Abnormal serum IgG subclass pattern in children with Down’s syndrome

G Annerén, C G M Magnusson, G Lilja, S L Nordvall

Abstract
Susceptibility to infections is a well known feature of Down’s syndrome. The possible relation between this predisposition and the serum concentrations of the IgG subclasses was studied in 38 children with Down’s syndrome aged 1–12 years. An age matched group of 50 healthy children served as controls. The serum concentrations of IgG1 and IgG2 were significantly raised among children with Down’s syndrome in all three age groups studied (that is 1–2.5, 4–8, and 9–12 years). The serum concentrations of IgG3 were normal in the first two groups but significantly reduced in the third age group. In contrast, the concentrations of IgG4 among children with Down’s syndrome were significantly reduced in all three age groups. Moreover, among the children with Down’s syndrome aged 4–12 years 68% (15/22) had IgG4 concentrations below 2 SDs of the geometrical mean of the controls. The results may partially explain the proneness of children with Down’s syndrome to infections with encapsulated bacteria. Although the underlying cause of these abnormalities is unknown, IgG subclass determination seems relevant in the clinical evaluation of children with Down’s syndrome.

Patients and methods
The study comprised 38 non-institutionalised children with chromosomally verified Down’s syndrome, 16 girls and 22 boys, who were aged 1 to 12 years. Nine of these patients had congenital cardiovascular malformations, none of which was of major clinical significance. Three of the patients had been operated upon in the neonatal period for treatment of congenital gastrointestinal malformations, and none of them suffered subsequently from any complications of these conditions. In the 38 children with Down’s syndrome blood samples were taken for serum IgG subclass determination. A brief interview with the parents concerning the dietary habits of the children confirmed that they had a normal diet. The proneness to infectious diseases was evaluated and the children underwent physical investigation at the time of blood sampling. None of them showed signs of current infection at that time.

Fifty age matched healthy children served as controls and because of the age dependency of IgG subclass concentrations, particularly IgG3 and IgG4 in early childhood,10 the children were split into three age groups: 1–2.5, 4–8, and 9–12 years. There were 16, 12, and 10 children with Down’s syndrome and 20, 15, and 15 control children in the three age groups respectively.

The serum samples were stored at −20°C before analysis. The concentrations of the subclasses of IgG were determined by a competitive two step microtitre enzyme linked immunosorbent assay (ELISA) based on subclass specific monoclonal antibodies. The assay conditions including the buffers used, incubation times, and sample dilutions, and the specificity, sensitivity, linearity, precision, and accuracy will be described in detail elsewhere (C G M Magnusson, to be published). All serum samples were assayed in duplicate and a commercial standard serum (H00–05, Janssen, Belgium), calibrated against the WHO 67/97 standard11 was used to produce standard curves. The interassay imprecision, which was evaluated by including two dilutions of a control serum on each plate, gave coefficients of variation on seven different plates not exceeding 9% for all four subclasses.

The Mann-Whitney U test with correction for ties was used in the statistical analyses of the results and a two tailed p<0.05 was considered significant.

Results
The individual values and the geometrical mean concentrations and ±1 SD of the four IgG subclasses in the controls and children with Down’s syndrome are presented in figs 1 and 2 and the table. There were no significant age...
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Figure 1  Individual and geometrical mean concentrations of the four IgG subclasses in children with Down's syndrome (DS) and control children (C). The children are split into three age groups (1–2.5, 4–8, and 9–12 years). The ± 1 of the geometrical mean concentrations of healthy children are indicated (shaded area). The levels of significance are given in the figure.

Figure 2  Individual concentrations of the four IgG subclasses in children with Down's syndrome in relation to age. The geometrical mean ± 1 SD of healthy children are indicated (shaded area).
IgG subclass concentrations (g/l) in serum of children with Down’s syndrome compared with healthy age matched control children in three age groups. Geometrical means (GM) ± 1 SD are presented

<table>
<thead>
<tr>
<th>Age groups (years)</th>
<th>1-2-5</th>
<th>4-8</th>
<th>9-12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Controls (n=20)</td>
<td>Down’s syndrome (n=16)</td>
<td>Controls (n=15)</td>
</tr>
<tr>
<td>Age (GM)</td>
<td>1.5</td>
<td>1.6</td>
<td>6.0</td>
</tr>
<tr>
<td>IgG2 (GM)</td>
<td>5.1*</td>
<td>6.3*</td>
<td>6.4**</td>
</tr>
<tr>
<td>+1SD</td>
<td>4.0</td>
<td>4.5</td>
<td>1.2</td>
</tr>
<tr>
<td>-1SD</td>
<td>0.62</td>
<td>0.63</td>
<td>1.9</td>
</tr>
<tr>
<td>IgG3 (GM)</td>
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<td>1.3</td>
<td>0.78</td>
</tr>
<tr>
<td>+1SD</td>
<td>0.37</td>
<td>0.41</td>
<td>0.41</td>
</tr>
<tr>
<td>-1SD</td>
<td>0.17</td>
<td>0.18</td>
<td>0.18</td>
</tr>
<tr>
<td>IgG4 (GM)</td>
<td>0.053**</td>
<td>0.019**</td>
<td>0.044***</td>
</tr>
<tr>
<td>+1SD</td>
<td>0.016</td>
<td>0.0072</td>
<td>0.016</td>
</tr>
</tbody>
</table>

Calculated significance levels in Mann-Whitney U test: *p<0.05, **p<0.01, ***p<0.001.

Discussion

The higher serum concentrations of IgG subclasses 1 and 3 in the children with Down’s syndrome compared with the controls may well be a consequence of polyclonal stimulation from repeated bacterial infections, which obviously does not include IgG2 and IgG4. This contrast strengthens the concept that children with Down’s syndrome fail to respond properly with antibodies of the latter subclasses. The results are in accordance with recent data for adults with Down’s syndrome and for children concerning IgG4 and are likely to be of pathogenetic significance for the susceptibility to infections. It is interesting to note that IgG4 deficiency is found in Down’s syndrome at all ages, but an IgG2 deficiency tends to develop later in life among children and adults with Down’s syndrome. Thus the IgG4 deficiency is not accompanied by an IgG2 deficiency in childhood in Down’s syndrome.

Children with Down’s syndrome are especially prone to respiratory bacterial infections. This may be partially explained by a deficiency in IgG2 and IgG4 antibodies, of which the former are known to be directed primarily against bacterial polysaccharide antigens of encapsulated bacteria, such as Diplococcus pneumoniae and Haemophilus influenzae. Even though the serum concentration of IgG4 is low, it may play a part in mucosal defence because of its higher relative concentration in secretions. Virus specific IgG antibodies are often of subclasses 1 and 3.

The mechanism underlying the abnormal serum IgG subclass pattern is probably not a gene dosage effect as none of the chromosome 21 genes are known to regulate immunoglobulin production. Secondary effects of either a factor related to immunoglobulin production or a deficiency of a trace element such as selenium are proposed as alternative explanations. We have recently reported that selenium supplementation in children with Down’s syndrome has a significant augmentative effect on the serum concentrations of IgG2 and IgG4, but not on those of IgG1 and IgG3.

Although the mechanism behind the abnormal subclass pattern in individuals with Down’s syndrome is unknown, it seems relevant to assay the IgG subclass concentrations among patients with Down’s syndrome who have repeated infections. If only the total serum IgG concentration is assayed a deficiency in the IgG2 and IgG4 subclasses will escape detection.

The skilful technical assistance of Mrs Maggy Magnusson is acknowledged. This study was supported by grants from the Sävastholm Society, the Marcus Borgström Foundation, and the Swedish Medical Research Council (grants 5445 and 16X-105).

1 Burgio GR, Uggazio AG, Nespoli L, Marcioni AF, Botteli AM, Pasquali F. Derangements of immunoglobulin levels, phystohemaglutinin responsiveness, and T and B cell markers in Down’s syndrome at different ages. Eur J Immunol 1975;5:600-3.
5 Levin S. The immune system and susceptibility to infections
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8 Anneren A, Soderstrom M. Mental and Deficiency and NK cell interferon production. In: McCoy EE, Epstein CJ, eds. Nashville: October 1991 and lays down criteria for the operation, which is something of a buzz word in paediatric surgical circles at the moment. It contains five articles about laparoscopic surgery: three about cholecystectomy, one about pyeloryotomy, and one about untwisting a torsion of the uterine adnexa.


The uses of laparoscopy

If the October 1991 issue of the Journal of Pediatric Surgery is anything to go by, laparoscopy is something of a buzz word in paediatric surgical circles at the moment. It contains five articles about laparoscopic surgery: three about cholecystectomy, one about pyeloryotomy, and one about untwisting a torsion of the uterine adnexa.

Galbladder disease in children is not common (see Archivist 1991:940) but not rare and workers in Montreal, Washington DC, and Nashville, Tennessee report a total of 13 laparoscopic cholecystectomies in children between the ages of 7 and 16 years. There were no complications and the children were less distressed postoperatively and recovered quicker.

A report from Limoges, France describes the treatment of 10 babies with pyloric stenosis using laparoscopic pyloromyotomy. The operation was successful and without complications in all 10. The final article in the series is one from Israel reporting the use of laparoscopic surgery in a girl of 11 years with torsion of the uterine adnexa.

An accompanying editorial discusses the advent of laparoscopic surgery (laparoscopic cholecystectomy in adults was first described in 1989) and lays emphasis on the need to ensure adequate training in these techniques and the potential for disaster in inexperienced hands. Clearly any surgeon new to the technique should at first operate only under supervision. According to the team in Nashville it takes some 15 to 20 operations to become competent.

ARCHIVIST


A good title is worth imitating. Richard Hoggart’s best known book, The Uses of Literacy, was published in 1957 and stays in the memory, I suspect, largely because of its title. In fact, it was to have been called ‘the abuses of literacy’, but was changed because of the objections of a libel lawyer. By the time I got round to reading it, it was way out of date and not very relevant. I enjoyed the first part of his autobiography though and am settling into the second, recommended reading for when you’ve finished the Archivist and want a break from pediatrics.
