Murine models of Omenn syndrome

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In the 40 years since Harvard medical student Gilbert Omenn first described a rare, inherited disorder producing a paradoxical combination of immunodeficiency and immune dysregulation, the pathogenesis of Omenn syndrome (OS) has remained mysterious. In separate studies reported in this issue of the *JCI*, two mouse models bearing mutations in the V(D)J recombinase analogous to those causing human OS have been shown to recapitulate the disease and provide insight into the genesis of immunodeficiency combined with autoimmunity and atopy in OS and other disease settings (see the related articles beginning on pages 1260 and 1270).

A perplexing combination of immunologic symptoms

Omenn syndrome (OS) is differentiated from SCID by the additional features of autoimmunity and atopy, which signify substantial immune dysregulation (1–4). Although the clinical picture of OS is variable, patients typically present in infancy with erythroderma, alopecia, hepatosplenomegaly, lymphadenopathy, chronic diarrhea, failure to thrive, and recurrent infections. Peripheral blood analyses reveal eosinophilia, severely decreased B cell counts, and hypogammaglobulinemia, but markedly elevated IgE levels. Although T cell counts are normal to elevated, T cells display a highly restricted, oligoclonal TCR repertoire (ref. 3 and references therein). When left untreated, OS is fatal, usually as a result of infections; the available therapies, bone marrow and cord blood stem cell transplantation, are variably successful (2, 4).

OS can be caused by any of several genetic defects that impair lymphocyte development. Mutations affecting (a) thymic development (resulting in atypical DiGeorge syndrome); (b) cytokine receptors required for T cell development (e.g., IL-7 receptor deficiency); or (c) mitochondrial RNA processing (e.g., the RNA component of mitochondrial RNA processing endoribonuclease gene, RMRP) have been reported (3, 5). The best-characterized defects, however, are homozygous or compound heterozygous mutations in either RAG1 or RAG2, which together encode the protein complex that catalyzes V(D)J recombination (6). This process, whereby DNA rearrangements at the TCR and Ig gene loci create a diverse repertoire of receptors, is required for lymphocyte development. The RAG mutations seen in OS are characteristically hypomorphic, partially disabling the activity of the V(D)J recombinase (hypomorphic mutations in Artemis, a DNA repair gene crucial for V(D)J recombination, can also cause OS; ref. 3). In contrast to severe, inactivating mutations in the RAG genes that lead to SCID, a hypomorphic V(D)J recombinase that is able to generate only a few productive antigen receptor gene rearrangements accounts for the immunodeficiency and oligoclonal repertoire in OS (7, 8).

A compelling explanation for the connection between a severely constrained TCR repertoire and the atopic/autoimmune features of OS has proven elusive. Pathogenesis is likely multifactorial. The involvement of modifying genes and epigenetic influences have been suggested (8), although no supporting evidence has yet emerged. Exposure to foreign antigens could also play a role: antigenic stimulation from recurrent infections could facilitate expansion of lymphocyte clones, including some with self reactivity (7–9). This idea is supported by the observation that a patient with T-B- SCID progressed to OS following a parainfluenza virus infection (10). Intragenic components, including prolonged courses of antibiotic and immunosuppressive therapy, could also influence the development or phenotypic expression of OS (8). One possible scenario is that these treatments alter the commensal microbial flora, thought to be important for immunologic tolerance by affecting the development of a functional Treg compartment (11). A peripheral imbalance of Tregs has also been mentioned as a possible cause of the loss of tolerance in OS (2, 3). Most recently, diminished expression of autoimmune regulator (AIRE) was found in the thymi of patients with OS, suggesting a mechanism for the impairment of negative selection (2, 12). The lack of an animal model for OS has hindered analysis of the contributions by these factors to the disease. Now, in this issue of the *JCI*, two groups have characterized two mouse models that recapitulate key features of human OS.

Two mouse models of OS

In the first report, Marella et al. (13) created knockin mice bearing a Rag2 mutation (R229Q) identified in several OS patients, including those in families with histories of both OS and SCID (8, 9). B and T lymphocyte precursors were arrested in early developmental stages, consistent with a previous finding that a mutation in the same residue, R229A, severely reduces recombination activity in transfected cells (14). Sixty percent of the homozygous mice developed alopecia; a small percentage of the mice also developed severe erythroderma and a wasting syndrome, replicating important features of human OS. Regardless of severity of clinical manifestations, all Rag2 R229Q mutant mice displayed abnormal architecture of the thymus, lymph nodes, and spleen, consistent with known OS pathology, as well as restricted TCR repertoires, eosinophilia, and hypogammaglobulinemia; only some mice developed hyper-IgE syndrome. Notably, Marella et al. observed that Aire expression in thymi was low in mutant mice and that the proportion of Foxp3+ Tregs was diminished, offering important clues as to the defects in central and peripheral tolerance in OS (13).

Independently, Khiong and colleagues (15) discovered a spontaneous Rag1 mutation (R972Q), identical to a mutation found in an OS patient (8), that resulted in elevated memory-type T cell numbers in a C57BL/10 mouse. Development of lymphocyte precursors in homozygous Rag1

Nonstandard abbreviations used: AIRE, autoimmune regulator; OS, Omenn syndrome.

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R972Q mutant mice was arrested, consistent with the severe DNA cleavage defect in vitro of a similar mutant (R972A) (16). The authors noted pronounced skin redness (though without immune infiltrates), eosinophilia, elevated IgE levels, oligoclonal T cells, and pathology of thymus, lymph nodes, and spleen. At 25 weeks the mice developed hepatosplenomegaly. It is interesting that, unlike most OS patients, the mice developed elevated IgM, IgG2a, and IgG2b levels (15). Importantly, Khiong et al. address the mechanism underlying atopy in OS: the Rag1 R972Q mutant mice have increased secretion of Th2 cytokines IL-4 and IL-6, and the hyper-IgE phenotype is dependent on these cytokines and on CD4+ T cells (15). In addition, the lymphoid compartment of the Rag1 R972Q mutant mice is primed for lymphocyte expansion, as wild-type donor CD4+ and CD8+ T cells expanded in mutant, but not wild-type, mice (15). This implies that homeostatic proliferation, also known as lymphopenia-
induced proliferation, is important for OS pathogenesis, a conclusion supported by the presence of surface activation markers on T cells in the mutant mice and in humans with OS (2, 3, 13, 15).

A new view of OS pathogenesis
We have integrated these findings into a comprehensive model for OS (Figure 1). Notably, both studies (13, 15) demonstrate that OS can develop in a controlled, specific pathogen-free environment; these observations suggest that variation in phenotypic expression of this disease is not solely due to environmental influences.

This model assumes conditions that diminish the generation of lymphocytes yet allow a few clones to be generated, resulting in lymphopenia and associated restricted T and B cell repertoire diversity (17). This is the case in OS patients—and mice—with hypomorphic RAG mutations and is consistent with other genetic causes of OS that critically limit the generation of lymphocytes. The stochastic nature of TCR and Ig rearrangements assures that no two clones are exactly the same and that OS can develop in a controlled, specific microenvironment, which is caused by environmental influences. This model suggests that OS develops in a pathogen-free environment; these observations support the idea that OS can develop in a controlled, specific environment.

DiGeorge syndrome or by low throughput recombination or environmental influences. This is the case in OS patients—and mice—bearing the same mutant allele. We thank Giulia Celli, Carlos E. Tadokoro, Vicky Brandt, Jennifer Posey, Rohit Chandwani, and the members of the Roth laboratory for their support and thoughtful critique of this commentary.

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Autosomal recessive cutaneous disorders, including various types of epidermolysis bullosa (EB), usually manifest shortly after birth. The clinical course of these diseases is often characterized by severe complications, limited therapeutic options, and a poor prognosis. A study by Pasmooj et al. reported in this issue of the JCI unravels the molecular mechanisms by which germline mutations in non-Herlitz junctional EB can be corrected in vivo by multiple spontaneously occurring somatic mutational events, a phenomenon known as revertant mosaicism (see the related article beginning on page 1240). These insights open new avenues of thinking for the design of future gene therapy strategies for skin diseases.

Mosaicism

The term mosaicism refers to the occurrence in an individual of two or more cell populations that are karyotypically or genotypically different and yet are derived from a single zygote (4). Mosaicism can result from a mutation during development that is propagated in only a limited number of the adult cells. In general, any type of cell may be affected by such a mutational event, including gametes (egg and sperm cells), blood cells, and skin cells. The best-known example of mosaicism is mammalian females (normal karyotype 46,XX), which are functional mosaics because one of their X chromosomes is randomly inactivated during embryogenesis (5).

In autosomal recessive mendelian disorders, the underlying mutations often cause embryonic or early postnatal death. Notwithstanding, studying the effects of such mutations at later developmental stages may be possible in individuals carrying the mutation in a mosaic form because gain or loss of genetic functions might be limited to specific cells and tissues or to selected stages of development, as recently shown in various organisms, including, for example, Caenorhabditis elegans, Drosophila, mice, and zebrafish (6–9). Therefore, mosaic organisms are perfectly suited for the investigation of the molecular processes orchestrating very early developmental phases. Further, they may be of use to study a specific cell type or tissue in which a given gene is required to assure proper functioning of signaling pathways and metabolic processes. With respect to organ systems, mosaic organisms can serve to determine whether a particular gene is cell autonomous, i.e., whether the gene is exerting its action exclusively within the cell in which it is expressed or if it also affects neighboring cells that do not manifest a phenotype themselves when carrying a mutation in that gene (8).

Cutaneous mosaicism: right before our eyes

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