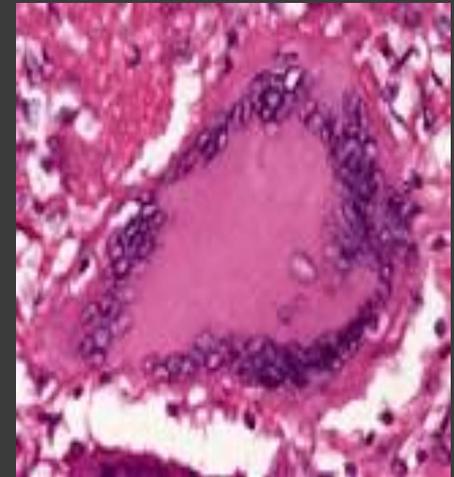


# Immunology of Tuberculosis

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# Objectives

- ① To know how *M. tuberculosis* infection is contracted and its initial encounter with the immune system.
- ① To understand delayed type of hypersensitivity reaction against *M. tuberculosis*
- ① To be familiar with the possible outcomes of the infection with *M. tuberculosis* in immuno-competent and immuno-compromised hosts.
- ① To understand the basis of tuberculin test and its importance in gauging immunity against *M. tuberculosis*

# Tuberculosis (TB)

Is an example of an infection in which **protective** immunity & **pathologic** hypersensitivity coexist, and the lesions are caused mainly by the host response

# Introduction

- Mycobacterium tuberculosis is the **second** most common infectious cause of death in adults worldwide.
- The **human host** serves as the natural reservoir for M. tuberculosis.
- The disease incidence is magnified by the concurrent epidemic of human immunodeficiency virus (**HIV**) infection.

# Mode of transmission

- Infection is acquired by **inhalation** of *M. tuberculosis* in aerosols and dust (airborne transmission)
- Infected people **cough up** large numbers of mycobacteria
- The organisms **waxy outer coat** can withstand drying and survive for long periods in air and house dust

# Virulence factors

- ⦿ **Waxy coat** blocks phagocyte enzymes
- ⦿ **Catalase-peroxidase**, which resists the host cell oxidative response
- ⦿ **Lipoarabinomannan (LAM)** a **glycolipid**.
  - Can induce cytokines and resist host oxidative stress
  - Interfere with antigen presentation by MHC class II molecules for priming CD4 T cells.

# Immunology

- ◎ The **majority** of individuals in the general population who become infected with *M. tuberculosis* **never develop** clinical disease
- ◎ This demonstrates that the **innate and adaptive immune response** of the host in controlling TB infection is effective.

# Host factors

- **Innate immunity**
- The tubercle bacillus ultimately gets taken up by macrophages and has evolved several strategies to evade early intracellular killing mechanisms. These include:
  - Resistance to **reactive oxygen** intermediates (ROIs)
  - Inhibition of **phagosome-lysosome fusion**
  - Inhibition of **phagosome acidification**
  - Escape from the phagosomal compartment into the **cytoplasmic space**

# Natural History of Infection

Inhalation of *M. tuberculosis* and deposition in lungs leads to one of the four possible outcomes

Immediate clearance of the organism

Latent Infection

Immediate onset of the disease (Primary Disease)

Onset of active disease after many years (Reactivation)

# Primary disease

(Approximately 10% of infected individuals)

- The tubercle bacilli establish infection in the lungs after they are carried in droplets to reach the alveolar space.
- If the **innate defense system** of the host fails to eliminate the infection, the **bacilli proliferate** inside alveolar macrophages and eventually kill the cells.
- The infected macrophages produce cytokines and chemokines that attract other phagocytic cells, which eventually form a nodular granulomatous structure called the **tubercle**.

# Primary disease

- If the bacterial replication is not controlled, the tubercle enlarges and the bacilli enter local draining lymph nodes.
- This leads to lymphadenopathy, a characteristic manifestation of primary TB.
- The lesion produced by the expansion of the tubercle into the lung parenchyma and lymph node involvement is called the **Ghon complex**.

# Ghon's and Ranke complex

- The lung lesions (tubercles -small granulomas (Ghon's focus) and the enlarged lymph nodes constitutes **Ghon's complex**
- Tubercles may heal become **fibrotic or calcified** and persist as such for a lifetime (**Ranke Complex**)

# Weeks after infection

M. Tuberculosis peptides presented to Th1 (CD4) lymphocytes releasing

Interferon gamma

Tumor Necrosis Factor (TNF)

Further activation of macrophage

Enhances the ability of macrophage to kill phagocytosed bacilli

Induces local inflammation and further activation of macrophages

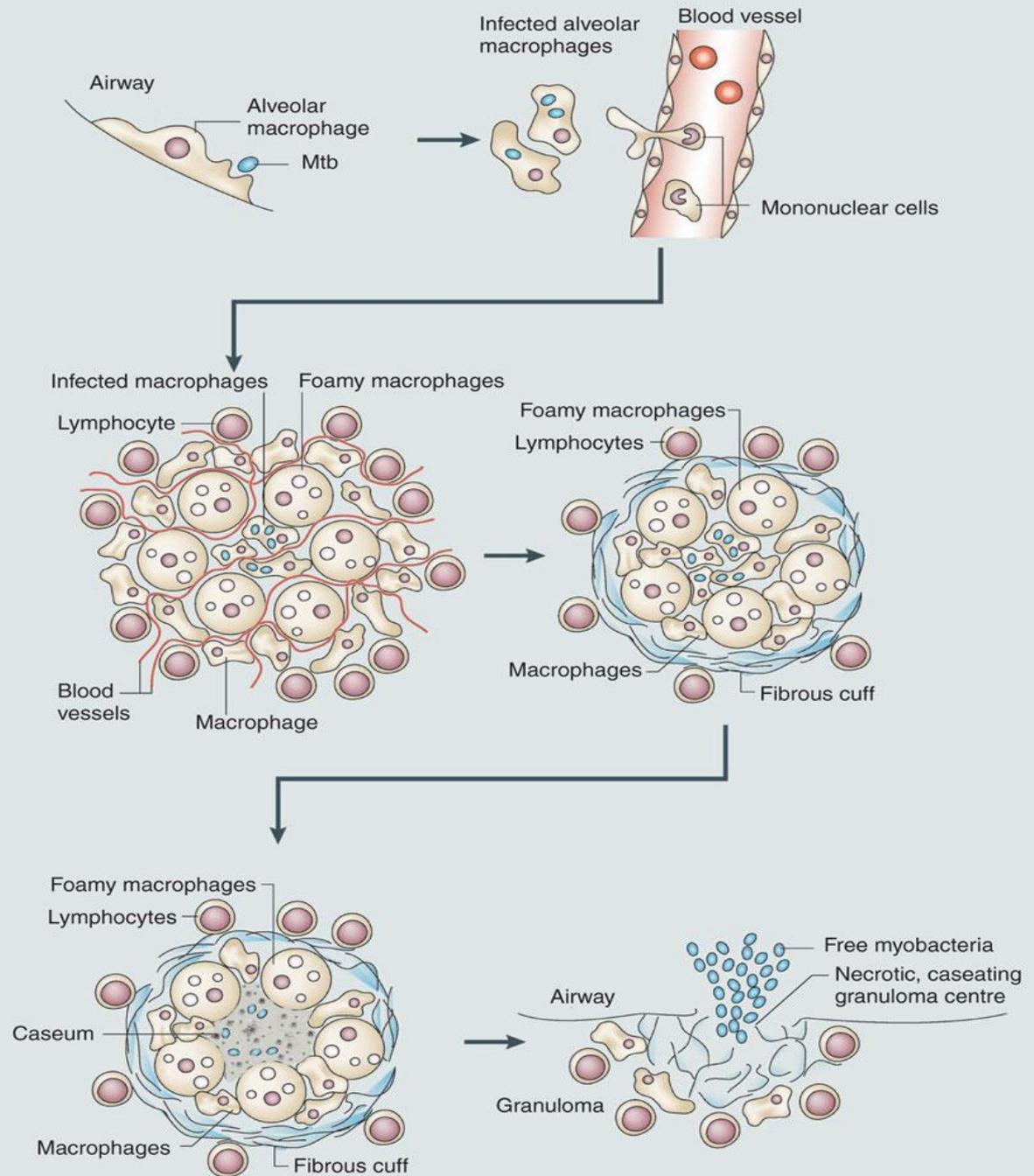
# Primary disease

- ① The bacilli continue to proliferate until an effective cell-mediated immune (CMI) response develops, usually **two to six weeks** after infection.
- ② Failure by the host to mount an effective CMI response and tissue repair leads to progressive **destruction of the lung** by:
  - Tumor necrosis factor (TNF)-alpha,
  - Reactive oxygen
  - Nitrogen intermediates
  - Contents of cytotoxic cells (granzymes, perforin)
- ③ All of the above may contribute to the development of **caseating necrosis** that characterizes a tuberculous lesion



# Outcomes

Bacilli can spread mechanically by erosion of the caseating lesions into the lung airways; at this point the host becomes infectious to others



# Miliary TB

- Unchecked bacterial growth may lead to **hematogenous spread** of bacilli to produce disseminated TB.
- Disseminated disease with lesions resembling millet seeds has been termed miliary TB.
- Most common presentation - **TB meningitis**



# Chronic Disease

- ⦿ In the **absence of treatment**, death occurs in 80 percent of cases.
- ⦿ The remaining patients develop **chronic disease or recover**.
- ⦿ Chronic disease is characterized by repeated episodes of healing by fibrotic changes around the lesions and tissue breakdown.
- ⦿ Complete spontaneous eradication of the bacilli is **rare**.

# Latent Tuberculosis

1

- Antigen presentation in the lymph nodes
- (Delayed type of hypersensitivity)

2

- Activation of CD4+ (Th1) lymphocytes
- (a phase coinciding with high rate of replication of bacilli)

3

- Low induction of CD8+ lymphocytes capable recognizing antigen and activating macrophages by production of IFN- $\gamma$

4

- Later induction of high number of CD8+ with increased production of IFN- $\gamma$  and cytotoxic activity (a phase coinciding with stabilization of bacterial growth)

5

- Bacterial load remains constant and infection is in latency (Latent TB)

# Latent TB

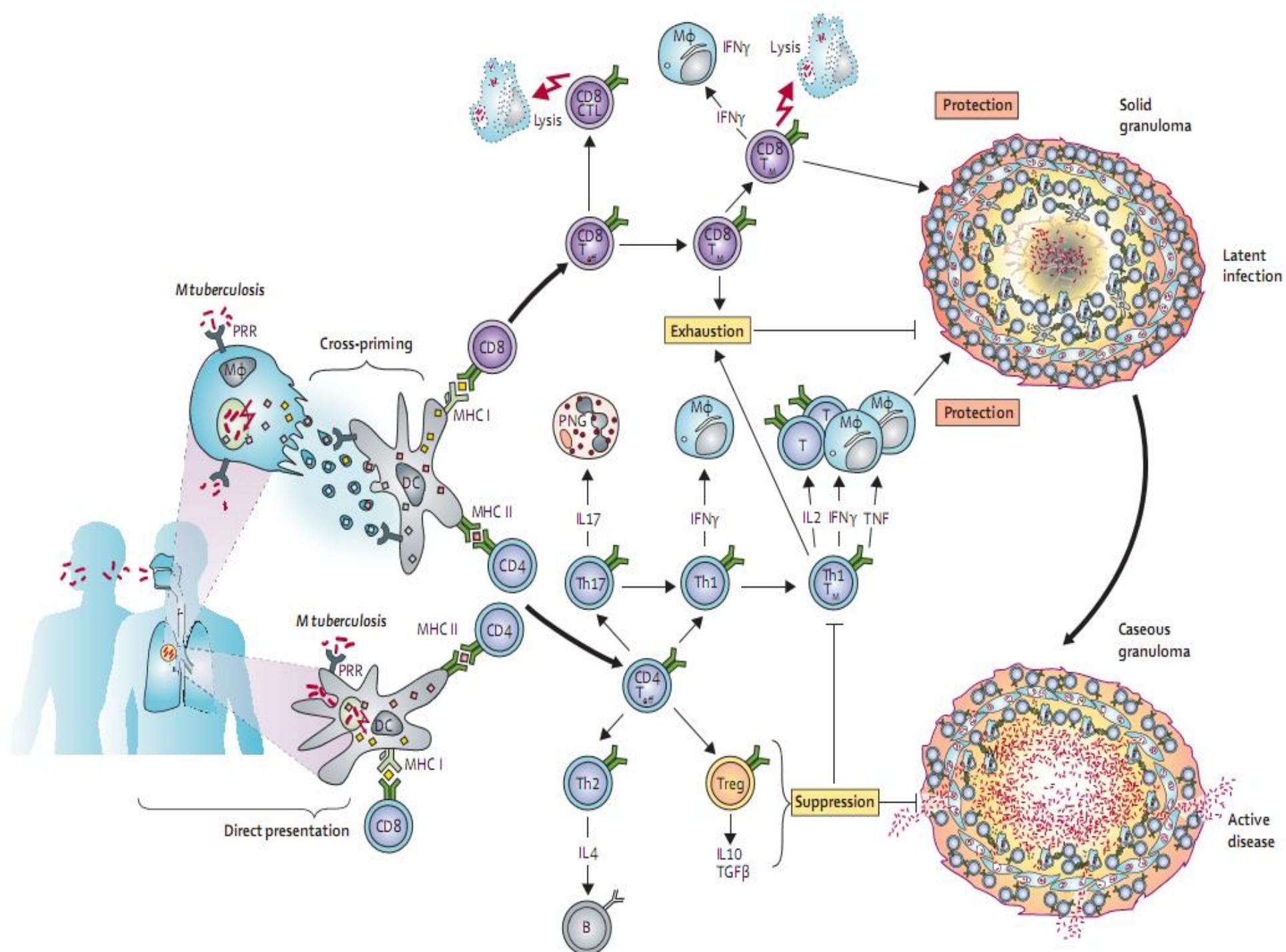
- This period of latency is sustained predominantly by a population of **non-replicating bacilli** rather than a population of growing bacilli.
- It is believed that the immune response is mainly directed towards **antigens secreted by growing bacilli**.
- Therefore non-replicating bacilli will be **less** obvious to the protective cellular response.
- This state correlates directly with an innate **resistance to anti-Mtb drugs**, most of which target processes active in replicating organisms.

# Reactivation disease

- Reactivation TB results from **proliferation of a previously dormant bacteria** seeded at the time of the primary infection.
- Among individuals with latent infection and no underlying medical problems, reactivation disease occurs in approximately **5 to 10 percent** of cases.
- The disease process in reactivation TB tends to be:
  - **Localized** (in contrast to primary disease)
  - **Little** regional lymph node involvement and **less caseation**.
  - The lesion typically occurs at the **lung apices**
  - **Disseminated disease is unusual**

# Reactivation disease

- ◎ **Immuno-suppression** is clearly associated with reactivation TB.
- ◎ Associated conditions include:
  - HIV infection and AIDS
  - End-stage renal disease
  - Diabetes mellitus
  - Malignant lymphoma
  - Corticosteroid use
  - Inhibitors of TNF-alpha and its receptor
  - Diminution in cell mediated immunity associated with age



The role of the granuloma as a host protective factor needs a revision in thinking as it may also play a role in protecting the tubercle bacilli for its long-term survival in the host

# Test for immunity against TB

Delayed hypersensitivity skin test  
Tuberculin test or (Mantoux)

Intradermal injection of PPD  
(purified protein derivative)

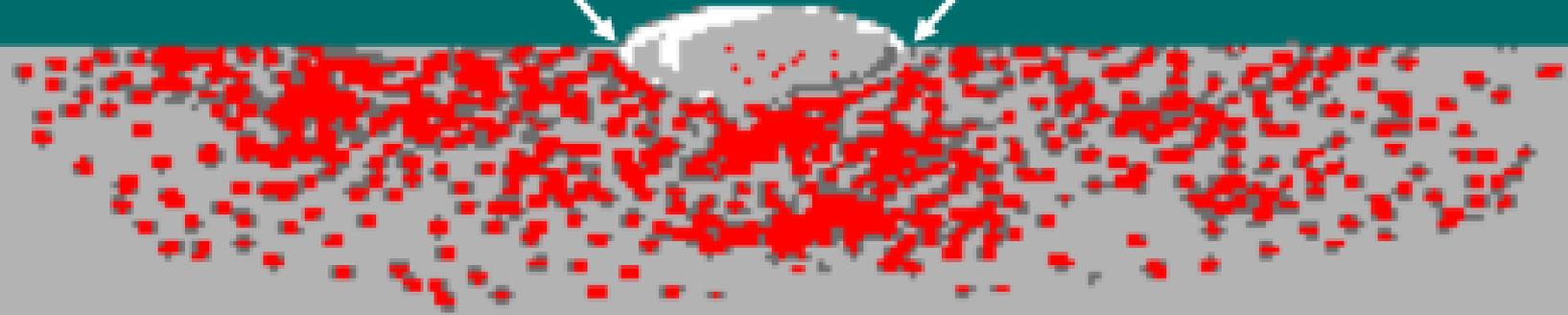


Correct interpretation of the result is unreliable in  
immuno-compromised states affecting CMI

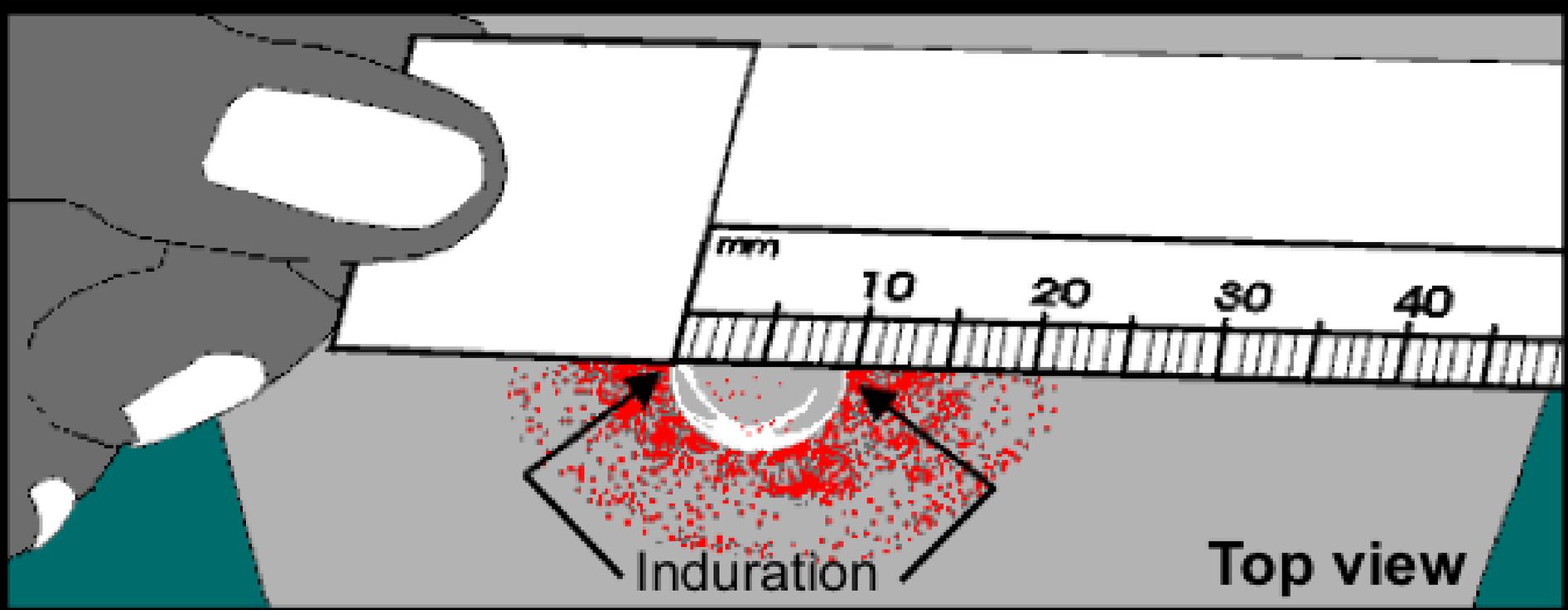
Test result is interpreted by measuring the diameter of the induration after 48 hours



Induration



Side view



Induration

Top view

# Delayed-type hypersensitivity (DTH) response

- The DTH response **does not correlate with protection against TB**, since numerous BCG vaccination trials have demonstrated that disease can occur in those who mount a DTH response.
- As a result, the protective T cell response must be distinguished from the T cell response associated with DTH.
- An in vitro **interferon-gamma release assay** has been developed.
- The assay is an **alternative** to the tuberculin skin test (TST) for detection of latent *M. tuberculosis* infection in human hosts.

# IFN- $\gamma$ release assay

- The test **measures** interferon-gamma released into blood from T cells when they are activated by *M. tuberculosis* antigens in vitro.
- The tests use antigens specific to *M. tuberculosis* including the **early secretory antigenic target 6 (ESAT-6)** and **culture filtrate protein (CFP-10)**.
- These proteins are **absent** in vaccine strain BCG, or *M. bovis*.
- This enables the test to differentiate those **latently infected with *M. tuberculosis*** from those **vaccinated with BCG**.

# Take home message

- ⦿ After exposure to *M. tuberculosis* immune handling of the infection determines the final outcome.
- ⦿ Relatively small proportion of individuals develop primary disease
- ⦿ Reactivation of tuberculosis can occur in patients who are immuno-compromised
- ⦿ Tuberculin test should be interpreted with caution as it may be difficult to differentiate between DTH against *M. tuberculosis* and latent disease.

Thank you