

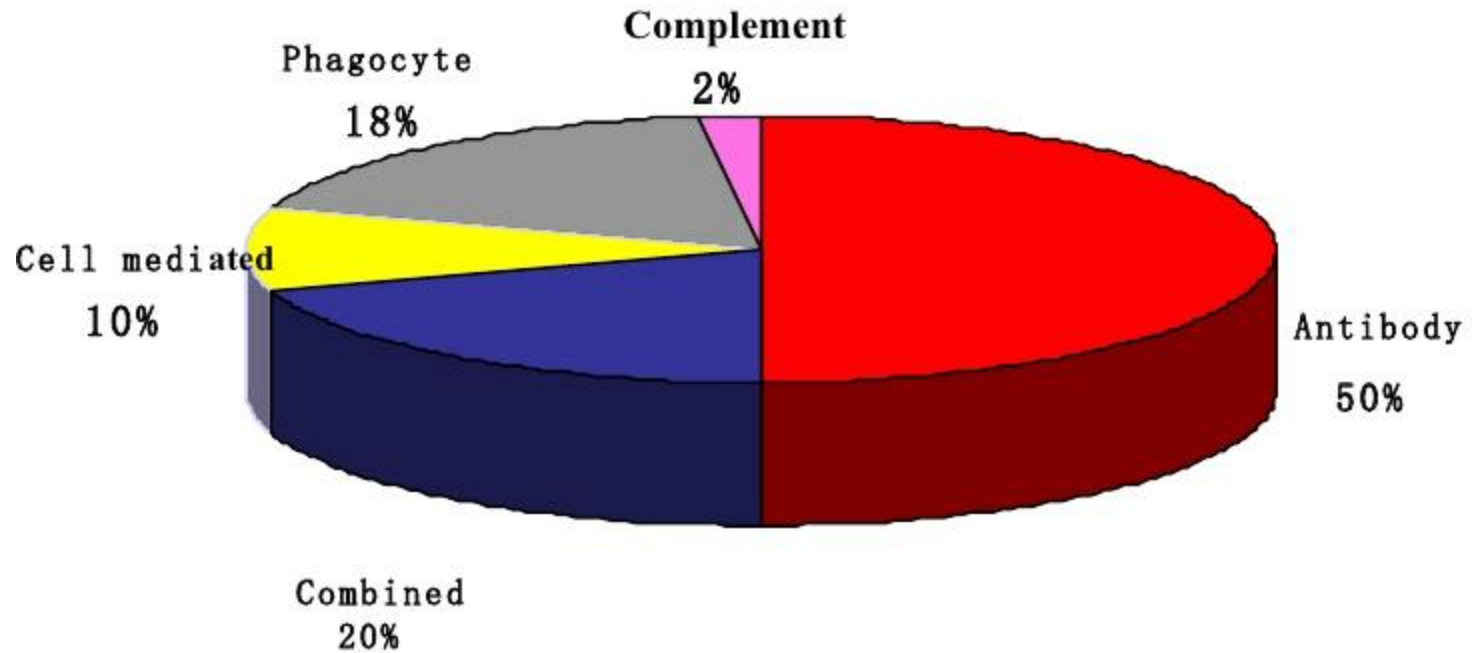
Primary Immunodeficiency Disease

- A group of disorders characterized by an **impaired ability to produce normal immune response**. Most of these disorders are caused **by mutations in genes** involved in the development and function of immune organs, cells, and molecules.
- Clinical features : **Recurrent infection**, high risk of autoimmune diseases, allergy and malignancy

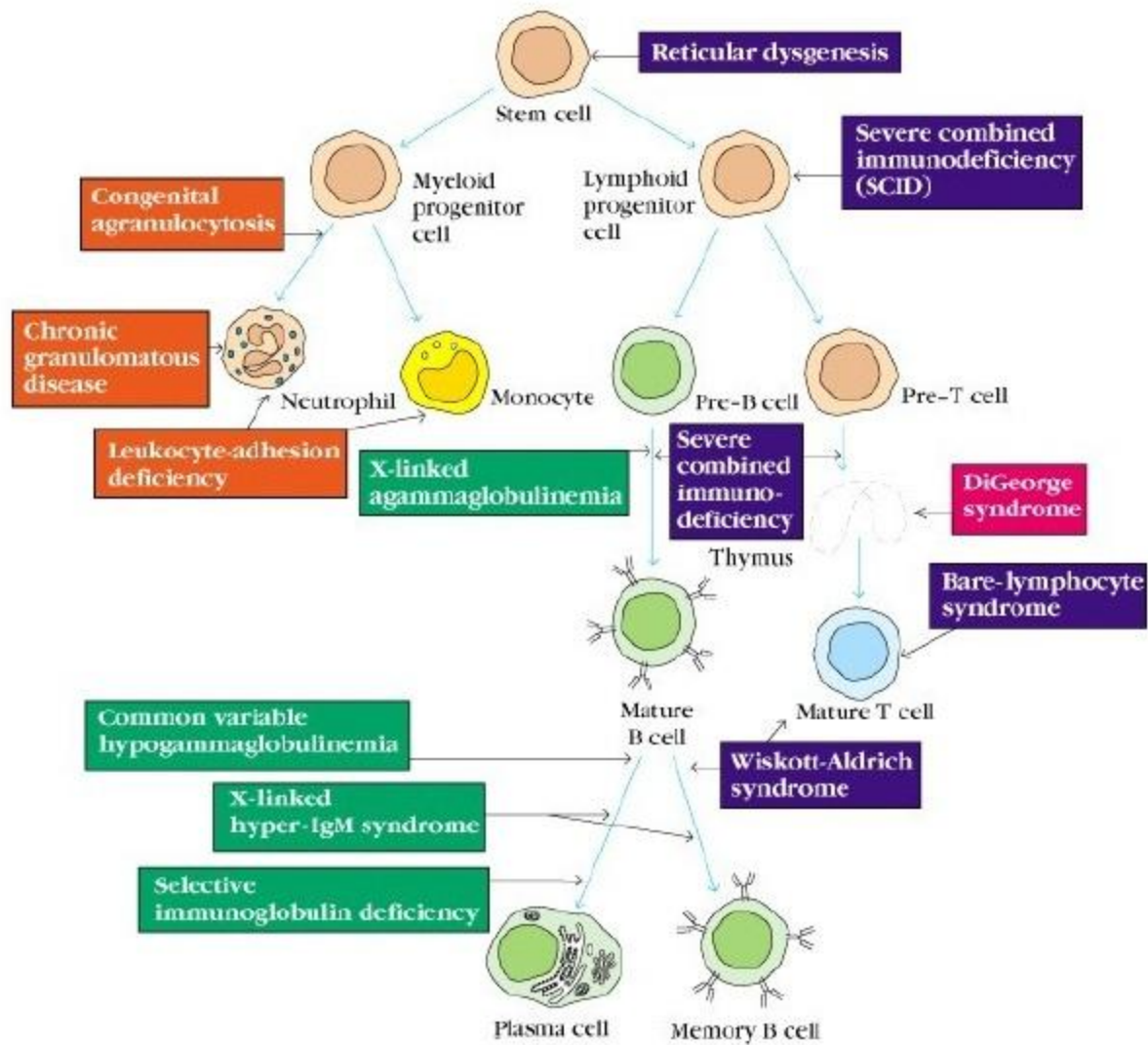
Prevalence

- **Most children with recurrent infections don't have primary immunodeficiency**
 - **90% have secondary cause**

Up to 2007 more than 200 kinds of PID reported



Distribution of PID



Classification(new)

- **Combined Immunodeficiency (B and T cells)**
- **Predominantly antibody deficiency (B cells and Ab)**
- **Predominantly T-cell deficiency (T cells)**
- **Immunodeficiency syndromes**

- **Phagocyte deficiency (PMN's)**
- **Complement deficiency**
- **Others**

Note:-- There is significant overlap among syndromes.

--Great variability in expression of disorders for all categories from mild to severe/fatal.

Combined immunodeficiencies (1)

1. Severe combined immunodeficiency (SCID)

X-linked (γ c deficiency)

Autosomal recessive (Jak3 deficiency)

RAG1/RAG2 deficiency

Adenosine deaminase (ADA) deficiency

Reticular dysgenesis

} T⁻B⁺

} T⁻B⁻

Combined immunodeficiencies

(2)

2. Hyper-IgM syndrome

3. Purine nucleoside phosphorylase

(PNP) deficiency

4. MHC class II deficiency

Clinical features of combined immunodeficiency

- **Onset age at early infants(4 - 5 months)**
- **Recurrent infection with fungi, virus, bacteria, mycobacterium, protozoa**
- **Opportunistic infections**
- **Poor prognosis, early infant deaths**
- **Severe infection after live virus vaccine and BCG**
- **GVHD after blood transfusion**
- **High risk of malignancy**

Common clinical manifestations

PID

- **Infection** recurrent
 - ▼ **Age** >50 % younger than 3 yrs
 - ▼ **Location** respiratory tract , GI tract...
 - ▼ **Pathogen**
 - ▼ **Course**
- **Malignancy and autoimmune disease**
- **Tendency of inheritance** <15yrs 80 % male
- **Others**

Table 1. Characteristic infections of the primary immunodeficiencies

component	primary pathogen	primary site	clinical example
T-cells	intracellular, bacteria viruses, protozoa, fungi,	non-specific	SCID, DiGeorge
B-cells	pneumococcus, streptococcus, haemophilus	lung, skin, CNS	IgG, IgM deficiency IgG, IgM deficiency
	enteric bacteria and viruses	GI, nasal, eye	IgA deficiency
phagocytes	Staphylococcal, Klebsiella Pseudomonas,	lung, skin, regional lymph node	Chronic granulomatous disease (CGD)
complement	neisseria, Haemophilus, pneumococcus, streptococcus	CNS lung skin	C3, Factors I and H, late C omponents

Predominantly antibody defects

- **Panhypogammaglobulinemia**

 - X-linked agammaglobulinaemia (Bruton disease)**

 - Common variable immunodeficiency (CVID)**

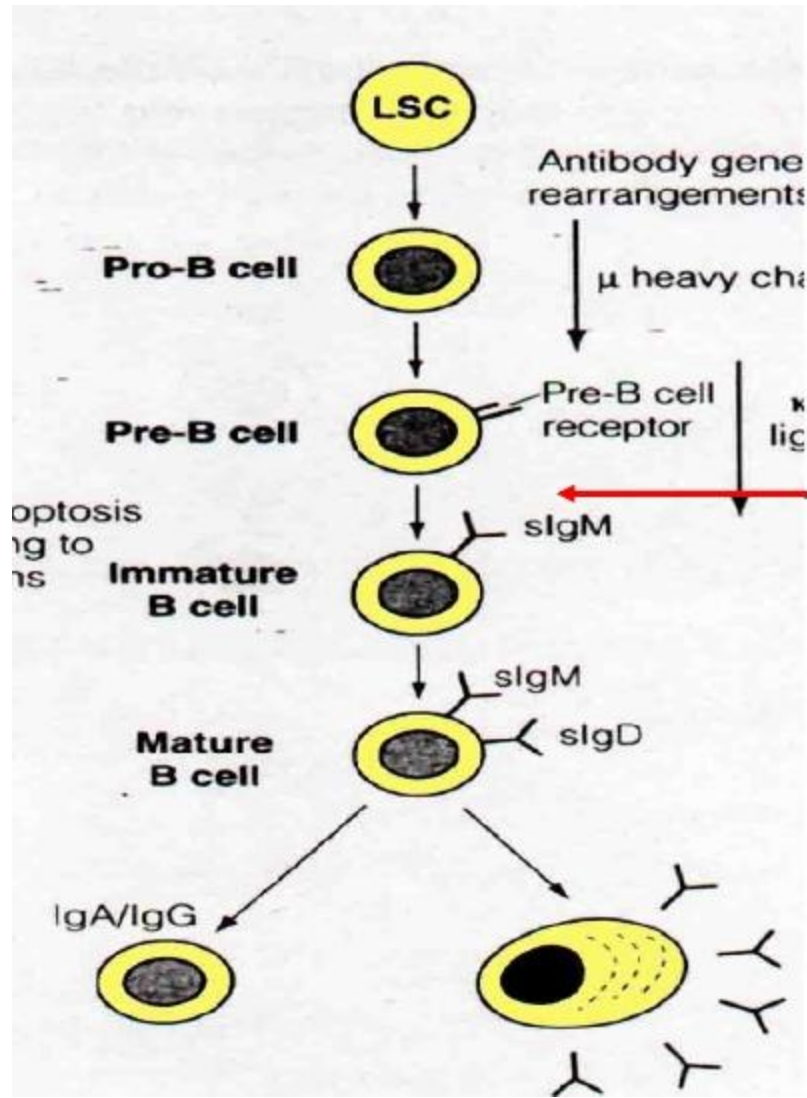
 - Transient hypogammaglobulinaemia of infancy (ITHG)**

- **Selective Ig deficiency**

 - Ig heavy chain deficiency**

 - IgA deficiency**

 - Selective IgG subclass deficiency**



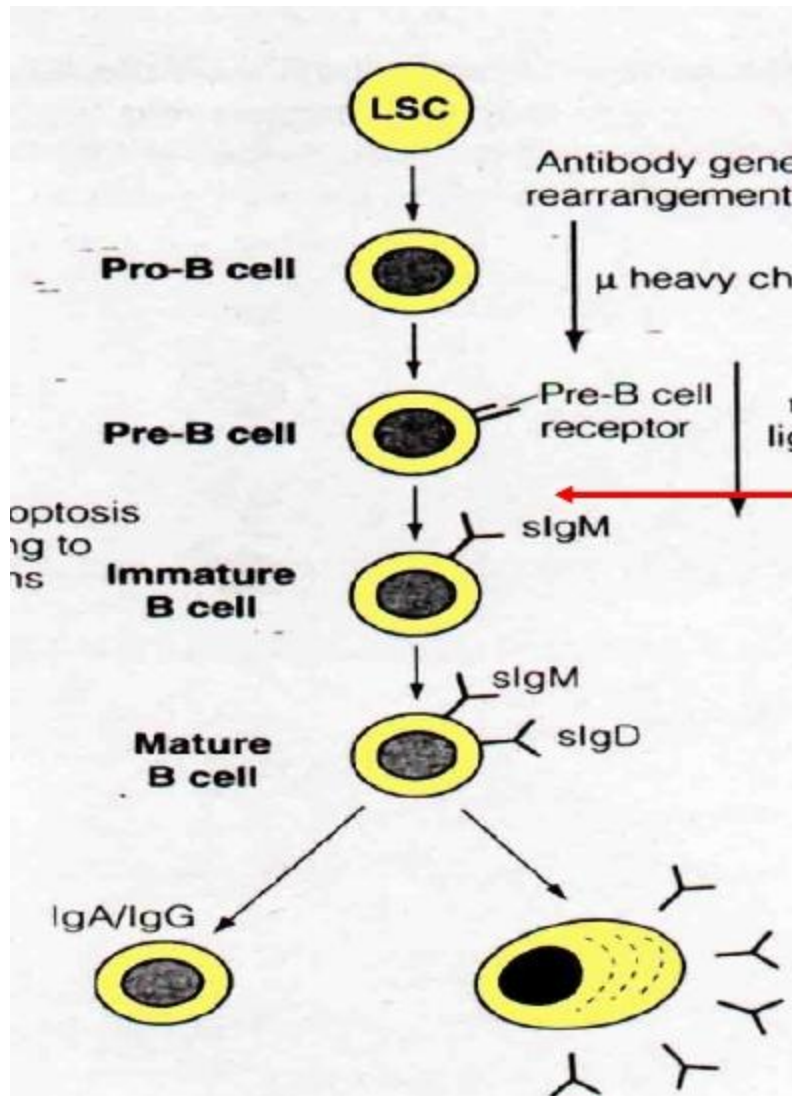
Bruton disease

- mutations in *btk*
- maturation disorder of pre-B cell

Predominantly antibody defects

Common clinical manifestations:

- **Recurrent bacterial infections (sepsis and meningitis)**
- **Viral ,fungal or protozoan infections rare**
- **Lymphatic system hypoplasia- tonsils, lymph node**
(**except CVID**)
- **Autoimmune disease**



Bruton disease

— mutations in *btk*

— maturation disorder

of pre-B cell

Predominantly antibody defects

Common clinical manifestations:

- **Recurrent bacterial infections (sepsis and meningitis)**
- **Viral ,fungal or protozoan infections rare**
- **Lymphatic system hypoplasia- tonsils, lymph node**
(**except CVID**)
- **Autoimmune disease**

Predominantly antibody defects

Laboratory test

- Serum Ig ↓ (< 3 ~ 4g/L)
- Natural antibody ↓ (hemagglutinin titers < 1:4)
- Common antibody ↓ , > 2 A , ASO < 1 : 10
- Antibody responses to vaccine antigens ↓
- Circulating B cell (CD₁₉⁺ 、 CD₂₀⁺) ↓ ,
bearing Ig cell ↓

Immunodeficiency syndrome

Destination	deficiencies			genetic defect	clinical findings
	serum Ig	B-cells	T-cells		
<ul style="list-style-type: none"> Wiskott-Aldrich Syn 	IgM↓	Normal	Progressive↓	XL Mutation in WAS	Thrombocytopenia eczema lymphoma
<ul style="list-style-type: none"> Ataxia-Telangiectasia 	IgA, E, G↓ IgM ↑	Normal	↓	ATM	Ataxia, telangiectasia
<ul style="list-style-type: none"> DiGeorge Syn 	Normal or ↓	Normal	↓or normal	Deletion of chromosome 22q11.2-pter	Hypoparathyroidism conotruncal defect abnormal facies

DiGeorge Syndrome

- **Deletion of chromosome 22q11.2**
 - Defective development of 3rd and 4th pharyngeal pouches
- **Absence of Thymus**
 - Therefore low or absent T cells
 - No B cell abnormalities except in more severe forms.
- **Associated Anomalies**
 - **Conotruncal Cardiac Defects**
 - VSD
 - Tetralogy of Fallot
 - Interrupted Aortic Arch
 - **Parathyroid Hypoplasia**
 - Low Calcium
 - Tetany

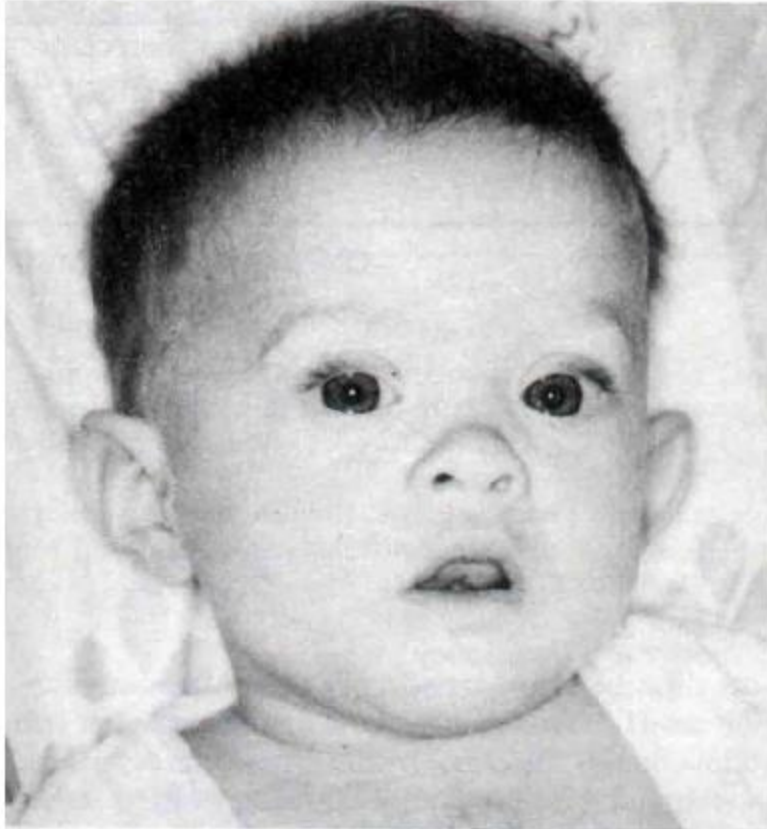
DiGeorge Syndrome

- **Other Anomalies**
 - Cleft Palate
 - Velocardiofacial Syndrome
 - Esophageal abnormalities
 - Ocular anomalies
 - Renal anomalies
 - Increased incidence of Autoimmune disease
- **Diagnosis – FISH**
 - Will often have decreased CD3 T cells
- **Treatment**
 - IVIG and antibiotic prophylaxis
 - Should be on TMP/SFA for PCP prophylaxis
 - Thymic transplant or Bone marrow transplant



DiGeorge anomaly

Facial features of children with DiGeorge syndrome



Hypertelorism

hooded eyelids

short philtrum with

fish-mouth appearance ,

micrognathia

Low set ears

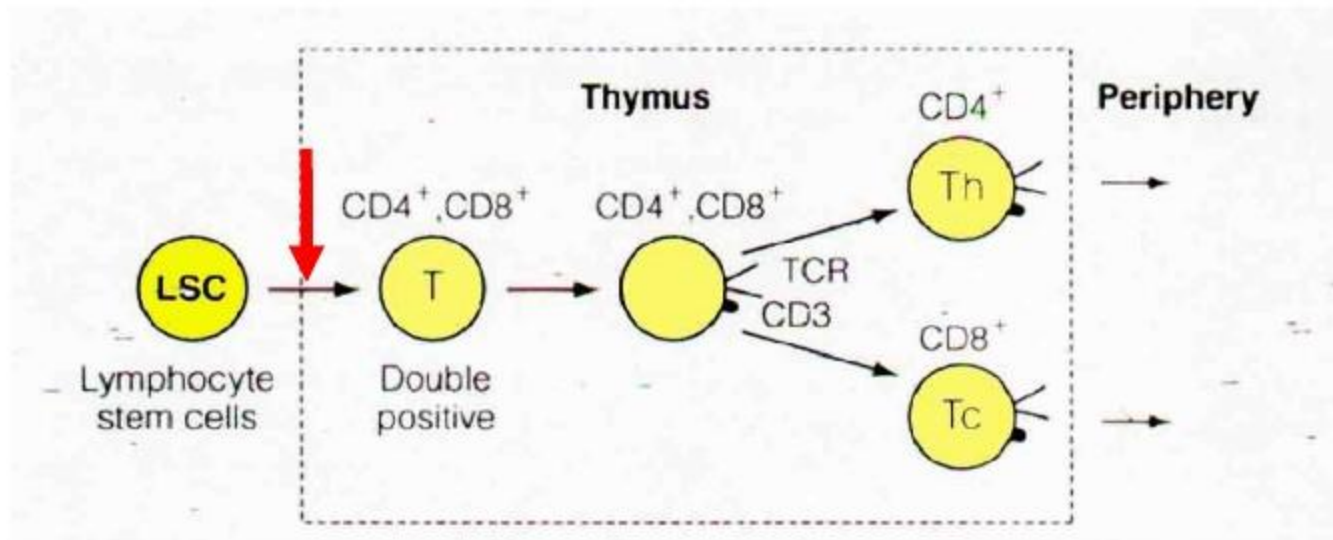
telecanthus with short

palpebral fissures



DiGeorge syndrome

DiGeorge Syndrome



**The parents of D. George are very concerned.
They wonder is there something wrong with him.**

- **Is it normal to have so many infections?**
- **Could there be something wrong with his
immune system?**
- **How are you going to figure this out?**
- **Does he need testing?**

Questions

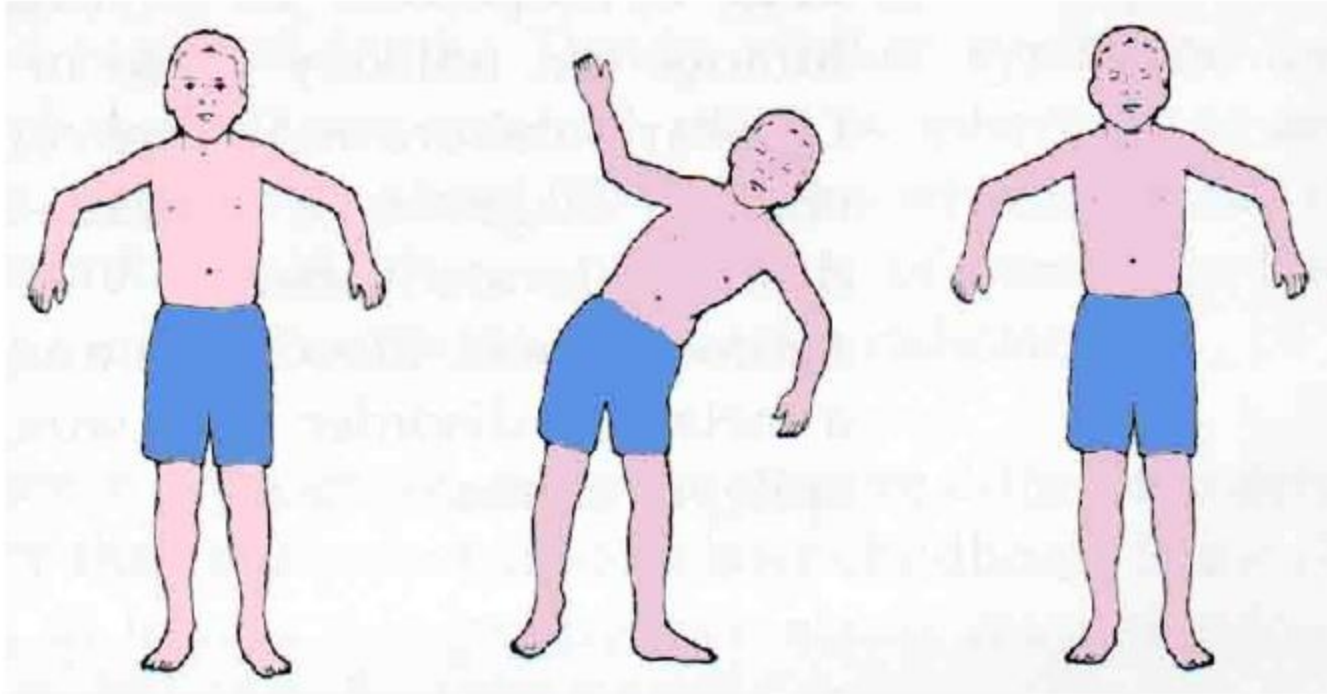
- **What other information should we try to get from D. George and the family?**
- **Are there clues we could be missing in the history?**
- **Are there clues in the physical?**

Wiskott-Aldrich Syndrome

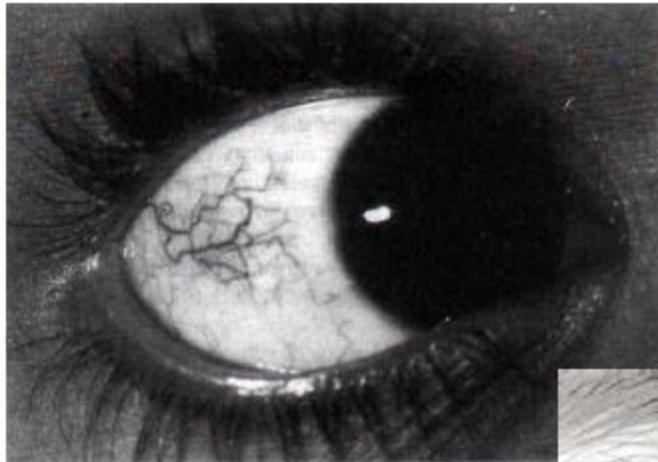
- **X-linked Recessive**
- **Gene defect of WAS protein**
- **B and T cell dysfunction**
- **Triad of**
 - **Thrombocytopenia**
 - **Eczema**
 - **Recurrent pyogenic infections**
- **Treatment – Stem cell or Bone Marrow transplant**
- **Prognosis - Average life expectancy 11 years**

Ataxia-Telangiectasia

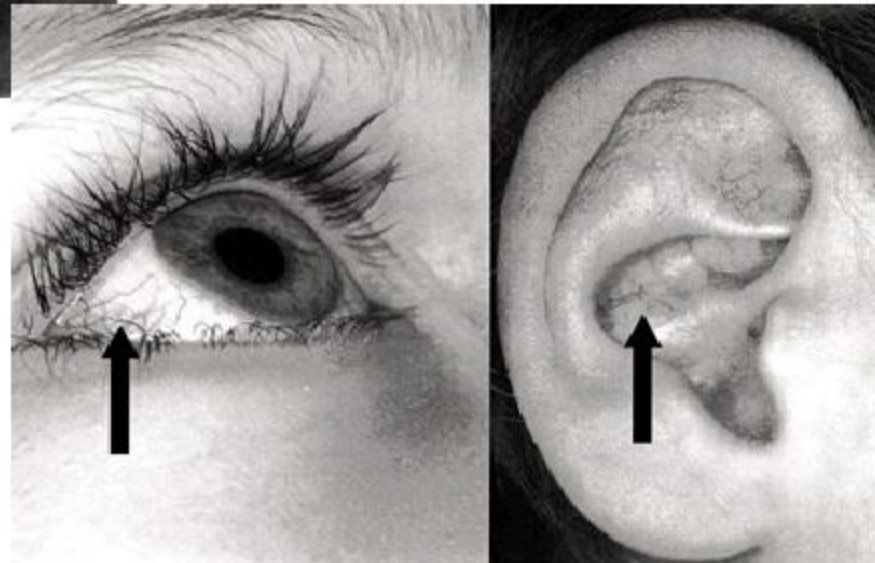
- **Autosomal Recessive**
- **Have both B and T cell dysfunction**
 - more characteristics of B cell dysfunction
- **Associated Symptoms**
 - Ataxia from early age – progressive
 - Telangiectasia develop after 2 yrs
 - High risk for various malignancies
 - Endocrine abnormalities – many with Diabetes
 - Liver Dysfunction
- **Treatment – supportive**
- **Prognosis – death often in early childhood**



Ataxia



telangiectasi



Telangiectasia Ocular and cutaneous telangiectasias (arrows) in a child with Ataxia-telangiectasia. Courtesy of Douglas J Barrett, MD.



(eczema)

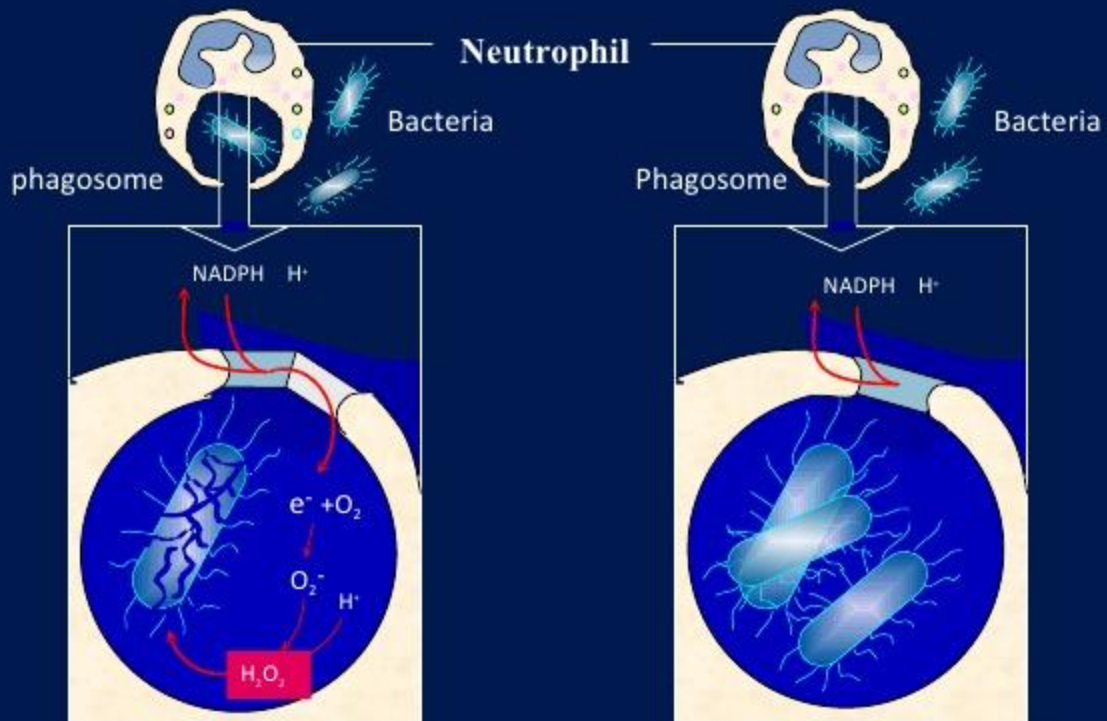
Congenital defects of phagocytic number and/or function

- **Sever congenital neutropenia**
(**SCN** , **Kostmann syndrome**)
- **Chronic granulomatous disease**
- **Chediak-Hiashi syndrome**

Chronic granulomatous disease

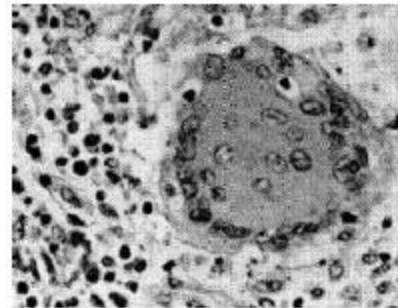
Normal phagocyte

Dysfunction of phagocyte



Chronic Granulomatous Disease

- **Rare – 20 cases/year in the US**
- **Genetics**
 - 70 % X-linked recessive
 - Defect in NADPH oxidase
 - Can't form reactive oxygen species to destroy micro-organisms
- **Symptoms**
 - Pneumonia, Abscesses, Adenitis, Osteomyelitis
 - Uniquely susceptible to Aspergillosis



Chronic Granulomatous Disease

- **Associated Symptoms**
 - Severe Acne
 - Excessive Granulomata – often in GI tract
 - Lupus
 - Chorioretinitis
- **Diagnosis – Nitroblue Tetrazolium Test (NBT)**
- **Treatment**
 - Antibacterial and antifungal prophylaxis
 - Interferon Gamma
 - Stem cell or Bone Marrow Transplant

Complement deficiency

Defects	Inheritance	Clinical findings
<ul style="list-style-type: none"> • Classical pathway (C1q, r, s, C₂, C₄) 	AR	Infections , Autoimmune disease
C ₁ inhibitor	AD	Hereditary angioedema
<ul style="list-style-type: none"> • Alternative pathway (C₃, FactorI, FactorH) 	AR	Recurrent pyogenic infection
<ul style="list-style-type: none"> • Others (C₅ - 8, properdin, factor D) 	AR	Neisseria infection Lupus-link syndrome
C ₉	AR	Asymptomatic

Approach to the patients with suspected immunodeficiency

- **The medical history in immunodeficiency**
- **Physical examination**
- **Laboratory investigation**



Initial and advanced laboratory tests for immunodeficiency

Disorder	Initial tests	Advanced tests
B cell deficiency	IgG,IgM,IgA,IgE levels	B cell phenotyping using flow cytometry
	Isohemagglutinin titers	IgG subclass levels
	Antibody response to vaccine antigens	Lymph node biopsy
T cell deficiency	Lymphocyte count	Mutation analysis
	Delayed hypersensitivity skin tests	Tcell phenotyping using flow cytometry
	Chest X-ray for size of thymus in infant only	T cell proliferative response to mitogens
	T cell count subset analysis	Detection of Ag(MHC)
		T cell receptor and signal transduction
Phagocytic cell defects	Phagocytic cell count and morphology	ADA and RNP levels in RBC
		CK synthesis
		Mutation analysis
		Flow cytometric respiratory burst assay
Complement deficiency	C3,C4 levels, CH50 activity	Chemotaxis assay
		Mutation analysis
		Specific component assays

10 Warning Signs of Primary Immunodeficiency

1	Eight or more new ear infections within 1 year.	Recurrent, deep skin or organ abscesses.	6
2	Two or more serious sinus infections within 1 year.	Persistent thrush in mouth or elsewhere on skin, after age 1.	7
3	Two or more months on antibiotics with little effect.	Need for intravenous antibiotics to clear infections.	8
4	Two or more pneumonias within 1 year.	Two or more deep-seated infections.	9
5	Failure of an infant to gain weight or grow normally.	A family history of Primary Immunodeficiency.	10

From INFO4PI.ORG

4 Stages of Immunologic Testing when Primary Immunodeficiency is Suspected



1

- History and physical examination, height and weight
- CBC and differential
- Quantitative Immunoglobulin levels IgG, IgM, IgA (related to age)

2

- Specific antibody responses (tetanus, diphtheria)
- Response to pneumococcal vaccine (pre/post)(for ages 3 and up)
- IgG subclass analysis

3

- Candida and Tetanus skin tests
- Lymphocyte surface markers CD3/CD4/CD8/CD19/CD16/CD56
- Mononuclear lymphocyte proliferation studies (using mitogen and antigen stimulation)
- Neutrophil oxidation burst (if indicated)

4

- Complement screening CH50, C3, C4
- Enzyme measurements (adenosine deaminase, purine nucleotide phosphorylase)
- Phagocyte studies (surface glycoproteins, mobility, phagocytosis)
- NK cytotoxicity studies
- Further complement studies AH50
- Neo antigen to test antibody production
- Other surface/cytoplasmic molecules
- Cytokine receptor studies
- Family/genetic studies

Management of PID

- **General treatment**
- **Replacement therapy**
- **Immune reconstruction**
- **Gene therapy**



General management of PID

- **Diet**
- **Avoidance of pathogens (“germ-free” care)**
- **Antibiotics**
 - Use in acute illness
 - Prophylactic
- **Avoid whole blood transfusion in combined immunodeficiency disorder(GVHR)**
- **Avoid live virus vaccines and BCG**



