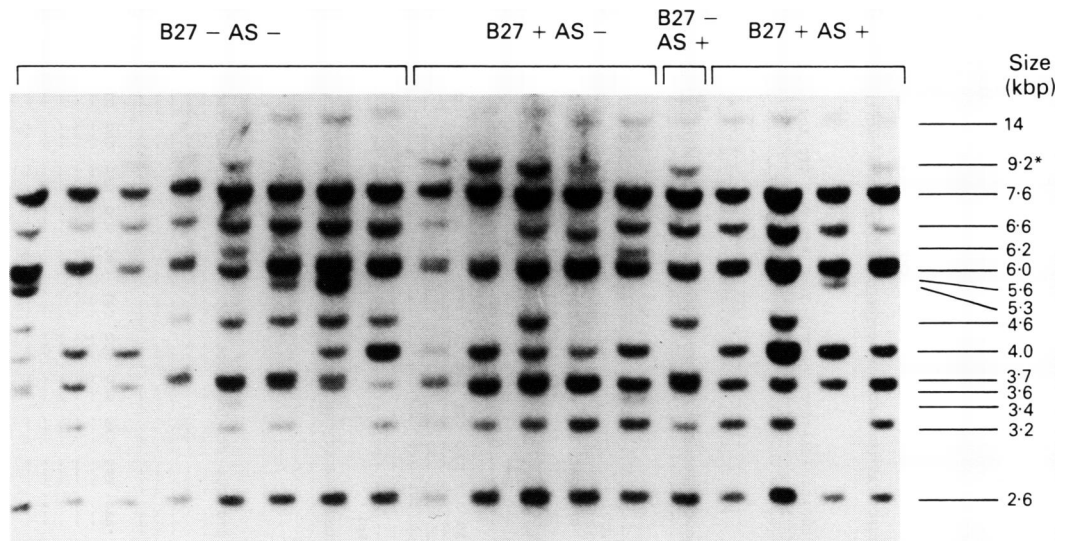


Figure 2 Autoradiograph of *PvuII* digested genomic DNA from eight HLA-B27 negative healthy subjects, five HLA-B27 positive healthy subjects, one HLA-B27 negative English patient with AS, and four HLA-B27 positive English patients with AS hybridised with the pB27-5' cDNA probe. The 9.2 kb *PvuII* fragment is indicated with an asterisk.

Prevalence of *PvuII* fragments hybridising to the pB27-5' cDNA probe in each subset of the English and Polish groups. The 9.2 kb *PvuII* fragment is indicated with an asterisk. The percentage of patients with each fragment is shown

Size (kbp)	English			Polish		
	B27+AS+ (n=34)	B27+AS- (n=7)	B27-AS- (n=25)	B27+AS+ (n=20)	B27+AS- (n=4)	B27-AS- (n=9)
14	82	29	72	70	75	78
9.2*	28	86	35	15	50	44
7.6	100	100	100	100	100	100
6.6	100	100	100	100	100	100
6.2	12	43	8	10	0	0
6.0	36	29	68	15	25	22
5.6	76	71	76	85	100	100
5.3	30	0	39	30	25	44
4.6	38	14	70	35	50	44
4.0	94	100	76	95	75	78
3.7	16	57	67	55	50	33
3.6	94	86	76	75	100	67
3.4	9	14	14	0	0	0
3.2	91	86	81	95	100	89
2.6	100	100	100	100	100	100

other studies¹⁰⁻¹³ reported a similar association. Only seven healthy subjects in our English control group had the HLA-B27 class I allele so this preferential association might not persist if a larger control group were to be studied. There is insufficient tissue typing data of our patient group to identify the MHC class I gene containing the 14 kb polymorphism. In addition, 4.6 kb and 3.7 kb polymorphic fragments were found which, in the English control group, were more prevalent in HLA-B27 negative subjects than in those who were HLA-B27 positive, and the 3.7 kb fragment was more prevalent in healthy subjects than in patients with AS irrespective of whether the subjects were positive for HLA-B27 or not. This seems to be a negative correlation among English patients with AS, but this association was not seen in the Polish group.

The conflicting results might be due to genetic differences between the groups studied. The HLA-A3/A9 allele might be linked with the disease allele in the Alabama group studied by McDaniel *et al.*,¹⁰ whereas such a linkage might not exist in the other groups with AS. Likewise, the 14 kb PvuII fragment, which appears to be preferentially linked together with HLA-B27 to AS in the English group as reported here, but absent in the other group studied, might reflect the genetic diversity between different populations. This implies that no additional MHC class I gene is involved in the pathology of AS. If the HLA-B27 gene is not the disease gene itself or if additional MHC encoded susceptibility genes exist then they must be very close to the HLA-B27 allele.

The discrepancy between the number of people carrying HLA-B27 and those developing AS could be explained if there existed particular susceptibility alleles of HLA-B27 which cannot be identified by restriction fragment analysis. We sequenced the entire structural HLA-B*2705 gene from a patient with AS. Our results show that the translated amino acid sequence is identical with the sequence of an HLA-B*2705 antigen isolated from a healthy person.¹⁶⁻²⁰ This is in complete agreement with Coppin and McDevitt,⁹ who found no differences between the translated sequence of exon II, III, and IV encoding the extracellular portion of the MHC class I antigen in HLA-B27 proteins from patients with AS and healthy subjects. Furthermore, our DNA sequence shows that the promoter and regulatory region of the HLA-B27 gene isolated by us is virtually identical to the non-diseased gene characterised by Weiss *et al.*¹⁶ This eliminates the possibility that the pathology of AS might be due to altered expression of the HLA-B27 antigen. We found very few nucleotide differences between the HLA-B*2705 gene isolated by us and the nucleotide sequence of a similar allele from a normal subject cloned and sequenced by Weiss *et al.*¹⁶ and Seeman *et al.*²⁰ We noted some nucleotide differences in exon II and IV but none which would result in amino acid differences. We also found sequence differences within intron I and II when compared with previously published sequences for non-diseased HLA-B*2705 alleles.¹⁶⁻²⁰ Interestingly, some of

these differences create or destroy potential binding sequences for the transcription factors SP1 or AP2. It has not been shown that such binding sites are used in regulation of the transcription, however.

The absence of any differences between the coding sequence of the HLA-B27 genes from patients and healthy subjects does not eliminate a direct role for HLA-B27 in the pathogenesis of the disease through its function as restriction element for antigen presentation to cytotoxic T cells.²¹ Many organ specific autoimmune diseases, like insulin dependent diabetes mellitus and Hashimoto's disease, are characterised by a cellular as well as a humoral immune response. Ankylosing spondylitis might well be initiated by an infection of klebsiella or related bacteria.²² The fact that the concordance rate for AS in identical twins is well below 50% clearly suggests the involvement of an environmental factor in a genetically susceptible host²³ who may have more than one susceptibility gene. Family studies suggest a possible role for a second susceptibility gene, not necessarily located in the MHC region. Such a second susceptibility gene could code for a self protein sharing a T cell epitope with a bacterial protein, which might have a restricted tissue distribution, and this might account for the tissue specificity of the disease. A shared T cell epitope would then only be presented by HLA-B27 or a related MHC class I antigen with a nearly identical antigen binding groove.²⁴

Clearly, further studies are required to resolve the problem of the association of HLA-B27 with AS.

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