Introduction

Autoimmune diseases affect about 5% of the population and are often characterized by the production of autoantibodies directed against self-antigens (1). An important role for B cells in autoimmune diseases is demonstrated by the successful treatment of patients with RA, type 1 diabetes (T1D), MS, and other autoimmune syndromes with anti-CD20 monoclonal antibodies that eliminate B cells (2–4). However, the underlying mechanisms that account for autoreactive B cells and autoreactive B cell production in autoimmune diseases remain elusive.

We previously established in healthy donors that most developing autoreactive B cells are removed at two discrete steps. A central B cell tolerance checkpoint removes the vast majority of developing B cells that express polyreactive antibodies in the bone marrow (5). A peripheral B cell tolerance checkpoint further counterselects autoreactive new emigrant B cells before they enter the mature naive B cell compartment (5). In contrast, untreated active RA and SLE patients exhibit defective central and peripheral B cell tolerance checkpoints that result in the accumulation of self-reactive mature naive B cells in their blood (6, 7). However, it is unclear whether these early B cell tolerance defects precede the onset of autoimmunity or result from chronic ongoing inflammation processes. We recently reported that methotrexate or anti–TNF-α antiinflammatory treatments improved RA patients’ condition without reseting early B cell tolerance checkpoints, suggesting that they may be controlled by intrinsic genetic factors (8).

Many susceptibility genes associated with autoimmune and inflammatory disease have recently been identified through genome-wide association studies (GWASs) (9). However, the mechanisms by which these gene variants contribute to the development of autoimmunity are unknown. We have focused on the role of a variant of the Protein tyrosine phosphatase nonreceptor type 22 (PTPN22) gene, which is associated with an increased risk for the development of many autoimmune diseases, including RA, T1D, and SLE (10–13). This variant is a single nucleotide change (cytidine to thymidine) at residue 1,858 that results in a single amino acid substitution from arginine to tryptophan at position 620 of the PTPN22/Lyp protein. Current data indicate that the 620W polymorphism in PTPN22/Lyp is a gain-of-function variant that leads to increased T cell receptor and BCR signaling, which may in turn regulate the establishment of human T and B cell tolerance (14, 15). In this study, we have analyzed the impact of the PTPN22 risk allele on the establishment of B cell tolerance in healthy donors and found that it interferes with the removal of developing autoreactive B cells. We thus demonstrate that early B cell tolerance defects common to RA, SLE, and T1D may result from specific polymorphisms and precede the onset of these autoimmune diseases.

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The PTPN22 allele encoding an R620W variant interferes with the removal of developing autoreactive B cells in humans

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Protein tyrosine phosphatase nonreceptor type 22 (PTPN22) gene polymorphisms are associated with many autoimmune diseases. The major risk allele encodes an R620W amino acid change that alters B cell receptor (BCR) signaling involved in the regulation of central B cell tolerance. To assess whether this PTPN22 risk allele affects the removal of developing autoreactive B cells, we tested by ELISA the reactivity of recombinant antibodies isolated from single B cells from asymptomatic healthy individuals carrying one or two PTPN22 risk allele(s) encoding the PTPN22 R620W variant. We found that new emigrant/transitional and mature naive B cells from carriers of this PTPN22 risk allele contained high frequencies of autoreactive clones compared with those from non-carriers, revealing defective central and peripheral B cell tolerance checkpoints. Hence, a single PTPN22 risk allele has a dominant effect on altering autoreactive B cell counterselection before any onset of autoimmunity. In addition, gene array experiments analyzing mature naive B cells displaying PTPN22 risk allele(s) revealed that the association strength of PTPN22 for autoimmunity may be due not only to the impaired removal of autoreactive B cells but also to the upregulation of genes such as CD40, TRAF1, and IRF5, which encode proteins that promote B cell activation and have been identified as susceptibility genes associated with autoimmune diseases. These data demonstrate that early B cell tolerance defects in autoimmunity can result from specific polymorphisms and precede the onset of disease.

Authorship note: Laurence Menard and David Saadoun contributed equally to this work.

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Results

Impaired central B cell tolerance in healthy donors carrying PTPN22 risk allele(s). The PTPN22 risk allele is associated with the development of autoimmune diseases such as RA and SLE, characterized by an impaired counterselection of developing autoreactive B cells (6, 7). To assess whether the central B cell tolerance checkpoint, which normally removes highly polyreactive and anti-nuclear developing B cells in the bone marrow, is affected by the presence of the PTPN22 risk allele(s), we cloned antibodies expressed by single CD20⁺CD10⁺CD21loIgMhiCD27⁻ new emigrant/transitional B cells from 9 carrier healthy donors (Supplemental Tables 1–9) and tested their reactivity by ELISA (5). The reactivities of antibodies expressed by transitional/new emigrant B cells from healthy donors carrying one or two PTPN22 risk allele(s) were compared with those of their counterparts in non-carrier control donors (Figure 1 and refs. 5, 8, 16–18). We found that polyreactive new emigrant/transitional B cells were significantly increased in all 5 healthy donors who carried one PTPN22 risk allele (T allele carriers; 21%–38% of the clones) compared with non-carrier healthy controls (C allele individuals; 5%–11%) (refs. 5, 8, 16–18, Figure 1, A and B, and Supplemental Figure 1; supplemental material available online with this article; doi:10.1172/JCI45790DS1). Healthy donors who were homozygotes for the PTPN22 risk allele also displayed elevated frequencies of polyreactive clones in their transitional B cell compartment that

![Figure 1](http://www.jci.org)

**Figure 1**
Altered central B cell tolerance checkpoint in healthy individuals carrying PTPN22 risk allele(s). (A) Antibodies from new emigrant/transitional B cells from healthy donors who did not carry the PTPN22 risk allele (HD-CC) or carried one (HD-CT) or two (HD-TT) PTPN22 risk allele(s) were tested by ELISA for reactivity against ssDNA, dsDNA, insulin and LPS. Polyreactive antibodies reacted against all 4 antigens. Dotted lines show ED38-positive control (5). Horizontal lines show cutoff OD₄₀₅ for positive reactivity. For each individual, the frequency of polyreactive and non-polyreactive clones is summarized in pie charts, with the number of antibodies tested indicated in the center. The frequencies of polyreactive (B) and anti-nuclear (C) new emigrant/transitional B cells are compared between healthy donors carrying or not carrying PTPN22 risk allele(s), and statistically significant differences are indicated. Each diamond represents an individual, and the horizontal bars show the average. (D) Autoreactive antibodies expressed by new emigrant (ne) B cells from PTPN22 risk allele carriers mostly show various cytoplasmic patterns of HEp-2 staining. Original magnification, ×40.

![Figure 2](http://www.jci.org)

**Figure 2**
The PTPN22 risk allele interferes with the peripheral B cell tolerance checkpoint. (A) Antibodies from mature naive B cells from healthy donors who did not carry the PTPN22 risk allele (HD-CC) or carried one (HD-CT) or two (HD-TT) PTPN22 risk allele(s) were tested by ELISA for anti–HEp-2 cell reactivity. Dotted lines show ED38-positive control (5, 29). Horizontal lines show cutoff OD₄₀₅ for positive reactivity. For each individual, the frequency of HEp-2–reactive and nonreactive clones is summarized in pie charts, with the number of antibodies tested indicated in the center. Frequencies of HEp-2–reactive and polyreactive clones in the mature naive fraction of healthy donors carrying or not PTPN22 risk allele(s) are summarized in B and C, respectively.
New emigrant B cells

T2D01-CC  T2D02-CC  T1D01-CC  T1D02-CC  T1D03-CC  T1D04-CC  T1D05-CC

ssDNA (OD$_{492}$)

dsDNA (OD$_{492}$)

Insulin (OD$_{492}$)

LPS (OD$_{492}$)

Concentration (µg/ml)

Non-polyreactive (%) Polyreactive (%)

New emigrant B cells

T1D903-CT  T1D929-CT  T1D340-TT

ssDNA (OD$_{492}$)

Insulin (OD$_{492}$)

dsDNA (OD$_{492}$)

LPS (OD$_{492}$)

Concentration (µg/ml)

Non-polyreactive (%) Polyreactive (%)

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were similar to those of heterozygote carriers, revealing a dominant effect of the PTPN22 risk allele on central B cell tolerance (Figure 1, A and B). Using indirect immunofluorescence assays with HEP-2 cell–coated slides, we found that the proportion of anti-nuclear clones in new emigrant/transitional B cells from individuals carrying the PTPN22 risk allele(s) was modestly increased, but differences compared with non-carrier controls did not reach significance (Figure 1C). Self-reactive antibodies expressed by new emigrant/transitional B cells from heterozygote and homozygote PTPN22 risk allele carriers mostly recognized cytoplasmic structures including cytoskeleton components (Figure 1D). We conclude that the elevated frequency of polyreactive B cells in new emigrant/transitional B cells from healthy donors carrying one or two PTPN22 risk allele(s) demonstrates that central B cell tolerance is altered by the expression of overactive phosphatases encoded by the PTPN22 risk allele(s). The finding also reveals that the altered counterselection of developing autoreactive B cells previously found in patients with RA and SLE is likely to precede the onset of autoimmunity and is not a consequence or a by-product of chronic inflammatory conditions (6–8).

The PTPN22 risk allele also interferes with the peripheral B cell tolerance checkpoint. A second B cell tolerance checkpoint normally further eliminates autoreactive B cells that may recognize self-antigens in the periphery before they enter the CD20−CD10 CD21 IgM−CD27− mature naive B cell compartment (5). The impact of the PTPN22 risk allele on this peripheral B cell tolerance checkpoint was assessed by characterization of the reactivity of antibodies expressed by mature naive B cells from healthy donors carrying one or two PTPN22 risk allele(s) using an ELISA to screen for binding to antigens expressed by mature naive B cells from T1D but not T2D patients, suggesting a defective peripheral B cell tolerance checkpoint associated with T1D (Figure 4B, Supplemental Figures 2 and 3, and Supplemental Tables 37 and 38). Thus, T1D but not T2D patients suffer from defective central and peripheral B cell tolerance checkpoints similar to RA and SLE patients (6, 7), demonstrating that a failure to remove developing autoreactive B cells is common to all three autoimmune conditions and may favor the development of autoimmunity.

Similar autoreactive B cell frequencies were observed in T1D patients whether or not they harbored PTPN22 risk allele(s), suggesting that other polymorphisms may result in altered autoreactive B cell counterselection in these patients (Figure 4, A and B). This observation could also be extended to RA patients (Figure 4, C and D, and Supplemental Tables 39–46). Interestingly, many polymorphisms that have been reported to be associated with most of these autoimmune diseases, such as in BLK, LYN, BANK1, and PTPN22 genes (9), which encode products mediating BCR signaling essential for the tuning of early B cell tolerance checkpoints, are therefore likely to also impact the removal of developing autoreactive B cells in humans.

The PTPN22 risk allele affects the expression of many other autoimmune susceptibility genes. We next defined the impact of the PTPN22 risk allele on B cell physiology by performing gene array profiling and comparing transcripts expressed in mature naive B cells isolated from healthy individuals carrying one or two PTPN22 risk allele(s) and non-carrier control donors (Supplemental Table 47). Differentially expressed genes specifically associated with B cell biology were shown in Figure 5, Supplemental Figure 4, and Supplemental Tables 48 and 49. We found that mature naive B cells expressing PTPN22 risk allele(s) significantly upregulated the transcription of many genes belonging to three major B cell activation pathways, i.e., the BCR, CD40, and TLR pathways converging to NF-κB, and potentially counterbalancing the excessive signal dampening by the 620W risk allele (Figure 5 and Supplemental Table 48). Cytokine receptor transcripts, including IL4R, IL13R, IL17R, and IL21R, which stimulate B cell proliferation and differentiation, were found to be upregulated in B cells carrying PTPN22 risk allele(s) (Figure 5). Some HLA and polymerase genes were also found to be upregulated in mature naive B cells carrying PTPN22 risk allele(s), suggesting an activated status of these cells (Supplemental Figure 4 and Supplemental Table 49).

In addition, mature naive B cells from PTPN22 risk allele carriers differentially expressed many genes associated with many autoim-
A

New emigrant B cells

B

Mature naive B cells

C

New emigrant B cells

D

Mature naive B cells

Figure 4
Healthy donors carrying the PTPN22 risk allele(s) display elevated frequencies of autoreactive B cells similar to those in T1D and RA patients. The frequencies of polyreactive new emigrant/transitional (A) and HEP-2-reactive mature naive (B) B cells are compared between healthy donors and T1D patients carrying (T1D-CT+TT) or not (T1D-CC) PTPN22 risk allele(s) as well as non-carrier T2D patients (T2D-CC). Similar analyses were performed in C and D with RA patients carrying (RA-CT+TT) or not (RA-CC) PTPN22 risk allele(s). Statistically significant differences are indicated. All T1D and RA patients display high frequencies of autoreactive clones similar to those from healthy donors carrying PTPN22 risk allele(s).

mune diseases in mice or humans, including BLK, PTPN22, CD40, TRAF1, CD19, SLAM, and IRFS, as well as other genes belonging to the same pathways (Figure 5, Supplemental Table 48, and refs. 9, 19, 20). To confirm the differential transcript regulation of several of these susceptibility and other pertinent genes, we utilized quantitative PCR to assess transcript levels in 16 risk allele carriers and 31 non-carrier control donors (Supplemental Table 50). Transcript levels of CD25, CD69, CD86, and FAS by flow cytometry after BCR or the increased cell surface expression of CD40 on naive B cells precede the onset of RA, SLE, and T1D because healthy individuals carrying the PTPN22 risk allele already display altered central

Discussion
We demonstrated that the PTPN22 risk allele interferes with the removal of developing autoreactive B cells and allows the accumulation of large numbers of self-reactive mature naive B cells in the periphery. The PTPN22 risk allele is associated with many autoimmune diseases, including RA, SLE, and T1D (10–13). Interestingly, T1D patients showed abnormal central and peripheral B cell tolerance checkpoints similar to those previously reported for RA and SLE patients, revealing that early B cell tolerance defects are common to all these autoimmune diseases and may favor autoimmunity. These impaired early B cell tolerance defects precede the onset of RA, SLE, and T1D because healthy individuals carrying the PTPN22 risk allele already display altered central

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and peripheral tolerance checkpoints similar to those in patients with autoimmune diseases. Hence, this increased production of autoreactive naive B cells in PTPN22 risk allele carriers may play a role in the development of autoimmune syndromes by allowing the capture and the presentation of self-antigens to T cells, as previously postulated (21). The PTPN22 risk allele is likely to directly interfere with the removal of developing autoreactive B cells by affecting BCR signaling. Indeed, the PTPN22 risk allele encodes a gain-of-function variant that leads to decreased BCR signaling, which has been shown to induce a defective central B cell tolerance checkpoint in humans (14–16). Hence, autoreactive immature B cells binding self-antigens may not generate proper BCR signaling in the presence of 620W PTPN22 phosphatases, resulting in a failure to induce B cell tolerance mechanisms and the release of autoreactive B cells in the periphery. In addition, the upregulation of BCL2 transcription identified by gene array and quantitative PCR experiments in B cells expressing the PTPN22 risk allele may also interfere with the removal of autoreactive B cells as previously demonstrated in mice (22). Moreover, increased CD40 expression on naive B cells from PTPN22 risk allele carriers is also likely to favor developing B cell survival. It remains to be determined whether the upregulation of these survival and activating genes is a direct or indirect effect of the PTPN22 risk allele and potentially reflects compensatory mechanisms for the reduction in BCR signaling associated with the gain of function of 620W PTPN22 dephosphorylating enzymes.

Gene array experiments analyzing B cells from healthy individuals carrying PTPN22 risk allele(s) also revealed that the presence of 620W PTPN22 phosphatases affected the expression of genes such as PTPN2, CD40, TRAF, SLAM, and IRF5 that have been found to be involved in the development of many autoimmune diseases (9, 20). These genes encode molecules belonging to important pathways leading to B cell activation, including those initiated by the BCR, CD40, TLR, and cytokine receptors. The validation of gene upregulation by quantitative PCR and flow cytometry further demonstrates the importance of 620W PTPN22 phosphatases in B cell physiology, in that they favor B cell activation. Indeed, we demonstrated that the upregulated expression of CD40 on the cell surface of naive B cells from individuals carrying the PTPN22 risk allele correlated with a stronger B cell activation after CD40L stimulation compared with B cells from non-carrier donors. The upregulated transcription of TRAF genes encoding components mediating CD40 functions, as well as IL-4R, IL-13R, and IL-21R, which play important roles in B cell proliferation and differentiation, is also likely to favor B cell activation in individuals carrying PTPN22 risk allele(s). Together, our results suggest that the increased frequency of autoreactive B cells combined with CD40-linked hyperactive B cell features in PTPN22 risk allele carriers may favor self-antigen presentation and interactions with T cells, potentially leading to the development of autoimmunity. In line with this hypothesis is the increased IRF5 expression in B cells displaying PTPN22 risk allele(s). Indeed, an SLE risk haplotype is associated with elevated expression of IRF5 (23), and animal mod-

**Figure 5**
Mature naive B cells from healthy donors carrying PTPN22 risk allele(s) upregulate the expression of many susceptibility genes associated with autoimmune diseases. Gene array comparisons of mature naive B cells from healthy donors (HD) carrying or not PTPN22 risk allele(s) using the Affymetrix Human Genome U133 Plus 2.0 Array. Selected transcripts differentially expressed and well known to be involved in B cell biology are presented. One or more probes are shown for each gene. Up- and downregulated transcripts are indicated in red and green, respectively. The magnitude of expression is depicted by the color bar. Additional differentially expressed genes are shown in Supplemental Figure 4.
els have also demonstrated that decreased IRF5 gene expression may thwart the development of autoimmunity (24). Thus, the strength of association of the PTPN22 risk allele with autoimmune disorders may be due not only to the altered BCR signaling resulting in defective early B cell tolerance checkpoints but also to the activation of potentially autoreactive B cells in the periphery.

Since the PTPN22 risk allele is also expressed in T cells and decreases T cell receptor signaling (14), it is likely that T cell selection in the thymus and in particular the regulatory T cell repertoire will be also affected by the PTPN22 risk allele, thereby further contributing to the emergence of autoimmune diseases. However, in the absence of MHC alleles known to be associated with autoimmune diseases, it is unlikely that individuals carrying PTPN22 risk alleles will develop such conditions (9). The strong association of the fairly common PTPN22 risk allele among individuals of European descent with many humoral autoimmune diseases may represent an interesting target to thwart autoimmunity in a large pool of patients. Indeed, small molecules inhibiting PTPN22 enzyme activity may reset the threshold for counterselection of developing autoreactive B cells by increasing BCR signaling in individuals carrying PTPN22 risk allele(s). Interestingly, emerging literature also suggests that the PTPN22 risk allele may confer resistance to certain infections (25, 26). We postulate that the PTPN22 risk allele, especially common in Northern Europe (9), may in fact favor the production of better protective antibodies by allowing the development of polyreactive B cells. In line with this hypothesis, broadly neutralizing antibodies to HIV have been shown to be enriched in polyreactive clones (27, 28). Thus, pharmacological mimics of the PTPN22 620W allele may also find utility in selected clinical situations to enhance the production of protective clones by the B cell arm of the immune system.

Methods

Patients and healthy donors. Healthy donors carrying or not the PTPN22 risk allele were enrolled through the Yale Autoimmunity Center of Excellence Core B (Supplemental Tables 47 and 50). Genotyping was assessed by TaqMan SNP genotyping (Applied Biosystems) or custom Sequenom iPlex array (Sequenom Inc.). Fresh, de-identified human blood was also collected from healthy control subjects following receipt of their consent by staff at the Feinstein Institute for Medical Research through the Institutional Review Board–approved Genes and Phenotype (GAP) Registry (IRB protocol 09-081), a national resource for genotype-phenotype studies (National Institute of Arthritis and Musculoskeletal and Skin Diseases project 1RC2AR059092). Additional frozen PBMC samples for this study were obtained from control and T1D participants in the Benaroya Research Institute Immune Mediated Disease Registry and Juvenile Diabetes Research Foundation (JDRF) Center for Translational Research. Research protocols were approved by the Benaroya Research Institute IRB. All T1D patients had absolute insulin deficiency and positive immunological markers of T1D and are described in Supplemental Table S1 with T2D patients. Patients RA01, RA02, RA03, RA04, RA05, RA06, RA11, and RA24 were previously analyzed, and none of those subjects carried the PTPN22 risk allele (6, 8). RA patient characteristics are reported in Supplemental Table S2. All samples were collected in accordance with IRB-approved protocols.

Cell staining and sorting. Peripheral B cells were purified from the blood of patients and control donors by positive selection using CD20 magnetic
beads (Miltenyi). Enriched B cells were stained with FITC anti–human CD27, phycoerythrin (PE) anti–human CD10, anti–human IgM biotin revealed using streptavidin-PECy7, and allophycocyanin (APC) anti–human CD21, all from BD Biosciences — PharMingen. Single CD21\(^{lo}\)CD10\(^+\)IgM\(^{hi}\)CD27\(^–\) new emigrant/transitional and CD21\(^+\)CD10\(^–\)IgM\(^+\)CD27\(^–\) peripheral mature naive B cells from patients and control donors were sorted on a FACSVantage (BD) into 96-well PCR plates containing 4 \(\mu\)l lysis solution (0.5×PBS containing 10 mM DTT, 8 U RNAsin [Promega], and 0.4 U 5′-3′ RNase Inhibitor [Eppendorf]) and immediately frozen on dry ice.

**cDNA, RT-PCR, antibody production, and purification.** RNA from single cells was reverse transcribed in the original 96-well plate in 12.5-\(\mu\)l reactions containing 100 U Superscript II RT (Invitrogen) for 45 minutes at 42°C. RT-PCR reactions, primer sequences, cloning strategy, expression vectors, antibody expression, and purification were as described previously (5, 29). Immunoglobulin sequences were analyzed by IgBLAST comparison with GenBank. Heavy chain CDR3 was defined as the interval between the conserved arginine/lysine at position 94 in \(V_H\) framework 3 and the conserved tryptophan at position 103 in \(J_H\) segments.

**ELISAs and IFAs.** Antibody concentrations and reactivity were as described previously (5, 29). Highly polyreactive ED38 was used as positive control in HEp-2 reactivity and polyreactivity ELISAs (5, 29). Antibodies were considered polyreactive when they recognized all 4 analyzed antigens, which included single-stranded DNA (ssDNA), dsDNA, insulin, and LPS. For indirect immunofluorescence assays, HEp-2 cell–coated slides (Bion Enterprises Ltd.) were incubated in a moist chamber at room temperature with purified recombinant antibodies at 50–100 \(\mu\)g/ml. FITC-conjugated goat anti-human IgG was used as detection reagent.

**Microarray gene expression profile analysis.** RNA was extracted from 1 \(\times\) 10\(^6\) to 3 \(\times\) 10\(^6\) batch sorted CD19\(^+\)CD21\(^+\)CD27\(^–\) conventional mature naive B cells using the Absolutely RNA Microprep Kit (Stratagene). 100–200 ng of RNA was obtained per sample, and the quality of the purified RNA was assessed by the Bioanalyzer from Agilent Technologies. Using the Ovation biotin system kit from NuGEN, 30–50 ng of RNA was amplified and labeled to produce cDNA. Labeled cDNA was hybridized on chips containing the whole human genome (Human Genome U133 Plus 2.0 Array from Affymetrix). The data discussed in this article have been deposited in the

**Figure 7**
Enhanced CD40 responses in naive B cells from PTPN22 risk allele carriers. Representative dot plots (A) and combined average expression (B) of CD25 and CD69 on naive B cells from healthy donors carrying or not the PTPN22 risk allele are shown after stimulation in vitro with various indicated concentrations of multimeric soluble recombinant CD40L (left) or F(ab')\(_2\) anti-IgM (right) for 2 days. Values in A represent the percentage of positive cells in each quadrant. Results for HDC10 (non-carrier of the PTPN22 risk allele) and HDP07 (carrier of one PTPN22 risk allele) are shown. Data are representative of 4 independent experiments, and statistical differences are indicated (*\(P < 0.05\), **\(P < 0.01\)).

Real-time quantitative RT-PCR. Mature naïve B cells were enriched from the blood of healthy donors by negative selection using the Naïve B Cell Isolation Kit II (Miltenyi), followed by the depletion of transitional/new emigrant B cells after PE anti-human CD10 staining and anti-PE magnetic bead treatment (Miltenyi). Total RNA was extracted from mature naïve B cells using the Absolutely RNA Microprep Kit, followed by cDNA synthesis with the Superscript II RT. Real-time quantification was performed by the iCycler IQ5 thermal cycler (Bio-Rad) using Evagreen (Bio-Rad) and thesis with the Superscript II RT. Real-time quantification was performed with an iCycler IQ5 thermal cycler (Bio-Rad) using Evagreen (Bio-Rad) and primers reported in Supplemental Table S3. Actin primers were a gift from O. Henegariu, Yale University. Quantification of the gene of interest was analyzed by the ΔΔCt method using ACTIN as the reference gene. Relative expression was calculated according the formula 2–(ΔΔCt).

B cell activation. Naïve B cells were plated at 150,000–200,000 cells per well in a 96-well plate in RPMI 10% serum and various concentrations of polyvalent F(ab)2; rabbit anti-human IgM (Jackson ImmunoResearch Laboratories Inc.) or multimeric soluble recombinant human CD40L (Alexis Biochemicals) for 48 hours. Flow cytometry analysis was performed using anti-CD25–FITC, CD86-APC (BioLegend), CD69-PE, CD19-PECy7, CD95/ Fas-APC (BD Biosciences – Pharmingen).

Statistics. Differences were analyzed for statistical significance with an iCycler IQ5 thermal cycler (Bio-Rad) using Evagreen (Bio-Rad) and primers reported in Supplemental Table S3. Actin primers were a gift from O. Henegariu, Yale University. Quantification of the gene of interest was analyzed by the ΔΔCt method using ACTIN as the reference gene. Relative expression was calculated according the formula 2–(ΔΔCt).

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