

[REVIEW ARTICLE]

IgG4-related Disease - A Systemic Disease that Deserves Attention Regardless of One's Subspecialty

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Abstract:

IgG4-related disease (IgG4-RD) is an inflammatory condition characterized by a high serum IgG4 concentration and the abundant infiltration of lymphocytes and IgG4-positive plasma cells in the tissue, as well as spatial (diverse clinical manifestations) and temporal (the possibility of recurrence) multiplicities. Since the initial documentation of IgG4-related disease in patients with autoimmune pancreatitis in 2001, a growing body of evidence has been accumulating to suggest that various-virtually all-organs can be affected by IgG4-RD. In general, steroid therapy is effective and is considered to be the first-line treatment for IgG4-RD. The precise mechanism underlying this systemic disorder has remained unknown. Considering that IgG4-RD was specified as being an intractable disease in 2015, further studies are needed to clarify whether IgG4-RD is indeed a distinct disease entity or a complex of disorders of different etiologies and clinical conditions.

Key words: IgG4-related disease, autoimmune pancreatitis

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Introduction

IgG4-related disease (IgG4-RD), a novel clinicopathological entity that was originally proposed by Japanese researchers, is now accepted worldwide (1-6). Not infrequently, patients diagnosed with IgG4-RD are found to have multiorgan involvement in various organs/tissue, including the pancreas (7-20), bile duct (21-28), lacrimal and salivary glands (12, 29-33), orbital or periorbital tissue (34-37), pachymeninx (38-41), hypophysis (33, 41-43), thyroid (44-47), lungs, pleura (48-58), pericardium (58-64), aorta, artery (64-66), kidneys (67-75), prostate (76-78), mediastinum, retroperitoneum (8, 33, 79-82), and lymph nodes (83-87). In this brief review, we describe the clinical and pathological characteristics of IgG4-RD, together with the diagnosis and treatment of the disease.

The Transition from Mikulicz Disease and Autoimmune Pancreatitis to IgG4-related Disease

In the history of IgG4-RD, the transition from Mikulicz disease and autoimmune pancreatitis has significant importance. Mikulicz disease, a disorder characterized by enlarged lacrimal and salivary glands, was first reported by Mikulicz (88). However, since the latter part of the 20th century, Mikulicz disease has been considered to be included in primary Sjögren's syndrome, due to the fact that these disorders share similar histopathological features (89).

Autoimmune pancreatitis (AIP) is an inflammatory pancreatic disorder that is characterized by pancreatic swelling and diffuse irregular narrowing of the entire main pancreatic duct (9). When AIP exhibits a mass lesion, it becomes difficult to distinguish AIP from pancreatic cancer (10). Yoshida et al. observed IgG increases in afflicted patients and cases in which steroid treatment was effective and proposed the

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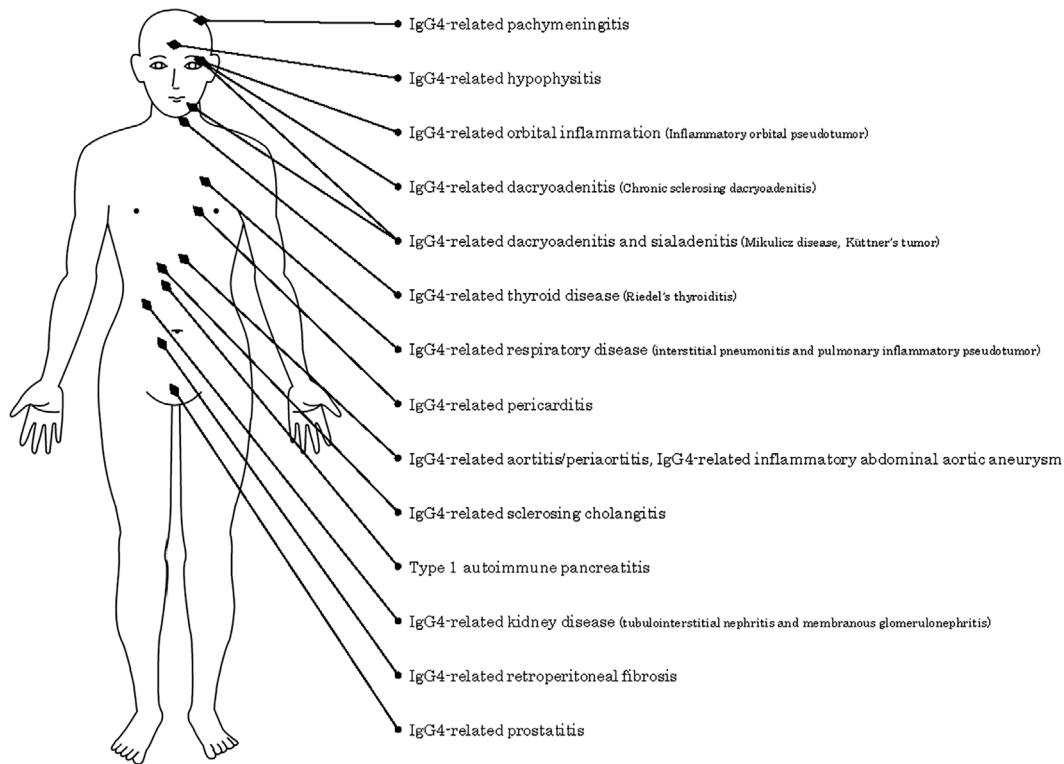


Figure 1. A key characteristic of IgG4-RD - spatial multiplicity. Spatial multiplicity can cause diverse clinical findings. The figure summarizes previous reported cases of IgG4-RD.

term AIP (11). Sarles et al. were the first to describe AIP (90) and Nakano et al. were the first to report a typical case of AIP with lachrymal and salivary lesions that was treated with steroids (91). The study by Kawaguchi et al. is renowned for its description of the typical pathological manifestations of AIP, which include marked fibrosis accompanying lymphocytic and plasmacytic infiltration (i.e., lymphoplasmacytic sclerosing pancreatitis with cholangitis; LPSP), and obliterative phlebitis (92). Since Toki et al. described the pancreatic duct findings in AIP as the diffuse irregular narrowing of the entire main duct (93), many case reports on AIP have been reported from Japan.

Hamano et al. reported that the serum IgG4 level is elevated in patients diagnosed with AIP (7), and that the abundant infiltration of IgG4-positive plasma cells was observed in the pancreas and fibroinflammatory retroperitoneal tissues (8). Based on the hematological and pathological findings, Kamisawa et al. suggested that the lachrymal and salivary lesions accompanying AIP and those accompanying Sjögren's syndrome may represent separate clinical conditions (12), and proposed the concept of IgG4-RD (1). Based on the finding that patients with Mikulicz disease have elevated serum IgG4 similar to that in AIP (29), Yamamoto and Masaki suggested that this condition is a systemic disease associated with IgG4-RD (2, 3).

The Comprehensive Diagnostic Criteria for IgG4-Related Disease 2011, created by Umehara et al., were the first diagnostic criteria for IgG4-RD in the world (4). As a result of Stone's efforts, the first international symposium on IgG4-RD was held in Boston in 2011 to finally recognize IgG4-

RD as a global phenomenon (5).

Spatial Multiplicity

A key characteristic of IgG4-RD is that patients may exhibit diverse clinical findings. Fig. 1 summarizes the previously reported cases of IgG4-RD (1-87), which demonstrate this spatial multiplicity. Interestingly, not all cases of IgG4-RD exhibit such a wide range of clinical findings; there are some cases in which only AIP lesions are present, while other cases show multiple lesions, such as AIP with concomitant lachrymal and salivary gland swelling. However, the question of whether diverse clinical findings such as these can truly be described as a single pathology remains under debate.

Temporal Multiplicity and Recurrence

Another characteristic feature of IgG4-RD is that patients frequently exhibit recurrence (94-97). This may be expressed as a temporal multiplicity. Spatial and temporal multiplicities are clinically problematic. There have been cases of AIP occurring 20 years after the appearance of lachrymal gland swelling, with many displaying clinical findings during recurrence that differ to those at the initial onset. Meanwhile, other cases do not exhibit recurrence, and to date no indicators have been established to predict recurrence in the initial stages of IgG4-RD. Fig. 2 shows the clinical course of the patient who had twice recurrences. Strangely, the symptom of cough was present before the onset and before each re-

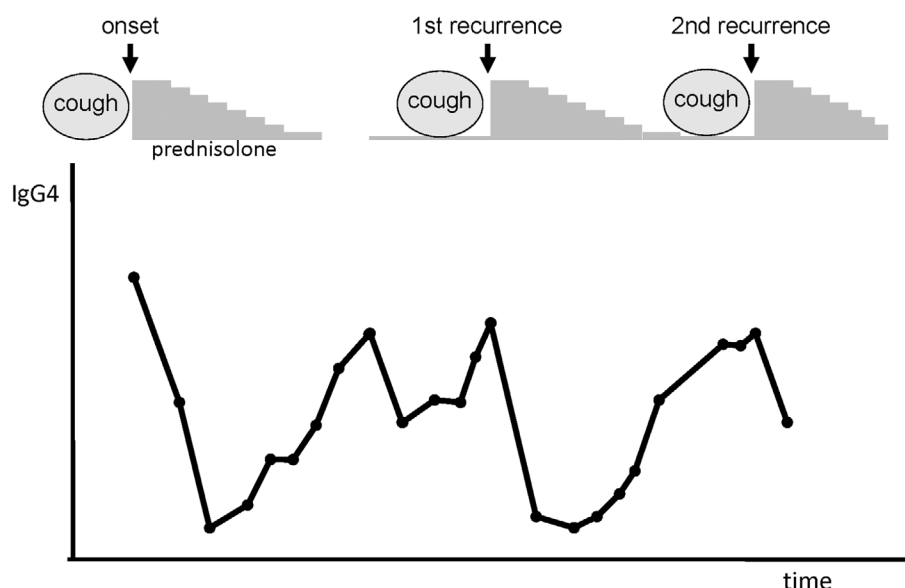


Figure 2. A key characteristic of IgG4-RD - temporal multiplicity and recurrence. Another characteristic feature of IgG4-RD is that patients frequently exhibit recurrence, which may be expressed as a temporal multiplicity. The figure shows the clinical course of the patient who had two recurrences. Interestingly, the patient had the symptom of cough before the onset and each of the recurrences.

Table. Comprehensive Diagnostic Criteria for IgG4-related Disease, 2011.

Comprehensive clinical diagnostic criteria for IgG4-RD
1. Clinical examination showing characteristic diffuse/localized swelling or masses in single or multiple organs
2. Hematological examination shows elevated serum IgG4 concentrations (135 mg/dL)
3. Histopathologic examination shows:
(1) Marked lymphocyte and plasmacyte infiltration and fibrosis
(2) Infiltration of IgG4+plasma cells: ratio of IgG4+/IgG+cells>40% and >10 IgG4+plasma cells/HPF
Definite: 1) + 2) + 3)
Probable: 1) + 3)
Possible: 1) + 2)
However, it is important to differentiate IgG4-RD from malignant tumors of each organ (e.g. cancer, lymphoma) and similar diseases (e.g. Sjögren's syndrome, primary sclerosing cholangitis, Castleman's disease, secondary retroperitoneal fibrosis, Wegener's granulomatosis, sarcoidosis, Churg-Strauss syndrome) by additional histopathological examination.
Even when patients cannot be diagnosed using the CCD criteria, they may be diagnosed using organ specific diagnostic criteria for IgG4-RD.

(Adapted from Umehara et al. Mod Rheumatol 2012; 22: 21-30)

currence.

The Diagnosis of IgG4-RD

The diagnosis of IgG4-RD is generally based on the detection of a high serum concentration of IgG4 and multiple manifestations of IgG4-positive plasma cell infiltration in affected organs/tissues (1, 4-6). It should be noted that other diseases may demonstrate similar clinicopathological features; thus, they should be included in the differential diagnosis.

The adoption of comprehensive diagnostic criteria (CDC) for IgG4-RD to facilitate practical use by general clinicians and non-specialists has been advocated (Table) (4). The criteria stipulate that an additional histopathological examination should be used to differentiate IgG4-RD from certain

malignant disorders, including malignant lymphoma, and from other conditions with similar features, including Sjögren's syndrome, primary sclerosing cholangitis, Castleman's disease, secondary retroperitoneal fibrosis, Wegener's granulomatosis, sarcoidosis, Churg-Strauss syndrome. Physicians should be aware that, in most cases, the C-reactive protein (CRP) level is not markedly elevated in IgG4-RD, and that a high CRP level may be indicative of other mimicking conditions, such as multicentric Castleman's disease (83-87).

Even with the CDC for IgG4-RD, it is sometimes difficult to diagnose IgG4-RD because there are cases in which a high serum IgG4 concentration and/or IgG4-positive plasma cell infiltration are absent. Nevertheless, the CDC for IgG4-RD seem to be advantageous due to their simplicity.

The Treatment of IgG4-RD

Steroid treatment is effective and is considered to be the standard therapy for IgG4-RD (6, 11, 91). Although patients with organ dysfunction or other symptoms are generally considered to be eligible for this therapy, the administration of steroids in asymptomatic cases remains controversial. Treatment involves the administration of oral prednisolone (30-40 mg/day; 0.6 mg/weight kg/day) over 2-4 weeks as AIP remission induction therapy, which is then progressively tapered every 1-2 weeks. Recurrence rates are relatively low in patients undergoing subsequent maintenance therapy; however, validation studies are required to confirm its utility (91, 97-99).

IgG4-RD frequently recurs, at which point an increased steroid dose is often effective. The rates of recurrence may in part depend on the speed of the steroid tapering (100). In addition to steroids, the effects of immunosuppressive agents and rituximab in patients with recurrent IgG4-RD are being investigated in clinical trials (6, 101, 102).

The Pathogenesis of IgG4-RD

Although the etiology of IgG4-RD remains unknown, it might represent certain deranged immunological and/or allergic conditions. Previous studies have indicated that IgG4-RD is a Th2-dependent disease in which the expression of regulatory T cells is promoted (103). Shiokawa et al. reported that mice that were given IgG from patients with IgG4-RD only exhibited lesions in organs that were affected in the patients, suggesting the presence of autoantibodies against the affected organs may have existed in the serum of patients. In addition, they reported that IgG1 had stronger pathogenicity than IgG4, and that IgG4 might modulate the pathogenicity of IgG1 (104). Taken together with the potential relationship between IgG4-RD and malignant diseases (105-108), the underlying pathogenesis requires further investigation.

The Validity of IgG4-RD as a Disease Entity

Many organ lesions have already been reported as manifestations of IgG4-RD (1-87, 94) according to the hematological finding of a high serum IgG4 concentration and pathological evidence of abundant IgG4-positive plasma cell infiltration. Variation has also been observed in IgG4-RD, including combinations of single-organ and multi-organ lesions (94), repeated recurrence (97-100), allergic complications (109, 110), decreased complement proteins (111-113), increased eosinophils (109, 110), increased IgE (109, 120), and malignant complications (105-108). Considering the diversity of these manifestations, there is a strong need for further investigation to determine whether IgG4-RD is truly a single disease entity or an aggregate of several IgG4-related syndromes.

One reason for the wide acceptance of IgG4-RD is that IgG4 is the most minor subclass of IgG and the appearance of large numbers of plasma cells in patients with IgG4 is very rare. Thus, it may be important to only consider IgG4 as an auxiliary diagnosis. It is also important to consider that it may not be possible to define IgG1-related disease, as the elevation of serum IgG1 and the tissue infiltration of IgG-positive cells can be observed in a wide variety of disorders.

Future Directions

We described the concept, diagnosis, and treatment of IgG4-RD. Although IgG4-RD, in general, shows a good response to steroid therapy, we should understand that in some cases this pathological condition might be refractory to medical therapy or recur after treatment, and that it can be life-threatening. More than 15 years have passed since IgG4-RD was discovered. It is therefore imperative that IgG4-RD be distinguished either as a distinct disease entity or a syndrome. In addition, this clinicopathological condition should not be overlooked by health care providers, regardless of their primary specialty. The pathogenic mechanism underlying the development of this disorder should be clarified in the future to facilitate further discussion on whether IgG4-RD is indeed a distinct disease entity or whether patients who are diagnosed with this condition simply show clinicopathological characteristics that are shared by various disorders.

The authors state that they have no Conflict of Interest (COI).

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