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Therapeutic efficacy of intravenous immunoglobulin preparations depends on the immunoglobulin G dimers: studies in experimental immune thrombocytopenia

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The clinical benefit of intravenous immunoglobulin (IVIG) preparations in the treatment of immune thrombocytopenic purpura (ITP) is supposed to be mediated by blockade of Fcγ receptor–bearing phagocytes. In 2 experimental models for ITP, it is shown that the therapeutic efficacy of IVIG preparations is related to the IgG dimer content present in these preparations. A rat monoclonal antibody (mAb; MWReg30) directed to the murine platelet-specific integrin αIIbβ3 (gpIIb/IIIa) was administered intraperitoneally either as bolus injection or continuous infusion. With bolus injection, the circulating platelet count dropped to almost zero within 3 hours. Pretreatment with cobra venom factor did not affect platelet depletion, whereas pretreatment with anti-FcγRIIa mAb 2.4G2 or IVIG greatly reduced platelet clearance. With continuous infusion, platelet numbers reached a steady state after 4 days, at approximately 25% of control. This reduction in platelets was, however, not observed in mice deficient for the FcγRI-chain, lacking FcγRI, FcγRII, and FcγRIIb in C57BL/6 mice. Infusion of a single dose of IVIG with a high IgG dimer content on the 4th day—ie, mimicking therapeutic administration—resulted in a platelet increase for several days. IVIG predominantly consisting of monomeric IgG had no effect on platelet numbers. In conclusion, continuous infusion of MWReg30 induces thrombocytopenia in mice by enhancing Fcγ receptor–mediated clearance of platelets. In this model, it is shown that IgG dimers present in IVIG preparations are responsible for the increase in platelet counts. (Blood. 2001;98:1095-1099)

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Fcy receptor expression between humans and mice is the expression of FcyRIIA, which is expressed on human but not on mouse platelets.11,12 Recently, McKenzie et al13 demonstrated an important role for this Fcy receptor in the induction of experimental ITP using mice overexpressing human FcRIIA.

IVIG preparations contain variable amounts of monomers and dimers and small amounts of aggregated IgG; it is unknown which of these fractions constitutes the active component, making standardization of IVIG preparations for the treatment of ITP tedious. The usefulness of the experimental model was demonstrated by assessing the component in IVIG-mediating therapeutic efficacy, which was shown to represent the IgG dimeric fraction.

Materials and methods

Animals

Female C57BL/6 mice of 20- to 25-g body weight were obtained from Harlan CPB (Zeist, Netherlands) and kept in our animal facilities. Fcγ-chain deficient and FcγRIII-deficient mice, lacking FcγRI and FcγRIII14,15 alone, respectively, were both used in a C57BL/6 background.

IVIG immunoglobulin preparations

Human γ-globulin for IVIG use was obtained from the CLB (immunoglobulin IV, 6% wt/vol, Amsterdam, The Netherlands). This is a freeze-dried product prepared from pooled plasma from at least 1000 donors by Cohn fractionation followed by pepsin incubation, pH 4. Fresh IVIG was immediately frozen after reconstitution and kept at −80°C until further use. To obtain an IVIG preparation with a high IgG dimer content, we reconstituted a freeze-dried IVIG preparation and stored it at 4°C (further referred to as aged IVIG). A gradual increase in dimer content was observed from less than 5% to values greater than 10% after 1 week of storage. The percentage of IgG dimers remained at this level when analyzed after several months or even after 1 year of storage. Monomeric IgG was prepared by gel filtration of IVIG on a TSK4000 column. Fractions corresponding to the monomeric peak were collected and concentrated to a concentration of 50 mg/mL using Centrisil concentrators according to the manufacturer’s instructions (Amicon, Beverly, MA). IVIG preparations used in the experiments were analyzed for actual monomer, dimer, and polymer content on a calibrated Superose 12 gel filtration column connected to an FPLC system (Pharmacia, Uppsala, Sweden). A computer program (EzChrom Chromatography Data System, version 6.5) was applied to determine the peak areas of chromatograms.

Reagents

Cobra venom factor (CoVF) was kindly provided by Dr J. S. Verbeek (LUMC, Leiden, The Netherlands). Rat antimuscle platelet monoclonal antibody (mAb; MWReg30, IgG1) and rat anti–mouse FcγRIII mAb (2.4G2, IgG2b) were obtained from Pharmingen (San Diego, CA). fluorescein isothiocyanate-conjugated F(ab)2 fragments of goat anti–rat IgG were obtained from Caltag (Burlingame, CA).

Induction of thrombocytopenia

Mice were rendered thrombocytopenic by administration of the rat mAb MWReg30, directed to the platelet-specific integrin αIIbβ3 (gpIIb/IIIa). In an acute model, a bolus of 5 μg mAb was injected in the peritoneal cavity in 200 μL saline. The effect of IVIG was determined in mice by giving IVIG (1 g/kg) or saline intravenously 1 hour before injection of MWReg30. Blood was obtained from the orbital plexus of anesthetized mice using heparinized hematocrit tubes (Clinitubes; Radiometer, Copenhagen, Denmark). Blood samples were taken before IVIG or saline treatment (t = 0), 5 minutes before injection of MWReg30 and 10, 60, and 180 minutes after injection of MWReg30. For determination of platelet numbers, blood (20 μL) was diluted in isotone and centrifuged at 300g for 10 minutes at room temperature. Numbers of platelets were counted using an electronic cell counter (model 2F and Channeliser model 256; Coulter Electronics, Dunstable, United Kingdom).

To obtain a clinically more relevant model for testing IVIG, MWReg30 was continuously infused using an osmotic pump implanted in the peritoneal cavity (Alzet micro-osmotic pump, model 1002; Alza, Palo Alto, CA). Mice were infused at a rate of 0.25 μL/h for a duration of 14 days with 44.3 μL saline containing 165 μg/mL human serum albumin (1.5 mg/mL) to prevent absorption of proteins to the device, and an irrelevant mouse mAb directed against human CRP to check for the infusion rate. Blood samples were taken under anesthesia at 0, 4, 5, and 6 days to determine numbers of platelets in peripheral blood. At day 4, aged IVIG, monomeric IgG, or saline was given intravenously at a dose of 1 g/kg.

Complement-depleted mice

Complement-depleted mice were prepared by intraperitoneal injection of 2 doses of 500 U CoVF in 200 μL saline at a 6-hour interval. Sera were analyzed on sodium dodecyl sulfate–polyacrylamide gel electrophoresis (SDS-PAGE) to confirm complement depletion.

Detection of anti-idiotype antibodies directed against MWReg30

To detect antibodies in the IVIG preparations with affinity to MWReg30, IVIG was added to 96-well microtiter plates (Maxisorb: Nunc, Roskilde, Denmark) coated with MWReg30 (0.8 μg/mL), human serum albumin (HSA; 1 μg/mL), or buffer. Bound antibodies were detected by an alkaline phosphatase–labeled monoclonal antibody to human IgG (clone GG-5; Sigma Chemical, St Louis, MO). After the addition of p-nitrophenyl phosphate as substrate, the optical density was measured with Titertek Multiscan (Flow Labs, McLean, VA).

Detection of free circulating MWReg30 in plasma and platelet-bound MWReg30

For the determination of membrane binding of MWReg30 to platelets, whole blood from mice with implanted pumps was stained at a final concentration of 5 μg/mL fluorescein isothiocyanate-conjugated F(ab)2 fragments of goat anti–rat IgG for 30 minutes (4°C in the dark) and analyzed with a FACScan flow cytometer (Becton Dickinson, San Jose, CA). To detect free circulating MWReg30 in plasma from thrombocytopenic mice, plasma from mice with implanted pumps was incubated for 1 hour at room temperature with whole blood from control mice. Binding of MWReg30 to platelets was assessed as described above.

Statistical analyses

Results are expressed as mean ± SEM. Statistical analyses were performed using Student t tests. P < .05 was considered significant.

Results

MWReg30 bolus injection model for ITP

First, we determined the clearance of platelets after intraperitoneal injection of a rat mAb directed against mouse platelet-specific integrin αIIbβ3 (gpIIb/IIIa; MWReg30), at a dose of 5 μg per mouse. After injection, platelet numbers decreased over several hours, reaching platelet counts of 1.43 ± 0.49 × 10^8/mL (n = 5, 22% of control, P < .01) at 3 hours (Figure 1). To determine the mechanism of antibody-induced thrombocytopenia, mice were pretreated with an mAb against FcγRIII or, alternatively, with CoVF to deplete complement. Figure 1 shows that in vivo blocking of FcγRIII by pretreatment with the 2.4G2 mAb completely prevented the MWReg30-induced clearance
Numbers were 6.37 ± 0.32 (ml) of blood. Results are expressed as the mean of 3 experiments ± SEM. Asterisks indicate statistically significant differences compared to saline control (*P < 0.05; **P < 0.01).

More, microscopic examination of the lungs did not show signs of lung damage, such as enhanced thickness of alveolar septa, because of edema and increased cellularity (not shown).

**Figure 1. Intraperitoneal injection antiplatelet mAb.** The role of Fcγ receptors in antibody-induced thrombocytopenia after intraperitoneal injection of 5 μg of antiplatelet mAb MWReg30. Time-course of mean platelet counts (± SEM, n = 6) is shown after injection of MWReg30 at t = 0 minute. Mice were pretreated with 2.4G2 ( ), 5 μg intravenously, CoVF (), or saline ( ), before MWReg30. Baseline platelet numbers were 6.37 ± 0.32 × 10^9/mL blood. Results are expressed as the mean of 3 experiments ± SEM. Asterisks indicate statistically significant differences compared to saline control (*P < 0.05; **P < 0.01).

**Table 1. Percentages of monomeric, dimeric, and polymeric immunoglobulin G in intravenous immunoglobulin preparations**

<table>
<thead>
<tr>
<th></th>
<th>Monomeric IgG (%)</th>
<th>Dimeric IgG (%)</th>
<th>Polymeric IgG (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresh IVIG</td>
<td>97.6</td>
<td>2.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Aged IVIG</td>
<td>87.2</td>
<td>12.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Monomeric IgG</td>
<td>99.5</td>
<td>0.4</td>
<td>&lt; 0.1</td>
</tr>
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Analysis was performed by size exclusion chromatography using a calibrated Superose 12 gel filtration column connected to an FPLC system, as described in "Material and methods." IgG indicates immunoglobulin G; IVIG, intravenous immunoglobulin.

**Figure 2. Effect of IVIG in antibody-mediated thrombocytopenia after intraperitoneal injection.** Thrombocytopenia after intraperitoneal injection of antiplatelet mAb MWReg30. Time-course of mean platelet counts (± SEM) is shown after injection of MWReg30 at t = 0 minute. Mice were pretreated with aged IVIG ( ), fresh IVIG ( ), or saline ( ) 1 hour before MWReg30 at a dose of 1 g/kg. Injection of aged IVIG alone, without subsequent injection of the antiplatelet mAb ( ), was used as a control. Results are expressed as mean of 6 experiments ± SEM on different occasions. The aged IVIG preparation used in the experiment was stored at 4°C for 1 year. Asterisks indicate statistically significant differences compared to saline control (*P < 0.05; **P < 0.01).

**Continuous MWReg30 infusion model**

To determine the effect of IVIG in a setting better paralleling the clinical situation, MWReg30 was continuously infused using an implanted osmotic pump. After 4 days, platelet numbers reached a steady state of approximately 25% of control (Figure 3). To check the efficacy of the osmotic pumps, an irrelevant mAb, directed against human CRP, was added to the mixture of MWReg30 and HSA. The amount of this antibody was determined using an enzyme-linked immunosorbent assay in plasma samples taken at different time points during the experiment (data not shown). All mice analyzed were found to have the same amount of circulating antibody until 6 days after implantation of the pumps, indicating pumps to be equally efficient in releasing antibodies.

In the acute bolus model, we used 2.4G2 to block Fc receptors. It is known that infusion of this antibody efficiently blocks Fc receptor–mediated immune clearance; however, the maximal inhibition by this antibody only persists for 24 hours. The continuous infusion model takes much longer; therefore, we decided to use Fc receptor knockout mice to avoid repeated injection of 2.4G2 in these mice. Mice deficient in the common FcRγ chain (Fcrγ−/−), lacking FcγRI and FcγRII, and mice deficient in the FcγRII, alone were used to determine the role of the different Fcγ receptors in this model. No MWReg30-induced thrombocytopenia was observed in either FcγRI chain−/− or FcγRII−/− mice, suggesting an important role for FcγRII in the clearance of antibody-sensitized platelets (Figure 3A).

Administration of IVIG in patients with ITP is often associated with a rapid increase in platelet counts. To determine whether administration of IVIG shows a similar effect on platelet counts in our model, mice were treated with aged IVIG or monomeric IgG 4 days after implantation of the pumps. To better determine the role of IgG dimers, we used in this series a monomeric IgG fraction isolated from IVIG instead of fresh IVIG because the latter still contains a significant amount of IgG dimers (Table 1). Infusion of a
single dose of aged IVIG resulted in a transient increase in platelets for several days (Figure 3B), reaching platelet counts of approximately 52% of baseline values. No increase in platelet counts was observed after infusion of monomeric IgG or saline.

Table 2 shows the results of FACS analysis for detecting binding of antibody in plasma was similar to a 1:2500 dilution of the infused MWReg30 solution, suggesting that approximately 5% of MWReg30 was not bound to platelets. Furthermore, membrane binding of MWReg30 in vivo was shown to be one third the maximal value for each type of administration.

**Anti-idiotypic antibodies against MWReg30 in IVIG**

IVIG efficacy in ITP could also result from the neutralization of platelet antibodies by anti-idiotypic antibodies in IVIG. Hence, aged IVIG and fresh IVIG were evaluated for the presence of anti-idiotypic antibodies with binding capacity to MWReg30. As a control, we tested possible binding capacity of components present in the IVIG preparations to human serum albumin. Binding of IgG to different coatings was similar: no specific binding to MWReg30 was observed when testing the various preparations (data not shown). We also evaluated whether IVIG could interfere with the binding of MWReg30 to platelets. Aged IVIG, at a concentration of 5 mg/mL, did not reduce MWReg30 binding of murine platelets in vitro.

**Discussion**

In the present study, we used 2 murine models for ITP to evaluate the effect of IVIG preparations that differed in the content of IgG dimers. We demonstrated that clearance of platelets sensitized with an anti-platelet mAb could only be reduced by administration of an IVIG preparation containing significant amounts of IgG dimers. An IVIG preparation without IgG dimers hardly showed an effect. The effect of IgG dimers was observed in both murine models for ITP, that is, a single intraperitoneal injection or continuous infusion of antiplatelet antibody. We recently described the hypotensive effects of IgG dimers in IVIG preparations, in which we compared 16 different IVIG preparations of 11 different manufacturers. This study revealed that commercially available IVIG preparations contain variable amounts of IgG dimers (range, 5%-15%). This is consistent with the observations of Tankersley et al that IgG dimers are a normal constituent of IVIG prepared from a large donor pool. The amount of dimers in the preparations mainly depends on the pool size and the storage conditions. Our present findings strongly suggest that because of differences in dimer content, preparations also will differ in therapeutic efficacy in the treatment of patients with ITP. They also suggest that therapeutic efficacy in ITP entails the risk for side effects, probably also related to the presence of IgG dimers through the activation of macrophages and neutrophils.

**Low-affinity Fcγ receptors apparently were involved in the antibody-dependent clearance of platelets in our model because in vivo blocking of FcγRII/III or the absence of these receptors in knock-out mice completely prevented the effect of antiplatelet mAb. The importance of low-affinity Fcγ receptors in the clearance of immune complexes has been shown in several human and animal studies.** Furthermore, infusion of mAbs against FcγRII caused a significant, transient increase in platelet counts in a patient with ITP. Infusion of an mAb directed against FcγRI did not change the platelet count over a 5-day course of treatment, whereas the administration of IVIG in this patient improved platelet count. Our experiments with blocking mAb (2.4G2) or in mice deficient for Fcγ receptors were compatible herewith and in particular pointed to a role for FcγRII in the clearance of antibody-sensitized platelets in vitro.
platelets, emphasizing the relevance of these models for human ITP. However, others have demonstrated involvement of the platelet Fcγ receptor in human immune thrombocytopenias accompanied by thrombosis, such as heparin-induced thrombocytopenia, and it cannot be precluded that this receptor also plays a pathophysiological role in other forms of ITP. Because mice do not express this Fcγ receptor on platelets, our model is unable to address beneficial or detrimental effects of IVIG on platelet Fcγ receptors. Hence, one should be careful to extrapolate the results obtained in this model to human ITP. Interference with FcγR expression level and FcγR-mediated functions (such as phagocytosis) are well-established characteristics of polymeric IgG and immune complexes. Furthermore, human IgG aggregates and IgG dimers bind more efficiently to low-affinity Fcγ receptors than do IgG monomers. Dimeric IgG may, therefore, have a stronger effect than monomeric IgG. It has been suggested that in IVIG, small amounts of aggregated IgG can form spontaneously and that these aggregates, rather than IgG monomer itself, constitute the active component of IVIG mediating Fcγ-receptor blockade in ITP. Augener reported that the efficacy of IVIG treatment of a patient with ITP was not associated with monomeric IgG levels but with the presence of IgG aggregates in the preparation. This patient showed normal levels of IgG complexes before treatment with IVIG and showed stepwise increases in total IgG levels, including aggregates, during therapy. When IVIG administration was terminated, the concentration of complexed IgG rapidly dropped to a normal level, and this was paralleled by a drastic decrease of platelet numbers even though IgG plasma levels were still high. In another study it was shown that the use of intramuscular preparations of anti-D that contained aggregates, during therapy. When IVIG administration was terminated, the concentration of complexed IgG rapidly dropped to a normal level, and this was paralleled by a drastic decrease of platelet numbers even though IgG plasma levels were still high. In another study it was shown that the use of intramuscular preparations of anti-D that contained aggregated IgG resulted in small platelet increases in several Rh-negative recipients. These observations agree well with the results of our study.

Acute systemic response seen on a bolus injection of a relatively high dose of MWReg30 is a process that requires a threshold-dose of antibody to occur. The density of antibodies bound to the platelets can explain these differences. In patients with ITP, platelet-specific antibodies are primarily directed to gpIb/IIIa—as is MWReg30. However, specific antiplatelet antibodies account for only a small fraction of the platelet-associated IgG, with the major fraction attributed to nonspecific IgG associated with platelets. This suggests that in a model with clinical relevance, the amount of antibody used to induce thrombocytopenia should be low, so that only the antibody occupies a few epitopes on the platelet surface. We showed that in our models only some of the MWReg30 binding sites were occupied.

An alternative mechanism for the reversal of thrombocytopenia by IVIG involves idiotype-anti-idiotype interaction with autoantibodies and anti-idiotype antibodies in the IVIG preparations. This mechanism is independent of RES blockade, but it postulates the neutralization of antiplatelet antibody by IVIG. However, it was shown that Fcγ fragments have the same therapeutic effects as IVIG in patients with ITP. Thus, anti-idiotypic effects of IVIG are not likely a major mechanism of action in ITP. In our study, binding of MWReg30 to platelets was not influenced by IVIG, nor did we find (anti-idiotypic) antibodies with binding capacity to MWReg30.

In conclusion, in a clinically relevant mouse model for ITP, we show the efficacy of IgG preparations containing high amounts of IgG dimers. The experimental model applied may not only help to define the mechanisms causing ITP but may also add to the evaluation of novel therapeutic strategies to treat this disease. We suggest that therapeutic efficacy of different IVIG preparations used to treat human ITP depends on the presence of IgG dimers, with preparations containing relatively high amounts of IgG dimers having better therapeutic efficacy.

References