A role for transcription factor NF-κB in autoimmunity: possible interactions of genes, sex, and the immune response

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THERE ARE SEX DIFFERENCES in the immune response and even more striking differences in autoimmune disease prevalence (Fig. 1). This sex difference is observed throughout the civilized world. Females have higher antibody levels than males, and they mount more robust immune responses to antigens. Females also have more CD4+ lymphocytes and different cytokine profiles. Autoimmune diseases predominate among females, who account for nearly 80% of the 8.5 million Americans with autoimmune diseases (8, 73). Relatedly, hormonal shifts in pregnancy, menopause, and aging are associated with fluctuations in the course of autoimmune disease. Multiple sclerosis and rheumatoid arthritis, for example, improve during pregnancy, whereas lupus appears to worsen.

These observations have long implicated sex hormones in autoimmune disease etiology, course, or severity. Steroid receptors are found in immune cells and thus could provide a plausible pathway by which steroid hormones affect autoimmunity (53). However, the precise pathophysiological mechanisms by which sex hormones may exert their effects on autoimmune disease are largely unknown.

Enter the ubiquitous transcription factor NF-κB, which, since its discovery in 1986, has attracted wide interest as an immunoregulatory protein. NF-κB appears to be a central player in several autoimmune diseases, according to recent studies of genetic defects in autoreactive lymphoid cells (the immune cell types responsible for autoimmunity) in both murine models of autoimmunity and humans with diverse forms of autoimmunity. Although the genes altering NF-κB appear to vary in different autoimmune diseases, usually decreased NF-κB activity in response to select cell surface cytokines is commonly observed (Fig. 2). A separate line of evidence has found that hormones also can influence NF-κB activity. This article discusses these two lines of evidence to hypothesize how both genes and steroid hormones might contribute to the pathogenesis of several autoimmune diseases through a common mechanism: reductions in NF-κB activity. Such decreases, in turn, can disrupt a range of disease-related immune functions, including cytokine balance, antigen presentation, lymphoid development, and lymphoid repertoire selection by apoptosis.

nuclear factor-κB; autoimmune; apoptosis

Hormone Effects on NF-κB

Estrogen and progesterone have been shown, in various ways, to modulate NF-κB activity. Glucocorticoids, which are regulated in part by sex hormones, are immunosuppressants that also may modulate NF-κB activity (26). Both glucocorticoid and progesterone receptors block activation...
of NF-κB (12, 36, 58). Glucocorticoids also block NF-κB activation by another mechanism: transcriptional activation of IκB-α (5, 58). Transcriptional activation increases the synthesis of IκB-α, which quickly reunits with free NF-κB, thereby lowering levels of the latter. In contrast, levels of NF-κB and secreted TNF-α are dose dependently altered by 17β-estradiol. An increase in 17β-estradiol was sufficient to have a possible physiological effect in the ratios of disease-causing cells with an altered cytokine balance (77). Auto-reactive cell populations are sometimes quantified by the ratios of T cell populations with secretion of proinflammatory versus anti-inflammatory cytokines. In an additional study (64), 17β-estradiol treatment of isolated cytotoxic human T cells showed a dose-dependent reduction of TNF-α.

Fig. 1. Sex distribution of autoimmune diseases. For most, but not all, autoimmune diseases, females express the disease more frequently.

Fig. 2. Normal and altered cellular signaling of NF-κB in autoimmunity. In a normal immune cell in the periphery, exposure to TNF triggers a complex pathway of NF-κB activation that culminates in an active NF-κB dimer entering the nucleus, i.e., the p50/p65 complex. This NF-κB complex ensures that the cell will survive. As shown, studies in autoimmunity have identified mutations and functional blocks in the NF-κB signaling pathway in autoimmune disease. These mutations alter the autoreactive T cells signaling due to disruptions in NF-κB activation. NK, natural killer cell; LMP2, large multifunctional peptidase 2; IKK, IκB kinase; AIRE, autoimmune regulator; SUMO4, small ubiquitin-like modifier 4; E2, 17β-estradiol; Ubc, ubiquitin-binding complex; NOD2, CARD15 gene; CK II, creatine kinase II.
induced cytotoxicity toward target antigens. Apoptosis of cytotoxic T cells was not directly assessed in these experiments, but the functional elimination of autoreactive T cell clones suggests that death of these cells was a likely mechanism. Estriol also directly alters T cell to secrete cytokines of the T helper type 2 (Th2) phenotype, a patterning that would inhibit baseline TNF-α secretion and perhaps hamper autoreactive T cell clones (77).

Hormonal effects on NF-κB also may help to explain the sex differences seen in response to treatment. A randomized clinical trial of IFN-β in multiple sclerosis uncovered an unexpected treatment × sex interaction (62a). At two different doses, women responded better to IFN-β than men. One possible explanation may stem from IFN-β’s reliance on NF-κB, as part of a nucleoprotein complex, to activate the transcription of target genes that control cell life and death decisions. If estradiol raises levels of NF-κB, female patients might be more responsive to treatment than men because of the higher baseline concentrations of NF-κB to activate target genes.

**Gene Effects on NF-κB**

Genetic defects altering NF-κB activity are a common denominator across several autoimmune diseases: Type 1 diabetes, lupus, Crohn’s disease, Sjogren’s Syndrome, autoimmune regulator diseases [autoimmune polyendocrinopathy syndrome (APS)-1 or autoimmune polyendocrinopathy candidasis ectodermal dystrophy], and scleroderma (Fig. 2). NF-κB dysregulation has been found not only in humans but in at least two animal models of autoimmune disease. Although the particular modulator of NF-κB activity varies by disease, the diseases remarkably overlap by almost uniformly hampering NF-κB formation or functional activity in ways that are particular to the immune cell type and autoimmune disease (Table 1).

The nonobese diabetic (NOD) mouse is an animal model of two autoimmune diseases, i.e., Type 1 diabetes and Sjogren’s syndrome. Most research work on NOD mice has centered on studies related to the onset of Type 1 diabetes in this animal model, a lethal disease. This autoimmune dis-

![Fig. 3. NF-κB controls cell death (apoptosis) and life decisions in immune cells in the periphery. If the NF-κB pathway is intact in the periphery, activated NF-κB enters the nucleus and results in the transcription of genes for survival. If the NF-κB pathway via is blocked, the cell will die instead with TNF exposure. TNF is essential in the peripheral in maintaining cell life and death decisions and control of T cell populations.](image-url)

**Table 1. Autoimmune diseases associated with disruptions in NF-κB in lymphocytes**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Species</th>
<th>Gene</th>
<th>Cell Type</th>
<th>Action on NF-κB</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crohn’s disease</td>
<td>Human</td>
<td>NOD2</td>
<td>Monocytes</td>
<td>Increases TLR2-induced NF-κB; reduces TNF secretion; decreases ubiquitination of NEMO</td>
<td>2, 19, 48, 72</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>Human</td>
<td>TNF</td>
<td>Monocytes</td>
<td>Prevents NF-κB activation</td>
<td>43</td>
</tr>
<tr>
<td>Ulcerative colitis</td>
<td>Human</td>
<td>NF-κB1 (p105/p50)</td>
<td>Monocytes</td>
<td>Less TNF; less NF-κB</td>
<td>69</td>
</tr>
<tr>
<td>Lupus</td>
<td>Human</td>
<td>NF-κB; TNFRII</td>
<td>Monocytes</td>
<td>Prevented activation of NF-κB</td>
<td>37</td>
</tr>
<tr>
<td>Type 1 diabetes</td>
<td>Human</td>
<td>NF-κB</td>
<td>Monocytes</td>
<td>Decreased NF-κB activity</td>
<td>31</td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>Human/mouse</td>
<td>LMP2/LMP 7</td>
<td>Monocytes</td>
<td>Prevents activation of NF-κB</td>
<td>16, 18, 23, 28–30, 76</td>
</tr>
<tr>
<td>Scleroderma</td>
<td>Human</td>
<td>CD8</td>
<td>NF-κB</td>
<td>Altered NF-κB; increased apoptosis</td>
<td>50</td>
</tr>
</tbody>
</table>

NOD2, CARD15 gene; TLR2, Toll-like receptor 2; NEMO, NF-κB essential modulator; TNFR1I, TNF receptor type II; LMP, large multifunctional peptidase.
ease features destruction of insulin-producing islet cells of the pancreas by autoreactive T cells. Female NOD mice are far more prone to disease onset, with a female-to-male ratio of at least 3:1. The first in a series of studies showed that diseased animals have a decreased ability to activate NF-κB in memory T cells, which are responsible for the direct islet destruction. In this animal model, this T cell defect is partly from the reduced expression of the protein large multifunctional peptidase 2 (LMP2), a proteasome subunit (76). The genetic defect traces to LMP2’s promoter region. Reduced LMP2 expression leads to defective proteasomes, which, among other functional effects, cannot degrade IκB-α to release active NF-κB (29). The reduced NF-κB activity, as a result of a feedback loop, also curtails the activity of the LMP2 gene (75). The overall effect of having reduced NF-κB activity (by either mechanism) is to increase the survival of a key subpopulation of highly activated and autoreactive T cells. In what may be a hormone-gene interaction, females with the same genetic defect as males produced autoreactive T cells, have proteasomes that degrade the IκB-α-subunit less effectively, and have autoreactive T cells (29). These autoreactive T cells have a hampered ability to produce active forms of NF-κB. Male mice have adequate NF-κB activation and thus do not form autoreactive T cells. Macrophages, which are important for maintaining the ratio of different forms of T cells, have a different phenotype in the NOD mouse after certain types of cellular stimulation. With at least some forms of surface stimulation, NF-κB activity is found to be increased, followed by the upregulation and secretion of proinflammatory cytokines that abnormally alter the T cell repertoire (47, 60). Remarkably, a recent human study (42) of isolated peripheral lymphocytes of patients with Sjogren’s syndrome uncovered a similar lack of LMP2 protein production, thereby suggesting that immune cells in Sjogren’s syndrome would have less NF-κB activity.

Humans with Type 1 diabetes have a genetic defect separate from that in NOD mice, but the defect also decreases NF-κB activity. Type 1 diabetes preferentially affects males of European descent (3:2 male-to-female ratio) (25). A new mutation has been identified in a gene [suppressor of mif two 3 homolog 4 (SUMO4)] expressed in monocytes (27). SUMO4 encodes a protein involved in the ubiquination of IκB-α, one of the necessary steps to form functional NF-κB (Fig. 2). A single-amino acid substitution defect alters NF-κB transcriptional activity in monocytes exposed to select stimuli. The role of this mutation in other immune cells has not yet been described. To date, expression of the SUMO4 variant has not been studied in T cells. NF-κB polymorphisms in the regulatory region of the NF-κB gene in one population-based study (31) also influenced the susceptibility to Type 1 diabetes.

In Crohn’s and ulcerative colitis, inflammatory diseases of the gut, the NOD2 gene has been identified as having mutations that confer disease susceptibility (34, 52). Defects in the NOD2 protein, a new protein unrelated to the NOD mouse, alters the activity of NF-κB in monocytes, most likely by lessened NF-κB activity (1, 48, 52). Although the precise physiological role of the protein is still evolving, depending on the cell type and cell surface trigger, the bottom line is that NF-κB activity is perturbed in yet another autoimmune disease. Some reports (48, 72) have shown higher or lower NF-κB activity depending on the cell type and stimulant used to induce NF-κB activity. Cell surface triggers or stimulants can be naturally occurring cytokines, chemokines, or hormones. Similar to Type 1 diabetes, an ulcerative colitis-specific NF-κB1 promoter polymorphism influences the risk for this autoimmune disease (38). Similar to lupus, associated TNF-α polymorphisms contribute further to the reductions of the NF-κB pathway in lymphoid cells and susceptibility to Crohn’s disease (43, 45).

Four other autoimmune diseases also are marked by alterations in NF-κB activity. Although the underlying defects vary, the common theme of altering NF-κB activity is consistent, and the defects sometimes also include TNF proteins. TNF works on the cell surface to activate the NF-κB pathway. Alterations in the levels of serum TNF, binding affinity of TNF to a possible mutant TNF receptor, and downstream intracellular steps of NF-κB signaling pathways have all been linked to human and murine autoimmune disease. Since the NF-κB pathway normally tightly regulates cell life and death decisions and controls many cytokine gene levels, single or cumulative defects could potentiate the survival of autoreactive cells. In lupus, activation of NF-κB signaling is attenuated in T cells due to the absence of the p65 appearance in the nucleus, one of the NF-κB subunits that binds to DNA (74). This is compounded in lupus by a polymorphism in TNF receptor 2, a version of the TNF receptor restricted to activated CD8 T cells. This mutation affects TNF-induced apoptosis by decreased NF-κB signaling and thus the set point for death (67). Finally, mutations in the AIRE gene, a single recessive mutation controlling a rare form of polyglandular autoimmunity, indicate that the AIRE protein is a ubiquitin ligase, a processing step necessary for NF-κB activation (32). This regulation maybe in the form of the AIRE protein itself, representing a ubiquitin ligase that alters IκB-α degradation. In an animal model of lupus, female New Zealand black mice (which are more disease prone than males) display an alteration in NF-κB activity upon cytokine activation of thymocytes, dendritic cells, and monocytes (47, 68). In scleroderma, NF-κB activity in T cells is lowered, also with heightened apoptosis of T cells upon exposure to TNF. Although the mechanisms of altering NF-κB are still being defined in each disease, reductions in NF-κB activity are correlated with higher levels of apoptosis in autoreactive T cells (CD8+) with the isolation of these cells in vitro (Fig. 4). This heightened apoptosis with a ligand such as TNF represents a well-known trait of cells with altered IκB-α degradation (33, 40).

Currently on the market for treatment of rheumatoid arthritis and Crohn’s disease are classes of drugs that remove or inactivate serum TNF. These so-called anti-TNF therapies come in a number of different formulations i.e., Remicade (infliximab), Enbrel (etanercept), and Humira (adalimumab). If the above data from diverse experiments suggest that some forms of autoimmunity may need more TNF for the death of autoreactive T cells or their specific death in the periphery after immune activation, these currently marketed forms of therapy may seem paradoxical. Although these drugs certainly can remove inflammation and thus improve the symptoms of autoimmunity, the data presented above predict that this therapy could exacerbate or
elicit new autoimmune disease in some patients. Indeed, neutralization of TNF by drug therapy with anti-TNF has been shown to induce, in some cases, new or exacerbated autoimmunity (Table 2).

Anti-TNF therapy has been used most broadly in rheumatoid arthritis. In some rheumatic patients, this therapy induces new forms of autoimmunity that mimic multiple sclerosis, autoimmune hemolytic anemia, Type 1 diabetes, lupus, and psoriasis (9, 11, 13, 21, 22a, 24, 35, 41, 46, 51, 61, 63, 71).

The second most common use of anti-TNF therapy is in Crohn’s disease. The induction of new autoimmunity has also been observed in these autoimmune patients with this drug therapy. Again, these symptoms can range from new autoantibodies often consistent with lupus to clinical lupus (55–57, 71). Trials were also conducted with anti-TNF therapy in multiple sclerosis patients. In these human studies (55–57, 71), patients consistently reported disease worsening. In combination with the new onset demyelization, side effects of anti-TNF therapy in both rheumatoid arthritis and Crohn’s disease, the data are consistent with some autoimmune patients not benefiting from the removal of TNF (20, 65).

The challenges ahead are to understand more about NF-κB and its role as a unifying pathogenic mechanism across autoimmune diseases, its role in specific immune cell types in response to different inducers, and how NF-κB may affect gene-hormone interactions and TNF signaling. This emerging area of knowledge will spur efforts to develop targeted therapies for specific autoimmune diseases or subgroups of patients. Certainly an area of important and future efforts should be studies examining the role of sex hormones in the regulation of the NF-κB pathway for T cell selection. These studies could contribute toward an understanding of why women are afflicted with more autoimmune diseases.

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GRANTS
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Table 2. Anti-TNF therapy induces new forms of second-degree autoimmunity

<table>
<thead>
<tr>
<th>Primary Disease</th>
<th>Autoantibodies</th>
<th>New Autoimmune Disease</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid arthritis</td>
<td>ANA; dsDNA ± nucleosome ± histone</td>
<td>Psoriatic skin</td>
<td>14, 17, 22, 39, 66, 70</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Autoimmune vasculitis</td>
<td>24, 35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type 1 diabetes</td>
<td>13, 21, 22a, 41, 46, 51, 71</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple sclerosis</td>
<td>46, 51</td>
</tr>
<tr>
<td>Juvenile rheumatoid arthritis</td>
<td>ANA; dsDNA</td>
<td>Multiple sclerosis</td>
<td>63</td>
</tr>
<tr>
<td>Colitis</td>
<td>ANA; dsDNA</td>
<td>Type 1 diabetes</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>ANA</td>
<td>Multiple sclerosis</td>
<td>56–58</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lupus; autoimmune hemolytic anemia</td>
<td>20, 65</td>
</tr>
<tr>
<td></td>
<td>DNA</td>
<td>Autoimmune hepatitis</td>
<td>58, 71</td>
</tr>
<tr>
<td></td>
<td>DNA</td>
<td>Lupus; autoimmune hemolytic anemia</td>
<td>49</td>
</tr>
</tbody>
</table>

ANA, anti-nuclear antibodies; dsDNA, double-stranded DNA.
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