Systemic inflammation and chronic kidney injury in a patient due to RNASEH2B defect

Tingyan He (hetingyan2017@outlook.com)
Shenzhen Children's Hospital
Yu Xia
Shenzhen Children's Hospital
Jun Yang
Shenzhen Children's Hospital

Research article

Keywords: Auto-inflammation, Autoimmunity, Aicardi-Goutieres syndrome, Chronic kidney injury, RNASEH2B

DOI: https://doi.org/10.21203/rs.3.rs-33775/v1

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Abstract

Background

Aicardi-Goutières (AGS) is a rare immune dysregulated disease due to mutations in TREX1, RNASEH2A, RNASEH2B, RNASEH2C, SAMHD1, ADAR1 or IFIH1. Severe systemic inflammation is not typically persistent in AGS. Chronic kidney injury (CKI) has been never reported in this syndrome. Herein, we report a patient presenting with systemic inflammation and CKI to broaden the clinical phenotype spectrum of RNASEH2B defect.

Methods

Clinical data extracted included medical history, clinical manifestations, laboratory results, radiological findings, management, and prognosis. Whole exome sequencing was performed on whole peripheral blood cells. After exposure to cGAMP in vitro for 24 hours, mRNA expression of twelve IFN-stimulated cytokine genes in PBMCs was assessed. Serum cytokine levels were detected by Milliplex.

Results

A 11-year-old female patient presented with recurrent aseptic fever, arthritis, chilblains, failure to thrive, mild hearing loss, and neurological manifestations. Laboratory and immunologic findings revealed lymphopenia, low complement levels, positive autoantibodies, elevated levels of acute phase reactants and inflammatory cytokines. Renal biopsy showed glomerular sclerosis in three of fourteen glomeruli, infiltration of lymphocytes and other mononuclear cells. Whole exome sequencing (WES) revealed a homozygous and heterozygous mutations in RNASEH2B. Over-expression of IFN-stimulated cytokine genes was observed in the patient, including IFI44, IFI27, IFIT1, IFIT2, IFIT3, ISG15, OAS1, and SIGLEC1.

Conclusions

Systemic autoinflammation and chronic renal injury may expand the clinical phenotype spectrum of RNASEH2B defect.

Trial registration:

Not applicable; this was a retrospective study.

Background
Aicardi-Goutières (AGS) is a rare immune dysregulated disease due to mutations in TREX1, RNASEH2A, RNASEH2B, RNASEH2C, SAMHD1, ADAR1 or IFIH1, characterized by encephalopathy, dystonia, basal ganglia calcifications, white matter abnormalities, and cerebral atrophy [1, 2]. Although most patients experienced severe neurological dysfunction within the first year of life, some patients presented with later onset of this disease with mild neurological manifestations and normal intellectual function. Systemic inflammation is not typically persistent. Renal dysfunction has been rarely described in AGS [2]. Here we report a patient with both homozygous and heterozygous mutations in RNASEH2B, presenting with later onset recurrent sterile fever, arthritis, chilblains, failure to thrive, mild hearing loss, and neurological manifestations, to broaden the clinical phenotype spectrum of RNASEH2B defect.

**Materials And Methods**

**Subjects**

This study was approved by the Ethics Committee of Shenzhen Children’s hospital. All human subjects (or their guardians) provided written informed consent. Clinical data of a patient with both homozygous and heterozygous variants in RNASEH2B was collected. Fifteen healthy volunteers were included as healthy controls. Venous blood (3 mL) was collected from each study subject.

**Whole Exome Sequencing (WES)**

Genomic DNA was extracted from peripheral blood cells isolated from the patient and her parent. The exonic regions and flanking splicing or intronic junctions of the whole genome were captured and sequenced using an Illumina HiSeq 2000 sequencer conducted by MyGenostics (Beijing, China). The FASTQ files were mapped to the human reference genome (hg19). The functional effects of variants were predicted using three algorithms (PolyPhen-2, SIFT, and MutationTaster), and amino acid conservation among species was analyzed. Sanger sequencing was used to confirm pathogenic variants. The primers used to target human RNASEH2B included (forward: CAGGGATTGAAGCTCTTTGG) and (reverse: TAGTGCTCTGTCCTGCACTGG).

**Cell Culture**

Peripheral blood mononuclear cells (PBMCs) were isolated by Ficoll-Paque PLUS (GE Healthcare) gradient density centrifugation and ACK lysis (Quality Biological). PBMCs were resuspended in complete RPMI (cRPMI) medium (Gibco, USA) containing 10% fetal bovine serum (BI, Israel), 2 mM glutamine, and penicillin-streptomycin (100U/mL each; Sigma-Aldrich, USA). Cells at 1 × 10⁶/mL were exposed to cyclic guanosine monophosphate-adenosine monophosphate (cGAMP, CST#35573) at the concentration of 10 ug/ml.
Real-time PCR

After exposure to cGAMP in vitro for 24 hours, mRNA expression of twelve IFN-stimulated cytokine genes in PBMCs was assessed. Total RNA was extracted from PBMCs isolated from the patient and five HCs by RNA isolation kit (DP424, TIANGEN). cDNA was derived following the GoScript Reverse Transcription System kit (A5001, Promega). Quantitative reverse transcription PCR analysis was performed with the GoTaq qPCR Master Mix (A6002, Promega). Primers for PCR included were described in the supplementary material.

Quantification Of Cytokine Levels

Plasma samples were isolated from the patient and fifteen HCs. Cerebrospinal fluid (CSF) sample was collected from the patient. Blood samples were collected in vacutainers containing sodium heparin. Plasma cytokine analyses were determined on a bead-based immunoassay (Milliplex, HCYTOMAG-60K, Millipore, USA) according to the manufacturer's protocol.

Statistical analysis

Data were analyzed using an unpaired two-tailed Student t-test. All statistical analyses were conducted in GraphPad Prism 7 software (GraphPad Software, Inc., San Diego, CA).

Results

Clinical manifestations

The patient presented with recurrent fever, arthritis, movement limitation, and growth retardation at the age of 11 years. At the age of 2 years, she began to suffer from recurrent aseptic fever with an intermittent resolution by traditional Chinese medicine. At the age of 5 years, she began to present with arthritis accompanied by mild hearing loss. She was born to a non-consanguineous healthy parent. At birth, her weight was 3 Kg, crown to heel length was 49 cm, and head circumference was 34 cm. She had standard motor and language development. Manifestations of failure to thrive had been significant since she was three years old. Physical examination revealed short stature with 106 cm top (<-3SD) (Fig. 1B3), macrocephaly with 54 cm head width, chilblains on elbows and lower limbs (Fig. 1B2), swelling and deformation of inter-phalangeal and knee joints (Fig. 1B1). Her Intelligence Quotient (IQ) test value was 108. Her EPQJ, CBCL, Conners, and HAMA scale tests did not demonstrate any social and psychological problems. Knee magnetic resonance imaging (MRI) revealed a thickness of the synovial capsule without invasive bone destruction (Fig. 1B4). Cerebral MRI showed cerebral atrophy and white matter abnormalities (Fig. 1B6). Intracranial calcification was further identified at the basal ganglia and cerebellum by CT scanning (Fig. 1B5 and Fig. 1B7). Laboratory findings revealed hyper-inflammation and chronic kidney insufficiency (Fig. 2B and Fig. 2F). Screening tests for fungal, bacteria and
Mycobacterium tuberculosis infection were all negative. Pathology of the renal biopsy showed glomerular sclerosis in three of fourteen glomeruli, a mild proliferation of mesangial cells without deposits of any amyloid, immunoglobulin or immune complex, expansion of the tubular lumen, partial tubular atrophy, mild tubular fibrosis, infiltration of lymphocytes and other mononuclear cells (Fig. 1C). Granule degeneration and calcium deposition were visible in renal tubules.

**Abnormality In Clinical Immunologic Phenotype**

Analysis of peripheral blood leukocyte revealed persistent lymphopenia with normal subset ratios (Fig. 2A). Except for rheumatoid factor (RF) and anti-cyclic peptide containing citrulline (anti-CCP), other auto-antibodies including anti-nuclear antibody (ANA) and anti-neutrophil cytoplasmic antibody (ANCA) were all negative. Other abnormal clinical immunologic phenotypes included intermediate elevation of IgM and IgA levels (Fig. 2C) and reduction of C3 and C4 levels (Fig. 2D).

**Both homozygous and heterozygous variants in RNASEH2B**

Whole exon sequencing revealed three variants in *RNASEH2B* gene (OMIM: 610181). There was a single nucleotide homozygous variant, c.859G > T, p.A287S (Fig. 1A). Predicted values of SIFT, PolyPhen_2, Mutation Taster and GERP++ were 0.235, 0.721, 1 and 6.06, respectively. Both parents carried a heterozygous mutation at the same locus. Another single nucleotide heterozygous variant, c.269C > T, p.P90L, was identified (Fig. 1A). The predicted values of SIFT, PolyPhen_2, Mutation Taster and GERP++ were 0.002, 0.988, 1 and 4.69, respectively. This heterozygous variation was further confirmed by Sanger in both her parents.

**Over-expression Of IFN-stimulated Cytokine Genes**

After exposure to cGAMP in vitro for 24 hours, mRNA expression of IFN-stimulated cytokine genes in PBMCs was detected by real-time PCR. In contrast to five healthy controls, over-expression of IFN-stimulated cytokine genes was observed in the patient, including IFI44, IFI27, IFIT1, IFIT2, IFIT3, ISG15, OAS1, and SIGLEC1. Normal mRNA expressions were found in IFNβ1 and IRF9 (Fig. 3B).

**Elevations In Inflammatory Cytokine Levels**

Compared to fifteen age-matched healthy controls, plasma cytokine levels were significantly elevated, including interleukin (IL) -1β, IL-6, tumor necrosis factor-α (TNFα), interferon-γ (IFN-γ), IFN-α, IL-4, IL-10, IL-12, IL-17A and IP-10 (Fig. 3A and Table 1). IFN-α level in CSF was very low.

**Treatment And Outcome**
A one-year course of growth hormone showed no response to improve her short stature. She had received long-term treatment of ibuprofen, methotrexate, folic acid, and prednisone for more than five years. Aseptic fever relapsed intermittently. Tocilizumab was started for the high dose dependence of glucocorticoids and elevated pro-inflammatory cytokine levels, including IL-6. Following a 48-week course of tocilizumab, the prednisone dose was gradually reduced to 0.2–0.3 mg/Kg.d, and some abnormal laboratory findings had been improved (Fig. 2B and Fig. 2F). While urine β2 microglobulin level sustained elevated significantly (Fig. 2E). Tocilizumab was discontinued. She began to receive tofacitinib for the over-expression of IFN-stimulated cytokine genes. The 12-week course of tofacitinib led to partial improvement of lymphocytes, C3 and C4 levels (Fig. 2A and Fig. 2D), failing to improve chronic renal injury.

**Discussion**

Biallelic mutations of *RNASEH2B* are most common in AGS. While three allelic variants in *RNASEH2B* have been identified in this patient. Homozygous variant c.859G > T, p.A287S in *RNASEH2B*, is reviewed as a benign or likely benign variant in ClinVar. The population frequency in East Asian is 0.02, with two homozygotes demonstrated in ExAC Browser. The heterozygous variant c.269C > T, p.P90L is highly conserved with extremely low population frequencies and no homozygotes in ExAC Browser. Its clinical significance remains uncertain in ClinVar. The tri-allelic mutations in *RNASEH2B* may cause a synergistic pathogenic effect since neither heterozygous nor homozygous variants alone can account for her skin and neurological manifestations.

This patient has demonstrated a later onset of AGS with average intelligence, presenting with chilblains, cerebral atrophy, white matter abnormalities, intracranial calcification, and over-expression of Interferon-stimulated genes. Besides, this patient has exhibited persistent systemic inflammation and chronic renal dysfunction, which are uncommon in AGS (Table 2). Systemic juvenile idiopathic arthritis (SoJIA), and later onset chronic infantile neurologic, cutaneous, and arthritis (CINCA) syndrome were once suspected. Different from the clinical manifestations in this patient, chilblains and intracranial calcification are not present in SoJIA or CINCA; leukocytosis, destructive arthritis, or macrophage activation syndrome (MAS) are noted in SoJIA [3–5]; visual impairment, sensor neural deafness or progressive chronic meningitis have been commonly reported in CINCA [4]. Chronic renal dysfunction due to amyloidosis has been rarely reported in SoJIA, which is common in CINCA (Table 2) [7]. Renal biopsy in this patient revealed glomerular sclerosis and tubular injury without amyloidosis. Human IFN-alpha is filtrated by the kidney, primarily reabsorbed, most probably catabolized within the tubular epithelium, and excreted in negligible amounts with the urine [8]. Hence, a fairly high IFN-a level within the tubular epithelium due to a persistently elevated IFN-a level in plasma may amplify the activation of the interferon pathway, leading to the infiltration of lymphocytes and mononuclear cells, and local chronic inflammation. Further investigations will help to explore the distinct pathogenesis underlying chronic renal dysfunction in RNASEH2B defect.
IL-6 is one of the downstream effector cytokines in the IFN signaling pathway. IL-6 blockade has good efficacy in a patient with a cerebral vasculopathy due to a homozygous \textit{SAMHD1} mutation. His cerebral vasculopathy was mostly reversed after tocilizumab treatment [9]. Tocilizumab has partial efficacy in this patient, leading to a reduction of acute-phase reactants. While it has failed to improve chronic renal tubular injury. Further structural clinical trials are required to clarify the efficacy of tocilizumab in AGS.

IFN-\(\alpha\) and IFN-\(\beta\) act on type I receptors (IFNAR1/2) to activate the Janus kinase (JAK)-signal transducers and activators of the transcription (STAT) pathway. JAK inhibitors have good efficacy in patients with some type I interferonopathies, including STING-associated vasculopathy, infantile-onset (SAVI), and proteasome-associated autoinflammatory syndrome (PRAAS) [10–13]. Sustained elevated IFN-\(\alpha\) and IFN-\(\beta\) levels are common in AGS. Hence, it makes sense that JAK inhibitors will help to reduce autoinflammation in AGS. Ruxolitinib has reduced neuroinflammation in an AGS7 patient with heterozygous p. Arg779Cys IFIH1 substitution [14]. Baricitinib could alleviate chilblain lesions in an AGS5 patient [15]. Tofacitinib ameliorated aortic valve calcification in a patient with Singleton-Merten syndrome (SMS) [16]. Ruxolitinib led to an improvement of psychomotor delay with a reduction in dystonic movements in two AGS2 patients [17].

On the other hand, ruxolitinib failed to prevent the onset of clinical signs in a patient with \textit{RNASEH2B} mutation [18]. Tofacitinib only demonstrated a partial response in this patient, failing to reduce autoinflammation and ameliorate chronic renal injury. Hence, based on limited case reports, the efficacy of JAK inhibitors in AGS remains uncertain. The currently ongoing trial conducted at the Children's Hospital of Philadelphia (ClinicalTrials.gov number, NCT03921554) will help to explore the efficacy and safety of baricitinib in AGS and AGS-related interferonopathies.

**Conclusions**

We have described a patient with both homozygous and heterozygous variants in \textit{RNASEH2B}, revealing a synergistic pathogenic effect among variants in the same gene. Her systemic autoinflammation and chronic renal injury will expand the clinical phenotype spectrum of this syndrome. The pathogenesis underlying chronic renal dysfunction in this patient remains poorly understood. The efficacy of tocilizumab and JAK inhibitors in AGS remains uncertain, and further clinical researches are needed.

**Abbreviations**

AGS: Aicardi-Goutières; WES: Whole exome sequencing; PBMCs: Peripheral blood mononuclear cells; cGAMP: cyclic guanosine monophosphate-adenosine monophosphate; IQ: Intelligence Quotient; MRI: magnetic resonance imaging; RF: rheumatoid factor; ANA: anti-nuclear antibody; ANCA: anti-neutrophil cytoplasmic antibody; TNF\(\alpha\): tumor necrosis factor-\(\alpha\); IFN-\(\gamma\): interferon-\(\gamma\); SoJIA: Systemic juvenile idiopathic arthritis; CINCA: onset chronic infantile neurologic, cutaneous, and arthritis syndrome; MAS: macrophage activation syndrome; JAK: Janus kinase; SAVI: STING-associated vasculopathy, infantile-onset; PRAAS: proteasome-associated autoinflammatory syndrome; SMS: Singleton-Merten syndrome.
Declarations

Availability of data and materials

Clinical datasets were collected from medical records of the participated patient in Shenzhen Children's hospital.

Ethics approval and consent to participate

All participated family members were enrolled upon approval of the ethics committee of Shenzhen Children's hospital and written consent of all the families.

Consent for publication

Written consent for publication of this anonymous information was obtained from the patient's parents.

Conflict of Interests

All authors declare no conflict of interest.

Funding

This work was supported by the Sanming Project of Medicine in Shenzhen (SZSM201812002), Science and Technology Planning Project of Shenzhen Municipality (JCY20170303155201082).

Authors’ Contribution

Tingyan He performed the main experiments, analyzed the data, and drafted the manuscript. Yu Xia collected clinical data from the patient. Jun Yang reviewed the manuscript. All authors read and approved the final manuscript.

Acknowledgments

The authors wish to thank all the patients, their families, and healthy controls for the participation.

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**Tables**

Due to technical limitations, Tables 1-2 are provided in the Supplementary Files section.

**Figures**
Figure 1

1 Clinical features and genetic analysis. A. Pedigree and a homozygous and heterozygous variants in RNASEH2B. B. Physical examinations and imaging findings showing deformed inter-phalangeal joints.
(B1), chilblains (B2), short stature (B3), synovial thickening (B4), cerebral atrophy and white matter abnormalities (B6), calcifications in basal ganglia and cerebellum (B5 and B7). C. Renal biopsy findings (10x20) showing glomerular sclerosis, a mild proliferation of mesangial cells, infiltration of lymphocytes and other mononuclear cells.
Figure 2
Abnormalities in laboratory findings. A. lymphopenia. B. Elevated CRP, ESR, and SAA levels. C. Immunoglobulin levels showing intermediate elevated IgM and IgA levels. D. Reduced C3 and C4 levels. E. Persistently elevated levels of urine β2 macroglobulin. F. Intermediate mild abnormalities in Cr and BUN. The normal reference ranges are as follows: lymphocytes (800–4000 cells/ul); CRP (0–10 mg/L); ESR (0–20 mm/h); SAA (0–6 mg/L); IgG (5.28–21 g/L); IgM (0.48–2.26 g/L); IgA (0.44–3.99 g/L); urine β2 macroglobulin (0–0.3 mg/L); Cr (21–65 umol/L); BUN (1.5–7 mmol/L). Single arrow and double arrows labeled the time when tocilizumab was started and discontinued, respectively. The asterisk labeled the time when tofacitinib was started.
Figure 3

Abnormalities in plasma cytokines and IFN-stimulated cytokine genes. A. Significantly elevated levels of all plasma cytokines in the patient. B. Over-expression of IFN-stimulated cytokine genes in the patient,
including IFI44, IFI27, IFIT1, IFIT2, IFIT3, ISG15, OAS1, and SIGLEC1. Normal mRNA expressions were observed in IFNβ1 and IRF9.

**Supplementary Files**

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