19.4: Immunodeficiency

Learning Objectives

• Compare the causes of primary and secondary immunodeficiencies
• Describe treatments for primary and secondary immunodeficiencies

Immunodeficiencies are inherited (primary) or acquired (secondary) disorders in which elements of host immune defenses are either absent or functionally defective. In developed countries, most immunodeficiencies are inherited, and they are usually first seen in the clinic as recurrent or overwhelming infections in infants. However, on a global scale, malnutrition is the most common cause of immunodeficiency and would be categorized as an acquired immunodeficiency. Acquired immunodeficiencies are more likely to develop later in life, and the pathogenic mechanisms of many remain obscure.

Primary immunodeficiencies, which number more than 250, are caused by inherited defects of either nonspecific innate or specific adaptive immune defenses. In general, patients born with primary immunodeficiency (PI) commonly have an increased susceptibility to infection. This susceptibility can become apparent shortly after birth or in early childhood for some individuals, whereas other patients develop symptoms later in life. Some primary immunodeficiencies are due to a defect of a single cellular or humoral component of the immune system; others may result from defects of more than one component. Examples of primary immunodeficiencies include chronic granulomatous disease, X-linked agammaglobulinemia, selective IgA deficiency, and severe combined immunodeficiency disease.

Chronic Granulomatous Disease

The causes of chronic granulomatous disease (CGD) are defects in the NADPH oxidase system of phagocytic cells, including neutrophils and macrophages, that prevent the production of superoxide radicals in phagolysosomes. The inability to produce superoxide radicals impairs the antibacterial activity of phagocytes. As a result, infections in patients with CGD persist longer, leading to a chronic local inflammation called a granuloma. Microorganisms that are the most...
common causes of infections in patients with CGD include *Aspergillus* spp., *Staphylococcus aureus*, *Chromobacterium violaceum*, *Serratia marcescens*, and *Salmonella typhimurium*.

**X-Linked Agammaglobulinemia**

Deficiencies in B cells due to defective differentiation lead to a lack of specific antibody production known as X-linked agammaglobulinemia. In 1952, Ogden C. Bruton (1908–2003) described the first immunodeficiency in a boy whose immune system failed to produce antibodies. This defect is inherited on the X chromosome and is characterized by the absence of immunoglobulin in the serum; it is called Bruton X-linked agammaglobulinemia (XLA). The defective gene, BTK, in XLA is now known to encode a tyrosine kinase called Bruton tyrosine kinase (Btk). In patients whose B cells are unable to produce sufficient amounts of Btk, the B-cell maturation and differentiation halts at the pre-B-cell stage of growth. B-cell maturation and differentiation beyond the pre-B-cell stage of growth is required for immunoglobulin production. Patients who lack antibody production suffer from recurrent infections almost exclusively due to extracellular pathogens that cause pyogenic infections: *Haemophilus influenzae*, *Streptococcus pneumoniae*, *S. pyogenes*, and *S. aureus*. Because cell-mediated immunity is not impaired, these patients are not particularly vulnerable to infections caused by viruses or intracellular pathogens.

**Selective IgA Deficiency**

The most common inherited form of immunoglobulin deficiency is selective IgA deficiency, affecting about one in 800 people. Individuals with selective IgA deficiency produce normal levels of IgG and IgM, but are not able to produce secretory IgA. IgA deficiency predisposes these individuals to lung and gastrointestinal infections for which secretory IgA is normally an important defense mechanism. Infections in the lungs and gastrointestinal tract can involve a variety of pathogens, including *H. influenzae*, *S. pneumoniae*, *Moraxella catarrhalis*, *S. aureus*, *Giardia lamblia*, or pathogenic strains of *Escherichia coli*.

**Severe Combined Immunodeficiency**

Patients who suffer from severe combined immunodeficiency (SCID) have B-cell and T-cell defects that impair T-cell dependent antibody responses as well as cell-mediated immune responses. Patients with SCID also cannot develop immunological memory, so vaccines provide them no protection, and live attenuated vaccines (e.g., for varicella-zoster, measles virus, rotavirus, poliovirus) can actually cause the infection they are intended to prevent. The most common form is X-linked SCID, which accounts for nearly 50% of all cases and occurs primarily in males. Patients with SCID are typically diagnosed within the first few months of life after developing severe, often life-threatening, opportunistic infection by *Candida* spp., *Pneumocystis jirovecii*, or pathogenic strains of *E. coli*.

Without treatment, babies with SCID do not typically survive infancy. In some cases, a bone marrow transplant may successfully correct the defects in lymphocyte development that lead to the SCID phenotype, by replacing the defective component. However, this treatment approach is not without risks, as demonstrated by the famous case of David Vetter (1971–1984), better known as “Bubble Boy” (Figure). Vetter, a patient with SCID who lived in a protective plastic bubble to prevent exposure to opportunistic microbes, received a bone marrow transplant from his sister. Because of a latent
Epstein-Barr virus infection in her bone marrow, however, he developed mononucleosis and died of Burkitt lymphoma at the age of 12 years.

David Vetter, popularly known as “The Bubble Boy,” was born with SCID and lived most of his life isolated inside a plastic bubble. Here he is shown outside the bubble in a suit specially built for him by NASA. (credit: NASA Johnson Space Center)

• What is the fundamental cause of a primary immunodeficiency?
• Explain why patients with chronic granulomatous disease are especially susceptible to bacterial infections.
• Explain why individuals with selective IgA deficiency are susceptible to respiratory and gastrointestinal infections.

A secondary immunodeficiency occurs as a result an acquired impairment of function of B cells, T cells, or both. Secondary immunodeficiencies can be caused by:

• Systemic disorders such as diabetes mellitus, malnutrition, hepatitis, or HIV infection
• Immunosuppressive treatments such as cytotoxic chemotherapy, bone marrow ablation before transplantation, or radiation therapy
• Prolonged critical illness due to infection, surgery, or trauma in the very young, elderly, or hospitalized patients

Unlike primary immunodeficiencies, which have a genetic basis, secondary immunodeficiencies are often reversible if the underlying cause is resolved. Patients with secondary immunodeficiencies develop an increased susceptibility to an otherwise benign infection by opportunistic pathogens such as Candida spp., P. jirovecii, and Cryptosporidium.

HIV infection and the associated acquired immunodeficiency syndrome (AIDS) are the best-known secondary immunodeficiencies. AIDS is characterized by profound CD4 T-cell lymphopenia (decrease in lymphocytes). The decrease in CD4 T cells is the result of various mechanisms, including HIV-induced pyroptosis (a type of apoptosis that stimulates an inflammatory response), viral cytopathic effect, and cytotoxicity to HIV-infected cells.

The most common cause of secondary immunodeficiency worldwide is severe malnutrition, which affects both innate and adaptive immunity. More research and information are needed for the more common causes of secondary immunodeficiency; however, the number of new discoveries in AIDS research far exceeds that of any other single cause
of secondary immunodeficiency. AIDS research has paid off extremely well in terms of discoveries and treatments; increased research into the most common cause of immunodeficiency, malnutrition, would likely be as beneficial.

- What is the most common cause of secondary immunodeficiencies?
- Explain why secondary immunodeficiencies can sometimes be reversed.

AN IMMUNOCOMPROMISED HOST

Benjamin, a 50-year-old male patient who has been receiving chemotherapy to treat his chronic myelogenous leukemia (CML), a disease characterized by massive overproduction of nonfunctional, malignant myelocytic leukocytes that crowd out other, healthy leukocytes, is seen in the emergency department. He is complaining of a productive, wet cough, dyspnea, and fatigue. On examination, his pulse is 120 beats per minute (bpm) (normal range is 60–100 bpm) and weak, and his blood pressure is 90/60 mm Hg (normal is 120/80 mm Hg). During auscultation, a distinct crackling can be heard in his lungs as he breathes, and his pulse-oximeter level (a measurement of blood-oxygen saturation) is 80% (normal is 95%–100%). He has a fever; his temperature is 38.9 °C (102 °F). Sputum cultures and blood samples are obtained and sent to the lab, but Benjamin goes into respiratory distress and dies before the results can be obtained.

Benjamin’s death was a result of a combination of his immune system being compromised by his leukemia and his chemotherapy treatment further weakening his ability to mount an immune response. CML (and leukemia in general) and corresponding chemotherapy cause a decrease in the number of leukocytes capable of normal function, leading to secondary immunodeficiency. This increases the risk for opportunistic bacterial, viral, protozoal, and fungal infections that could include *Staphylococcus*, enteroviruses, *Pneumocystis*, *Giardia*, or *Candida*. Benjamin’s symptoms were suggestive of bacterial pneumonia, but his leukemia and chemotherapy likely complicated and contributed to the severity of the pneumonia, resulting in his death. Because his leukemia was overproducing certain white blood cells, and those overproduced white blood cells were largely nonfunctional or abnormal in their function, he did not have the proper immune system blood cells to help him fight off the infection.

Table summarizes primary and secondary immunodeficiencies, their effects on immune function, and typical outcomes.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Effect on Immune Function</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic granulomatous disease</td>
<td>Impaired killing of bacteria within the phagolysosome of neutrophils and macrophages</td>
<td>Chronic infections and granulomas</td>
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<tr>
<td>Selective IgA deficiency</td>
<td>Inability to produce secretory IgA</td>
<td>Predisposition to lung and gastrointestinal infections</td>
</tr>
<tr>
<td>Severe combined immunodeficiency disease (SCID)</td>
<td>Deficient humoral and cell-mediated immune responses</td>
<td>Early development of severe and life-threatening opportunistic infections</td>
</tr>
<tr>
<td>X-linked agammaglobulinemia</td>
<td>Flawed differentiation of B cells and absence of specific antibodies</td>
<td>Recurrent infections almost exclusively due to pathogens that cause pyogenic infections</td>
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https://bio.libretexts.org/TextMaps/Map%3A_Microbiology_(OpenStax)/19%3A_Diseases_of_the_Immune_System/19.4%3A_Immunodeficiency
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<td>Immunosuppressive therapies (e.g., chemotherapy, radiotherapy)</td>
<td>Impaired humoral and/or cell-mediated immune responses</td>
<td>Opportunistic infections, rare cancers</td>
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<tr>
<td>Secondary immunodeficiencies</td>
<td>Impaired humoral and/or cell-mediated immune responses</td>
<td>Opportunistic infections, rare cancers</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>Impaired cell-mediated immune responses due to CD4 T-cell lymphopenia</td>
<td>Opportunistic infections, rare cancers</td>
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<td>Viral infection (e.g., HIV)</td>
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- **Primary immunodeficiencies** are caused by genetic abnormalities; **secondary immunodeficiencies** are acquired through disease, diet, or environmental exposures.
- Primary immunodeficiencies may result from flaws in phagocyte killing of innate immunity, or impairment of T cells and B cells.
- Primary immunodeficiencies include chronic granulomatous disease, X-linked agammaglobulinemia, selective IgA deficiency, and severe combined immunodeficiency disease.
- Secondary immunodeficiencies result from environmentally induced defects in B cells and/or T cells.
- Causes for secondary immunodeficiencies include malnutrition, viral infection, diabetes, prolonged infections, and chemical or radiation exposure.

Compare the treatments for primary and secondary immunodeficiencies.