

# Imbalances of Gamma Globulin Subgroups and Gene Defects in Patients with Primary Hypogammaglobulinemia

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**ABSTRACT** Analysis of immunoglobulin classes,  $\gamma$ G subgroups, and Gm genetic markers from 59 patients with various types of immune deficiencies was undertaken to assess the function of the several cistrons concerned with synthesis of gamma globulins. 13 patients including two sibling pairs were found to have  $\gamma$ G subgroup imbalances. All of these patients had non sex-linked disease. 11 of the 13 had preponderance of the  $\gamma$ G3 subgroup. In most instances of  $\gamma$ G3 preponderance it was the Gm(b) type of  $\gamma$ G3 that was selectively retained; the Gm(g) type, controlled by the allelic gene was markedly depressed but not absent in the cases where it could be studied. Other imbalances, either seen concomitantly with  $\gamma$ G3 preponderance or independently, included predominance of the  $\gamma$ G2 subgroup and selective absence of single  $\gamma$ G subgroups.

One family was encountered with probable structural gene abnormalities in the autosomal Gm loci. Both parents had different abnormal gene complexes detectable by absence of specific Gm markers and the propositus received both types from the parents. Similar gene complexes have been seen previously in rare instances through population screening but only in the heterozygous state and were not associated with clinically evident hypogammaglobulinemia. Of several other families of patients with subgroup imbalance, two were informative in that structural gene defects could be excluded. Studies on 22 first degree relatives of patients with subgroup imbalances indicated that the most common abnormality detected was in  $\gamma$ A which was absent in 3 and markedly decreased in 2 others; other abnormalities included decreased levels of specific genetic types of  $\gamma$ G globulin. It is concluded that  $\gamma$ G subgroup imbalances are frequently found in non sex-linked immuno-

globulin deficiency disorders and in some instances may be associated with family abnormalities suggesting either regulator or structural gene defects.

## INTRODUCTION

Human  $\gamma$ G immunoglobulin has been shown to contain four subgroups based on antigenic differences in the polypeptide heavy chains (1-3). The approximate percentages in normal  $\gamma$ G are:  $\gamma$ G1, 66%;  $\gamma$ G2, 23%;  $\gamma$ G3, 7% (4); and  $\gamma$ G4, 4%. Individual Gm genetic markers are found only in molecules of a single subgroup (5, 6). Varying relationships between genetic markers, especially the new markers Gm(n) at the  $\gamma$ G2 locus (7) and Gm(g) at the  $\gamma$ G3 locus (8), have provided evidence for close linkage between the three cistrons for which markers are available and have led to the conclusion that some of the differences in gene complexes among population groups arose through crossover events (9-13). Gene complexes which are characteristic for the Caucoid population group are shown in Table I. Current evidence suggests that the order of  $\gamma$ G heavy-chain cistrons may be  $\gamma$ G2,  $\gamma$ G3,  $\gamma$ G1 (12-14). A number of rare gene complexes have been observed in large surveys of families from different populations; included among these were families with either an apparent deletion of the  $\gamma$ G3 locus ( $\gamma$ G2, —,  $\gamma$ G1) or of the  $\gamma$ G1 locus ( $\gamma$ G2,  $\gamma$ G3, —) (15).

The availability of reagents to identify virtually all  $\gamma$ G molecules by heavy-chain subgroup and approximately 85% as to Gm genetic markers has permitted a more detailed analysis of  $\gamma$ G synthesis in patients with hypogammaglobulinemia. Disproportionate synthesis of  $\gamma$ G heavy-chain subgroups resulting from genetic defects was sought for, especially in those patients showing restricted electrophoretic heterogeneity and disproportionate ratios of kappa : lambda light-chain types (16, 17). The

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TABLE I

Horizontal Rows of Gm Gene Complexes Illustrating Normal Caucasoid Gene Complexes and Associated  $\gamma$ G Subgroups. The Rare Gene Complexes Associated with Hypogammaglobulinemia from the Present Study are Shown

	$\gamma$ G Subgroup		
	$\gamma$ G2	$\gamma$ G3	$\gamma$ G1
Usual Caucasoid Gm gene complexes		g	za
		g	zax
	n	b	f
		b	f
Rare Caucasoid		—	za
	n	b	—

possibility that structural or regulator gene defects, recognized in associated family members, might be responsible for asynchronous gamma globulin synthesis was examined in particular detail. A preliminary report of this work has been presented (18).

## METHODS

**Patients.** Sera were collected from 59 patients with hypogammaglobulinemia of various types. All of the patients studied were Caucasoid. From clinical criteria and family studies patients were classified as to type of hypogammaglobulinemia (Table II) (19). Only specimens before treatment or specimens taken several weeks or months after an injection of gamma globulin were studied. Normal concentrations and percentages of  $\gamma$ G subgroups were determined from sera selected from a group of 600 normal blood donors provided by Dr. Fred Allen of The New York Blood Center. For each of the 13 patients with  $\gamma$ G subgroup imbalance, 2 normal persons matched for age, sex, and race were studied. In addition, 10 normal children between the ages of 3 and 9 months were studied to assess levels at the nadir of  $\gamma$ G levels after birth.

**Myeloma proteins.** Several myeloma proteins from each of the four  $\gamma$ G subgroups and the two  $\gamma$ A subgroups,  $\gamma$ D proteins and Waldenström macroglobulins were isolated by zone electrophoresis (20) on polyvinyl copolymer (Pevikon) (21). In some instances further purification was effected either by gel filtration on Sephadex G-200 equilibrated with 0.1 M [tris(hydroxymethyl)aminomethane hydrochloride] (Tris-HCl) and 0.15 M sodium chloride, or by DEAE cellulose chromatography. Fragments from papain (22) or pepsin digestion of myeloma proteins were isolated by zone electrophoresis on Pevikon followed by gel filtration. Isolated proteins were reduced in 0.55 M Tris-HCl buffer made 0.1 M with  $\beta$ -mercaptoethanol for 1 hr at room temperature, and then alkylated by the addition of recrystallized iodoacetamide to a final concentration of 0.11 M. Heavy and light chains were separated by filtering the reduced and alkylated proteins through Sephadex G-100 equilibrated with 0.5 M propionic acid. Isolated heavy chains were concentrated by ultrafiltration and then exhaustively dialyzed against phosphate buffered saline, pH 7.4, before use in animal immunizations.

**Antisera.** Antisera specific for  $\gamma$ G,  $\gamma$ A,  $\gamma$ M,  $\gamma$ D, kappa, lambda,  $\gamma$ G heavy-chain subgroups, and genetic factors were prepared by immunization of rabbits, cynomolgus or

rhesus monkeys or baboons with isolated whole immunoglobulins, polypeptide chains, or enzymatic digestion fragments. The antisera were absorbed with isolated Bence Jones proteins, myeloma proteins, or digestion fragments, fraction II, isolated normal  $\gamma$ G or selected whole sera in order to obtain the light-chain type or heavy-chain class, subgroup, or Gm specificity sought as has been described previously (1, 4, 7, 9, 14, 15). The baboon antisera were prepared through the cooperation of Dr. J. Moor-Jankowski and the Laboratory for Experimental Medicine and Surgery in Primates. Quantitation of  $\gamma$ G,  $\gamma$ A,  $\gamma$ M,  $\gamma$ D, kappa, lambda and  $\gamma$ G2,  $\gamma$ G3, and  $\gamma$ G4 subgroups was carried out by radial immunodiffusion (23, 24) modified as previously described for the  $\gamma$ G3 subgroup (4). The isolated immunoglobulins used as standards were tested in high concentration on radial diffusion plates for concentrations of contaminant proteins and were found to be less than 1% contaminated by proteins of other classes, subgroups or of the opposite light-chain type. Protein concentrations of standard solutions were determined by the Folin-Lowry technique and Kjeldahl nitrogen determination (25). Of many antisera showing  $\gamma$ G subgroup specificity, only a few were suitable for quantitative radial immunodiffusion (26). Because most  $\gamma$ G1 antisera were not ideal for quantitative radial immunodiffusion,  $\gamma$ G1 levels were determined by two alternative procedures, direct hemagglutination inhibition with an anti  $\gamma$ G1 Fc antiserum and by subtracting levels of  $\gamma$ G2,  $\gamma$ G3, and  $\gamma$ G4 from the total  $\gamma$ G.

**Gm typing.** Gm typing was carried out using hemagglutination-inhibition systems (9, 14). Gm(n) typing was performed by coupling Gm(n<sup>+</sup>) myeloma proteins to group O Rh positive red blood cells using bis-diazotized benzidine (BDB) (15). In similar fashion, antigens specific for  $\gamma$ G1-Fc,  $\gamma$ G1-kappa,  $\gamma$ G3-Fc,  $\gamma$ G3-Fab,  $\gamma$ G2-Fc,  $\gamma$ G2-kappa,  $\gamma$ G4, and  $\gamma$ D molecules were measured with more sensitive hemagglutination-inhibition techniques (14).

TABLE II

Patients with Primary Hypogammaglobulinemia Studied for Imbalances of  $\gamma$ G Subgroups

Diagnosis	Imbalance found	Number studied
Infantile sex-linked agammaglobulinemia (Bruton)*	0	8
Non sex-linked primary immunoglobulin deficiency with variable onset and expression		
(a) low $\gamma$ G, $\gamma$ A, and $\gamma$ M	10	39
(b) low $\gamma$ G and $\gamma$ A, normal $\gamma$ M	2†	6
Congenital rubella syndrome	1	1
Immune deficiency with thrombopenia and eczema	0	1
Alymphocytic agammaglobulinemia (Swiss)	0	2
Unclassified	0	2
	—	—
Total	13	59

\* In some of these cases the sex-linked pattern could not be clearly established and the diagnosis is presumptive.

† An associated thymic abnormality was present in one of these patients.

## RESULTS

*$\gamma$ G subgroup imbalance.* A total of 59 patients were studied which were grouped according to a recently recommended classification of the primary immunoglobulin deficiency syndromes (19) (Table II). Except for one patient with the congenital rubella syndrome, all the patients with subgroup imbalance were from patients with non sex-linked primary immunoglobulin deficiency of variable onset and expression. This group includes "acquired" deficits and "congenital" non sex-linked forms of hypogammaglobulinemia (19). 13 patients showed imbalances of  $\gamma$ G subgroups and these are shown in Table III. Predominance of the  $\gamma$ G3 subgroup was the most common imbalance and was seen in 11 of the 13 patients. Subgroup concentrations and percentages for normal caucasoid adults and for sera from two normal controls for each patient with subgroup imbalance matched for age, sex, and race are shown. The  $\gamma$ G3 subgroup comprised  $7.3 \pm 3.8\%$  of total  $\gamma$ G in 145 normal sera with no specimen exceeding 18% of total  $\gamma$ G. In the remaining 46 sera from patients with hypogammaglobulinemia and in the matched control sera, percentages equivalent to those in caucasoid adults were found. In five patients with  $\gamma$ G3 preponderance (Bon., Rod., And., Mes. M., and Mes. B.) (Table III), the remaining  $\gamma$ G subgroups were all reduced proportionately. The most striking members of this group were two siblings, patients M. Mes. and B. Mes., with epispadias, bony abnormalities, and the adult onset of propensity for infections. Levels of  $\gamma$ G3 were in the high normal range, and despite spontaneous fluctuations in total  $\gamma$ G, percentages of  $\gamma$ G3 subgroup in the range of 50–65% were consistently seen in both siblings.

In six patients with predominance of  $\gamma$ G3, a variety of associated subgroup imbalances were seen (Table III). In patient Hx., for example, nearly half the  $\gamma$ G molecules were  $\gamma$ G3 subgroup, and no  $\gamma$ G2 or  $\gamma$ G4 molecules could be detected, even when sensitive hemagglutination inhibition techniques were employed to confirm the radial immunodiffusion results.  $\gamma$ G1 molecules were present but reduced approximately 20-fold as determined by hemagglutination inhibition. The high level of  $\gamma$ G3 subgroup was confirmed by inhibition studies employing both antigens of the Fc portion of the heavy chains and antigens of the Fd portion. These findings were consistently present in serum specimens collected over a period of 2 yr. Selective suppression of  $\gamma$ G1, the major subgroup, was an associated abnormality in patients Tia., Gau., J. Tu., and G. Tu. This was most striking in patient Tia. where  $\gamma$ G1 molecules were undetectable instead of the normal 66%; the genetic marker, Gm(f), which with the system employed is detectable in normal sera at dilutions of 1:10,000, was reduced approximately 1000-fold indicating trace amounts of Gm(f<sup>+</sup>)  $\gamma$ G1 molecules. In

patient Gau. 57% of the total serum gamma globulin was  $\gamma$ G3 subgroup, and  $\gamma$ G1 was markedly reduced in absolute concentration and relative amounts (12% instead of the expected 66%). The  $\gamma$ G4 subgroup was not detected. Patients J. Tu. and G. Tu. also showed  $\gamma$ G1 suppression with the total  $\gamma$ G composed primarily of  $\gamma$ G2 and  $\gamma$ G3 molecules. These sera were from a pedigree shown to have low levels of  $\gamma$ A in the same two siblings. Patient Lind. showed a preponderance of  $\gamma$ G3 and  $\gamma$ G4 which together comprised 70% of his low level of total  $\gamma$ G. This was the only patient in whom a relative preponderance of  $\gamma$ G4 was observed.

Two of six sera from patients with non sex-linked primary immunoglobulin deficiency having normal  $\gamma$ M and low  $\gamma$ G and  $\gamma$ A levels (dysgammaglobulinemia type I) showed unusual types of  $\gamma$ G subgroup imbalances. One serum (Geo., Table III) was almost exclusively  $\gamma$ G2 subgroup and totally lacked  $\gamma$ G1 and  $\gamma$ G3 subgroup markers both by radial diffusion and by hemagglutination inhibition. The genetic markers associated with  $\gamma$ G1 and  $\gamma$ G3 subgroups including Gm(za, f, b, and g) were undetectable, but the Gm(n) marker known to occur on the Fc portion of  $\gamma$ G2 molecules was present. In subsequent specimens the  $\gamma$ M also was diminished, but the  $\gamma$ G remained predominantly  $\gamma$ G2 subgroup. Other features concerning this patient have been described in a previous communication (27). The second patient (Feld.) showed selective paucity of  $\gamma$ G2 subgroup and  $\gamma$ A molecules with moderately diminished total  $\gamma$ G but normal levels of  $\gamma$ G3 and  $\gamma$ G4 subgroups. The patient, a young boy, also manifested persistent neutropenia and died at age 3 of varicella pneumonia. No detectable thymus could be found at postmortem examination.

In addition to the 59 patients listed in Table II with primary deficiencies of  $\gamma$ G, five patients with selective absence of  $\gamma$ A, two patients with ataxia telangiectasia and absence of  $\gamma$ A, and eight patients with secondary hypogammaglobulinemias (nephrosis, protein-losing enteropathy, lymphomas) were also studied and no subgroup imbalances were detected. Proportionate levels were also present in a group of 10 infants ranging in age from 3 to 9 months.

*Genetic studies.* Immunoglobulin concentrations and studies for the autosomal Gm genetic markers were carried out in 22 first degree relatives of 7 propositi with  $\gamma$ G subgroup imbalance and 52 first degree relatives of 18 propositi without subgroup imbalance in a search for possible genetic explanations for the hypogammaglobulinemia. One family was of special interest (Fig. 1). The propositus (Hx., Table III) had a preponderance of  $\gamma$ G3 subgroup and lack of  $\gamma$ G2 and  $\gamma$ G4 subgroup molecules. The propositus and mother both exhibited an abnormal  $Gm^a Gm^b Gm^-$  gene complex which lacked the normally associated  $Gm^f$  marker at the major or  $\gamma$ G1

TABLE III  
*Immunoglobulin Concentrations in Patients with Non Sex-Linked Immunoglobulin Deficiency with Variable Onset and Expression and Imbalance of  $\gamma$ G Subgroups*

Patient	Age	Sex	H-Chain subgroup* (per cent of $\gamma$ G)							Class of immunoglobulin				Light-chain type			
			$\gamma$ GI†	$\gamma$ G2	$\gamma$ G3	$\gamma$ G4	$\gamma$ G	$\gamma$ A	$\gamma$ M	$\gamma$ D	kappa	lambda	kappa/lambda ratio				
						mg/ml											
Bon.	5	M	1.61 (42)	0.28 (7)	1.62 (43)	0.32 (8)	3.83	0.025	0.050	0	2.45	2.03	1.2 ]				
Rod.	42	M	1.23 (56)	0.27 (12)	0.66 (30)	0.03 (1)	2.19	0.20	0.063	0	1.45	0.38	3.8				
And.	1½	F	4.37 (80)	0.28 (5)	0.85 (16)	0	5.50	0.034	1.95	0	3.6	2.4	1.5				
Mes., M.	24	M	0.75 (30)	0.15 (6)	1.62 (64)	0	2.52	0.38	0.056	0.018	1.51	1.25	1.2				
Mes., B.	21	M	0.77 (31)	0.13 (5)	1.55 (63)	0	2.45	0.38	0.041	0.022	1.30	1.04	1.3				
Hx.	18	M	0.54 (52)	0	0.49 (48)	0	1.03	0.030	0.030	0	0.55	0.60	0.9				
Tia.	20	M	0	0.26 (46)	0.31 (54)	0	0.62	0.31	0.088	0	0.40	0.30	1.3				
Gau.	30	M	0.08 (12)	0.21 (31)	0.39 (57)	0	0.68	0.10	0.110	0	0.37	0.34	1.1				
Tu., J.	15	M	0.23 (6)	1.95 (53)	1.49 (41)	0	3.67	0.025	0.075	0.034	1.60	0.84	1.9				
Tu., G.	14	M	1.27 (31)	1.75 (42)	1.12 (27)	0	4.14	0.29	0.153	0.116	2.70	1.20	2.2				
Lind.	37	M	0.08 (17)	0.06 (13)	0.17 (35)	0.17 (35)	0.48	0	0.030	0	0.25	0.07	3.6				
Feld.	3	M	4.33 (76)	0.10 (2)	0.52 (9)	0.77 (13)	5.72	0	2.30	0							
Geo.	19	F	0	0.38 (89)	0	0.025 (11)	0.43	0	0.45	0	0.26	0.12	2.2				
Adult Caucasoid normals			9.4 ± 1.9 (66 ± 8)	3.2 ± 1.3 (23 ± 8)	1.0 ± 0.45 (7.3 ± 3.8)	0.62 ± 0.48 (4.2 ± 2.6)	14.1 ± 2.5	1.94 ± 0.58	0.53 ± 0.20	0.030 ( < 0.002-0.6)							
Controls matched for age, sex, and race			8.2 ± 2.8 (69 ± 9)	2.3 ± 1.2 (20 ± 7)	0.67 ± 0.40 (5.5 ± 2.4)	0.64 ± 0.47 (5.3 ± 3.4)	11.9 ± 3.8	1.32 ± 0.55	0.67 ± 0.35	0.025 ( < 0.002-0.046)							

\* Normal value ± 1 sd for adult Caucasoid population and matched controls.

† Values are estimated by difference; 0 = absence by direct measurement by hemagglutination inhibition.

subgroup locus (Table I). It was undetectable; and based on the sensitivity of the Gm(f) system, a reduction of Gm(f) of at least 1000-fold below normal titers was observed. The propositus and his father both showed a  $Gm^{n-} Gm^{-} Gm^{za}$  gene complex which lacked the  $Gm^f$  marker which is normally present with  $Gm^{za}$ . The titers of Gm(z) and Gm(a) were normal in the father but detectable and reduced 30-fold in the propositus. The titer of Gm(n) was normal in the mother but detectable and reduced 250-fold in the propositus. Both parents and the sister showed normal levels of total  $\gamma$ G and normal percentages of the  $\gamma$ G3 subgroup although the level of  $\gamma$ G in the mother was in the low normal range (8.4 mg/ml). Both parents had normal  $\gamma$ G1 and  $\gamma$ G2 subgroup concentrations. Normal titers were present for Gm(z), Gm(a), and Gm(f) in the father, Gm(z), Gm(x), and Gm(a) in the mother, and Gm(n) in both parents.

Quantitative determinations (28) of Gm(a) and Gm(f) were performed by Dr. S. D. Litwin on the sera of the Hx. family. The father had levels of Gm(a) (1.28 mg/ml) and Gm(f) (3.5 mg/ml) which fall within the normal range for caucasoid heterozygotes. The sister had a normal homozygous level of Gm(f) (5.75 mg/ml). The mother, who lacked the expected  $\gamma$ G1 marker Gm(f), had a level of Gm(a) of 2.42 mg/ml which is below the normal range for homozygotes (2.92–7.72 mg/ml) and is clearly in the heterozygous range. Careful quantitative analysis of  $\gamma$ G1 in the mother gave

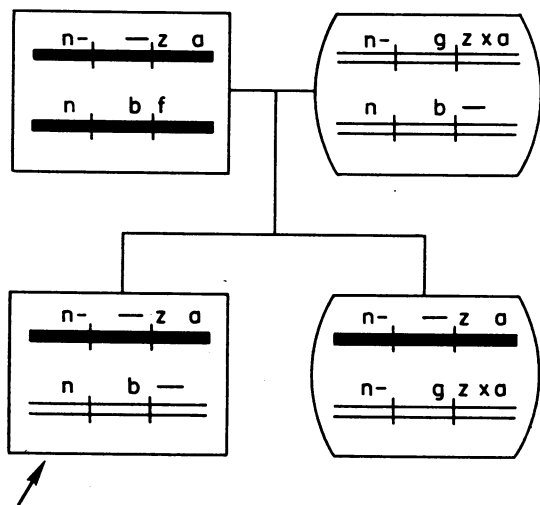


FIGURE 1 Gene complexes, family Hx. A Caucasian family in which the hypogammaglobulinemic propositus inherited from both parents abnormal Gm gene complexes with deletions of genetic markers. The propositus and his mother had Gm(b) and Gm(n) molecules but lacked the normally associated Gm(f) marker which is indicated as (—). The propositus, sister, and father had the Gm(az) markers but lacked the normally associated Gm(g) marker.

levels that corresponded closely with the value for Gm(a) indicating that it was highly unlikely that a new allele was operative in replacing the missing Gm(f) marker. For the propositus calculated levels of  $\gamma$ G1 were 0.93 mg/ml and levels of Gm(a) were 0.90 mg/ml on the same specimen. The possibility of a Negroid  $Gm^{n-} Gm^b Gm^{za}$  gene complex in the father is ruled out by the presence of  $Gm^{n-} Gm^{-} Gm^{za}$  in the sister of the propositus. A Negroid  $Gm^{n-} Gm^b Gm^{za}$  gene complex in the father would require that the sister of the propositus was illegitimate. Red cell genotypes for ABO, Rh, MS, Jk, Ns, K, Lewis, and Duffy were studied and offered support for the family relationships illustrated in Fig. 1. The possibility of a  $Gm^n Gm^b Gm^{za}$  gene complex in the mother and propositus is highly unlikely for two reasons: first, because  $Gm^n$  has never been found associated with  $Gm^b Gm^{za}$  in any previous studies, and second, because this would necessitate that the mother be homozygous Gm(az) while the quantitative studies indicated heterozygous levels.

Another unusual finding for the genetic antigens was in two male siblings of family Tu. (Table III). Both showed a preponderance of  $\gamma$ G3 molecules with marked diminution of  $\gamma$ G1 subgroup and absence of the  $\gamma$ G4 subgroup. Gm(a<sup>+</sup>) markers were readily detected but with markedly reduced titer. Gm(f) was markedly diminished but detectable in both siblings. However, it was of special interest that, along with the marked relative increase in  $\gamma$ G3 level, the two  $\gamma$ G3 genetic markers, Gm(b) and Gm(g), showed a wide difference in level (Table IV). The propositi were clearly heterozygous but the Gm(g) was reduced approximately 100-fold although still detectable while Gm(b) was not reduced at all. Both siblings showed this unusual differential in products of allelic genes in exactly the same fashion. For the  $\gamma$ G1 markers in J. Tu., Gm(f) was in excess of Gm(a) but no asynchrony was seen in G. Tu. The father was homozygous Gm(f) and no reduction was observed. However, it is of special interest that the Gm(n) titer was reduced approximately 8-fold. The latter finding is strongly indicative of a gene defect in the father. The mother could not be studied.

The family of Tia., a patient demonstrating selective reduction of the  $\gamma$ G1 subgroup and moderate diminution of  $\gamma$ A and  $\gamma$ M, was informative. The propositus was heterozygous at the  $\gamma$ G3 locus with asynchronous synthesis of the associated genetic markers; Gm(b) was minimally reduced but Gm(g) was more markedly reduced in titer. There was a striking absence of the Gm(z) and Gm(a) markers normally linked to Gm(g) in Caucasoids. Gm(z) and Gm(a) are detectable in normal persons at titers of 1/640. Gm(g, z, and a), all of maternal origin, were present in normal titers in the mother and in two female siblings of the propositus.

TABLE IV  
*Predominance of Gm(b) vs. Gm(g) Allelic Product in Heterozygous Hypogammaglobulinemic Siblings  
 in Hemagglutination Inhibition Systems for Gm(b) and Gm(g). Agglutination Is Designated  
 0 (Complete Inhibition) to 3 (No Inhibition)*

Inhibitor	whole	1/2	1/4	1/10	1/20	1/40	1/80	1/160	1/320	1/640	1/1280
<b>Gm(b)</b>											
Normal serum b; b	0	0	0	0	0	0	0	0	2	3	3
Normal serum b; g	0	0	0	0	0	0	0	2	3	3	3
Normal serum g; g	3	3	3	3	3	3	3	3	3	3	3
Patient J. Tu.	0	0	0	0	0	0	0	0	3	3	3
Patient G. Tu.	0	0	0	0	0	0	0	0	0	1	3
<b>Gm(g)</b>											
Normal serum b; b	3	3	3	3	3	3	3	3	3	3	3
Normal serum b; g	0	0	0	0	0	0	0	0	2	3	3
Normal serum g; g	0	0	0	0	0	0	0	0	0	0	2
Patient J. Tu.	0	1	3	3	3	3	3	3	3	3	3
Patient G. Tu.	0	1	3	3	3	3	3	3	3	3	3

Despite the normal levels of Gm(b) in the propositus, the associated markers Gm(f) at the  $\gamma$ G1 locus and Gm(n) at the  $\gamma$ G2 locus were both markedly reduced (250- and 320-fold respectively). The Gm(n, b, and f) markers, of paternal origin, were present in normal titers in the father and two sisters of the propositus. The parents and two siblings all had normal levels of immunoglobulin classes and  $\gamma$ G subgroups. The concentration of  $\gamma$ G3 subgroup molecules in one brother was at the upper limit of normal (1.95 mg/ml). The propositus therefore exhibited extreme  $\gamma$ G1 suppression along with more moderate decreases in the other immunoglobulins with selective retention of ability to synthesize  $\gamma$ G3, Gm(b<sup>+</sup>) molecules.

The family of Gau., another patient with predominant  $\gamma$ G3, was informative in that the propositus, who was Gm(f<sup>+</sup>b<sup>+</sup>n<sup>-</sup>a<sup>-</sup>g<sup>-</sup>), had three children who were Gm(f<sup>+</sup>b<sup>+</sup>n<sup>-</sup>a<sup>+</sup>g<sup>+</sup>) with Gm(a<sup>+</sup>g<sup>+</sup>) derived from the mother. Although the Gm(f) titer was reduced 64-fold in the propositus, Gm(f) titers were normal in the children as were the  $\gamma$ G globulin and  $\gamma$ G subgroup concentrations. The propositus therefore transmitted the capacity to synthesize  $\gamma$ G1 Gm(f) molecules normally. The mother of the propositus was uninformative from a genetic standpoint but had a low level of  $\gamma$ G globulin (5.3 mg/ml) which was proportionate for reductions of all subgroups. The oldest of the patient's three children, a 13 yr old daughter, totally lacked  $\gamma$ A molecules (less than 0.020 mg/ml).

The other families of patients with subgroup imbalance were not informative and genetic defects could not be ruled in or out. However, absence of  $\gamma$ A was found in two first degree relatives and two others showed striking depressions of  $\gamma$ A. Thus in the entire group of patients with subgroup imbalance, 5 of 22 first degree relatives

showed absence or marked depression of  $\gamma$ A. The parents and another sibling of the hypogammaglobulinemic Mes. siblings with predominant  $\gamma$ G3 were Gm(b<sup>+</sup>f<sup>+</sup>g<sup>-</sup>a<sup>-</sup>) and therefore uninformative from a genetic standpoint. Of 18 other relatives 8 were heterozygous and normal both for genetic markers and  $\gamma$ G3 concentrations. 10 additional relatives were homozygous with normal concentrations of  $\gamma$ G3, but an 11 yr old paternal male cousin had very low levels of  $\gamma$ A (0.040 mg/ml) and polyclonal elevation of  $\gamma$ G. A 2 yr old male cousin had low levels of  $\gamma$ G for his age group (4.1 mg/ml). The family of patient Feld, with selective absence of  $\gamma$ G2 and  $\gamma$ A was uninformative regarding genetic markers. The  $\gamma$ G level of the father was low (6.2 mg/ml) with proportionate reduction of  $\gamma$ G subgroups. The propositus and two female siblings also manifested lymphopenia and impaired delayed hypersensitivity. One of the female siblings lacked  $\gamma$ A as well; the other had mild proportionate reduction of all subgroups. The mother and other siblings all had normal levels of  $\gamma$ G2 and other subgroups. The mother, a brother, and sister of patient Geo. with predominant  $\gamma$ G2 and absent  $\gamma$ G1 and  $\gamma$ G3 were also uninformative regarding Gm typing. The brother lacked  $\gamma$ A. The levels of immunoglobulin classes, subgroups, and Gm markers were otherwise normal. 18 family members of a patient with selective absence of  $\gamma$ G2 subgroup have revealed a 2½ yr old sibling with significant reduction in concentration of  $\gamma$ G2 (0.105 mg/ml) and  $\gamma$ M (0.093 mg/ml), a maternal uncle with  $\gamma$ G2 significantly diminished (0.38 mg/ml) and significant diminution of  $\gamma$ G3 as well (0.078 mg/ml), and low levels of  $\gamma$ G2 in a 12 yr old maternal aunt (0.89 mg/ml).

Families from 18 patients without subgroup imbalance were also studied. The type of hypogammaglobulinemia in the propositus included the following: infantile

sex-linked, 4 patients; non sex-linked, 7 patients; selective inability to produce  $\gamma A$ , 3 patients; immune deficiency with thrombopenia and eczema, 1 patient; focal nodular hyperplasia, 1 patient; and unclassified, 2 patients. Of 52 first degree relatives, 27 were heterozygous and no abnormal gene complexes or quantitative abnormalities of  $\gamma G$ ,  $\gamma A$ , or  $\gamma M$  were encountered except for a low level of  $\gamma G$  in the mother of one patient and a polyclonal elevation of  $\gamma A$  in the male sibling of another.

*Relationship of subgroup imbalance to imbalances of light-chain types and other immunoglobulin classes.* Quantitation of kappa and lambda light-chain determinants were carried out on sera from all the patients with hypogammaglobulinemia and some available family members. Isolated  $\gamma G$  myeloma proteins or pools of  $\gamma G$  proteins of a single light-chain type were employed as standards because the majority of remaining  $\gamma$  globulin in the patients was the  $\gamma G$  class. The pooled and individual normal sera and fraction II gamma globulin consistently demonstrated expected ratios of kappa:lambda molecules of approximately 2:1, as did most of the patients with hypogammaglobulinemia. Three patients with hypogammaglobulinemia, one of whom had  $\gamma G$  subgroup imbalance, showed reversal of the normal kappa:lambda ratio with lambda type molecules in excess of kappa (Table III). Patient Hx. from the family with structural gene abnormalities showed a consistent slight excess of lambda to kappa in specimens studied over a 2 yr interval. Six additional patients from the group with  $\gamma G$  subgroup imbalance showed kappa:lambda ratios of 1.5 or less.

The possibility of "monoclonality" of  $\gamma G3$  in patients with predominance of  $\gamma G3$  subgroup was evaluated by study of the distribution of light-chain types among the  $\gamma G3$  molecules. Detailed studies of the relationship of the  $\gamma G3$  line on Ouchterlony plates with respect to kappa and lambda precipitin lines in patient Hx. and two additional patients with  $\gamma G3$  predominance indicated that the  $\gamma G3$  molecules clearly represented a mixture of kappa and lambda types. The precipitin line produced with  $\gamma G3$  antiserum penetrated through that produced by the kappa antiserum and the lambda antiserum. In addition, both the kappa and lambda lines penetrated through the  $\gamma G3$  line but each was decreased in intensity as a result. In two other patients with  $\gamma G3$  preponderance and marked excess of kappa chain (Rod. and Lind., Table III), technical difficulties prevented a similar analysis. The remaining patients without subgroup imbalances showed ratios of kappa:lambda molecules of approximately 2:1.

Among the patients with  $\gamma G$  subgroup imbalance, low levels of  $\gamma A$  were observed in all instances and normal levels of  $\gamma M$  were noted in only three instances (Table III). Retained capacity to synthesize  $\gamma M$  was associated

with a variety of subgroup imbalances (predominant  $\gamma G3$ , predominant  $\gamma G2$ , low  $\gamma G2$ ). The selective absence of  $\gamma A$  was not associated with  $\gamma G$  subgroup imbalance in four asymptomatic probands and in one patient with chronic respiratory infections or in two patients with ataxia telangiectasia. The capacity to synthesize  $\gamma D$  molecules was preserved in both sibling pairs exhibiting  $\gamma G$  subgroup imbalance (Table III).

## DISCUSSION

The chance mating of persons with structural or regulator gene abnormalities might be expected to result in individuals who lack the capacity to synthesize specific types of heavy chains and manifest as hypogammaglobulinemia. Disproportionate levels of  $\gamma G$  subgroups would then be expected since the heavy chains are synthesized at separate although closely linked loci. Numerous instances of such alteration in subgroup concentration were noted in the present study. The most common finding was a relative increase in the  $\gamma G3$  subgroup, although a slight absolute increase was noted in three instances. The  $\gamma G2$  subgroup was also relatively increased in several instances, strikingly so in patient Geo. However, no example was encountered where only one subgroup was depressed without an associated abnormality in another immunoglobulin.

One family, in which the proband, Hx., had a relative increase in  $\gamma G3$  concentration, clearly showed evidence of gene abnormalities. The mother lacked the expected  $\gamma G1$  marker, Gm(f), and the father lacked the expected  $\gamma G3$  marker, Gm(g). The accumulated evidence indicated that the proband inherited the two abnormal gene complexes from his parents and was hypogammaglobulinemic. His sister only inherited one abnormal gene complex and was normal. The abnormalities in the two parents were of differing types although they involved closely linked genetic loci. In the patient both chromosomes involved in heavy-chain synthesis contained a defect that appeared to involve structural genes. Just how this defect related to the severe depression of his  $\gamma G1$  and  $\gamma G2$  globulin or to the decrease in  $\gamma A$  and  $\gamma M$  is not entirely clear. One might have expected the  $\gamma G1$  and  $\gamma G3$  levels to be reduced to one-half without effecting the  $\gamma G2$  subgroup or the other immunoglobulins. However, little is known about the regulation and interrelationships of such closely linked and partially similar structural genes as those involved in the synthesis of different heavy chains. Despite the fact that there appeared to be a complete absence of the specific gene products, the possibility of a regulator gene abnormality in at least one of the parents certainly remains. The associated abnormalities in the other immunoglobulins perhaps favor such an interpretation.

Genetic abnormalities similar to those found in the family of patient Hx. have been encountered in rare instances through population screening (9, 14). However thus far they have only been observed singly in the heterozygous state, and no severe abnormality was noted. They resembled the parents and other relatives of patient Hx. The patient might be considered a double heterozygote for the two defects even though they involved separate heavy-chain subgroups. Detailed studies of the rare families encountered in population screening who showed  $\gamma$ G3 gene defects in the heterozygous state (15) revealed that their  $\gamma$ G3 levels averaged approximately one-half the normal level, although clear exceptions were encountered. The father of Hx. in the present study had normal levels of  $\gamma$ G3 despite a missing  $\gamma$ G3 marker. In the case of the families with  $\gamma$ G1 abnormalities, the results were not as clear.<sup>1</sup> 2 individuals were encountered with  $\gamma$ G1 levels that were strikingly low; however, 19 others, also heterozygotes, showed levels in the normal range. Compensatory synthesis by the other gene in these heterozygous individuals appears to be a common phenomenon in the  $\gamma$  globulin system. No cases either in the present study or in the earlier investigations have been encountered that showed any similar defects in the homozygous state. It can be predicted that such cases will be found. The absence of the expected Gm(f) marker in these families and in the Hx family might also result from the production of an altered  $\gamma$ G1 molecule where the Gm(f) site is altered or deleted. The production of unusual proteins such as those found in Franklin's heavy-chain disease cases could account for the findings. Studies are underway in a search for such altered molecules.

The explanation for the hypogammaglobulinemia in the other patients with subgroup imbalance remains unclear. Most of the families were uninformative. Therefore, possible explanation similar to that for Hx. cannot be ruled in or out. However, two families were partially informative, and here such an explanation for the subgroup variations probably could be excluded. Studies on the first degree relatives of these patients indicated a number of defects with reduced  $\gamma$ A levels being the most striking. Other abnormalities encountered in the relatives included selective depression of  $\gamma$ G2 and  $\gamma$ G3, low levels of Gm(f) and Gm(n), and levels of  $\gamma$ G and  $\gamma$ M which were slightly reduced or in the low normal range. Previous studies (29) had indicated that multiple abnormalities are found in the families of patients of this type including  $\gamma$ A depression. Recently, Rivat, Burtin, and Ropartz (30) have noted alterations involving certain genetic markers in a few similar families. Future studies with genetic markers for  $\gamma$ A and  $\gamma$ M may

<sup>1</sup>Litwin, S. D., W. J. Yount, L. Martensson, E. Van Loghem, and H. G. Kunkel. Unpublished observations.

well reveal relevant structural gene defects. However, at the present time the possibility of regulator gene abnormalities, as proposed some years ago by Parker and Bearn (31), would appear the more attractive explanation for the partial reductions observed in various family members.

The subgroup imbalances noted in the 13 patients of this study were found primarily in those cases showing imbalance of the  $\gamma$ G,  $\gamma$ A, and  $\gamma$ M levels. This might to some extent be expected since the class and subgroup distinction is in part artificial. Current evidence indicates that the heavy chains which determine class and subgroup all are controlled by independent but closely linked genetic loci (11). These appear to have arisen by gene duplication with the closely related subgroup genes representing the most recent duplications. Variations in the distribution of  $\gamma$ G subgroups have also been observed, although to a much lesser degree in patients with diffuse hyperglobulinemia, as in systemic lupus erythematosus (4), and in rare patients with normal levels of  $\gamma$ G (32).

Subgroup imbalances may be suspected in patients with hypogammaglobulinemia by the configuration of the  $\gamma$ G precipitin arc on immunoelectrophoresis. The  $\gamma$ G2 and  $\gamma$ G4 subgroups are more anodal, the  $\gamma$ G1 and  $\gamma$ G3 more cathodal. The relative paucity of anodally migrating proteins, which has been observed primarily in some patients with hypogammaglobulinemia (33), would be compatible with either  $\gamma$ G1 or  $\gamma$ G3 preponderance and requires subgroup specific antisera for further evaluation. Several of the quantitative systems employed in the present study require subgroup-specific antigens occurring in both the Fd and Fc portions of  $\gamma$ G subgroup heavy chains. Spurious values might be obtained if some of these antigens are lacking. One instance of an apparent imbalance of  $\gamma$ G subgroups, in a serum lacking Gm genetic markers (34), has been shown to be due to the presence of hybrid molecules of  $\gamma$ G3- $\gamma$ G1, analogous to the delta-beta chain hybrids established for Lepore-type hemoglobins (14). An unequal homologous crossover involving mispairing of heavy-chain cistrons was postulated to explain the deletion of heavy-chain markers (14). Such aberrations were sought in the present study by hemagglutination-inhibition techniques but no such instance was encountered. Patients with preponderance of  $\gamma$ G3 had increased levels of  $\gamma$ G3 Fc and  $\gamma$ G3 Fab antigens; absence of  $\gamma$ G2 or  $\gamma$ G1 was for antigens both on the Fab and Fc portions of these molecules.

The possibility was considered that the selective elevation of the  $\gamma$ G3 subgroup might be explained in a fashion similar to that for fetal hemoglobin involving a type of nonspecific reversion. For this reason a panel of 5-7 month old infants was studied, a time when nadirs



of gamma globulin concentration have been reached and rising levels reflect autologous synthesis. Disproportions of  $\gamma$ G subgroups, and particularly  $\gamma$ G3 preponderance were not found. The relative preponderance of  $\gamma$ G3 might in some instances reflect decreased catabolism. However, this mechanism would require increased survival of  $\gamma$ G3 relative to other subgroups, a situation just the reverse of that found in normal individuals (35, 36). The rate of  $\gamma$ G3 degradation has been found to exceed that of the remaining  $\gamma$ G subgroups.

Another possible mechanism for subgroup imbalances might be the presence of small amounts of monoclonal bands in some patients. The serums of several of the patients in the present series have been shown previously to have limited electrophoretic distribution of gamma globulins when compared with normal individuals, which at times was bimodal (16, 17). The abnormal kappa to lambda ratios for the light chain types of both  $\gamma$ G and  $\gamma$ M, previously noted in some of these patients (17), were confirmed in the present study. Monoclonal bands have occasionally been described in other patients with primary immune deficiency (37). In the present study considerable attention was paid to this question and this was ruled out in those instances where sera could be tested. The chief evidence against such a possibility was that the subgroup selectively retained contained both kappa and lambda light chains. However, it was not possible to study all cases with regard to this question, and low concentrations of monoclonal bands remains a possibility in some instances. Another possible mechanism for subgroup or light-chain homogeneity is the proliferation of selective clones of immunocompetent cells either transplantally or after therapeutic grafting. Such examples were not evident in the present series but have been shown to result in synthesis of monoclonal proteins (38).

Some cases of subgroup imbalance might relate to selective microbial or other antigenic stimulation of a limited number of heavy-chain cistrons. Such imbalances would be masked in normal individuals within the total gamma globulin spectrum. It has been recently shown with isolated human antibodies to certain carbohydrates that a single subgroup may be predominant (26). Thus, the minor  $\gamma$ G2 class was the major heavy-chain type for antibodies to dextran, levan, and teichoic acid. Variations in light-chain type have also been noted in isolated human antibodies (26, 39), so that isolated antibodies may be enriched in kappa or lambda when fractionated on the basis of specificity. Such a mechanism might be involved in some of the altered light-chain ratios encountered in the present study.

It is perhaps of special interest that in most instances where  $\gamma$ G3 subgroup retention was observed in patients with hypogammaglobulinemia it was the Gm(b) type

that was selectively present. The Gm(g) type which is coded for by the gene allelic to Gm(b) was very markedly reduced although still detectable by hemagglutination-inhibition techniques. This was particularly striking in two siblings where the Gm(b) molecules showed a 100-fold greater concentration than Gm(g). The significance of this striking imbalance remains obscure. Levels of the  $\gamma$ G3 subgroup in normal persons have been shown to relate to genetic type with significantly higher levels in homozygous Gm(b+) individuals, lower levels in homozygous Gm(g+) persons, and intermediate levels in heterozygotes (4).

None of the patients with infantile sex-linked agammaglobulinemia showed an imbalance of subgroup concentration and no gene defects were demonstrable in 18 first degree relatives. The structural genes involved in gamma globulin synthesis have not been found on the X-chromosome in any species studied so that similar gene defects in these cases would not be expected. Other explanations must be sought in these cases such as alterations involved in cell maturation and differentiation.

The relationship between genetic defects observed in the present series and the impaired capacity of lymphocytes isolated from first degree relatives of some patients with adult onset hypogammaglobulinemia to respond to phytohemagglutinin remains obscure (40). The latter suggests a defect in the thymus-derived cells which appear to be primarily involved in cellular immunity. Combined defects in both the antibody-forming and cellular immune systems are frequently encountered in these patients.

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#### REFERENCES

1. Grey, H. M., and H. G. Kunkel. 1964. H chain subgroups of myeloma proteins and normal 7S  $\gamma$ -globulin. *J. Exp. Med.* 120: 253.
2. Terry, W. D., and J. L. Fahey. 1964. Subclasses of human  $\gamma_2$ -globulin based on differences in the heavy polypeptide chains. *Science (Washington)*. 146: 400.
3. Kunkel, H. G., J. L. Fahey, E. C. Franklin, E. F. Osserman, and W. D. Terry. 1966. Notation for human immunoglobulin subclasses. *Bull. World Health Organ.* 35: 953.
4. Yount, W. J., H. G. Kunkel, and S. D. Litwin. 1967. Studies of the Vi ( $\gamma_{2c}$ ) subgroup of  $\gamma$ -globulin. A relationship between concentration and genetic type among normal individuals. *J. Exp. Med.* 125: 177.

5. Kunkel, H. G., J. C. Allen, H. M. Grey, L. Mårtensson, and R. Grubb. 1964. A relationship between the H chain groups of 7S  $\gamma$ -globulin and the Gm system. *Nature (London)*. 203: 413.
6. Terry, W. D., J. L. Fahey, and A. G. Steinberg. 1965. Gm and Inv factors in subclasses of human IgG. *J. Exp. Med.* 122: 1087.
7. Kunkel, H. G., W. J. Yount, and S. D. Litwin. 1966. Genetically determined antigen on the Ne subgroup of gamma-globulin: detection by precipitin analysis. *Science (Washington)*. 154: 1041.
8. Natvig, J. B. 1966. Gm(g)—a "new" gamma globulin factor. *Nature (London)*. 211: 318.
9. Litwin, S. D., and H. G. Kunkel. 1967. The genetic control of  $\gamma$ -globulin heavy chains. Studies of the major heavy chain subgroup utilizing multiple genetic markers. *J. Exp. Med.* 125: 847.
10. Mårtensson, L. 1966. Genes and immunoglobulins. *Vox Sang.* 11: 521.
11. Natvig, J. B., and H. G. Kunkel. 1968. Genetic markers of human immunoglobulins. *Ser. Haematol.* 1: 66.
12. Natvig, J. B., H. G. Kunkel, and T. Gedde-Dahl. 1967. Genetic studies of the heavy chain subgroups of  $\gamma$ G-globulin. Recombination between the closely linked cistrons. In Third Nobel Symposium, Gamma Globulins. J. Killander, editor. Almqvist & Wiksell, Publishers, Stockholm. 313.
13. Natvig, J. B., H. G. Kunkel, and S. D. Litwin. 1967. Genetic markers of the heavy chain subgroups of human  $\gamma$ G globulin. *Cold Spring Harbor Symp. Quant. Biol.* 32: 173.
14. Kunkel, H. G., J. B. Natvig, and F. G. Joslin. 1969. A "leptore" type of hybrid  $\gamma$  globulin. *Proc. Nat. Acad. Sci. U. S. A.* 62: 144.
15. Natvig, J. B., H. G. Kunkel, W. J. Yount, and J. C. Nielsen. 1968. Further studies on the  $\gamma$ G-heavy chain gene complexes, with particular reference to the genetic markers Gm(g) and Gm(n). *J. Exp. Med.* 128: 763.
16. Hong, R., and R. A. Good. 1967. Limited heterogeneity of gamma globulin in hypogammaglobulinemia. *Science (Washington)*. 156: 1102.
17. Seligmann, M., G. Meshaka, and F. Danon. 1967. Anomalies des immunoglobulines dans certaines agammaglobulinémies primitives. *Rev. Fr. Etud. Clin. Biol.* 12: 604.
18. Yount, W. J., R. Hong, M. Seligmann, R. A. Good, and H. G. Kunkel. 1969. Structural gene defects and preponderance of  $\gamma$ G3 subgroup in patients with hypogammaglobulinemia. *J. Clin. Invest.* 48: 92a. (Abstr.)
19. Seligmann, M., H. H. Fudenberg, and R. A. Good. 1968. A proposed classification of primary immunologic deficiencies. *Amer. J. Med.* 45: 817.
20. Kunkel, H. G. 1954. Zone electrophoresis. *Methods Biochem. Anal.* 1: 141.
21. Müller-Eberhard, H. J. 1960. A new supporting medium for preparative electrophoresis. *Scand. J. Clin. Lab. Invest.* 12: 33.
22. Porter, R. R. 1959. The hydrolysis of rabbit  $\gamma$ -globulin and antibodies with crystalline papain. *Biochem. J.* 73: 119.
23. Mancini, G., A. O. Carbonara, and J. F. Heremans. 1965. Immunochemical quantitation of antigens by single radial immunodiffusion. *Immunochemistry*. 2: 235.
24. Fahey, J. L., and E. M. McKelvey. 1964. Quantitative determination of serum immunoglobulins in antibody-agar plates. *J. Immunol.* 94: 84.
25. Kabat, E. A., and M. M. Mayer. 1961. Experimental Immunochemistry. Charles C. Thomas Publisher, Springfield, Ill. 2nd edition.
26. Yount, W. J., M. M. Dorner, H. G. Kunkel, and E. A. Kabat. 1968. Studies on human antibodies. VI. Selective variations in subgroup composition and genetic markers. *J. Exp. Med.* 127: 633.
27. La Plane, R., P. Burtin, S. Curioni, C. Houet, D. Graveleau, and J. C. LeBalle. 1962. Sur un cas d'agammaglobulinémie atypique. Étude biologique et génétique. *Semain des Hôpitaux, Paris*. 38: 1485.
28. Litwin, S. D. 1970. "Allelic balance" between Gm(a) and Gm(f) on human  $\gamma$ G1 heavy chains. *Fed. Proc.* 29: 257. (Abstr.)
29. Fudenberg, H. H., J. L. German III, and H. G. Kunkel. 1962. The occurrence of rheumatoid factor and other abnormalities in families of patients with agammaglobulinemia. *Arthritis Rheum.* 5: 565.
30. Rivat, L., P. Burtin, and C. Ropartz. 1969. Mise en évidence d'un mécanisme génétique contrôlant la synthèse de certaines sous-classes des  $\gamma$ G dans des hypogammaglobulinémies dites acquises. *Humangenetik*. 8: 183.
31. Parker, W. C., and A. G. Bearn. 1963. Application of genetic regulatory mechanisms to human genetics. *Amer. J. Med.* 34: 680.
32. Terry, W. D. 1968. Variations in the subclasses of IgG. *Birth Defects Orig. Artic. Ser.* 4: 357.
33. Gobejowska, H., and D. S. Rowe. 1967. Immunoglobulin G of restricted electrophoretic mobility in certain human sera. *Clin. Exp. Immunol.* 2: 275.
34. Steinberg, A. G., W. A. Muir, and S. A. McIntire. 1968. Two unusual Gm Alleles: their implications for the genetics of the Gm Antigens. *Amer. J. Hum. Genet.* 20: 258.
35. Spiegelberg, H. L., B. G. Fishkin, and H. M. Grey. 1968. Catabolism of human  $\gamma$ G immunoglobulins of different heavy chain subclasses. *J. Clin. Invest.* 47: 2323.
36. Morell, A., W. D. Terry, and T. A. Waldmann. 1970. Metabolic properties of IgG subclasses in man. *J. Clin. Invest.* 49: 673.
37. Danon, F., J. P. Clauvel, and M. Seligmann. 1967. Les paraprotéines de type IgG et IgA en dehors de la maladie de Kahler. *Rev. Fr. Etud. Clin. Biol.* 12: 681.
38. Harboe, M., H. Pande, P. Brandtzaeg, K. J. Tvetter, and P. F. Hjort. 1966. Synthesis of donor type  $\gamma$ G globulin following thymus transplantation in hypogammaglobulinemia with severe lymphocytopenia. *Scand. J. Haematol.* 3: 351.
39. Mannik, M., and H. G. Kunkel. 1963. Localization of antibodies in Group I and Group II  $\gamma$  globulins. *J. Exp. Med.* 118: 817.
40. Kamin, R. M., H. H. Fudenberg, and S. D. Douglas. 1968. A genetic defect in "acquired" agammaglobulinemia. *Proc. Nat. Acad. Sci. U. S. A.* 60: 881.