ABSTRACT. Objective. Identification of an association between IRF5 rs2004640 and systemic sclerosis (SSc) has highlighted a key role for type 1 interferon (IFN). Additional functional IRF5 variants have been identified as autoimmune susceptibility factors. Our aim was to investigate whether IRF5 haplotypes confer susceptibility to SSc, and to perform genotype haplotype-phenotype correlation analyses.

Methods. We genotyped IRF5 rs377385, rs2004640, and rs10954213 in 1623 individuals of French European Caucasian origin. SSc patient subphenotypes were analyzed according to cutaneous subsets and for SSc-related pulmonary fibrosis.

Results. Case-control studies of single markers revealed an association between IRF5 rs3757385, rs2004640, and rs10954213 variants and SSc. We identified an IRF5 risk haplotype “R” (p adj = 0.024, OR 1.23, 95% CI 1.07–1.40) and a mirrored protective haplotype “P” (p adj = 8.8 × 10−3, OR 0.78, 95% CI 0.68–0.90) for SSc susceptibility. Genotype-phenotype correlation analyses failed to detect any association with a single marker. By contrast, phenotype-haplotype correlation analysis was able to detect intra-cohort association and to discriminate SSc patients with from those without the following clinical traits: “R” and/or “P” haplotypes identified diffuse cutaneous SSc (p = 0.0081) and fibrosing alveolitis (p = 0.018).

Conclusion. IRF5 haplotypes are more informative than single markers, suggesting that they could be helpful for risk stratification of SSc patients. Our study provides further evidence of a key role of IRF5 in SSc severity. (First Release March 15 2010; J Rheumatol 2010;37:987–92; doi:10.3899/jrheum.091163)
Systemic sclerosis (SSc) is an orphan complex multiorgan disease affecting the microvascular network, the immune system, and connective tissue. Progressive organ failure makes SSc a severe chronic disease leading to major disability or death. To date no drug has proven its efficacy to counteract the generalized multiorgan fibrotic process. Recent data have highlighted the poor efficacy of current available drugs, in particular in the 2 major causes of death, interstitial lung disease and pulmonary arterial hypertension.

The type 1 interferon (IFN) pathway has been postulated to play a key role in autoimmune diseases. Indeed, an increased expression of type 1 IFN genes by peripheral blood mononuclear cells, referred to as an IFN signature, has been detected in multiple autoimmune diseases such as systemic lupus erythematosus (SLE), rheumatoid arthritis (RA), and Sjögren’s syndrome (SS) and in a subgroup of patients with SSc. The interferon regulatory factors (IRF) are major regulators of genes activated by the type 1 IFN. Recently, the interferon regulatory factor 5 gene (IRF5) has been identified as an autoimmune disease susceptibility gene in the background of SS, SLE, RA, and SSc. Our original finding of an association between the type 1 IFN pathway in SSc was also reported to confer susceptibility to autoimmunity. The interferon regulatory factor 5 (SNP), which creates a donor splice site in intron 1 of the IRF5 gene resulting in transcription of the alternative exon 1B, displayed association with SSc in 2 independent patient cohorts from French Caucasian populations. Further, our data provided new clues for a role of IRF5 and IFN pathways in fibrosing alveolitis. Recently, different additional functional IRF5 variants have been convincingly identified as autoimmune genetic factors. Among these IRF5 variants, the rs10954213 SNP alters the polyadenylation site of IRF5, the rare A allele leading to a shorter and more stable mRNA. A 5-bp biallelic insertion deletion polymorphism (CGGGG indel) located in the first intron of the IRF5 gene, resulting in increased binding of the transcription factor SP1 to the risk allele of the 5-bp indel, was also reported to confer susceptibility to autoimmunity.

Interestingly, the functional CGGGG indel polymorphism could be unambiguously inferred from haplotype reconstructions due to the high linkage disequilibrium with the 3 following SNP: rs377385, rs2004640, and rs10954213. Therefore, the aim of our study was to investigate whether IRF5 haplotypes determined by those 3 SNP may be also involved in the genetic background of SSc and to account for the respective subphenotypes.

MATERIALS AND METHODS

Study population and design. We performed a large case-control association study including 827 SSc patients and 989 controls from the French SSc network as described. All SSc patients were classified according to the cutaneous subtype classification of LeRoy, et al., and phenotypically assessed as recommended. Controls consisted of healthy unrelated individuals ethnically matched to the SSc cases.

RESULTS

IRF5 single-marker analysis. Genotype frequencies of the 3 IRF5 SNP were in Hardy-Weinberg equilibrium in the control population.

Among the 829 patients and 989 controls investigated, complete genotyping data for the 3 IRF5 variants were available for 743 and 880 individuals, respectively. Allelic and genotypic frequencies of the IRF5 rs377385, rs2004640, and rs10954213 SNP were in good agreement with frequencies reported among the European Caucasian population. The case-control association study involving...
743 SSc cases and 880 controls revealed an association between IRF5 rs3757385, rs2004640, and rs10954213 variants and SSc (Table 1). The magnitude of the association was most important for IRF5 homozygous genotypes for the risk allele of rs3757385 and rs2004640 SNP, suggesting a dosage effect (p = 0.009, OR 1.51, 95% CI 1.10–2.08 and p = 3.5 × 10−5, OR 1.81, 95% CI 1.36–2.40, respectively).

We tested whether the associated SNP constituted an independent effect. Pair-wise correlation coefficient (r²) analysis found rs3757385 in relatively high linkage disequilibrium with rs2004640 (r² = 0.57) and rs10954213 (r² = 0.34). Multiple logistic regression analysis of the 3 SNP revealed no independent effect: the rs2004640 was the only variant that remained significantly associated conditionally to the 2 others (p = 0.0086).

**IRF5 haplotype analysis.** Among the 8 IRF5 haplotypes defined by the 3 IRF5 rs3757385, rs2004640, and rs10954213 SNP, 4 common haplotypes (frequency > 5% in both controls and cases) were predicted from our sample. Of these 2 common haplotypes C-T-A and A-G-G were present at a frequency of 44% and 33%, respectively, in our control chromosomes. Taking into account the IRF5 risk alleles rs3757385*C, rs2004640*T, and rs10954213*A, we tested for association of the IRF5 C-T-A risk haplotype (“R” haplotype). The IRF5 “R” haplotype was associated with SSc as its frequency was significantly increased in SSc patients (49%) compared to controls (44%) (p_adj = 0.024, OR 1.23, 95% CI 1.07–1.40). We also observed that the C-T-A “mirror” haplotype, i.e., the A-G-G haplotype, acts with a protective (“P” haplotype) effect, its frequency being decreased in the SSc population (27.8%) compared to controls (32.9%) (p adj = 8.8 × 10−5, OR 0.78, 95% CI 0.68–0.90; Table 2).

**Phenotype-genotype correlation in SSc.** We previously reported results identifying IRF5 rs2004640 as a new SSc susceptibility gene, with a strong effect in the genetic background of diffuse cutaneous SSc (dcSSc) and SSc-related fibrosing alveolitis. Following those results we investigated the effect of the IRF5 “R” and “P” haplotypes in subsets of SSc (dcSSc, limited cutaneous SSc (lcSSc), and patients with and without fibrosing alveolitis).

In this study, we observed a strong association of the IRF5 rs2004640 TT genotype with both dcSSc (p_adj = 2.6 × 10−3, OR 2.01, 95% CI 1.39–3.05) and SSc-related pulmonary fibrosis (p_adj = 3.7 × 10−4, OR 2.19, 95% CI 1.50–3.20). The TT risk genotype was also strongly associated with the subset of severe organ involvement, compared to controls (p_adj = 2.2 × 10−4, OR 2.16, 95% CI 1.50–3.09). The IRF5 rs3757385 variant was also found to be associated with the different SSc subsets; conversely, no association was detected with rs10954213 (Table 1).

However, regarding the phenotype-genotype correlation, intra-cohort analyses failed to detect any significant differences comparing the allele and genotype frequencies of the 3 IRF5 SNP and the 3 subsets (i.e., cutaneous phenotype, pulmonary fibrosis, and severe organ involvement; data not shown).

### Table 1. Genotype and allele frequency comparisons of the IRF5 rs3757385, rs2004640, and rs10954213 polymorphisms in SSc patients and controls. For each IRF5 SNP p values are given as follows: risk allele, homozygous and heterozygous genotypes for the risk allele.

<table>
<thead>
<tr>
<th>rs3757385</th>
<th>rs2004640</th>
<th>rs10954213</th>
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<tbody>
<tr>
<td></td>
<td>CC</td>
<td>CA</td>
</tr>
<tr>
<td>SSc, n = 743</td>
<td>341 (45.9)</td>
<td>318 (42.8)</td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dcSSc, n = 252</td>
<td>115 (45.4)</td>
<td>106 (42.1)</td>
</tr>
<tr>
<td>lcSSc, n = 448</td>
<td>211 (47.1)</td>
<td>192 (42.9)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>With FA, n = 292</td>
<td>149 (51.0)</td>
<td>139 (37.3)</td>
</tr>
<tr>
<td>Non-FA, n = 397</td>
<td>173 (43.6)</td>
<td>182 (45.8)</td>
</tr>
<tr>
<td>Controls, n = 880</td>
<td>330 (37.5)</td>
<td>427 (48.5)</td>
</tr>
</tbody>
</table>

* Adjusted after Bonferroni correction for multiple comparisons. dcSSc: diffuse cutaneous systemic sclerosis; lcSSc: limited cutaneous systemic sclerosis; FA: fibrosing alveolitis.
Phenotype-haplotype correlation in SSc. Regarding the IRF5 C-T-A “R” haplotype, we found an association restricted to dcSSc (padj = 0.037, OR 1.32, 95% CI 1.10–1.59). The IRF5 A-G-G “P” haplotype was found to act with a protective effect restricted to the diffuse cutaneous subtype and the subset of SSc patients with fibrosing alveolitis (Table 2). When phenotype-haplotype correlation was investigated, intra-cohort analyses revealed a significantly increased frequency of the “R” haplotype in dcSSc compared to lcSSc (p = 0.0081). Conversely, the “P” haplotype was found to be underrepresented in the subset of SSc patients having fibrosing alveolitis compared to those without (p = 0.018); the frequency of the “R” haplotype did not differ between the 2 SSc subsets (Table 2). As fibrosing alveolitis is reported to be linked to dcSSc, we next compared the frequencies of the IRF5 “P” haplotype between patients with and those without fibrosing alveolitis in the lcSSc subset: we observed a decreased frequency of the “P” haplotype in the patient subset without fibrosing alveolitis; however, this did not achieve statistical significance (data available upon request from the author).

As previously stated, the susceptibility CCGGG indel allele was inferred from the 2 IRF5 “R” and “P” haplotypes. Among a group of 100 SSc patients and controls who were homozygous for the “R” haplotype, 100% were carrying the CCGGG indel insertion allele; conversely, among 40 individuals homozygous for the IRF5 “P” haplotype, none had the CCGGG indel susceptibility allele, corroborating that the “R” haplotype harbors the CCGGG indel risk allele.

DISCUSSION

We previously reported an association between the functional IRF5 rs2004640 polymorphism and SSc. Identification of IRF5 as a genetic susceptibility factor shared by various autoimmune diseases is an important step for understanding type I IFN-driven autoimmunity. Further, this has generated new clues about interstitial lung disease in the context of SSc, which has become a leading cause of death, without established therapeutic options. However, to date, many IRF5 functional variants have been identified as risk factors for different autoimmune diseases and remain to be investigated in SSc. Our study is the first to provide evidence for association between 2 IRF5 haplotypes and SSc. We identify an IRF5 risk haplotype (“R”) defined by the alleles rs3757385*C, rs2004640*T, and rs10954213*A (C-T-A) that confers susceptibility to SSc. The IRF5 “R” haplotype was found to confer susceptibility to defined subsets of SSc including dcSSc and SSc-related pulmonary fibrosis. These findings illustrate that IRF5 may contribute to the typical heterogeneity of SSc. This observation is in good agreement with our original study, as the main subphenotype associations were the diffuse cutaneous and fibrosing alveolitis subsets. In this sample, intra-cohort single-marker analyses failed to provide evidence for using one of the 3 IRF5 variants as a marker for a particular SSc subset. This discrepancy with our previous findings could be related to the cross-sectional design of the study and a smaller sample size (743 SSc cases, 880 controls) leading to a weaker power to detect such intra-cohort associations. Of
interest, phenotype-haplotype correlation analysis did detect intra-cohort association signals. Indeed, IRF5 “R” and/or “P” haplotypes were able to discriminate dcSSc and fibrosing alveolitis. Those results emphasize that IRF5 haplotype analyses are more informative than single-marker analyses of rs3757385, rs2004640, and rs10954213, suggesting the haplotype biomarker could be helpful for risk stratification of patients with Ssc.

It is noteworthy that the same risk haplotype has been reported to be associated with high serum levels of type 1 IFN in patients with SLE. It could be hypothesized that the IRF5 “R” haplotype harbors one or multiple causal polymorphisms. Interestingly, a 5-bp biallelic insertion-deletion polymorphism (CGGGG indel) located in the first intron of the IRF5 gene was recently reported to be associated with multiple autoimmune diseases. The CGGGG risk insertion, which results in increased binding of the SP1 transcription factor, has recently been reported to regulate the expression of IRF5 mRNA. The CGGGG risk insertion suggested to be the causal variant of IRF5 in SLE and in primary SS could be unambiguously inferred from haplotype reconstructions with the 3 IRF5 SNP tested in our study. Hence, the IRF5 “R” haplotype is the exclusive haplotype carrying the CGGGG insertion risk allele, suggesting a possible contribution of this functional variant in the genetic background of SSc.

As previously reported, the susceptibility CGGGG indel allele was unambiguously inferred from the 2 IRF5 “R” and “P” haplotypes in a French Caucasian population. This haplotype was also reported to confer susceptibility to multiple sclerosis in the European Caucasian population. However, resequencing of the IRF5 gene in patients homozygous for the “R” haplotype is required for a conclusion that the CGGGG insertion deletion is the definite IRF5 causal variant. Further, it is notable that multiple IRF5 SNP including rs2070197 and rs12539741, located in the 3’UTR, were reported to confer susceptibility to SLE and may be involved in SSc susceptibility. Of interest, those SNP are in perfect linkage disequilibrium with several additional Hapmap SNP distributed over a 10-kb region located 3’ of the IRF5 gene that contains the transportin 3 (TNPO3) gene. The reported pair-wise linkage disequilibrium between these SNP and the CGGGG indel is very low, suggesting that the SNP could tag an independent SLE signal association; this remains to be investigated in SSc.

Genetic studies of SSc susceptibility have made great progress, and considering the current efforts, more genetic risk factors will be identified. In contrast, the field of the genetics of SSc heterogeneity is relatively unexplored. Following our results, IRF5 should be investigated in genetics of SSc phenotypic heterogeneity. Identification of the IRF5 gene as a susceptibility factor for multiple autoimmune disorders emphasizes that similar immunogenetic mechanisms underlie autoimmune diseases. It is also important for understanding type I IFN-driven autoimmunity — IFN regulatory factors (IRF), such as IRF5, coordinate the expression of type I IFN, which are assumed to participate in the pathogenesis of connective tissue disorders including SLE, SS, and SSc. IRF5 also coordinates the expression of interleukin-6, which was found to be elevated in plasma serum of patients with dcSSc and SSc-related pulmonary fibrosis. Increased understanding of the role of genetics in disease outcomes in SSc may promote the development of new therapies.

Our study provides evidence for IRF5 as a new SSc gene playing a key role in disease severity, and supports the pivotal role of type 1 IFN in the pathophysiology of SSc. Further research is needed on the pathogenesis of this severe autoimmune disease, for which there is no cure.

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