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Cutting Edge: A Soluble Form of CTLA-4 in Patients with Autoimmune Thyroid Disease

Martin K. Oaks¹ and Karen M. Hallett

We have recently identified a novel transcript of the CTLA-4 gene that may represent a native soluble form of CTLA-4 (sCTLA-4). To determine whether sCTLA-4 was expressed in humans, we applied a sensitive enzyme immunoassay on serum from patients with autoimmune thyroid disease (ATD). Eleven of 20 patients with ATD had circulating levels of sCTLA-4 ranging from 28 to 78 ng/ml, whereas only 1 of 30 apparently healthy volunteers had a level greater than 4 ng/ml. sCTLA-4 immunoreactivity was inhibited by its binding to B7.1, suggesting that sCTLA-4 is a functional receptor. Immunoprecipitation analysis of serum from patients with ATD revealed a polypeptide consistent with the predicted size of sCTLA-4. We conclude that a native soluble form of CTLA-4 is derived from an alternate transcript of the CTLA-4 gene, and its level in plasma is elevated among a population of patients with ATD. The Journal of Immunology, 2000, 164: 5015–5018.

CTLA-4 is a B7 binding protein (2, 3). The emerging notion of the function of CTLA-4 is that it represents a negative regulator of T cell activation (4). The most compelling data that supports such a role for CTLA-4 comes from experiments in which the gene is rendered inactive via construction of CTLA-4 knockout mice (5, 6). The emerging notion of the function of CTLA-4 is that it represents a negative regulator of T cell activation. That is, ligation of CTLA-4 on the T cell surface initiates a series of biochemical events that attenuates an ongoing immune response (4). The most compelling data that supports such a role for CTLA-4 comes from experiments in which the CTLA-4 gene is rendered inactive via construction of CTLA-4 knockout mice (5, 6).

Cytoxic T lymphocyte associated gene-4 (CTLA-4) was initially described as a classical type I glycoprotein on the surface of activated T cells (1). CTLA-4 is a member of the Ig gene superfamily and along with its homologue, CD28, is a B7 binding protein (2, 3). The emerging notion of the function of CTLA-4 is that it represents a negative regulator of T cell activation. That is, ligation of CTLA-4 on the T cell surface initiates a series of biochemical events that attenuates an ongoing immune response (4). The most compelling data that supports such a role for CTLA-4 comes from experiments in which the CTLA-4 gene is rendered inactive via construction of CTLA-4 knockout mice (5, 6). Such mice demonstrate profound polyclonal lymphoproliferative disorders that infiltrate most major organ systems and die a few weeks after birth. The majority of animals have increased levels of IgG, which illustrates the role of CTLA-4 on humoral immune responses as well. A role for CTLA-4 in autoimmune disease is suggested by the observations that blockade of B7: CTLA-4 interaction via administration of anti-CTLA-4 mAbs exacerbates animal models of autoimmune disease such as experimental autoimmune encephalomyelitis (7) and diabetes (8).

It has long been known that Graves’ disease and insulin-dependent diabetes mellitus have a substantial genetic basis as suggested by the relatively high rate of concordance in monozygotic twins and the clustering of disease within certain families. The human leukocyte Ag genes residing on chromosome 6 are known to represent a genetic component of these autoimmune endocrine disorders, but other genetic factors remain to be elucidated. A search for genetic markers that segregate with Graves’ disease revealed an association with CTLA-4 polymorphisms (9). Such an association was further substantiated in other ethnic populations as well as other endocrine autoimmune disease (10–17). Thus, it would appear that CTLA-4 is closely linked to a susceptibility gene for autoimmune thyroid disease (ATD) or is itself the susceptibility gene. To date, however, there are no available data that implicate alteration of CTLA-4 structure, function, or expression in any autoimmune disorder.

In 1997, we submitted the nucleic acid sequences of alternate transcripts of CTLA-4 in man, mouse, and rat that lacked transmembrane encoding regions to the GeneBank Sequence Database (accession nos. U90273, U90270, and U90271, respectively). Recently, Magistrelli et al. (18) described the same transcript and detected immunoreactive material in human serum that is consistent with the presence of a native soluble form of CTLA-4 (sCTLA-4). Initial experiments designed to identify the sCTLA-4 polypeptide by ELISA and Western blotting in normal human serum were unsuccessful in our laboratory. Because of the well-known association between CTLA-4 polymorphisms and ATD, we speculated that a reasonable starting point in the search for expression of the native sCTLA-4 would be in patients with Graves’ disease and Hashimoto’s thyroiditis. To that end, we developed an immunoassay for circulating CTLA-4 in human serum, and show in this communication that a soluble form of CTLA-4 is present in patients with ATD.

Materials and Methods

 Patients

All patients in this study had a recent diagnosis of Graves’ disease (n = 17) or Hashimoto’s thyroiditis (n = 3) based upon clinical presentation and laboratory findings. The patients ranged in age from 19 to 47 years, and 16 were female and 4 were male. Serum was obtained at the time of diagnosis, and none of the patients studied had remarkable co-morbidity. All patients were studied before any treatment for ATD. Control sera were from normal healthy laboratory volunteers of similar age and sex mix relative to the

¹ Address correspondence and reprint requests to Dr. Martin K. Oaks, Transplant Research Laboratory, St. Luke’s Medical Center, 2900 West Oklahoma Avenue, Milwaukee, WI 53215. E-mail address: Moaks@execpc.com

² Abbreviations used in this paper: ATD, autoimmune thyroid disease; sCTLA-4, soluble CTLA-4; EIA, enzyme immunoassay.
To determine whether a circulating form of CTLA-4 was present in human serum, we devised a sensitive EIA using available mAbs to CTLA-4. The assay was optimized using commercially available CTLA4-Ig as a standard and then applied to testing of human serum samples. Fig. 1 shows combined data from the EIA on patients with ATD and normal apparently healthy volunteers. Circulating CTLA-4 was virtually undetectable in healthy volunteers as defined by the limit of sensitivity of 4 ng/ml for this assay. A single serum sample among 30 from healthy controls had detectable CTLA-4. By contrast, 11 of 20 patients with ATD had detectable circulating CTLA-4 levels in the range of 28–78 ng/ml. Of the 11 patients with detectable sCTLA-4, 8 had Graves’ disease (8 of 17 studied) and the remaining 3 had Hashimoto’s thyroiditis (3 of 3 studied). There was no obvious relationship between the sex and age of the patient and levels of sCTLA-4. sCTLA-4 was detectable using several commercially available mAbs to CTLA-4 as capture Abs (data not shown), arguing against the possibility that autoantibodies or anti-idiotypic Abs were responsible for these effects.

To determine whether CTLA-4 immunoreactivity in serum consisted of an intact and functional molecule as opposed to degraded or shed CTLA-4 polypeptides, we attempted to block the CTLA-4 immunoassay by preincubating positive sera with B7-Ig fusion proteins. Data from a representative experiment is shown in Fig. 1. In this case, a sample containing 28 ng/ml sCTLA-4 was completely neutralized in the presence of 200 ng B7.1-Ig fusion protein. Neutralization of immunoreactivity was obtained on three independent serum samples and ranged from 33 to 95% inhibition. Negligible inhibition (<5%) was observed when a control fusion protein (Muc18-Ig) was tested in these experiments. These data show that the CTLA-4 immunoreactive material present in human serum represents an intact functional receptor for the B7.1 ligands.

The primary limitation of the EIA for circulating CTLA-4 described here and that used by others (18) is that they are based on the use of Abs reactive with epitopes within the B7-binding region of the molecule. As a result, they cannot distinguish native soluble

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FIGURE 1. A soluble form of CTLA-4 is found in serum of patients with ATD. ●, Data from patients with ATD; ○, data from healthy lab personnel; ▲, representative data from a experiment to test whether B7-Ig was capable of inhibiting CTLA-4 immunoreactivity. The sample is from a patient with ATD and was tested without the addition of B7-Ig (top triangle) or with the addition of 200 ng B7.1-Ig fusion protein (lower triangle). Each data point represents the mean of triplicate determinations.

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CTLA-4 receptors derived from the transcript lacking the transmembrane domain from those that might be present in serum due to proteolytic digestion or shedding of the CTLA-4 integral membrane protein. To determine whether the immunoreactive material in serum of ATD patients was derived from the gene product of the alternate transcript, we designed immunoprecipitation experiments using a pool of commercially available mAbs as a precipitin and a polyclonal Ab raised against a novel epitope within the carboxyl terminus of sCTLA-4 that is generated by a frame shift mutation that occurs during RNA splicing. Fig. 2 shows a representative experiment. This combination of Abs predominantly identifies a polypeptide species ~23 kDa, which is consistent with the predicted size based on the amino acid sequence and predicted N-linked glycosylation pattern of sCTLA-4. Western blotting of serum proteins from several patients with ATD also showed a predominant species of about 23 kDa when tested directly against the 8K antisera (data not shown). This species was not evident when probed with a pre-immune serum from the same animal used for immunization, even when run 50-fold concentrated than immune sera.

Discussion

We and others (18) have recently described an alternate transcript of the CTLA-4 gene that encodes a protein that lacks a transmembrane region and likely represents a native soluble form of CTLA-4. The work presented in this report documents the finding of CTLA-4 immunoreactive material in serum of patients with ATD including Graves’ disease and Hashimoto’s thyroiditis. Because the immunoreactive material contains two epitopes, one of which is unique to the putative sCTLA-4 protein, we propose that sCTLA-4 is a novel polypeptide product of the CTLA-4 gene. The fact that CTLA-4 immunoreactivity can be blocked by one of its known ligands (namely, B7.1) supports the notion that sCTLA-4 encodes a functional receptor. Like other soluble receptors (20–25), sCTLA-4 may have important immunoregulatory functions. The effect of sCTLA-4 binding to B7 molecules might depend on the activation status of the cells involved. For example, on resting cells, sCTLA-4 may block B7-CD28 interactions, thereby interfering with T cell costimulation. On the other hand, inhibition of B7-CTLA-4 interactions on activated T cells (conditions under which the transmembrane form of the molecule is selectively expressed) may prevent down-regulation of T cell responses. The functional activity of sCTLA-4 adds an additional level of complexity to the current description of the role of CTLA-4 in immunoregulation. For example, what are the relative roles of sCTLA-4 versus the transmembrane form of the molecule in the immune dysfunction observed in CTLA-4 knockout mice? CTLA-4 knockouts develop a profound polyclonal lymphoproliferative disorder that has commonly been attributed to inhibition of the attenuating effect of CTLA-4 on activated cells; however, because these animals contain deletions within the exon 2 which includes the B7-binding domains, they would lack both the soluble as well as the transmembrane forms of CTLA-4.

Our data differs from that reported by Magistrelli et al. (18) in that they report detection of circulating CTLA-4 in 14 of 64 healthy subjects (18). By contrast, we observed a value of >4 ng/ml in only one sample of 30 healthy individuals. It is possible that these differences are due to technical variables such as the different mAbs used for detection. Alternatively, they may be attributed to differences in the ethnic background of the populations tested or to the relatively undefined immunological status of the two control groups, for example, recent infection, allergy, etc.

We believe our findings to be provocative because they may also provide a link between the genetic susceptibility to ATD and differences in the expression of the various forms of the CTLA-4 molecule. Population genetics data clearly suggest a role for the CTLA-4 gene region in the susceptibility to ATD; however, a specific change in CTLA-4 structure or function has not been described. Two polymorphisms within the CTLA-4 gene have been studied with respect to population genetic associations with endocrine autoimmune disease. One of them represents a single nucleotide polymorphism that results in an amino acid substitution (Thr/Ala) within the signal sequence of the CTLA-4 polypeptide (19). The Ala allele has been reported to have statistically significant higher frequency among patients with Graves’ disease (17) as well as insulin dependent diabetes mellitus (10–12). No relationship between this dimorphism and CTLA-4 structure, function, or expression has been described. A small number of patients from this study (n = 5) who were positive for sCTLA-4 were typed for the Thr/Ala polymorphism, but this analysis revealed no exclusive association with a specific genotype (data not shown). A larger population needs to be studied to fully examine the relationship, if any, between CTLA-4 polymorphisms and circulating levels of sCTLA-4.

A second polymorphism with population genetic associations with autoimmune endocrine disease is a dinucleotide repeat (AT)n within exon 3 of the human CTLA-4 gene (9, 26). The dinucleotide repeat is within a noncoding region of the gene, but is potentially important because it might effect mRNA stability. Long runs of A and T are found in the 3’ untranslated regions of a variety of transcripts that are transiently expressed including mRNAs for cytokines, lymphokines, and protooncogenes (27). It is possible that polymorphisms within this repeat unit effect stability or splicing of one or more of the alternate CTLA-4 transcripts, resulting in changes in expression observed in this study. This study does not, of course, provide support for such a concept, and it is certainly possible that the polymorphisms described to date merely serve as markers for variation within the CTLA-4 gene, the CD28 gene (which is closely linked to CTLA-4 (19)), or unknown genes in linkage disequilibrium with CTLA-4. Nevertheless, our findings of increased levels of sCTLA-4 in patients with ATD may reveal important information regarding CTLA-4 function as well as the pathogenesis of autoimmune disease. An interesting question that our data raises is whether elevated levels of sCTLA-4 represent a constitutive effect of a CTLA-4 susceptibility gene per se or rather are due to a physiologic response to the activation status of T cells.
with reactivity to thyroid autoantigens. To that end, we are currently examining the relationship between sCTLA-4 levels and disease onset in ATD.

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References