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A mutation in caspase-9 decreases the expression of BAFFR and ICOS in patients with immunodeficiency and lymphoproliferation

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Lymphocyte apoptosis is mainly induced by either death receptor-dependent activation of caspase-8 or mitochondria-dependent activation of caspase-9. Mutations in caspase-8 lead to autoimmunity/lymphoproliferation and immunodeficiency. This work describes a heterozygous H237P mutation in caspase-9 that can lead to similar disorders. H237P mutation was detected in two patients: Pt1 with autoimmunity/lymphoproliferation, severe hypogammaglobulinemia and Pt2 with mild hypogammaglobulinemia and Burkitt lymphoma. Their lymphocytes displayed defective caspase-9 activity and decreased apoptotic and activation responses. Transfection experiments showed that mutant caspase-9 display defective enzyme and proapoptotic activities and a dominant-negative effect on wild-type caspase-9. Ex vivo analysis of the patients’ lymphocytes and in vitro transfection experiments showed that the expression of mutant caspase-9 correlated with a downregulation of BAFF receptor (BAFFR) in B cells and inducible T-cell costimulator (ICOS) in T cells. Both patients carried a second inherited heterozygous mutation missing in the relatives carrying H237P: Pt1 in the transmembrane activator and CAML interactor (TACI) gene (S144X) and Pt2 in the perforin gene (N252S). Both mutations have been previously associated with immunodeficiencies in homozygosis or compound heterozygosis. Taken together, these data suggest that caspase-9 mutations may predispose to immunodeficiency by cooperating with other genetic factors, possibly by downregulating the expression of BAFFR and ICOS.

INTRODUCTION

Caspases are a family of cysteine-dependent aspartate-directed proteases present in the cytoplasm as inactive proenzymes; some are involved in apoptotic induction, whereas others are involved in cell activation.1–3 In the immune system, apoptosis has a crucial role in the deletion of autoreactive lymphocytes and in cell-mediated cytotoxicity. Apoptosis acts via two pathways: the extrinsic pathway triggered by surface death receptors that belong to the tumor necrosis factor receptor family, which induce activation of caspase-8 and -10, and the intrinsic pathway that proceeds through the mitochondrial release of cytochrome c and activation of caspase-9.4 Both pathways converge in the activation of effector caspases (caspase-3, -6 and -7) and are partly interconnected because caspase-8 cleaves BH3 interacting-domain death agonist (Bid) and this induces cytochrome c release from the mitochondria.5–7

Caspases may also exert non-apoptotic functions, such as influencing cell proliferation, migration and the immune response.8,9 They are involved in the differentiation of several cell types, including macrophages, and may have a role in the secretion of cytokines and growth factors.10–13 Moreover, activation of caspases in a temporally and spatially restricted manner may mediate localized cellular remodeling.13

Deleterious caspase-8 gene mutations cause a peculiar immunological phenotype, in which B- and T-cell accumulation in the lymph nodes and spleen is associated with severe hypogammaglobulinemia, increased susceptibility to infections and defective apoptosis and lymphocyte activation in vitro.14 The involvement of caspase-8 in lymphocyte activation was confirmed by several reports showing that its inhibitors decrease lymphocyte activation in vitro and its inactivation causes immunodeficiency in mice.13,15 It has been suggested that this effect may depend on the inhibition of a caspase-dependent cleavage of proteins involved in either cell cycle control (such as p27KIP1) or signaling (such as FADD-like interleukin-1β-converting enzyme-inhibitory protein, FLIP). Moreover, caspase-8 is involved in the activation of the nuclear factor-κ-light-chain-enhancer of activated B cells (NF-κB), a transcription factor that is crucial for lymphocyte activation.16–18

Caspase-3 has also been suggested to influence the immune system; its loss in mice results in B- and T-cell accumulation in the lymph nodes and spleen, ascribed to defective apoptosis for T cells and to altered regulation of cell cycle for B cells.19 Loss-of-function mutations of the caspase-10 gene (CASP10) can cause the autoimmune lymphoproliferative syndrome (ALPS; OMIM no. 601859) due to defective function of the Fas death receptor.20 In most ALPS patients, the Fas defect is due to...
mutations of the Fas gene, although mutations of the Fas ligand (FasL) or caspase-10 genes have been occasionally detected, whereas the mutated gene is unknown in some patients.20–24 ALPS is characterized by polyclonal accumulation of lymphocytes in the spleen and lymph nodes, with lymphadenomegaly and/or splenomegaly and expansion of T-cell receptor αβ⁺ T cells lacking CD4 and CD8, namely double-negative T cells. These patients frequently display autoimmune manifestations during childhood and may develop lymphomas in adulthood.24 We have also previously described an incomplete form of ALPS that lacks the expansion of double-negative T cells, a required criterion for ALPS diagnosis; this variant form has been named Dianzani autoimmune lymphoproliferative disease (DALD) by Victor McKusick (OMIM no. 605233).25,26

Typically, ALPS patients display hypergammaglobulinemia, but we previously described a subgroup that developed hypogammaglobulinemia during the course of disease.24,27 This phenotype resembles that of common variable immunodeficiency (CVID; OMIM no. 240500), a primary immunodeficiency characterized by defective antibody production and hypogammaglobulinemia.28,29 CVID usually manifests during the second and third decade by recurrent bacterial infections of the upper and lower respiratory tract; up to 20% of CVID patients also display signs of autoimmunity and lymphoproliferation (splenomegaly). Moreover, both ALPS and CVID patients may display a skewed distribution of B-cell subsets.30,31

CVID may be caused by variations in several genes involved in B-cell activation and differentiation, including the CD19/CD21/CD81, transmembrane activator and calcium modulator and cyclophilin ligand interactors (TACI or TNFRSF13B), B-cell-activating factor (BAFF) receptor (BAFFR) and inducible T-cell costimulator (ICOS) genes.29,32 CD19, CD21 and CD81 are components of the coreceptor of the B-cell receptor and are involved in B-cell activation. TACI and BAFFR (or TNFRSF13C) are expressed by B cells and bind the BAFF cytokine, thereby having a role in B-cell activation and survival. ICOS is expressed by activated T cells and has a role in the formation of lymphoid follicles by binding the ICOS ligand (B7h or B7H2) expressed by B cells.32

Other diseases that may display mixed features of lymphoproliferation and immunodeficiency are familial hemophagocytic lymphohistiocytosis (FHL; OMIM no. 603553), due to defective function of perforin, which leads to ineffective immune hyperactivation upon viral infection, with tissue damage and a fatal outcome.33,34 and X-linked lymphohistiocytosis (XLP; OMIM no. 308240), due to the deficiency of either SAP (SLAM-associated protein) or XIAP (X-linked inhibitor of apoptosis protein), thereby causing increased susceptibility to Epstein–Barr virus infection.35 All these cases are intriguing because they show that autoimmunity/lymphoproliferation and immunodeficiency overlap in several diseases. The aim of this study was to assess the involvement of mutations in the caspase-9 gene (CASP9) in the development of hypogammaglobulinemia and/or lymphoproliferation. We began our analysis with patients displaying both clinical phenotypes and then considered those with either ALPS or hypogammaglobulinemia. We detected a heterozygous H237P mutation in two patients who also carried a second heterozygous mutation: one in the TNFRSF13B gene, which encodes TACI, and the other in PRF1 gene, which encodes perforin. Analysis of the patients’ lymphocytes and the transfection experiments of the mutated CASP9 cDNA in lymphocytes showed that expression of the mutated caspase-9 protein correlated with the downregulation of BAFFR in B cells and ICOS in T cells, which may be involved in the patients’ low immunoglobulin (Ig) levels.

RESULTS

Patient analyses

CASP9 variations were searched in the genomic DNA from seven patients displaying autoimmunity, chronic lymphadenomegaly and/or splenomegaly and hypogammaglobulinemia. We sequenced exons 2–9 and their intron/exon boundaries but not exon 1, as no amplification was obtained with four different sets of primers because of its high GC content. We detected a heterozygous 710A>C nucleotide substitution (nucleotide position given from the ATG translation initiation site) in exon 5 in one patient (Pt1) (Figures 1 and 2a, b). This mutation results in the amino-acid substitution H237P (CASP9H237P) and it was not detected in any of the 140 healthy donors. This variation has been described in the dbSNP database as a rare variant with an allelic frequency <0.01% (rs 146054764).

Pt1 was an 18-year-old male, displaying features of both ALPS and CVID since the age of 3 years. The signs of ALPS were chronic thrombocytopenia, lymphadenomegaly, splenomegaly and expansion of double-negative T cells (8–10%) in the peripheral blood, whereas those of CVID were severe hypogammaglobulinemia (low IgM, IgG and IgA levels), recurrent pulmonary infections with bronchiectasia and retarded physical growth. In his family, the mutation was carried by the father (F1) and the elder sister (S1a), but not by the mother (M1) or the younger sister (S1b) (Figure 2b).

Figure 1. CASP9 variation carried by the patients. Graphical representation (not in scale) of caspase-9 gene: (a) boxes represent the exons; arrows indicate the mutation and protein (b); and numbers indicate the amino-acid positions. CARD, caspase recruitment domain; LD: linker between the two subunits; LSCD, large subunit catalytic domain; SSCD: small subunit catalytic domain.
The discovery of a mutation in CASP9 in a subject with signs of both ALPS and CVID prompted us to extend the analysis to 78 patients with ALPS or DALD, lacking Fas, Fasl, caspase-10 and caspase-8 mutations, and 51 patients with primary hypogammaglobulinemia, including 45 who fulfilled the diagnostic criteria for CVID, but who displayed no signs of ALPS or DALD. We found the same mutation (710A>C) in one adult patient (Pt2), who displayed recurrent otitis media and respiratory infections during childhood and low serum IgM levels, whereas his IgA and IgG levels were, respectively, borderline and normal. He never showed signs of ALPS or DALD and he remained healthy in adulthood until he developed Burkitt lymphoma at the age of 30 years. In Pt2’s family, the mutation was carried by the father (F2) and sister (S2) but not by the mother (M2) (Figure 2b). Both Pt1 and Pt2 were Italian but were of different geographic origins. No other mutations in CASP9 were detected in any patient.

Because both Pt1 and Pt2 displayed hypogammaglobulinemia, we assessed the Ig levels in the available sera of the healthy family members. The results showed that all the relatives displayed normal Ig levels, except for individuals S1a and S2, who carried CASP9 mutants and displayed slightly decreased IgA and IgM levels, respectively (Figure 2c). This analysis was not performed in individuals F2 and M2 as their sera were not available.

Then, the genetic analysis was extended to the ICOS, TACI and BAFFR genes, involved in CVID, and CASP9 and PRF1 involved in ALPS, FAS, FASL and CASP10 involved in ALPS, PRF1, UNC13D and STX11 (sintaxin 11) involved in FLH, TACI and BAFFR involved in XLP. Results showed that Pt1 carried two mutations in TACI, a 431C>G and a 577T>C substitution that result in the S144X and S193R changes, respectively (Figures 2a and b). Homozygosity for a different base change causing S144X (431C>A) has previously been associated with CVID and this mutant allele is not expressed. Both mutations were detected in M1 and S1b, but neither were detected in F1 and S1a, which shows that they were located at the same allele (Figure 2b). Furthermore, the S144X mutation was not detected in any of the 100 healthy individuals. By contrast, Pt2 carried a variation in PRF1, an A>G substitution at position 755 causing an N252S change (rs150053969) that has been associated with FLH, ALPS, type 1 diabetes and B-cell lymphomas. This mutation was detected in M2, but not S2 (Figure 2b). In healthy donors, its allelic frequency was >0.02% (2/816).

As both patients displayed decreased Ig levels in vivo, we assessed surface expression of CD19, TACI, BAFFR and ICOS (involved in CVID) in the patients’ peripheral blood mononuclear cells (PBMCs) by immunofluorescence and flow cytometry (Figure 3). In resting PBMCs, we assessed the expression of TACI, BAFFR and HLA-DR in CD19 B cells, whereas the expression of ICOS, HLA-DR and CD25 was assessed in CD3 T cells from phytohaemagglutinin (PHA)-activated PBMCs. The results showed that both patients displayed decreased expression of BAFFR in B cells and decreased expression of ICOS in activated T cells. By contrast, expression of TACI was in the normal range in the B cells of both patients, but it was borderline in Pt1, congruent with his mutation of the TACI gene. Moreover, B-cell expression of CD19 and HLA-DR, and T-cell expression of CD3, CD8, CD4, HLA-DR and CD25 were in the normal range in both patients (data not shown).

Lymphocyte activation was assessed in the patients’ PBMCs by evaluating the response to anti-CD3 monoclonal antibody (mAb) in terms of proliferation and interleukin (IL)-2 secretion (Figure 4a) and the response to pokeweed mitogen (PWM) in terms of proliferation and secretion of IgM and IgG (Figure 4b). The results showed that all these lymphocyte activation responses were defective in both patients. Moreover, we evaluated whether the defective proliferative response to CD3 could be overcome by CD28 costimulation, or by the addition of exogenous IL-2.

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Figure 3. Surface expression of TACI, BAFFR and ICOS in PBMCs from patients and healthy donors. Cyttofluorimetric histograms showing the surface expression of TACI and BAFFR assessed in CD19⁺ cells and of ICOS in PHA-activated CD3⁺ T cells by two-color immunofluorescence: unstained cells (white) and stained cells (black). The graphs on the right show the MFI ratios of the patients and the controls; the gray boxes indicate the 5th–95th percentile and the dashed lines show the median of 17 controls.

Figure 4. Proliferation and effector properties after stimulation with anti-CD3 mAb or PWM in Pt1 and Pt2. (a) Cell proliferation and IL-2 secretion induced by stimulation of PBMCs with anti-CD3 mAb (1 μg ml⁻¹) and cell proliferation induced by anti-CD3+exogenous IL-2 (10 U ml⁻¹) and anti-CD3+anti-CD28 (10 μg ml⁻¹) mAb. (b) Cell proliferation and secretion of IgM and IgG induced by stimulation of PBMCs with PWM (10 μg ml⁻¹). The dotted lines indicate the 5th percentile of the activity displayed by all normal controls (n = 19). Each patient was analyzed four times using different blood samples and the results are shown as the mean ± s.e.
(10 U ml\(^{-1}\)) because both patients displayed defective IL-2 secretion. The results showed that both exogenous IL-2 and CD28 costimulation had some effect in both patients and exogenous IL-2 rescued the defect in Pt2 (Figure 4a).

Functional characterization of CASP9H237P

To assess the function of the mutated protein (CASP9H237P), either anti-Fas mAb or etoposide was used to activate the extrinsic or the mitochondrial pathway, respectively, and trigger apoptosis in PBMCs from both patients. Then, we analyzed the apoptotic response in terms of cell loss and activation of caspase-8 (extrinsic pathway), caspase-9 (mitochondrial pathway) and caspase-3 (effector pathway). Figure 5 shows that both patients displayed defective activation of caspase-9 and normal activation of caspase-8 in response to either anti-Fas or etoposide. Moreover, they displayed defective cell loss and defective activation of caspase-3 in response to etoposide but not to anti-Fas.

To further assess CASP9H237P function, cDNAs coding for CASP9H237P or the wild-type protein (caspase-9\(^{WT}\)) were cloned into the pcDNA3.1 vector (Mock), fused to hemagglutinin (HA)- or FLAG-tag sequences, respectively (H237PHA and WTFLAG plasmids). Then, 293T cells, expressing minimal levels of endogenous caspase-9, were transiently transfected with either Mock alone (293TH237PHA or 293TWT), WTFLAG plus Mock (293TWT/H237P) or WTFLAG plus H237PHA (293WT/H237PHA). Western blot analysis showed that spontaneous cleavage of caspase-9, which is a sign of its autoactivation, was detectable in 293TWT but not in 293TH237P or 293TWT/H237P, expressing cells (Figure 6a). Then, we assessed cell recovery and activation of caspase-9 in these cells cultured in the presence and absence of etoposide. Results showed that cell recovery was significantly lower and caspase-9 activity was higher in 293TWT than in 293TH237P and 293TWT/H237P either in the presence or in the absence of etoposide. These data indicate that CASP9H237P is less active than caspase-9\(^{WT}\) and that it exerts a dominant-negative effect on caspase-9\(^{WT}\). As caspase-9 activity involves caspase-9 interaction with apoptotic protease-activating factor (APAF)-1 to form the apoptosome, we assessed this interaction by immunoprecipitation-caspingase-9 and assessing APAF-1 co-immunoprecipitation by western blot in 293TWT and 293TH237P. Results detected the co-immunoprecipitation in 293TWT but not in 293TH237P (Figure 6d), which shows that CASP9H237P displays defective interaction with APAF-1.

To confirm these data, PBMCs from healthy donors were transfected with a Mock plasmid carrying green fluorescent protein (GFP) in the absence (PBMCs\(^{GFP}\)) or presence (PBMCs\(^{H237P/GFP}\)) of H237PHA and cultured for 5 days in the presence of PWM or PHA. Then, cell proliferation was assessed by the incorporation of [\(^{3}H\)]thymidine (Tdr). The results showed that cell proliferation was lower in PBMCs\(^{H237P/GFP}\) than in PBMCs\(^{GFP}\) (Figure 7a). The effect on the apoptotic response was assessed on PHA-activated PBMCs (PHA-PBMCs) transfected at day 5 of culture to obtain PBMCs\(^{H237P/GFP}\) and PBMCs\(^{H237P/GFP}\). Twenty-four hours later, cells were treated with anti-Fas mAb or etoposide to evaluate cell loss and activation of caspase-9. Results showed that PHA-PBMCs\(^{H237P/GFP}\) displayed lower cell loss and caspase-9 activation than PHA-PBMCs\(^{GFP}\) in response to both treatments (Figures 7b and c). Finally, the effect on cell cycle was analyzed by assessing the expression of p27\(^{WIP}\) in PHA-PBMCs transfected at day 5 to obtain PHA-PBMCs\(^{GFP}\) and PHA-PBMCs\(^{H237P/GFP}\), or co-transfected with WTFLAG plus H237PHA (PHA-PBMCs\(^{WT/H237P/GFP}\). Twenty-four hours later, western blot analysis detected higher levels of p27\(^{WIP}\) in PHA-PBMCs\(^{H237P/GFP}\) and PHA-PBMCs\(^{WT/H237P/GFP}\) than in PHA-PBMCs\(^{GFP}\) (Figure 7d).

To assess whether CASP9H237P influences the expression of BAFFR, we compared the expression of BAFFR, TACI, HLA-DR and B7h in CD19\(^{+}\) B cells from resting PBMCs\(^{H237P/GFP}\) and PBMCs\(^{GFP}\) by...
two-color immunofluorescence 24 h after the transfection. Moreover, the effect on the expression of ICOS was assessed on PHA-PBMCs transfected at day 3 of culture to obtain PHA-PBMCsGFP and PHA-PBMCsH237P. Twenty-four hours later, expression of ICOS, CD25 and HLA-DR was assessed in CD3+, CD4+ and CD8+ T cells by two-color immunofluorescence. The results showed that CD19+ PBMCsH237P expressed lower levels of BAFFR than CD19+ PBMCsGFP (Figure 8a), whereas the expression of TACI, HLA-DR, B7h and CD19 was similar in the two cell preparations (data not shown). Moreover, CD3+ PHA-PBMCsH237P expressed lower levels of ICOS than CD3+ PHA-PBMCsGFP (Figure 8b), which was detected in both the CD4+ and CD8+ T-cell subsets (data not shown), whereas expression of CD3, CD4, CD8, CD25 and HLA-DR was similar in the two cell preparations (data not shown). To confirm these results, the transfection experiments were repeated in TonsBCs (B cells from tonsils) and Raji cells, expressing high levels of BAFFR, and in PHA-TH (PHA-activated purified CD4+ T helper cells) expressing high levels of ICOS. The results demonstrated that the expression of BAFFR was lower in TonsBCsH237P and RajiH237P than in TonsBCsGFP and RajiGFP (Figure 8a) and that the expression of ICOS was lower in PHA-THH237P than in PHA-THGFP (Figure 8b).

To confirm that defective caspase-9 activity may modulate the expression of BAFFR and ICOS and cell proliferation, we treated PHA-activated PBMCs from healthy donors with Z-VAD-FMK (30 μM), inhibiting caspase-9 and other caspases, at day 3 from activation and assessed BAFFR and ICOS expression, cell proliferation and the apoptotic response to etoposide at day 5. Results showed that Z-VAD-FMK significantly decreased BAFFR and ICOS expression, cell proliferation and cell apoptosis (Supplementary Figure 1).

**DISCUSSION**

This work shows that the H237P substitution decreases caspase-9 activity and impairs lymphocyte apoptosis and activation. The defective enzyme activity caused by this mutation is in line with the notion that the hydrazolic group of histidine 237 may coordinate the key cysteine of the catalytic site.40

The defects in caspase-9 activity and apoptotic response were demonstrated in primary patient lymphocytes, as well as in cell lines transfected with H237PHA. Transient transfection of 293T cells showed that CASP9H237P had lower enzymatic and proapoptotic activity than caspase-9 WT and also inhibited the function of caspase-9WT through a dominant-negative effect. This was surprising because caspase-9 activation requires aggregation of the apoptosome, a molecular platform composed of seven molecules of APAF-1, cytochrome c and ATP. Each APAF-1 molecule binds to one procaspase-9 molecule, which then recruits another APAF-1 molecule.41 Therefore, recruitment of inactive forms of caspase-9 or a reduced association with APAF-1 may affect the overall function of the apoptosome, as has been previously shown by other authors using deletion mutants of caspase-9.42 Transient transfection of 293T cells showed that CASP9H237P, differently from caspase-9 WT, is not associated to APAF-1 at detectable levels.

The defect in lymphocyte activation was shown in the patients’ lymphocytes that displayed defective CD3-induced proliferation and IL-2 secretion and defective PWM-induced proliferation and Ig secretion. The effect of defective caspase-9 activity on lymphocyte activation was confirmed by the decreased proliferative response displayed by normal PBMCs transfected with CASP9H237P or treated with the caspase inhibitor Z-VAD-FMK.
The dual effect of the caspase-9 defect on lymphocyte apoptosis and activation mimics the defects observed in two siblings carrying homozygous mutations of the caspase-8 gene. They displayed defective lymphocyte apoptosis, as well as impaired activation of T, B and natural killer cells, defective IL-2 secretion and developed a disease with ALPS, hypogammaglobulinemia and increased susceptibility to infections. The heterozygous carriers were healthy.

In Pt1 and Pt2, as in the caspase-8 deficient patients, the lymphocyte apoptosis and activation defects paralleled a clinical phenotype with impaired immune function and lymphoproliferation. The most severe phenotype was displayed by Pt1 with overt CVID and ALPS, hypogammaglobulinemia and increased susceptibility to infections. The heterozygous carriers were healthy.

PBMC

Figure 7. CASP9H237P impairs the proliferative and apoptotic responses and caspase-9 activation in transfected PBMCs. (a) Resting PBMCs from normal donors were transiently transfected with vectorGFP alone or plus H237PH/A (C9). Cell proliferation in response to PWM or PHA was assessed by incorporation of [3H]thymidine. (b) Cell loss and (c) caspase-9 activity in response to treatment with anti-Fas mAb or etoposide. Data are expressed as the mean ± s.e. (n = 9). (d) Western blot and respective relative expression levels (± s.e.) of p27KIP1 normalized to actin expression from four independent experiments in transfected PHA-PBMCs. The black arrow indicates the p27KIP1 relative band. Asterisks mark differences from GFP-transfected cells. The percentage of GFP-positive cells was 52 ± 5% (mean ± s.e.) for PBMCsGFP and 54 ± 4% for PBMCsH237P.

The inhibitory effect of CASP9H237P on cell proliferation and apoptosis was independent of its effect on the expression of BAFFR and ICOS. This is shown by the finding that both patients displayed decreased expression of these receptors in B cells and activated T cells, respectively. Moreover, transfection of CASP9H237P or treatment with Z-VAD-FMK decreased the expression of BAFFR in B cells and ICOS in activated T cells from normal donors. This effect was specific because expression of several other cell markers was unchanged.

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whereas ICOS is expressed by T helper follicular cells and interacts with both cognate and bystander B cells. Therefore, the low expression of BAFFR and ICOS may explain the low Ig levels of our patients, which seems to be a hallmark of the CASP9 mutation because it was detected in all of the patients’ family members carrying the CASP9H237P mutation but not in the others. Unfortunately, we could not assess BAFFR and ICOS expression in these family members because their cells were not available.

Penetrance of CASP9H237P seems to be incomplete as the four carriers in the patients’ families were healthy, although two of them (S1a and S2) displayed a subclinical defect with a mild decrease of serum IgM and IgA, respectively. The severity of the clinical outcome may thus depend on the influence of concurrent genetic and environmental factors. Congruent with the role of concurrent genetic factors, Pt1 and Pt2 each carried heterozygous mutations of a second gene. This was inherited from their CASP9H237P-free mothers and may have contributed to their clinical outcome.

Pt1 carried a S144X mutation in TNFRSF13B coding for TACI, a receptor that binds BAFF and APRIL (a proliferation-inducing ligand). TACI is expressed on peripheral blood B cells, particularly on the CD27+ subset. TACI-deficient mice display humoral immunodeficiency together with autoimmunity and lymphoproliferation. In humans, several TNFRSF13B mutations have been associated with both CVID and IgA deficiency. In particular, Salzer et al. detected homozygous S144X mutations in a patient with hypogammaglobulinemia and hepatosplenomegaly; his brother, who was healthy, carried the same mutations and displayed lymphocytosis. The mutation inserts a stop codon in exon 3 and impairs the expression of the TACI protein and mRNA. In line with this, Pt1 displayed a borderline expression of TACI in B cells. Pt1 also carried a second mutation (C193R) in exon 4 of the same allele, but this should be irrelevant as it is located downstream of the inserted stop codon. S144X seems non-penetrant in heterozygosity as shown both by Salzer et al. and by our analysis of heterozygous patients M1 and S1b. Therefore, the finding that Pt1 is the only member of the family with both S144X and CASP9H237P suggests that the two mutations may have cooperated in the disease development of Pt1, possibly through the borderline expression of TACI and the decreased expression of BAFFR and ICOS, which are all involved in B-cell function.

Pt2 carried a heterozygous mutation of PRF1 coding for perforin, which is stored in the lytic granules of cytotoxic cells and involved in cell-mediated cytotoxicity. Biallelic PRF1 mutations cause FHL, an immunodeficiency characterized by hemophagocytosis, fever, hepatosplenomegaly, cytopenia, hypertriglyceridemia, hypofibrinogenemia, frequent nervous system involvement and

![Figure 8. Surface expression of BAFFR and ICOS in lymphocytes of healthy donors after transient transfection of CASP9H237.](image-url)
increased frequency of lymphomas.33 The disease is ascribed to the decreased capacity of cytotoxic cells to clear viral infections, whose persistence may support the lymphoproliferative picture. FHL is a recessive disease and subjects carrying heterozygous PRF1 mutations are generally healthy; however, inherited PRF1 mutations have also been associated with the development of lymphomas and ALPS.34 In lymphomas, they can be either heterozygous or homozygous, whereas they are heterozygous in ALPS but are associated with inherited defects that affect Fas function. A similar role as a risk factor for ALPS has also been described for the UNC13D gene encoding for MUNC13-4, which is involved in perforin secretion and the development of a genetic variant of FHL.35,36 The N252S mutation has been detected in FHL, ALPS and lymphomas.33,37-39 It occurs within the membrane attack complex, a region critically involved in the pore-forming activity of perforin, but its functional significance has been debated because it has been associated with normal natural killer activity.32 In Pt2, a double caspase-9 and perforin defect may be involved in the development of his Burkitt lymphoma as both mutations may impair the immune response and favor lymphoproliferation.

The clinical phenotype of our heterozygous patients is very different from the high perinatal lethality, severe alteration of central nervous tissue development, and minor alterations of the immune system impairment displayed by the caspase-9/−/− mice. These differences, however, may reflect the residual caspase-9 activity displayed by our heterozygous patients and the cooperation of their second mutations.51

In conclusion, our data show that caspase-9 is involved in both lymphocyte apoptosis and activation and that its defective activity can induce a clinical pattern of immunodeficiency and lymphoproliferation qualitatively similar to that induced by defective caspase-8 activity.

MATERIALS AND METHODS

Patients

We analyzed 136 unrelated Italian patients: 7 with autoimmunity, chronic lymphadenomegaly and/or splenomegaly and hypogammaglobulinemia, 78 with ALPS or DALL, lacking Fas, Fasl, caspase-10 and caspase-8 mutations and 51 with primary hypogammaglobulinemia. ALPS/DALL patients were diagnosed using the criteria established at the 2009 ALPS NIH International Workshop.49 A total of 140 healthy individuals were used as controls.

The study was planned according to the guidelines of the local ethical committee, Azienda Ospedaliera della Carità, Novara that approved the study (Protocol 106/CE). Written, informed consent was signed by the patients or by their parents if they were minors.

Sequence analyses

Specific primers were used to amplify the exons and intron boundaries of CASP9 (gene ID: 842), FAS (ID: 355), FASL (ID: 356), CASP10 (ID: 843), TNFRSF13B (TACI) (ID: 23495), TNFRSF13C (BAFFR) (ID: 115650), ICOS (ID: 29851), PRF1 (ID: 5551), UNC13D (ID: 201294), STX11 (ID: 8676), SH2D1A (SAP) (ID: 4068) and XIAP (ID: 331) genes. The PCR products were sequenced with the ABI PRISM BigDyeTM Terminator Kit (Applied Biosystems, Foster City, CA, USA) on an automatic sequencer, Applied Biosystems 3100 Genetic Analyzer (Applied Biosystems), using the same primers, except for exon 3 of PRF1 for which we used also an internal primer.

Cells

PBMCs were obtained by density gradient centrifugation from patients’ blood and buffy coats, provided by the local Blood Transfusion Service (Novara, Italy). Total CD4+ T cells from healthy controls were purified using the CD4+ T Cell Isolation Kit II (Miltenyi Biotec, Teterow, Germany). This approach provided >97% cells displaying the CD3+CD4+CD45RA−CD45RO−CD14−CD16− phenotype, as assessed by direct immunofluorescence and flow cytometry. B cells were purified, after homogenization, by density gradient centrifugation from the tonsils of patients undergoing tonsillectomy in the Otolaryngology Clinic of Azienda Ospedaliera della Carità, Novara, Italy. Cell surface markers were assessed by immunofluorescence and flow cytometry using the appropriate mAb to BAFFR (BioLegend, San Diego, CA, USA), ICOS (eBioscience, San Diego, CA, USA), B7h (R&D Systems, Minneapolis, MN, USA), TACI (BioLegend), CD19 (Immunotech, Friesoythe, Germany), CD3 (Becton Dickinson, Franklin Lakes, NJ, USA), CD4 (Sigma, St Louis, MO, Canada), CD8 (Invitrogen, Burlington, Ontario, Canada), CD25 (BioLegend) and HLA-DR (Becton Dickinson).

In some experiments, cells were treated with Z-VAD-FMK (30 μM) (Enzo Life Sciences, Florence, Italy).

Antigenic density was expressed as the mean fluorescence intensity ratio using the following formula: mean fluorescence intensity of sample histogram (arbitrary units)/mean fluorescence intensity of control histogram (arbitrary units).

Cell death assays

PBMCs (1 × 10^6) were incubated in flat-bottom 96-well plates with control medium (200 μl) with or without anti-Fas mAb (0.5 μg ml−1) (CH11; UPSTATE Waltham, MA, USA) or with etoposide (5 μg ml−1) (Sigma) in the presence of IL-2 (1 U ml−1) to minimize spontaneous cell death. Eighteen hours later, the live cells were counted by the trypan blue exclusion test and live cells were detected using flow cytometry by blocking cells that were propidium iodide (Becton Dickinson) and annexin V-FITC positive (Becton Dickinson); the two methods gave overlapping results. These assays were performed in duplicate. In some experiments, PBMCs were treated with Z-VAD-FMK (30 μM) (Enzo Life Sciences). In transfected human embryonic kidney 293T cells (ATCC; no. CRL-11266), cell death assay was assessed after transfection and in the last 18 h by etoposide (5 μg ml−1) or no stimulus was added to the media of culture. The specific cell loss % was calculated as follows: 100 – (total live cell count in the assay well/total live cell count in the control well) × 100. Caspase-8, -3 and -8 activity was assessed in cell lysates using a fluorimetric assay (MBL, Watertown, MA, USA). At least three control samples, using PBMCs from different healthy donors, were run in parallel. In transfected human embryonic kidney 293T cells, caspase-9 activity was assessed 24 h or 48 h after transfection to evaluate activation after treatment with etoposide (5 μg ml−1) or spontaneous autoactivation, respectively.

PBMCs activation assays

PBMCs (1 × 10^6 per well) were cultured in flat-bottom 96-well microplates with RPMI 1640+10% fetal calf serum in the presence or absence of the appropriate stimulus. The anti-CD3 mAb (OKT3 1 μg ml−1) in phosphate-buffered saline (ATCC; no. CRL-8001) was precoated into the plates by overnight incubation at 4 °C. PHA and PWM (Sigma) were used at 1 and 10 μg ml−1, respectively. PBMC proliferation was assessed in triplicate by measuring the uptake of [3H]TdR (1 μCi per well) (Perkin-Elmer, Waltham, MA, USA) in the last 6 h of culture on days 3 and 5 for OKT3- or PHA- and PWM-treated cells, respectively; the cells were harvested and radioactivity was detected with a β-counter (Perkin-Elmer). IL-2 secretion was evaluated by performing an enzyme-linked immunosorbent assay on the day 3 culture supernatants (Beckton Dickinson). In PWM-treated cells, IgG, IgM and IgA secretion was evaluated by enzyme-linked immunosorbent assay on the day 5 supernatants (Rockland, Gilbertsville, PA, USA). In some experiments, cells were treated with Z-VAD-FMK (30 μM) (Enzo Life Sciences).

Caspase-9 cloning and transfection

Total RNA was extracted from Pt1 PBMCs using the NucleoSpin RNA II Kit (Macherey-Nagel, Düren, Germany) and reverse transcribed with the ThermoScript RT-PCR System (Invitrogen, Milan, Italy). CASP9 was amplified with the same reverse primer and with two alternative forward primers, one adding the HA-tag and the other the FLAG-tag. Because Pt1 was heterozygous for CASP9<sup>33,37</sup>, both the wild-type (FLAG-tagged) and the mutated (HA-tagged) amplifiers were obtained. These cDNAs were cloned into the pcDNA3.1 vector (Invitrogen) and sequenced.

The 293T cells were cultured in Dulbecco’s modified essential medium (Invitrogen) supplemented with 10% fetal calf serum at 37 °C. A total of 3 × 10^5 cells were plated in 90 mm dishes and transfected with 15 μg of the empty vector, the WTT<sup>1+LAC</sup> vector, the H237P<sup>14</sup> vector or a combination of them using the Lipofectamine 2000 Kit (Invitrogen).

PBMCs, CD4+ T cells, TonsBCs and Raji cells (ATCC; no. CCL-86) were cultured in RPMI 1640 medium+10% fetal calf serum and transfected using
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the Amazx Cell Line Nucleofactor Kit V (Lonza, Basel, Switzerland), according to the manufacturer’s instructions. Briefly, 4 µg of each construct were co-transfected with 1 µg of the pEGFP vector (Invitrogen). Transfection efficiency was analyzed by cytofluorimetric evaluation of the proportion of GFP-expressing cells.

After 30 h, adherent and floating cells were harvested into ice-cold AKT buffer (20 mM Tris, pH 7.5, 5 mM ethylenediaminetetraacetic acid, 150 mM NaCl, 1% Triton X-100, 10% glycerol, 0.5 mM dithiothreitol, 1 mM phenylmethylsulfonyl fluoride), 1 µg/ml leupeptin, 1 µg/ml aprotinin, 1 µg/ml pepstatin) for 20 min and sonicated three times. Cell debris was removed by centrifugation and equal amounts of the cleared lysates were electrophoresed on a 10% sodium dodecyl sulfate-polyacrylamide gel with a 5% stacking gel. After electrophoresis, gels were stained with Coomassie Blue, washed three times, boiled in sodium dodecyl sulfate-polyacrylamide gel electrophoresis sample buffer, separated by sodium dodecyl sulfate-polyacrylamide gel electrophoresis and blotted with anti-APAF-1 (Sigma) and anti-caspase-9 (Sigma) antibodies.

Statistical analysis

Statistical analysis was performed using the analysis of variance followed by Dunnett’s multiple comparison test, and paired t-test for analysis of transfected lymphocytes. The results are shown as the mean ± s.e. Genotype distributions were analyzed using the Fisher’s exact test. All P-values are two-tailed, and the significance cutoff was *P < 0.05 and **P < 0.01. Statistical analysis was performed with GraphPad Instat (GraphPad Software, San Diego, CA, USA) software.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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