M1 - Immunology, Winter 2008

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THE COMPLEMENT SYSTEM IN HUMAN DISEASE

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J. Fantone, M.D. 2/12/08
THE COMPLEMENT SYSTEM IN HUMAN DISEASE

I. LEARNING OUTCOMES: To Understand the

• role of complement in inflammation and the effects of specific complement deficiencies on patients.
• mechanisms by which the complement system is activated and regulated.
• effector molecules of complement activation and their biologic function.
• role of complement in bacterial clearance and lysis.
• use of plasma CH50 levels in the assessment of disease processes.
COMPLEMENT SYSTEM

• The learning outcomes for this topic will be attained by viewing a self-directed learning module supplemented by the syllabus.
  http://www.umich.edu/~projbnb/imm/complement.swf

• It is expected that the student will view the video prior to the lecture presentation on phagocytic cells (2/12: 9-10:00am).

• Any questions will be addressed by Dr. Fantone prior to and after the Phagocytic Cell lecture
II. Why study the complement system?

- Innate & Adaptive Immunity
- Infection
- Inflammation
- Cell lysis
- Immune complex disease
- Autoimmune disease
III. Definition: Complement consists of more than 20 proteins present in plasma and on cell surfaces that interact with each other to produce biologically active inflammatory mediators that promote cell and tissue injury.

Nomenclature:

a. the first component of complement is named C1 (etc.) other components are designated by capital letters and names: Factor B, Properidin

b. when cleaved: fragments of complement components are designated by small letters (e.g. C3a and C3b)
Factor B → Ba + Bb

Factor H

Factor I
IV. Summary of Complement Pathways

3 pathways for activation:

1. classical: most specific (antibody dependent activation, binds C1)
2. lectin binding: some specificity (mannose binding protein, binds C4)
3. alternative: most primitive (non-specific, auto-activation of C3)
Complement System

Regulation

Activation

Amplification

Biologic Function
Classical Complement Pathway

- C1qrs
- Antibody
- C4b
- Bacteria
- C4
- C2
- C3
- C5
- C4a
Classical Complement Pathway

C1qrs → C4b → C2b → Antibody → Bacteria

C1qrs → C4 → C2 → C3 → C5 → C4a → C2a
Classical Complement Pathway
Classical Complement Pathway

Animation complete
Classical Complement Pathway

Animation complete
V. Amplification:

C3 convertase: binds and cleaves multiple C3 molecules on surface to form C3b + C3a

- classical: C4b2b
- alternative: C3bBb
Lectin Binding Complement Pathway
Lectin Binding Complement Pathway
Lectin Binding Complement Pathway
Lectin Binding Complement Pathway

Animation complete
Lectin Binding Complement Pathway

Animation complete
Alternative Complement Pathway
Alternative Complement Pathway

Bacteria

C3
B
C5
C3b
Bb
C3a
Alternative Complement Pathway

Animation complete
Alternative Complement Pathway
VI. Biologic Function:

- anaphylatoxins: C3a and C5a: mast cell degranulation
  - smooth muscle contraction
  - mast cell degranulation mediator release (histamine, leukotrienes)
  - vascular changes: dilation, increased permeability (edema)
  - C5a also leukocyte adhesion and chemotaxis (recruitment)

- opsonization: C3b, C3bi, C3d: (binding to complement receptors and enhanced phagocytosis by neutrophils and macrophages)

- clearance of circulating immune complexes

- membrane attack complex: C5b-C9 (cell lysis)
MAC PORES

C5b, C6, C7, C8 and C9 together form the membrane attack complex

Source: www.wikimedia.org

Source: undetermined
SUMMARY OF COMPLEMENT ACTIVATION

Classical Pathway

\[ C1q \rightarrow \text{MBP} \rightarrow [C4b2b] \rightarrow [C3bBbP] \rightarrow C3\text{ Convertase} \]
\[ \rightarrow C3b \rightarrow C3a \text{ anaphylatoxins} \rightarrow C3b, C3bi \text{ (opsonization)} \]
\[ \rightarrow C5a \rightarrow C5b \rightarrow C5b-C9 \text{ (membrane attack complex)} \]

Cell Injury
VII. Regulation:

- Inhibit activation: classical pathway
  - C1 inhibitor (C1INA): plasma protein

- spontaneous decay (hydrolysis) of C3 convertases:

- inhibit C3 convertase:
  - Plasma proteins: Factor I
  - Cell membrane proteins:
    - decay accelerating factor (DAF):
    - membrane co-factor protein (MCP):
VII. Regulation

• Inactivate anaphylatoxins: cleave C3a and C5a
  – serum carboxypeptidase N (SCPN):

• Inhibit MAC:
  – Protectin (CD59): cell associated protein
SUMMARY OF COMPLEMENT ACTIVATION

Classical Pathway

Lectin-Binding Pathway

Alternative Pathway

C1q

MBP

C3

[C4b2b] [C3bBbP]

C3 Convertase

C3a

C3b

C5a

C5b

C5b-C 9

(membrane attack complex)

Cell Injury

Hydrolysis DAF-cell

Factor I MCP-cell

Protectin-cell
VIII. Complement Deficiencies:

• early components: auto-immune disease
• middle and late components: pyogenic bacterial and nisseria infections
• most common congenital deficiency: C2
• C1INA deficiency: hereditary angioedema
• DAF deficiency: paroxysmal nocturnal hemoglobinuria
IX. Clinical Laboratory Testing

A. Serum complement hemolytic activity: CH50
   (serum dilution at which 50% hemolysis occurs)
if low = complement deficiency:
   - acquired vs. congenital
   - classical vs. alternative pathway defect

B. Individual Components
RBC + AB + SERUM $\rightarrow$ HEMOLYSIS

% HEMOLYSIS

SERUM DILUTION

N

P

1/500 1/250 1/50 1/10
Case A: A 23yo man complains of fever (102ºF), headache, neck stiffness and fatigue of 2 days duration. Lumbar puncture shows increased pressure with cloudy cerebrospinal fluid containing large numbers of neutrophils, increased protein, decreased glucose and gram negative diplococci. Laboratory studies show C5 (5th component of complement) levels at 18% normal and normal levels of C2, C3 and C7. The patient recovers after institution of intravenous antibiotic therapy.
Case A: Why would this patient be at increased risk for developing bacterial meningitis?

What is the relationship among the three pathways of complement activation and bacterial clearance?

Would a defect in C2 alone place a patient at increased risk of developing bacterial meningitis? Explain.
Case B: A 14yo girl has a long history of excessive swelling after mild traumatic injury. During the past 2 years she has complained of 7 episodes of intermittent abdominal pain sometimes accompanied with watery diarrhea. Laboratory tests show decreased levels of C4 and normal C3 levels. C1 inhibitor levels are 20% of normal.
What pathologic changes would explain this patient's symptoms?

What is the effect of defective C1 esterase levels on complement system regulation?

What other inflammatory mediator systems are affected by C1 esterase inhibitor?

Why are these patients not at significant risk for bacterial infection?
Complement Cases

Case A:

Diagnosis: acute bacterial meningitis secondary to deficiency of C5

All three pathways can be activated and the bacteria can be opsonized with C3b and its derivatives: however, the deficiency in C5 results in an inability to generate the chemotactic peptide C5a and assemble the membrane attack complex (MAC) and cause target cell injury.

Defects in the early complement components are more frequently associated with the development of autoimmune syndromes (e.g. systemic lupus erythematosus, SLE).

In C2 deficiency, the alternative complement pathway remains functional, target cells can still be opsonized with C3b and the MAC formed.
CaseB:

The patient’s symptoms are the result of increased vascular permeability changes leading to soft tissue swelling and diarrhea.

In the absence if C1 inhibitor there is spontaneous activation of the classical complement pathway with cleavage of C4 and C2. Since there is no target cell surface for complement binding, C3 cleavage does not occur to any significant degree and if some C3b is formed, it undergoes spontaneous hydrolysis –

The C2a and its subsequent products can cause vascular permeability changes. Also, C1 inhibitor interacts with the kallikriken-kinin mediator system. A deficiency in this inhibitor also results in increased kinin formation (e.g. bradykinin), which also promotes vascular permeability changes.

These patients (even if C2 and C4 are depleted) have an intact alternative complement pathway.
Additional References:

**Phagocytic Cells:**
Kumar, Abas, and Fausto: Pathologic Basis of Disease (7th ed.) pages 64-66.