SHORT REPORT

Cytomegalovirus infections and anti-GM2 antibodies in Guillain-Barré syndrome

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Abstract
To investigate whether antecedent cytomegalovirus (CMV) infections in patients with Guillain-Barré syndrome are associated with the presence of specific antiganglioside antibodies, acute phase serum samples from 130 patients with Guillain-Barré syndrome and 200 controls were tested. Anti-GM2 IgM antibodies were found more often in patients with Guillain-Barré syndrome with CMV infection (22%) than in patients without the infection (2%) (P = 0.003). CMV infections may elicit anti-GM2 antibodies in susceptible patients, which may contribute to the pathogenesis of Guillain-Barré syndrome associated with CMV.

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Keywords: Guillain-Barré syndrome; anti-GM2 antibodies; cytomegalovirus

Antecedent infections and antiganglioside antibodies are related to various clinical patterns in the Guillain-Barré syndrome.1 Campylobacter jejuni infections are associated with anti-GM1 antibodies and a more severe and pure motor variant of Guillain-Barré syndrome.2,3 Some C jejuni strains express GM1-like epitopes and may induce anti-GM1 antibodies.4 Cytomegalovirus (CMV) infections are the most frequent viral infections preceding Guillain-Barré syndrome,5 and are associated with severe sensory loss, cranial nerve involvement, and respiratory insufficiency.5 Recently, three patients with Guillain-Barré syndrome were reported with a CMV infection and antibodies against the ganglioside GM2.6 Such antibodies may contribute to the pathogenesis of Guillain-Barré syndrome, as GM2 is found in peripheral nerves.6 In the present study we investigated in a large group of patients with Guillain-Barré syndrome whether CMV infections are associated with anti-GM2 antibodies in the acute phase of the disease.

Patients and methods
PATIENTS
Pretreatment serum samples, obtained within two weeks of onset of weakness, were available for serological testing in 130 of the 147 patients with Guillain-Barré syndrome who participated in the Dutch Guillain-Barré syndrome trial.9 The 17 excluded patients did not differ from the other patients in clinical manifestations and course of disease. Serum samples were also tested from patients with other neurological diseases (n = 50), controls infected with CMV (n = 50), and controls infected with C jejuni (n = 50) both without neurological involvement, and normal controls (n = 50). The group of other neurological diseases comprised inflammatory polyneuropathy (n = 24), non-inflammatory polyneuropathy (n = 12), and neurological diseases other than polyneuropathy (n = 14).

DETECTION OF ANTIBODIES AGAINST GLYCOLIPIDS
IgM and IgG antibodies against GM2 were tested by enzyme linked immunosorbent assay (ELISA) and thin layer chromatography overlay, as described previously.3 Serum samples, tested at a dilution of 1:100 in ELISA, with an optical density (OD) of more than 3 SD above the mean value of 50 normal control serum samples were tested by thin layer chromatography overlay. Positive samples were tested again by ELISA, using serial dilutions starting at 1:100. The reciprocal of the highest dilution that resulted in an OD higher than the cut off value was then taken to be the titre. The patients with Guillain-Barré syndrome with anti-GM2 antibodies were also tested for IgM and IgG antibodies against GM1, GM3, GD1b, GD2, asialo-GM1 (GA1), and asialo-GM2 (GA2).

All patients were serologically tested for CMV and C jejuni infection. IgM antibodies against CMV indicated a recent CMV infection,6 and a recent C jejuni infection was indicated by IgA, IgM, or high titres of IgG antibodies against C jejuni.3

STATISTICAL ANALYSIS
Differences in proportions were tested with Fisher's exact test. A P value < 0.05 was considered significant.

Results
Anti-GM2 IgM antibodies were detected in six (5%) of 130 patients with Guillain-Barré syndrome.
Controls (NC). Patients with neurological other C jejuni CMV infection with 200- 2800- - <100 - anti-GM2 diseases IgM CMV and Three CMV+ GBS GBS (18) (CJC) patients GBS CMV/CJ- cytomegaloz jejuni infection 0 both without GM infection (CMV+) C jejuni infection (CJ+), and those without CMV and C jejuni infection (CMVCJ-). Three patients with Guillain-Barré syndrome had a dual infection with CMV and C jejuni and were negative for anti-GM2 antibodies.

Discussion
The association between CMV infections and anti-GM2 antibodies described in this study further supports the concept that antecedent infections are related to antiglycolipid antibodies and clinical subgroups in Guillain-Barré syndrome. It parallels the previously reported associations between C jejuni infections and anti-GM1 antibodies, and between Mycoplasma pneumoniae infections and antagalactocerebrosidase antibodies.

Our results are partly in accordance with those published by Irie et al. They found anti-GM2 antibodies in all three patients with Guillain-Barré syndrome and CMV infection and in none of the patients with Guillain-Barré syndrome without CMV infection. In a large group of patients with Guillain-Barré syndrome we showed the presence of anti-GM2 antibodies in a lesser percentage (22%) of patients infected with CMV. However, serum samples in the study of Irie et al. were obtained at rather a long time after neurological onset (mean 24, range two to 180 days) compared with our study (mean six, range one to 14 days) which may lead to an underestimation of CMV infections in their patients. In addition, we also found anti-GM2 antibodies in some patients with Guillain-Barré syndrome with C jejuni infections, but the frequency was significantly less than in patients infected with CMV.

Antiganglioside antibodies in patients with Guillain-Barré syndrome are predominantly
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IgG, although IgM and IgA antibodies are also found. Remarkably, the anti-GM2 antibodies in our study were all IgM. This is probably not related to specific antecedent infections, as the anti-GM2 antibodies in the patients infected with C jejuni were also IgM, and others found anti-GM2 IgG antibodies in patients infected with CMV. As serum with these antibodies show no activity against similar gangliosides such as GM3, the anti-GM2 IgM antibodies found in our study are not aspecific.

Instead, two specific patterns of antibody activity against GM2 may be present in patients with Guillain-Barré syndrome. Firstly, some patients have additional antibodies that bind to GA2 or GD2 but not to GM1, which may suggest that the antibodies recognize the shared GalNAc(β1-4)Gal terminal in GM2, GA2, and GD2. The three patients in the study of Irie et al and the four patients in our study with this pattern of antibody activity all had a CMV infection. Secondly, other patients show additional antibody activity against GM1 but not against GA2 or GD2, indicating that these antibodies bind with the GalNAc(β1-4)[NeuAcc2-3Gal](β1-4)Glc moiety which GM2 and GM1 have in common. We found this pattern in two patients with antecedent C jejuni. These antibodies may be produced initially during the antecedent infection, as lipopolysaccharides from several C jejuni strains are recognized by monoclonal antibodies against GM1 and GM2, and have a terminal tetrasaccharide identical to that of GM2. However, the number of anti-GM2 positive patients is too small to conclude that these two antibody patterns are associated with specific antecedent infection.

The clinical characteristics of the patients with Guillain-Barré syndrome and anti-GM2 antibodies were related to the antecedent infection and did not differ from those of other patients with Guillain-Barré syndrome with CMV or C jejuni infections. In previous studies we found that CMV infections are associated with severe sensory loss, cranial nerve involvement, and respiratory insufficiency, and C jejuni infections with severe and predominantly distal weakness without sensory or cranial nerve involvement. In the six anti-GM2 positive patients with Guillain-Barré syndrome, these clinical differences may be related to the fine specificity of the anti-GM2 antibodies. At present, the role of CMV in the pathogenesis of Guillain-Barré syndrome is unknown. Direct infection of peripheral nerves is unlikely, as the CMV genome was not detected in sural nerve biopsies of patients infected with CMV with Guillain-Barré syndrome. Serum anti-GM2 antibodies have been shown to bind with CMV infected cells, indicating that these antibodies in Guillain-Barré syndrome may be induced by antecedent CMV infection. Only one patient with a CMV infection without neurological involvement had anti-GM2 antibodies. This suggests that CMV infections are not the only factor determining the production of anti-GM2 antibodies and the development of immune mediated polyneuropathy. Further research is needed to investigate whether anti-GM2 antibodies are induced by CMV infections, and whether they are involved in the pathogenesis of CMV related Guillain-Barré syndrome.

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