Tuberculosis in Association with Human Leukocyte Antigen

Attapon Cheepsattayakorn1,2 and Ruangrong Cheepsattayakorn3

1Pulmonologist, Past Director, 10th Zonal Tuberculosis and Chest Disease Center, 143 Sridornchai Road, Changklan Muang, Chiang Mai 50100, Thailand
2Deputy Director, 10th Office of Disease Prevention and Control, 447 Lumphun Road, Watgate Muang, Chiang Mai 50000, Thailand
3Associate Professor, Department of Pathology, Faculty of Medicine, Chiang Mai University, Chiang Mai 52000 Thailand

*Corresponding author: Attapon Cheepsattayakorn, 10th Zonal Tuberculosis and Chest Disease Center, 143 Sridornchai Road, Changklan Muang, Chiang Mai 50100, Thailand, Tel: 66-53-140767; Fax: 66-53-140773; E-mail: attaponche@yahoo.com

Rec date: Jun 10, 2014; Acc date: Jul 23, 2014; Pub date: Aug 05, 2014
Copyright: © 2014 Cheepsattayakorn A, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Commentary

Currently, association between human leukocyte antigen (HLA) and the development of tuberculosis (TB) is still not widely known. Tuberculosis is still a global threatening disease in this century, particularly in the developing countries like Asian and African countries. Excellent knowledge in TB-related HLA is substantially needed for the development of novel strategic measures against TB, particularly multidrug-resistant TB around the world, such as the development of novel adult TB vaccines. The articles selected and cited in this review are mostly related to the developing countries, particularly Asian countries, where TB is a threatening public health problem.

HLA studies conducted in India revealed that there was association of HLA-DQ*01 and -DR*2 antigens with susceptibility of pulmonary TB [1]. A study in North Indian patients demonstrated that the allele DRB1*1501 of HLA-DR 2 was higher compared with DRB1*1502 [1] whereas HLA-DQB1*0601 (a subtype of HLA-DQ 1), -DRB1*1501 and DRB1*02 were demonstrated to be positively associated with pulmonary susceptibility among South Indian patients [1]. Antigen processing gene 2 and mannose-binding protein (MBP) genes along with HLA-DR2 have been associated with pulmonary TB [1]. Mannose-binding lectin-5 heterozygotes may be associated with protection against TB meningitis [1]. HLA-DQB1*0601 and HLA-DRB1*0803 were associated with TB disease progression in Korean populations [2]. The frequencies of HLA-DQB1*0402 and antigens DR4 and DR8 were significantly decreased in patients with pulmonary TB but the frequencies of HLA-DQA1*0101, -DQB1*0501 and -DRB1*1501 were significantly increased in immunocompetent patients with pulmonary TB [3]. An increased frequency of HLA-β27 in the Greeks, HLA-A2 and -B5 in the Egyptians, HLA-β5, -B15 and -DR5 in the North American blacks, HLA-β8 in the Thais were observed [1] whereas HLA-DQB1*0502 and -DQB1*0503 alleles were demonstrated among the Thai and Vietnamese TB patients, respectively [1,4]. HLA-β17-tumor-necrosis-factor-α-238/A, -tumor-necrosis-factor-α-308/2 and -tumor-necrosis-factor-β-2 have been shown to be associated with TB bacteriological relapse among Indian population [5]. Recently, a novel HLA-DR-restricted peptide E7 from the ESAT-6 protein of Mycobacterium tuberculosis before and during TB treatment was used to prepare modified HLA-DR0803/E7 and HLA-DR0818/E7 tetramers to monitor tetramer-positive CD4+ T-cells in direct staining of single specimen and flow cytometric analyses and resulted in 0.1 to 8.8% in the initial pulmonary TB patients’ blood, 0.1 to 10.7% in pleural fluid of the initial tuberculous pleuritis patients, 0.02 to 2.2% in non-TB patients’ blood, 0.02 to 0.48% in healthy donors’ blood and mostly resulted in 0 to 0.2% in umbilical cord blood [6]. After 90-120 days of initial TB symptoms, levels of tetramer-positive CD4+T cells in tetramer-positive CD4+T cells reached and kept at low even normal at 0.03 to 0.3% [6]. Tetramer-positive, interferon-γ-producing and/or tumor-necrosis-factor-a-producing CD4+T cells in pulmonary granuloma, lymph node and cavernous tissues of TB patients could be detected by in situ staining [6]. Sensitivity and specificity of tetramer molecules should be confirmed in the future in order to develop possible diagnostic reagents and research [6].

References