



HAL
open science

Natural Antibodies: from first line defense against pathogens to perpetual immune homeostasis

Mohan S. Maddur, Sébastien Lacroix-Desmazes, Jordan D. Dimitrov, Michel D. Kazatchkine, Jagadeesh Bayry, Srini V. Kaveri

► To cite this version:

Mohan S. Maddur, Sébastien Lacroix-Desmazes, Jordan D. Dimitrov, Michel D. Kazatchkine, Jagadeesh Bayry, et al.. Natural Antibodies: from first line defense against pathogens to perpetual immune homeostasis. *Clinical Reviews in Allergy and Immunology*, In press, 58 (2), pp.213-228. 10.1007/s12016-019-08746-9 . hal-02328279

HAL Id: hal-02328279

<https://hal.science/hal-02328279v1>

Submitted on 23 Oct 2019

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

Natural Antibodies: from first line defense against pathogens to perpetual immune homeostasis

Mohan S. Maddur¹, Sébastien Lacroix-Desmazes¹, Jordan D. Dimitrov¹, Michel D. Kazatchkine², Jagadeesh Bayry¹, Srimi V. Kaveri¹

¹ Institut National de la Santé et de la Recherche Médicale; Centre de Recherche des Cordeliers; Sorbonne Université; Université Paris Descartes, Sorbonne Paris Cité, Paris, F-75006, France

²United Nations Special Envoy for AIDS in Eastern Europe and Central Asia, Geneva, Switzerland

Correspondence to: Srimi V Kaveri, Institut National de la Santé et de la Recherche Médicale Unité 1138, Centre de Recherche des Cordeliers, 15 rue de l'Ecole de Médecine, Paris, F-75006, France. Tel: 00 33 1 44 27 82 03; Fax: 00 33 1 44 27 81 94
E-mail: Srimi.Kaveri@crc.jussieu.fr

Sources of Funding: Supported by the Institut National de la Santé et de la Recherche Médicale (INSERM), Sorbonne Université, Université Paris Descartes France and the Indo-French Center for Promotion of Advanced Research (CEFIPRA) Project 5203-3.

Conflicts of Interests statement: The research on intravenous immunoglobulin is supported in part by grants from CSL Behring (France and Switzerland) and Laboratoire Français du Fractionnement et des Biotechnologies, France.

Total word count: 5279

Abstract: 243

Abstract

Natural antibodies (nAbs) are most commonly defined as immunoglobulins present in the absence of pathological conditions or deliberate immunizations. Occurrence of nAbs in germ- and antigen-free mice, suggest that their production is driven, at least in part, by self-antigens. Accordingly, nAbs are constituted of natural autoantibodies (nAAbs), and can belong to the IgM, IgG or IgA subclasses. These nAbs provide immediate protection against infection while the adaptive arm of the immune system mounts a specific and long-term response. Beyond immediate protection from infection, nAbs have been shown to play various functional roles in the immune system, which include clearance of apoptotic debris, suppression of autoimmune and inflammatory responses, regulation of B cell responses, selection of the B cell repertoire, and regulation of B cell development. These various functions of nAbs are afforded by their reactivity, which is broad, cross-reactive, and shown to recognize evolutionarily fixed epitopes shared between foreign and self-antigens. Furthermore, nAbs have unique characteristics that also contribute to their functional roles and set them apart from antigen-specific antibodies. In further support for the role of nAbs in the protection against infections and in the maintenance of immune homeostasis, the therapeutic preparation of polyclonal immunoglobulins, intravenous immunoglobulin (IVIG), rich in nAbs is commonly used in the replacement therapy of primary and secondary immunodeficiencies and in the immunotherapy of a large number of autoimmune and inflammatory diseases. Here we review several topics on nAbs features and functions, and therapeutic applications in human diseases.

Introduction

The successful treatment of diphtheria using immune serum by Emil Adolf von Behring and Émile Roux in the 19th century paved the way for discovery of antibodies in serum as gamma globulin proteins, and its basic structure was elucidated in the 20th century [1, 2]. There was a parallel expansion in the application of serum with anti-infection capabilities against other microbial diseases to confer immunity against dreadful pathogens, hence the name immunoglobulins (Igs) came into practice. Subsequently, thorough characterization of the antibodies produced following microbial infection or immunization, referred to as immune antibodies, was done [3]. Further studies identified varieties of Igs differing in their structure and function. These are divided into five classes/isotypes, namely IgG, IgM, IgA, IgE, and IgD [4]. Antibody production is the main function of differentiated B cells. Well established as effector molecules of the adaptive compartment, Abs also participate as links or organizing factors for certain functions of the innate immune system by identifying and neutralizing the pathogens in part through the triggering of Fc receptors (FcRs) and activation of the complement system [5].

In the early 1960s, the existence of circulating antibodies in neonates (cord blood) and healthy adults in the absence of exogenous antigen stimulation or deliberate immunization, referred to as natural antibodies (nAbs), was also identified [6]. Although the origin and function of nAbs have been the subject of age-old discussions, one hallmark of nAbs is that they can be found in germ- and antigen-free mice, observations which suggest that their production may be driven, at least in part, by self-antigens. However, it is also clear that exposure to microorganisms, either intentionally or environmentally derived, results in long-lasting effects on the clonal diversity of these Abs, their circulating levels, and ultimately their biological functions which include first

line defense as well as immunoregulatory activities. Here we review several topics on nAbs features and functions, and therapeutic applications in human diseases.

Source and origin of natural antibodies

Emerging information in mice: Despite the continued interest in nAbs since 1960s, the evidence for their cellular source began to emerge only after 1983, particularly in mice. A subset of B cells, named B-1 cells, was recognized as the source of nAbs. B-1 cells were initially identified by their expression of CD5 and were further characterized by surface expression of IgM^{high}, IgD^{low}, CD19^{high}, B220^{low}, CD23⁻, and CD43⁺, which contrasts with the surface phenotype of follicular B2 cells: CD5⁻, IgM^{low}, IgD^{high}, CD19⁺, B220⁺, CD23⁺, and CD43⁻ (Table. 1). Subsequently, an additional population of B-1 cells was identified, which shared the characteristics of CD5⁺ B1 but lacked CD5 expression. These two populations of B-1 cells are termed B-1a (CD5⁺) and B-1b (CD5⁻) cells [7, 8]. B-1 cells are found in various tissues of adult mice, including the peritoneal cavity, pleural cavity, spleen, bone marrow, lymph nodes and blood that contribute to greater than 90% of nAb [7]. Interestingly, B-1 cells located in the peritoneal cavity and pleural cavity serve as an important reservoir for B-1a cells and form a pool of long-lived, self-renewing B cells that produce most of the circulating natural IgM antibodies [9]. However, it has been suggested that within the B-1 cell population, those residing in the bone marrow and the spleen are the true nAb-secreting cells, whereas body cavity B-1 cells constitute a population of responder (memory type) lymphocytes, which after stimulation migrate and differentiate into IgM-secreting cells [8, 10]. In addition, a population of CD138⁺ B-1a cells and marginal zone B cells, subset of B-2 cells, are also found to produce nAbs in mice. Therefore, more than one B cell population is responsible for nAb production and not all subsets of B-1 cells spontaneously secrete nAbs that accumulate in serum, as some of the B-1 cells can

differentiate into antigen-induced antibody secreting cells (Table.1) [7]. It should be noted that, although B-cell receptor (BCR)-signaling is critical for B-1 cell development, BCR- and T cell-independent innate immune activation of B-1 cells in body cavities and marginal zone B cells (both referred to as innate-like B cells) can induce nAb production. These stimuli include IL-5, IL-10, toll-like receptor (TLR) agonists or whole bacteria that can alter the B-1 cell normal trafficking patterns and induce differentiation into cells that secrete large amounts of IgM and/or IgA. Furthermore, similar to phenotypic diversity, B-1 cells are also capable of differentiating into antigen-induced Ab-secreting cells [7]. Thus, the generalized concept of B-1 cells as source/producers of nAbs may not be a complete description. Nevertheless, extensive research points to the possibility that, at least in mice, nAbs can originate from multiple B cell subsets that arise at different times of development from a distinct progenitor cells [11]. Future studies should lead us to an understanding of the role of different source and origin (B cell subsets and their stimuli) of nAbs and its contribution to the nAb pool.

Evidence in humans: In line with mice, nAb secreting cells in humans were first identified as CD5⁺ peripheral B cells [12]. However, CD5⁻CD45RA_{lo} peripheral B cells were also found to produce natural IgM [8, 13]. Further, expression of surface CD5 on cord blood B cells is not a definitive marker of an auto/polyreactive population, and also CD5 may be an activation marker on human B cells. Notably, recent efforts based on natural/spontaneous antibody secretion refined the phenotypic characteristics of nAb-producing cells in human adult and cord blood as CD20⁺CD27⁺CD43⁺CD70⁻CD38_{mod}, the majority of which express CD5 and this is in contrast to the phenotype of plasmablasts: CD20⁻CD27^{high}CD38^{high} (immune Ab-secreting cells) and activated memory B cells: CD20⁺CD27⁺CD43⁺CD70⁺ (Table.1) [14, 15]. Interestingly, similar to mice, not all human B-1 cells spontaneously secrete nAbs, and polyclonal stimulation, like TLR9

ligand, CpG, increased the frequencies of antibody-secreting cells, a feature also seen in memory B cells [15] and transitional B cells [16]. Nevertheless, the phenotype of nAb-secreting cells in humans is still unclear, and further studies are required to clarify the specific types of cells capable of producing nAbs and also their locations other than in blood.

Characteristics and reactivity of natural antibodies

Classes of nAbs and generation in mice and humans: Natural antibodies in the circulation of normal healthy individual can be of IgM, IgG and IgA classes. However, studies in mice suggest that nAbs are mainly IgM, but also IgA, IgG3 and IgE types, and are proposed to be T-cell independent. Although nAbs are mainly germline-like in mice as evidenced by absence of non-templated nucleotides (N-additions during VDJ recombination) with minimum to no somatic hypermutation in VDJ of B-1a cells [17], nAbs with significantly more N-additions and hypermutations with isotype switching (IgM to IgG) are seen with increasing age [18]. Accordingly, IgG and IgA are also part of the nAb pool in mice, although, unlike serum natural IgM, their levels are dependent on exogenous antigen stimulation as evidenced by decreased amounts in germ-free mice [8]. Interestingly, unlike mice, IgM is not the only isotype present in the prenatal repertoire of human B cells. It was demonstrated that after 26 weeks of gestation, B cell clones encoding IgG start to appear in a frequency similar to a frequency observed in healthy infants [19]. Therefore, contrary to observations in mice, the nAb pool in humans contains IgM, IgG and IgA classes and exhibit similar reactivity in cord blood to that of adults. Furthermore, both fetal and adult derived human B cells express Ig with numerous N-additions in VDJ [8], and somatic hypermutations occur during human fetal B cell development even in a T cell-independent fashion [19]. However, there is no evidence in humans for T-cell dependency of nAb production, despite the presence of autoreactive T cells in healthy individuals, although

mainly with regulatory roles [20]. Autoreactive CD4⁺ T cells specific for a number of self-antigens, including myelin basic protein, the acetylcholine receptor, the thyroglobulin-stimulating hormone receptor and the gpIIbIIIa platelet antigen have been reported in healthy individuals. It has been also hypothesized that natural autoreactive B cells are endowed with some switching ability in the absence of cognate interactions with T cells, based on the finding of small amounts of IgG in the serum of CD40L-deficient patients with the hyper-IgM syndrome [21]. Thus, the mechanisms of generation of natural IgM, IgG and IgA antibodies are poorly understood and may differ from each other.

Characteristics of nAbs: In general, nAbs are characterized by their low affinity, high avidity and broad/multi reactivity against self-antigens (nAAbs), but some have the ability to recognize evolutionarily conserved epitopes occurring in foreign antigens (Figure. 1). In mice, prenatal B-1 cells express a mainly germ line–encoded repertoire, while postnatally developing B-1 cells can express Ig with a greater degree of variation [7]. Yet, the probability of nAb recognition of foreign structures as a result of cross-reactivity against self-antigens is still a hotly debated topic. However, it is being increasingly appreciated that nAAb production does not represent non-specific, antigen-independent 'leakage' of terminal B-cell differentiation, but the result of positive selection processes for autoreactive B cells dependent on the variable (V) region, resulting in low affinity reactivity directed at a set of evolutionarily conserved (auto)antigens, such as circulating antigens, cell surface and intracellular structures [20, 22]. These epitopes may exist constitutively or represent neoepitopes that result from altered glycosylation of host proteins or oxidation of host constituents. Targeting of these endogenous epitopes, which are usually sequestered from immunosurveillance, provides beneficial housekeeping functions [23]. Therefore, nAAbs are considered to be a manifestation of physiological autoreactivity expressed

in healthy individuals, and represent normal responses to self-antigens [20]. In line with this, it has been estimated that 5–15% of splenic B-cells activated in vivo can secrete nAbs [21] and up to 20% of circulating human B-cells are autoreactive [24].

Reactivities of nAbs: Notably, the well-characterized epitopes for nAbs to date are shared by pathogens and host, which include phospholipids, oxidized lipids, glycolipids, and glycoproteins, both in mice and humans. The best characterized B-1 cell-derived nAb binds the phospholipid phosphorylcholine (PC) and utilizes VHS107.1 [25]. PC is found within the bacterial cell wall of *Streptococcus pneumoniae* and is also exposed on apoptotic cells and oxidized lipids, but hidden in healthy cells [26]. Studies in mice revealed nAb binding to red blood cells treated with bromelain (that exposes phosphatidylcholine, PtC) were B-1 cell derived and utilized VH11, VH12 and Q52 [8]. Antibodies that recognize glycan epitopes are also highly abundant in both mice and humans. Glycan epitopes are observed on both glycoproteins and glycolipids and can be present in autologous or pathogen-associated exogenous structures. In mice, the specificities of such antibodies include α -1,3-glucan, N-acetyl-d-glucosamine, and α -1,3-galactose epitopes [27]. In humans, the best known anti-glycan antibodies react with blood group antigens A and B, the xenoantigen Gal-alpha-1, 3Gal-beta-1,4GlcNAc, Forssman glycolipid antigen, and gangliosides such as the tumor-associated antigen Neu5GcGM3 [8, 23].

Broad reactivity or polyreactivity of nAbs toward self and/or foreign antigens does not correlate with their connectivity (i.e., their ability to interact with variable regions of other autoantibodies) [Reviewed in [28]]. Polyreactivity does not suggest lack of specificity, but nAbs are “polyreactive” only in the sense that they bind the identical epitope on a variety of molecular entities and also feature their own distinct set of epitopic specificities. The notion that an antibody must be of high affinity in order to be biologically relevant originates primarily from

the analysis of the requirements for an efficient immune response against pathogens. This concept does not necessarily apply to natural antibodies. Accordingly, earlier literature suggested that nAbs might exhibit a broad range of affinities, with dissociation constants ranging between 10^{-5} and 10^{-8} M. However, advanced technologies to measure protein–protein interactions have shown that overall affinity of natural IgG autoantibodies specific for molecules such as HLA class I, CD4, the RGD (Arg-Gly-Asp tripeptide) motive and autologous blood group antigens, in the micromolar range [21].

The germ-line neonatal B-cell repertoire encoding IgM antibodies in the fetus has been evolutionarily selected for its reactivity with self-antigens. Interestingly, the self-reactive repertoire of IgG is established within the first 2–4 years of life and it is highly homogenous among children and similar to that expressed by the IgG of healthy young and older adults, whereas the repertoire of IgG (cross)-reactivities toward foreign and self-antigens is diverse and dependent on the history of each individual's immune system [Reviewed in [28]]. Therefore, it is now becoming clear that exposure to microorganisms, either intentionally or environmentally derived, results in long-lasting effects on the clonal diversity of these Abs, their circulating levels, and ultimately their biological functions which include first line defense as well as immunoregulatory activities [23].

Functions of natural antibodies

Several lines of evidence have clarified the evolutionarily conserved (cross-)reactivity of nAbs supporting an important physiological role in immune system [20], and hence multiple functions of nAbs have been postulated. Owing to its cross-reactivity to foreign antigens, nAbs neutralize microbes and microbial toxins, strongly suggesting a role for nAbs in natural host defense against infection. A major role for nAbs is in immune regulation, which include the removal of

senescent/altered self-molecules, cells, and tumors, and controlling untoward autoimmune responses, possibly by virtue of their ability to modify the functions of some of their target antigens. Indeed, it has been shown that antibodies from healthy individuals display a promiscuous hydrolytic activity, as opposed to more specific enzymatic activity of antigen-specific autoantibodies in patients with autoimmune diseases [Reviewed in [29]].

Natural antibodies as a first-line of defense against pathogens

The most relevant roles for infectious disease control are the ability of nAbs to provide protection against pathogens, and in the clearance of endotoxin. The first indication of the crucial role of nAbs in controlling infections came from the evidence that primary Ig-deficient patients display high susceptibility for recurrent infections from bacteria, virus, fungi, and parasites. In particular, nAbs have been shown to provide protection against *Streptococcus pneumoniae*, *Borrelia hermsii*, *influenza virus*, *Listeria monocytogenes*, *vesicular stomatitis virus*, *lymphocytic choriomeningitis virus*, *Cryptococcus neoformans*, *Pneumocystis murina*, and *Francisella tularensis* [Reviewed in [8]]. Such protection is afforded by virtue of nAbs' cross-reactivity towards ubiquitous bacterial antigens/epitope recognition. For example, in mice, nAbs to phosphocholine can protect against intravenous infection with type 3 *Streptococcus pneumoniae* [30].

Studies using mice and human sera antibodies suggest that anti-microbial nAbs are mainly of IgM isotype (Figure. 2), and act by virtue of the ability of polyclonal nIgM to directly recognize a wide range of Pathogen Associated Molecular Patterns (PAMPs) that leads to inhibition of the growth of microbial pathogens through their direct neutralization, by activation of the classical complement pathway to inhibit bacterial growth by lysis, generation of anaphylatoxin C5a, enhancement of phagocytosis, neutralization of the functional activity of endotoxin, and

amplification of humoral immune responses, leading to the enhanced phagocytosis of these opsonized pathogens [31–33]. Mice deficient in natural IgM might be less resistant to viral infection or also succumb to infections as a result of a lack of pathogen clearance, decreased neutrophil recruitment, and elevated proinflammatory serum cytokines [32, 34].

In addition, nAbs also alert and prime the adaptive immune system against subsequent pathogen attack and are essential in the induction of an immune response that protects against bacterial and viral pathogens. The IgG response to T-cell dependent antigens was impaired in IgM-deficit mice, which can be rescued by administration of normal IgM prior to immunization [35]. For example, lack of natural anti-influenza IgM leads to delayed T-cell-dependent IgG2a response and increased mortality in mice [36]. Several mechanisms may be involved in this function of nAbs. The formation of immune complexes by nAbs can direct Ags to the secondary lymphoid organs, where presentation to T and B-cells is efficient. nAbs may guide the ensuing functional polarization of T cell responses, as well the isotype class-switch recombination of the induced B cell response and the induction of long-term immune memory. IgM immune complexes with pathogens bind complement that in turn binds to complement receptors on DCs and B-cells [34, 37]. It is known that crosslinking the complement receptor2 (CR2) reduces the triggering threshold of B-cells. By allowing simultaneous engagement of BCR and the CD21/CD19, nAbs may therefore lower the threshold of B-cell activation. Furthermore, virus/nAb complexes with increasing particle size enhance phagocytosis by macrophages in a CR3- and CR4-dependent fashion, which can now present virus-derived peptides to T-cells. Finally, polymeric IgM nAbs can crosslink the BCR on B-cells that have already captured antigen (Figure. 2) [Reviewed in [28]].

Interestingly, in contrast to the direct recognition of microbes by nIgM, recent *in vitro* studies have revealed that natural IgG purified from uninfected/healthy human serum recognized a range of gram-negative (eg. *Pseudomonas aeruginosa*) and gram-positive (eg. *Staphylococcus aureus*) bacteria with the aid of serum lectin innate receptors (e.g., ficolin and Mannan-binding lectin, MBL), which are known to bind to sugar residues (e.g., N-acetylglucosamine) on the microbes. The partnership between natural IgG and lectins (prebound on the microbe) efficiently drive phagocytosis of the bacteria via the Fc γ R1 receptor on human monocytes [38]. Furthermore, the interaction between natural IgG (CH2-CH3 domain on Fc) with ficolin (P-subdomain of FBG domain) can be triggered under infection–inflammation conditions to augment the immune response [39].

As previously discussed, exposure to microorganisms that have antigenic epitopes similar to that of self-antigens, influences the clonal diversity of nAbs. It is proposed that neonatal exposure to conserved epitopes (host and bacterial cells and other common environmental allergens) reprograms the natural antibody repertoire directed toward these antigens by clonal expansion, alterations in clonal dominance, and increased serum antibody levels. For example, the production of nAbs to N-acetyl-D-glucosamine (GlcNAc) shared with bacterial polysaccharide (PS) substantially increases in humans with neonatal infection of pneumococcus or group A streptococcus (GAS) levels. This has been demonstrated to provide protection against diverse pathogenic organisms that may be relevant to the development of allergic diseases. The proposed mechanisms of neonatal microbial exposure-induced protection against allergic airway inflammation is by engaging epitopes common to multiple allergens, including GlcNAc (chitin), PC, and glucans, and this leads to interruption of microorganism–innate receptor interactions, which can result in an attenuated allergic airway response to fungi-, house dust mite-, and

cockroach-associated allergens as seen in mouse models. Here, nAbs may abrogate the recognition of these moieties with innate receptors, which recognize the allergens and promote immune activation that results in sensitization [23]. However, significant protection against airway sensitization is dependent on the timing of induction and the antigenic targets of these Abs. The similarities between the murine and human natural antibody repertoires suggest that reduced microbial exposure in children may have the opposite effect, providing a potential mechanistic explanation for the hygiene hypothesis. In line with this, it is suggested that understanding the effects of childhood infections on the natural antibody repertoire and the mechanisms of antibody-mediated immune regulation observed in allergy models will lead to the development of prevention/interventional strategies for treatment of allergic asthma [23].

In further support for the role of nAbs in protection against infections, the therapeutic preparation of polyclonal immunoglobulins, intravenous immunoglobulin (IVIG), rich in nAbs is commonly used for antibody replacement therapy in primary and secondary immunodeficiency patients [40]. Routinely, IVIG (400 mg/kg) is used in patients with X-linked agammaglobulinaemia (XLA), common variable immunodeficiency (CVID), X-linked hyper-IgM, severe combined immunodeficiency, Wiskott-Aldrich syndrome, and selective IgG class deficiencies (Table. 2) [40]. Variations in the processing of IVIG products and the geographical location of plasma donors might influence the efficacy of IVIG in immunodeficiency [41]. Interestingly, several lines of experimental and clinical evidence gathered in recent years reveal that therapeutic benefits of IVIG therapy extend beyond the mere anti-infective mechanisms via passive transfer of antibodies into the active role of immune homeostasis even in immunodeficiency [29, 40, 42–45].

Natural antibodies in tissue homeostasis and immune tolerance

nAbs may have first arisen to reinforce an important goal of maintaining homeostasis. In line with this, as noted previously, the repertoire of nAbs is dominated by self-reactive ones (nAAbs) and contributes/mediates the immune regulatory functions of nAbs in physiology, and also the disease ameliorative effects of therapeutic immunoglobulin (IVIg) in autoimmune and inflammatory disorders. Interestingly, antibody immunodeficiencies are also associated with autoimmunity and inflammatory conditions, suggestive of a dysregulated immune status, thus supporting the role for nAbs in immune tolerance and maintaining tissue homeostasis [46].

Natural IgM (nIgM): role of nAbs in apoptosis and immune regulation: Apoptosis is an obligatory outcome of development, proliferation, and cell differentiation that continues throughout life. Every day, $>10^{11}$ cells in our body die by apoptosis, and therefore, apoptotic cell (AC) clearance is essential for tissue homeostasis. In health, ACs do not pose an immediate threat to the host, as there are redundant means mediated by soluble innate immune molecules, such as complement C1q, mannose-binding lectin (MBL) and nAbs to ensure rapid and efficient cell corpse clearance by macrophages and dendritic cells (DCs) [47]. If efficiency of AC clearance is limited, there can be progression to secondary necrosis and the ensuing release of nuclear Ags and other components of dying cells (danger-associated molecular patterns, DAMPS), which are believed to activate pattern-recognition receptors (PRRs) of innate immune cells that include TLR, leading to inflammatory responses. Necrotic cells can also release autoantigens that can select pathogenic B and T cell clones, which together can lead to the development of autoimmune disease in predisposed individuals [47, 48].

Newborn humans and naïve mice have considerable levels of nIgM that recognize AC membranes (ACMs), whereas even higher levels can be induced by intravenous infusions of

large numbers of ACs [49, 50]. Furthermore, experimental models have shown that suppression of inflammatory arthritis mediated by ACs may require nIgM that can directly inhibit macrophage and DC activation [49] and may also promote IL-10-secreting B and T cells [51]. It is observed that these effects are facilitated mainly by nAbs to the oxidation-associated phosphorylcholine (PC) and malondialdehyde (MDA) neodeterminants on ACMs, which can distinguish healthy versus apoptotic cells [50]. Therefore, nIgM directed against PC and MDA can have two major regulatory functions, enhanced clearance of ACs by phagocytes (termed efferocytosis); and direct suppression of proinflammatory responses induced by agonists for TLR3, TLR4, TLR7, and TLR9 and likely many other innate pathways [49, 50]. In consensus with murine studies, observations in patients with systemic lupus erythematosus highlighted the association of nIgM levels in protection against autoimmunity. For example, decreased levels of anti-PC IgM Abs are characteristic features of active lupus compared with the disease in remission [52]. Therefore nIgM, through clearance of apoptotic cells, may serve as regulators of the innate immune system to help maintain homeostasis and, in certain cases, suppress the development of inflammatory and autoimmune diseases [Reviewed in [53]].

Furthermore, nIgM is also implicated in suppression of disease-associated IgG autoantibody production, since insufficiency of serum IgM may predispose humans for the development of IgG autoantibodies [54]. It has also been argued that the protective effect of IgM may at times involve anti-idiotypic (i.e., targeting of the Ag receptors of some clonally related lymphocytes) downregulation of some autoimmune responses or result from the induction by some IgM anti-idiotypic Abs of apoptotic death of pathogenic B cell clones or the selection of other protective B cell subsets. Another important role of nIgM in tissue homeostasis implicates clearance of altered or malignant cells via complement-dependent cell lysis and induction of apoptosis [55]. The

maintenance of tissue homeostasis by nIgM may also involve the enhanced clearance of misfolded proteins, which could have clinical implications for conditions like Alzheimer's disease in which pathogenesis results from the deposition of misfolded proteins such as β -amyloid plaques in the brain (Figure. 2) [Reviewed in [53]].

Normal human plasma contains a substantial amount of nIgM, An IgM-enriched Ig preparation, Pentaglobin® that contains 12% IgM has been successfully used for treating infections associated with sepsis in patients, as well as transplant rejection, and for certain inflammatory conditions in experimental models [53, 56]. Such preparations may also provide benefits to combat infections that arise in patients with autoimmune disease [57]. Interestingly, a natural human mAb, IgM22 that binds to oligodendrocytes and promotes their remyelination was recently tested in human clinical trial, and has demonstrated safe profiles [53].

Natural IgG (nIgG): role of nAbs in immune tolerance/homeostasis: As mentioned previously, in addition to nIgM, IgG also constitute a major portion of nAbs (as nAAbs). There is little information on direct demonstration of the functions of nAbs in immune homeostasis. However, most of the functions that have been attributed to IgG nAbs are deduced from the wide range of observed effects of IVIG when administered to patients with autoimmune and inflammatory situations [29, 58]. IVIG symbolizes a complete repertoire of normal circulating IgG. The distribution of IgG subclasses and IgG glycosylation patterns in IVIG generally overlaps with normal human plasma/serum. Although a single donor might lack certain individual IgG specificities, it is likely to be compensated in IVIG because of pooling of plasma. As IVIG is nothing but pooled IgG from normal donors, the effect of IVIG likely represents a primordial function of circulating nIgG in regulating immune homeostasis [59]. Natural antibodies and natural autoantibodies with low to medium affinity are likely to be the major active components

of IVIG, but these specificities are not in high frequencies. Thus, given the altered physiology in autoimmune patients, it is conceivable that these natural autoantibodies are needed at higher amounts than those present in the normal circulation of a donor.

IVIG is prepared from pools of plasma obtained from several thousand healthy blood donors, and hence IVIG represents a privileged source of nAbs (nAAbs) [60]. Although initially conceived for the IgG replacement therapy of primary and secondary immunodeficiencies, following successful use of IVIG in immune thrombocytopenic purpura (ITP) by Paul Imbach [61], high-dose IVIG (1–2 g/kg) is now used for the immunotherapy of many autoimmune and inflammatory diseases including Guillain–Barré syndrome, Kawasaki disease, myositis, immune thrombocytopenic purpura, chronic inflammatory demyelinating polyradiculoneuropathy, and many others [42, 62, 63]. Newer indications are continuously being explored, and IVIG is currently used in more than 100 different diseases in an off-label manner (Table. 2) [42, 58, 64]. As discussed below, numerous mutually non-exclusive mechanisms may play role in the beneficial effect of IVIG therapy in these diseases. The success of IVIG in these wide-range pathologies provides strong arguments for the therapeutic value of nIgG.

The effective immunotherapy of autoimmune and inflammatory diseases using IVIG also led to the investigation of cellular and molecular mechanisms of action [65]. Autoimmune and inflammatory diseases are characterized by abnormal activation of the cells of innate and adaptive immune compartments and release of inflammatory mediators. The emerging evidence suggests that IVIG targets various arms of the immune system, culminating in inhibition of inflammatory cells and soluble mediators while reciprocally enhancing immune regulatory cells and their functions. Several mechanisms of action for IVIG have been proposed since its first successful therapeutic use in ITP [3]. It was thought initially that IVIG exerts a beneficial effect

in autoimmune disease patients via saturation/blockade of Fc receptors on phagocytes such as monocytes and macrophages and reduces the immune complex-mediated activation of these innate cells [59, 66]. In addition, saturation of FcRn (neonatal Fc receptor), a protective receptor that prevents the catabolism of IgG, by IVIG is implicated in accelerated clearance of pathogenic antibodies and has a role at least in the initial phase of ameliorative effects of IVIG [65, 67]. IVIG has also been shown to neutralize pathogenic autoantibodies by anti-idiotypic Abs against idiotypes expressed by disease-associated autoantibodies (to factor VIII, acetylcholine receptor, thyroglobulin, DNA and others) and by inhibiting autoantibody production by binding to autoreactive B lymphocytes [59, 65, 68]. Further, binding of IVIG to C3b and C4b fragments of complement, thereby inhibiting their tissue deposition as well as generation of the C5 convertase, and hampering the subsequent formation of C5-C9 membrane attack complex, as a consequence, prevents complement-mediated cell death and tissue damage. Additionally, IVIG neutralizes C3a and C5a anaphylatoxins via a F(ab')₂-mediated mechanism [62, 69]. IVIG also contains an array of anti-cytokine antibodies against various inflammatory cytokines, including granulocyte-macrophage colony-stimulating factor (GM-CSF), B-cell activating factor (BAFF) that can dampen inflammatory process [59, 70, 71].

Interestingly, F(ab')₂ and Fc portions of IVIG can inhibit lymphocyte (B and T cells) proliferative responses and modulate inflammatory cytokines [63, 72, 73]. In addition, IVIG can also induce apoptosis of mononuclear cells implicating death receptor Fas [74], polymorphonuclear cells via Siglec [75], and also conversely block of Fas in toxic epidermal necrolysis to inhibit apoptosis [76]. IVIG also normalizes the functions of DCs and other innate immune cells [43, 77, 78]. Further, IVIG induces expansion of regulatory T cells (Tregs) and reciprocally inhibits Th17 cells [79, 80, 89, 81–88]. Interestingly, recent studies in mouse models

suggest that α -(2, 6) sialylated Fc of IVIG signals through type II lectin receptors to enhance inhibitory Fc γ RIIB on effector macrophages via basophil-secreted IL-4 and induce Tregs by dendritic cell-specific intercellular adhesion molecule-3-grabbing nonintegrin (DC-SIGN)-induced IL-33 secretion [90, 91]. However, translation of these findings to humans failed to recapitulate the mechanisms although requirement of sialylation has been confirmed in other experimental models [78, 79, 82, 83, 88, 89, 92]. Studies in humans have revealed that IVIG can directly interact with basophils to induce IL-4 secretion, and can act either directly on Tregs or on DCs to expand Tregs [46, 65, 93–96].

In summary, IVIG can interfere at all steps of immune response from the early initiation phase to the later effector phase that leads to clinical disease (Figure. 3). Accordingly, binding of nAAbs to antigens contributes to their internalization by antigen-presenting cells and thus modulates the processing of antigens and their subsequent presentation to T cells. Of particular interest for the dissection of the effects of IVIG in autoimmune diseases, is the role of nAAbs in the inhibition of soluble mediators of inflammation (including complements and cytokines), maintenance of cellular homeostasis, in preventing the expansion of specific autoreactive clones of T and B cells, and in the ability of nAAbs to regulate self-reactivity (pathogenic autoantibodies). Thus, the mechanisms of action of IVIG are complex and unlike other specific antibody-based therapies that are either in clinic or in development [97-102], a single mechanism might not account for its therapeutic benefit in autoimmune diseases [42, 65, 103].

In line with the immune modulatory effects of IgG and IgM nAbs, other subclasses of normal Igs, particularly IgA, have been explored. Preclinical evaluation of pooled IgA (analogous to IVIG) provided evidence that normal IgA also ameliorates inflammation and hence demands further clinical evaluation [104, 105].

Conclusions

Natural antibodies are distinct from pathogenic-specific immune antibodies and pathologic autoantibodies (Table. 3). Notably, nAbs can exert immune modulatory function as evidenced by activating as well as inhibitory effects based on the host immune status (immunodeficiency versus inflammatory). This phenomenon is similar to the diverse effects of B cells (source of Abs/nAbs) on different immune cells, e.g. DCs, depending on the activation stimuli [106-110]. More than half of the nascent B cells in humans initially express autoreactive antibodies. However, most of these autoantibodies are removed from the repertoire at two checkpoints before maturation into naive B cells. A third checkpoint excludes remaining autoantibodies from the antigen-experienced IgM⁺ and IgG⁺ memory B cell pool [111, 112]. Nevertheless, low-affinity self-reactive antibodies of all classes IgM, IgG and IgA are frequently found in the serum of normal individuals. However, little attention has been paid to their role in immune responses or how their production can be manipulated to the host's advantage [113, 114]. The inordinate focus on the dogma that high affinity IgG response is the goal of immunization and that so-called sticky, low-affinity Abs should be avoided is the primary reason for this dearth of information. Recent investigations in the field should lead to more focus on the functions of this first-line component of the adaptive immune response.

References

1. Macnalty AS (1954) Emil von Behring, born March 15, 1854. *Br Med J* 1:668–70
2. Marrack JR (1933) The chemistry of antigens and antibodies. *J Phys Chem* 38:989–989. <https://doi.org/10.1021/j150358a015>
3. João C, Negi VS, Kazatchkine MD, et al (2018) Passive serum therapy to immunomodulation by IVIG: a fascinating journey of antibodies. *J Immunol* 200:1957–1963. <https://doi.org/10.4049/jimmunol.1701271>
4. Black CA (1997) A brief history of the discovery of the immunoglobulins and the origin of the modern immunoglobulin nomenclature. *Immunol Cell Biol* 75:65–68. <https://doi.org/10.1038/icb.1997.10>
5. Dunkelberger JR, Song W-C (2010) Complement and its role in innate and adaptive immune responses. *Cell Res* 20:34–50. <https://doi.org/10.1038/cr.2009.139>
6. Boyden S V. (1966) Natural Antibodies and the Immune Response. *Adv Immunol* 5:1–28. [https://doi.org/10.1016/S0065-2776\(08\)60271-0](https://doi.org/10.1016/S0065-2776(08)60271-0)
7. Baumgarth N (2011) The double life of a B-1 cell: self-reactivity selects for protective effector functions. *Nat Rev Immunol* 11:34–46. <https://doi.org/10.1038/nri2901>
8. Holodick NE, Rodríguez-Zhurbenko N, Hernández AM (2017) Defining natural antibodies. *Front Immunol* 8:872. <https://doi.org/10.3389/fimmu.2017.00872>
9. Kawahara T, Ohdan H, Zhao G, et al (2003) Peritoneal cavity B cells are precursors of splenic IgM natural antibody-producing cells. *J Immunol* 171:5406–14. <https://doi.org/10.4049/JIMMUNOL.171.10.5406>
10. Baumgarth N, Waffarn EE, Nguyen TTT (2015) Natural and induced B-1 cell immunity to infections raises questions of nature versus nurture. *Ann N Y Acad Sci* 1362:188–199. <https://doi.org/10.1111/nyas.12804>
11. Montecino-Rodriguez E, Dorshkind K (2012) B-1 B Cell Development in the Fetus and Adult. *Immunity* 36:13–21. <https://doi.org/10.1016/j.immuni.2011.11.017>
12. Casali P, Notkins AL (1989) CD5+ B lymphocytes, polyreactive antibodies and the human B-cell repertoire. *Immunol Today* 10:364–368. [https://doi.org/10.1016/0167-5699\(89\)90268-5](https://doi.org/10.1016/0167-5699(89)90268-5)
13. Kasaian MT, Ikematsu H, Casali P (1992) Identification and analysis of a novel human surface CD5- B lymphocyte subset producing natural antibodies. *J Immunol* 148:2690–702
14. Griffin DO, Holodick NE, Rothstein TL (2011) Human B1 cells in umbilical cord and adult peripheral blood express the novel phenotype CD20+CD27+CD43+CD70-. *J Exp Med* 208:67–80. <https://doi.org/10.1084/jem.20101499>
15. Quách TD, Rodríguez-Zhurbenko N, Hopkins TJ, et al (2016) Distinctions among circulating antibody-secreting cell populations, including B-1 cells, in human adult peripheral blood. *J Immunol* 196:1060–1069. <https://doi.org/10.4049/jimmunol.1501843>
16. Capolunghi F, Cascioli S, Giorda E, et al (2008) CpG drives human transitional B cells to terminal differentiation and production of natural antibodies. *J Immunol* 180:800–808. <https://doi.org/10.4049/JIMMUNOL.180.2.800>

17. Desiderio S V, Yancopoulos GD, Paskind M, et al Insertion of N regions into heavy-chain genes is correlated with expression of terminal deoxytransferase in B cells. *Nature* 311:752–755
18. Yang Y, Wang C, Yang Q, et al (2015) Distinct mechanisms define murine B cell lineage immunoglobulin heavy chain (IgH) repertoires. *Elife* 4:e09083. <https://doi.org/10.7554/eLife.09083>
19. Rechavi E, Lev A, Lee YN, et al (2015) Timely and spatially regulated maturation of B and T cell repertoire during human fetal development. *Sci Transl Med* 7:276ra25-276ra25. <https://doi.org/10.1126/scitranslmed.aaa0072>
20. Coutinho A, Kazatchkine MD, Avrameas S (1995) Natural autoantibodies. *Curr Opin Immunol* 7:812–818. [https://doi.org/10.1016/0952-7915\(95\)80053-0](https://doi.org/10.1016/0952-7915(95)80053-0)
21. Lacroix-Desmazes S, Kaveri S V, Mouthon L, et al (1998) Self-reactive antibodies (natural autoantibodies) in healthy individuals. *J Immunol Methods* 216:117–137. [https://doi.org/10.1016/S0022-1759\(98\)00074-X](https://doi.org/10.1016/S0022-1759(98)00074-X)
22. Hayakawa K, Asano M, Shinton SA, et al (1999) Positive selection of natural autoreactive B cells. *Science* 285:113–116. <https://doi.org/10.1126/science.285.5424.113>
23. Kearney JF, Patel P, Stefanov EK, King RG (2015) Natural antibody repertoires: development and functional role in inhibiting allergic airway disease. *Annu Rev Immunol* 33:475–504. <https://doi.org/10.1146/annurev-immunol-032713-120140>
24. Wardemann H, Yurasov S, Schaefer A, et al (2003) Predominant Autoantibody Production by Early Human B Cell Precursors. *Science* 301:1374–1377. <https://doi.org/10.1126/science.1086907>
25. Feeney AJ (1991) Predominance of the prototypic T15 anti-phosphorylcholine junctional sequence in neonatal pre-B cells. *J Immunol* 147:4343–50
26. Binder CJ, Hörkkö S, Dewan A, et al (2003) Pneumococcal vaccination decreases atherosclerotic lesion formation: molecular mimicry between *Streptococcus pneumoniae* and oxidized LDL. *Nat Med* 9:736–743. <https://doi.org/10.1038/nm876>
27. New JS, King RG, Kearney JF (2016) Manipulation of the glycan-specific natural antibody repertoire for immunotherapy. *Immunol. Rev.* 270:32–50
28. Bayry J, Misra N, Dasgupta S, et al (2005) Natural autoantibodies: immune homeostasis and therapeutic intervention. *Expert Rev Clin Immunol* 1:213–222. <https://doi.org/10.1586/1744666X.1.2.213>; [10.1586/1744666X.1.2.213](https://doi.org/10.1586/1744666X.1.2.213)
29. Kaveri S V (2012) Intravenous immunoglobulin: exploiting the potential of natural antibodies. *Autoimmun Rev* 11:792–4. <https://doi.org/10.1016/j.autrev.2012.02.006>
30. Briles DE, Nahm M, Schroer K, et al (1981) Antiphosphocholine antibodies found in normal mouse serum are protective against intravenous infection with type 3 streptococcus pneumoniae. *J Exp Med* 153:694–705. <https://doi.org/10.1084/JEM.153.3.694>
31. Zhou Z-H, Zhang Y, Hu Y-F, et al (2007) The broad antibacterial activity of the natural antibody repertoire is due to polyreactive antibodies. *Cell Host Microbe* 1:51–61. <https://doi.org/10.1016/j.chom.2007.01.002>
32. Ochsenbein AF, Fehr T, Lutz C, et al (1999) Control of early viral and bacterial distribution and disease by natural antibodies. *Science* 286:2156–2159. <https://doi.org/10.1126/science.286.5447.2156>

33. Heyman B (2000) Regulation of antibody responses via antibodies, complement, and Fc receptors. *Annu Rev Immunol* 18:709–737. <https://doi.org/10.1146/annurev.immunol.18.1.709>
34. Boes M, Prodeus AP, Schmidt T, et al (1998) A critical role of natural immunoglobulin M in immediate defense against systemic bacterial infection. *J Exp Med* 188:2381–2386. <https://doi.org/10.1084/JEM.188.12.2381>
35. Ehrenstein MR, O’Keefe TL, Davies SL, Neuberger MS (1998) Targeted gene disruption reveals a role for natural secretory IgM in the maturation of the primary immune response. *Proc Natl Acad Sci U S A* 95:10089–10093. <https://doi.org/10.1073/PNAS.95.17.10089>
36. Baumgarth N, Herman OC, Jager GC, et al (2000) B-1 and B-2 cell-derived immunoglobulin M antibodies are nonredundant components of the protective response to influenza virus infection. *J Exp Med* 192:271–280. <https://doi.org/10.1084/JEM.192.2.271>
37. Boes M (2000) Role of natural and immune IgM antibodies in immune responses. *Mol Immunol* 37:1141–1149. [https://doi.org/10.1016/S0161-5890\(01\)00025-6](https://doi.org/10.1016/S0161-5890(01)00025-6)
38. Panda S, Zhang J, Tan NS, et al (2013) Natural IgG antibodies provide innate protection against ficolin-opsonized bacteria. *EMBO J* 32:2905–2919. <https://doi.org/10.1038/emboj.2013.199>
39. Panda S, Zhang J, Yang L, et al (2015) Molecular interaction between natural IgG and ficolin – mechanistic insights on adaptive-innate immune crosstalk. *Sci Rep* 4:3675. <https://doi.org/10.1038/srep03675>
40. Kaveri S V., Maddur MS, Hegde P, et al (2011) Intravenous immunoglobulins in immunodeficiencies: more than mere replacement therapy. *Clin Exp Immunol* 164:2–5. <https://doi.org/10.1111/j.1365-2249.2011.04387.x>
41. Roifman CM, Schroeder H, Berger M, et al (2003) Comparison of the efficacy of IGIV-C, 10% (caprylate/chromatography) and IGIV-SD, 10% as replacement therapy in primary immune deficiency: A randomized double-blind trial. *Int Immunopharmacol* 3:1325–1333. [https://doi.org/10.1016/S1567-5769\(03\)00134-6](https://doi.org/10.1016/S1567-5769(03)00134-6)
42. Perez EE, Orange JS, Bonilla F, et al (2017) Update on the use of immunoglobulin in human disease: A review of evidence. *J Allergy Clin Immunol* 139:S1–S46. <https://doi.org/10.1016/J.JACI.2016.09.023>
43. Bayry J, Lacroix-Desmazes S, Donkova-Petrini V, et al (2004) Natural antibodies sustain differentiation and maturation of human dendritic cells. *Proc Natl Acad Sci U S A* 101:14210–5. <https://doi.org/10.1073/pnas.0402183101>
44. Bayry J, Lacroix-Desmazes S, Kazatchkine MD, Kaveri S V (2004) Intravenous immunoglobulin for infectious diseases: back to the pre-antibiotic and passive prophylaxis era? *Trends Pharmacol Sci* 25:306–310. <https://doi.org/10.1016/j.tips.2004.04.002>
45. Bayry J, Fournier EM, Maddur MS, et al (2011) Intravenous immunoglobulin induces proliferation and immunoglobulin synthesis from B cells of patients with common variable immunodeficiency: A mechanism underlying the beneficial effect of IVIg in primary immunodeficiencies. *J Autoimmun* 36:9–15. <https://doi.org/10.1016/j.jaut.2010.09.006>

46. Maddur MS, Kaveri SV, Bayry J (2017) Circulating normal IgG as stimulator of regulatory T cells: lessons from intravenous immunoglobulin Trends Immunol. 38:789–792. <https://doi.org/10.1016/j.it.2017.08.008>
47. Elliott MR, Ravichandran KS (2010) Clearance of apoptotic cells: implications in health and disease. J Cell Biol 189:1059–70. <https://doi.org/10.1083/jcb.201004096>
48. Manderson AP, Botto M, Walport MJ (2004) The Role of complement in the development of systemic lupus erythematosus. Annu Rev Immunol 22:431–456. <https://doi.org/10.1146/annurev.immunol.22.012703.104549>
49. Chen Y, Khanna S, Goodyear CS, et al (2009) Regulation of dendritic cells and macrophages by an anti-apoptotic cell natural antibody that suppresses TLR responses and inhibits inflammatory arthritis. J Immunol 183:1346–1359. <https://doi.org/10.4049/jimmunol.0900948>
50. Chen Y, Park Y-B, Patel E, Silverman GJ (2009) IgM antibodies to apoptosis-associated determinants recruit C1q and enhance dendritic Cell phagocytosis of apoptotic cells. J Immunol 182:6031–6043. <https://doi.org/10.4049/JIMMUNOL.0804191>
51. Notley CA, Brown MA, Wright GP, Ehrenstein MR (2011) Natural IgM is required for suppression of inflammatory arthritis by apoptotic cells. J Immunol 186:4967–4972. <https://doi.org/10.4049/jimmunol.1003021>
52. Anania C, Gustafsson T, Hua X, et al (2010) Increased prevalence of vulnerable atherosclerotic plaques and low levels of natural IgM antibodies against phosphorylcholine in patients with systemic lupus erythematosus. Arthritis Res Ther 12:R214. <https://doi.org/10.1186/ar3193>
53. Kaveri S V., Silverman GJ, Bayry J (2012) Natural IgM in immune equilibrium and harnessing their therapeutic potential. J Immunol 188:939–945. <https://doi.org/10.4049/JIMMUNOL.1102107>
54. Ehrenstein MR, Cook HT, Neuberger MS (2000) Deficiency in serum immunoglobulin (Ig)M predisposes to development of IgG autoantibodies. J Exp Med 191:1253–8. <https://doi.org/10.1084/JEM.191.7.1253>
55. Schwartz-Albiez R, Laban S, Eichmüller S, Kirschfink M (2008) Cytotoxic natural antibodies against human tumours: An option for anti-cancer immunotherapy? Autoimmun Rev 7:491–495. <https://doi.org/10.1016/J.AUTREV.2008.03.012>
56. Norrby-Teglund A, Haque KN, Hammarström L (2006) Intravenous polyclonal IgM-enriched immunoglobulin therapy in sepsis: a review of clinical efficacy in relation to microbiological aetiology and severity of sepsis. J Intern Med 260:509–516. <https://doi.org/10.1111/j.1365-2796.2006.01726.x>
57. Maddur MS, Vani J, Lacroix-Desmazes S, et al (2010) Autoimmunity as a predisposition for infectious diseases. PLoS Pathog 6:e1001077. <https://doi.org/10.1371/journal.ppat.1001077>
58. Gilardin L, Bayry J, Kaveri S V (2015) Intravenous immunoglobulin as clinical immune-modulating therapy. CMAJ 187:257–264. <https://doi.org/10.1503/cmaj.130375>
59. Kazatchkine MD, Kaveri S V. (2001) Immunomodulation of autoimmune and inflammatory diseases with intravenous immune globulin. N Engl J Med 345:747–755. <https://doi.org/10.1056/NEJMra993360>

60. Seite J-F, Shoenfeld Y, Youinou P, Hillion S (2008) What is the contents of the magic draft IVIg? *Autoimmun Rev* 7:435–439. <https://doi.org/10.1016/J.AUTREV.2008.04.012>
61. Imbach P, d'Apuzzo V, Hirt A, et al (1981) High-dose intravenous gammaglobulin for idiopathic thrombocytopenic purpura in childhood. *Lancet* 317:1228–1231. [https://doi.org/10.1016/S0140-6736\(81\)92400-4](https://doi.org/10.1016/S0140-6736(81)92400-4)
62. Lünemann JD, Nimmerjahn F, Dalakas MC (2015) Intravenous immunoglobulin in neurology—mode of action and clinical efficacy. *Nat Rev Neurol* 11:80–89. <https://doi.org/10.1038/nrneurol.2014.253>
63. Gelfand EW (2012) Intravenous immune globulin in autoimmune and inflammatory diseases. *N Engl J Med* 367:2015–2025. <https://doi.org/10.1056/NEJMr1009433>
64. Sewell WAC, Kerr J, Behr-Gross M-E, Peter H-H (2014) European consensus proposal for immunoglobulin therapies. *Eur J Immunol* 44:2207–2214. <https://doi.org/10.1002/eji.201444700>
65. Galeotti C, Kaveri S V, Bayry J (2017) IVIG-mediated effector functions in autoimmune and inflammatory diseases. *Int Immunol* 29:491–498. <https://doi.org/10.1093/intimm/dxx039>
66. Nimmerjahn F, Ravetch J V. (2007) The antiinflammatory activity of IgG: the intravenous IgG paradox. *J Exp Med* 204:11–15. <https://doi.org/10.1084/JEM.20061788>
67. Akilesh S, Petkova S, Sproule TJ, et al (2004) The MHC class I-like Fc receptor promotes humorally mediated autoimmune disease. *J Clin Invest* 113:1328–33. <https://doi.org/10.1172/JCI18838>
68. Rossi F, Dietrich G, Kazatchkine MD (1989) Anti-idiotypes against autoantibodies in normal immunoglobulins: Evidence for network regulation of human autoimmune responses. *Immunol Rev* 110:135–149. <https://doi.org/10.1111/j.1600-065X.1989.tb00031.x>
69. Basta M, Dalakas MC (1994) High-dose intravenous immunoglobulin exerts its beneficial effect in patients with dermatomyositis by blocking endomysial deposition of activated complement fragments. *J Clin Invest* 94:1729–35. <https://doi.org/10.1172/JCI117520>
70. Le pottier L, Bendaoud B, Dueymes M, et al (2007) BAFF, a new target for intravenous immunoglobulin in autoimmunity and cancer. *J Clin Immunol* 27:257–265. <https://doi.org/10.1007/s10875-007-9082-2>
71. Watanabe M, Uchida K, Nakagaki K, et al (2007) Anti-cytokine autoantibodies are ubiquitous in healthy individuals. *FEBS Lett* 581:2017–2021. <https://doi.org/10.1016/J.FEBSLET.2007.04.029>
72. Séité J-F, Goutsmedt C, Youinou P, et al (2014) Intravenous immunoglobulin induces a functional silencing program similar to anergy in human B cells. *J Allergy Clin Immunol* 133:181–188.e1-9. <https://doi.org/10.1016/j.jaci.2013.08.042>
73. Séité J-F, Cornec D, Renaudineau Y, et al (2010) IVIg modulates BCR signaling through CD22 and promotes apoptosis in mature human B lymphocytes. *Blood* 116:1698–704. <https://doi.org/10.1182/blood-2009-12-261461>
74. Prasad NK, Papoff G, Zeuner A, et al (1998) Therapeutic preparations of normal polyspecific IgG (IVIg) induce apoptosis in human lymphocytes and monocytes: a

- novel mechanism of action of IVIg involving the Fas apoptotic pathway. *J Immunol* 161:3781–90
75. von Gunten S, Simon H-U (2008) Natural anti-Siglec autoantibodies mediate potential immunoregulatory mechanisms: Implications for the clinical use of intravenous immunoglobulins (IVIg). *Autoimmun Rev* 7:453–456. <https://doi.org/10.1016/J.AUTREV.2008.03.015>
 76. Viard I, Wehrli P, Bullani R, et al (1998) Inhibition of toxic epidermal necrolysis by blockade of CD95 with human intravenous immunoglobulin. *Science* 282:490–3
 77. Bayry J, Lacroix-Desmazes S, Carbonneil C, et al (2003) Inhibition of maturation and function of dendritic cells by intravenous immunoglobulin. *Blood* 101:758–765. <https://doi.org/10.1182/blood-2002-05-14472002-05-1447> [pii]
 78. Bayry J, Lacroix-Desmazes S, Delignat S, et al (2003) Intravenous immunoglobulin abrogates dendritic cell differentiation induced by interferon- α present in serum from patients with systemic lupus erythematosus. *Arthritis Rheum* 48:3497–3502. <https://doi.org/10.1002/art.11346>
 79. Maddur MS, Othy S, Hegde P, et al (2010) Immunomodulation by intravenous immunoglobulin: role of regulatory T cells. *J Clin Immunol* 30 Suppl 1:S4-8. <https://doi.org/10.1007/s10875-010-9394-5>
 80. Kessel A, Ammuri H, Peri R, et al (2007) Intravenous Immunoglobulin Therapy Affects T Regulatory Cells by Increasing Their Suppressive Function. *J Immunol* 179:5571–5575. <https://doi.org/10.4049/jimmunol.179.8.5571>
 81. Maddur MS, Rabin M, Hegde P, et al (2014) Intravenous immunoglobulin exerts reciprocal regulation of Th1/Th17 cells and regulatory T cells in Guillain-Barre syndrome patients. *Immunol Res* 60:320–329. <https://doi.org/10.1007/s12026-014-8580-6>
 82. Maddur MS, Trinath J, Rabin M, et al (2015) Intravenous immunoglobulin-mediated expansion of regulatory T cells in autoimmune patients is associated with increased prostaglandin E2 levels in the circulation. *Cell Mol Immunol* 12:650–652. <https://doi.org/10.1038/cmi.2014.117>
 83. Maddur MS, Vani J, Hegde P, et al (2011) Inhibition of differentiation, amplification, and function of human TH17 cells by intravenous immunoglobulin. *J Allergy Clin Immunol* 127:823-830.e1–7. <https://doi.org/10.1016/j.jaci.2010.12.1102>
 84. Maddur MS, Kaveri S V., Bayry J (2011) Comparison of different IVIg preparations on IL-17 production by human Th17 cells. *Autoimmun Rev* 10:809–810. <https://doi.org/10.1016/j.autrev.2011.02.007>
 85. Trinath J, Hegde P, Sharma M, et al (2013) Intravenous immunoglobulin expands regulatory T cells via induction of cyclooxygenase-2-dependent prostaglandin E2 in human dendritic cells. *Blood* 122:1419–1427. <https://doi.org/10.1182/blood-2012-11-468264>
 86. Othy S, Hegde P, Topçu S, et al (2013) Intravenous gammaglobulin inhibits encephalitogenic potential of pathogenic T cells and interferes with their trafficking to the central nervous system, implicating sphingosine-1 phosphate receptor 1-mammalian target of rapamycin axis. *J Immunol* 190:4535–4541. <https://doi.org/10.4049/jimmunol.1201965>
 87. Maddur MS, Sharma M, Hegde P, et al (2013) Inhibitory effect of IVIG on IL-17 production by Th17 cells is independent of anti-IL-17 antibodies in the

- immunoglobulin preparations. *J Clin Immunol* 33 Suppl 1:S62-6. <https://doi.org/10.1007/s10875-012-9752-6>
88. Massoud AH, Yona M, Xue D, et al (2014) Dendritic cell immunoreceptor: a novel receptor for intravenous immunoglobulin mediates induction of regulatory T cells. *J Allergy Clin Immunol* 133:853–863. [https://doi.org/S0091-6749\(13\)01476-0](https://doi.org/S0091-6749(13)01476-0) [pii]10.1016/j.jaci.2013.09.029
 89. Bozza S, Käsermann F, Kaveri S V, et al (2019) Intravenous immunoglobulin protects from experimental allergic bronchopulmonary aspergillosis via a sialylation-dependent mechanism. *Eur J Immunol* 49:195–198. <https://doi.org/10.1002/eji.201847774>
 90. Kaneko Y, Nimmerjahn F, Ravetch J V (2006) Anti-Inflammatory Activity of Immunoglobulin G Resulting from Fc Sialylation. *Science* 313:670–673. <https://doi.org/10.1126/science.1129594>
 91. Fiebiger BM, Maamary J, Pincetic A, Ravetch J V (2015) Protection in antibody- and T cell-mediated autoimmune diseases by antiinflammatory IgG Fcs requires type II FcRs. *Proc Natl Acad Sci U S A*. <https://doi.org/1505292112> [pii]10.1073/pnas.1505292112
 92. Schwab I, Mihai S, Seeling M, et al (2014) Broad requirement for terminal sialic acid residues and FcγRIIB for the preventive and therapeutic activity of intravenous immunoglobulins in vivo. *Eur J Immunol* 44:1444–1453. <https://doi.org/10.1002/eji.201344230>
 93. Galeotti C, Stephen-Victor E, Karnam A, et al (2018) Intravenous immunoglobulin induces IL-4 in human basophils by signaling through surface-bound IgE. *J Allergy Clin Immunol*. [Epub ahead of print] <https://doi.org/10.1016/J.JACI.2018.10.064>
 94. Maddur MS, Stephen-Victor E, Das M, et al (2017) Regulatory T cell frequency, but not plasma IL-33 levels, represents potential immunological biomarker to predict clinical response to intravenous immunoglobulin therapy. *J Neuroinflammation* 14:58. <https://doi.org/10.1186/s12974-017-0818-5>.
 95. Sharma M, Schoindre Y, Hegde P, et al (2014) Intravenous immunoglobulin-induced IL-33 is insufficient to mediate basophil. *Sci Rep* 4:5672. <https://doi.org/10.1038/srep05672>
 96. Sharma M, Das M, Stephen-Victor E, et al (2018) Regulatory T cells induce activation rather than suppression of human basophils. *Sci Immunol* 3:eaan0829. <https://doi.org/10.1126/sciimmunol.aan0829>
 97. Chan AC, Carter PJ (2010). Therapeutic antibodies for autoimmunity and inflammation. *Nat Rev Immunol* 10:301–316. <https://doi:10.1038/nri2761>.
 98. Spirig R, Campbell IK, Koernig S, et al. (2018) rIgG1 Fc hexamer inhibits antibody-mediated autoimmune disease via effects on complement and FcγRs. *J Immunol* 200:2542–2553. <https://doi:10.4049/jimmunol.1701171>.
 99. Stephen-Victor E, Bayry J. (2018) Multimerized IgG1 Fc molecule as an anti-inflammatory agent. *Nat Rev Rheumatol* 14:390–392. <https://doi:10.1038/s41584-018-0013-9>.
 100. Kiessling P, Lledo-Garcia R, Watanabe S, et al (2017) The FcRn inhibitor rozanolixizumab reduces human serum IgG concentration: A randomized phase 1 study. *Sci Transl Med*.9: eaan1208. <https://doi:10.1126/scitranslmed.aan1208>.

101. Ulrichs P, Guglietta A, Dreier T, et al (2018) Neonatal Fc receptor antagonist efgartigimod safely and sustainably reduces IgGs in humans. *J Clin Invest*. 128:4372-4386. [https://doi: 10.1172/JCI97911](https://doi.org/10.1172/JCI97911).
102. Bayry J, Kaveri SV (2018) Kill 'Em All: Efgartigimod immunotherapy for autoimmune diseases. *Trends Pharmacol Sci* 39:919-922. [https://doi:10.1016/j.tips.2018.08.004](https://doi.org/10.1016/j.tips.2018.08.004).
103. von Gunten S, Shoenfeld Y, Blank M, et al (2014) IVIG pluripotency and the concept of Fc-sialylation: challenges to the scientist. *Nat Rev Immunol* 14:349-349. <https://doi.org/10.1038/nri3401-c1>
104. Saha C, Das M, Patil V, et al (2017) Monomeric immunoglobulin A from plasma inhibits human Th17 responses in vitro independent of Fc α RI and DC-SIGN. *Front Immunol* 8:275. <https://doi.org/10.3389/fimmu.2017.00275>
105. Rossato E, Ben Mkaddem S, Kanamaru Y, et al (2015) Reversal of arthritis by human monomeric IgA through the receptor-mediated SH2 domain-containing phosphatase 1 inhibitory pathway. *Arthritis Rheumatol* 67:1766-1777. <https://doi.org/10.1002/art.39142>
106. Morva A, Lemoine S, Achour A, et al (2012) Maturation and function of human dendritic cells are regulated by B lymphocytes. *Blood* 119:106-114. <https://doi.org/10.1182/blood-2011-06-360768>
107. Maddur MS, Kaveri S V, Bayry J (2012) Regulation of human dendritic cells by B cells depends on the signals they receive. *Blood* 119:3863-3864. <https://doi.org/10.1182/blood-2012-02-408948>
108. Maddur MS, Kaveri S V., Bayry J (2018) Induction of human dendritic cell maturation by naïve and memory B-cell subsets requires different activation stimuli. *Cell Mol Immunol* 15:1074-1076. <https://doi.org/10.1038/s41423-018-0017-z>
109. Bayry J, Lacroix-Desmazes S, Kazatchkine MD, et al (2005) Modulation of dendritic cell maturation and function by B lymphocytes. *J Immunol* 175:15-20. <https://doi.org/10.4049/JIMMUNOL.175.1.15>
110. Maddur MS, Sharma M, Hegde P, et al (2014) Human B cells induce dendritic cell maturation and favour Th2 polarization by inducing OX-40 ligand. *Nat Commun* 5:1-13. <https://doi.org/10.1038/ncomms5092>
111. Tiller T, Tsuiji M, Yurasov S, et al (2007) Autoreactivity in human IgG⁺ memory B cells. *Immunity* 26:205-13. <https://doi.org/10.1016/j.immuni.2007.01.009>
112. Sabouri Z, Schofield P, Horikawa K, et al (2014) Redemption of autoantibodies on anergic B cells by variable-region glycosylation and mutation away from self-reactivity. *Proc Natl Acad Sci USA* 111:E2567-2575. <https://doi.org/10.1073/pnas.1406974111>
113. Shopsin B, Kaveri S V., Bayry J (2016) Tackling difficult *Staphylococcus aureus* infections: Antibodies show the way. *Cell Host Microbe* 20:555-557. <https://doi.org/10.1016/J.CHOM.2016.10.018>
114. Diep BA, Le VTM, Badiou C, et al (2016) IVIG-mediated protection against necrotizing pneumonia caused by MRSA. *Sci Transl Med* 8:357ra124. <https://doi.org/10.1126/scitranslmed.aag1153>

Figure Legends

Figure. 1. Natural antibodies and pathogen-specific immune antibodies. In addition to immune antibodies that develop following active exposure to pathogen-derived antigens through infection or immunization, our immune system also produces natural antibodies (nAbs) that are constitutively expressed in the absence of external antigens. Further, unlike the monoreactivity of immune antibodies, nAbs are predominantly polyreactive capable of binding many structurally unrelated antigens with similar affinity.

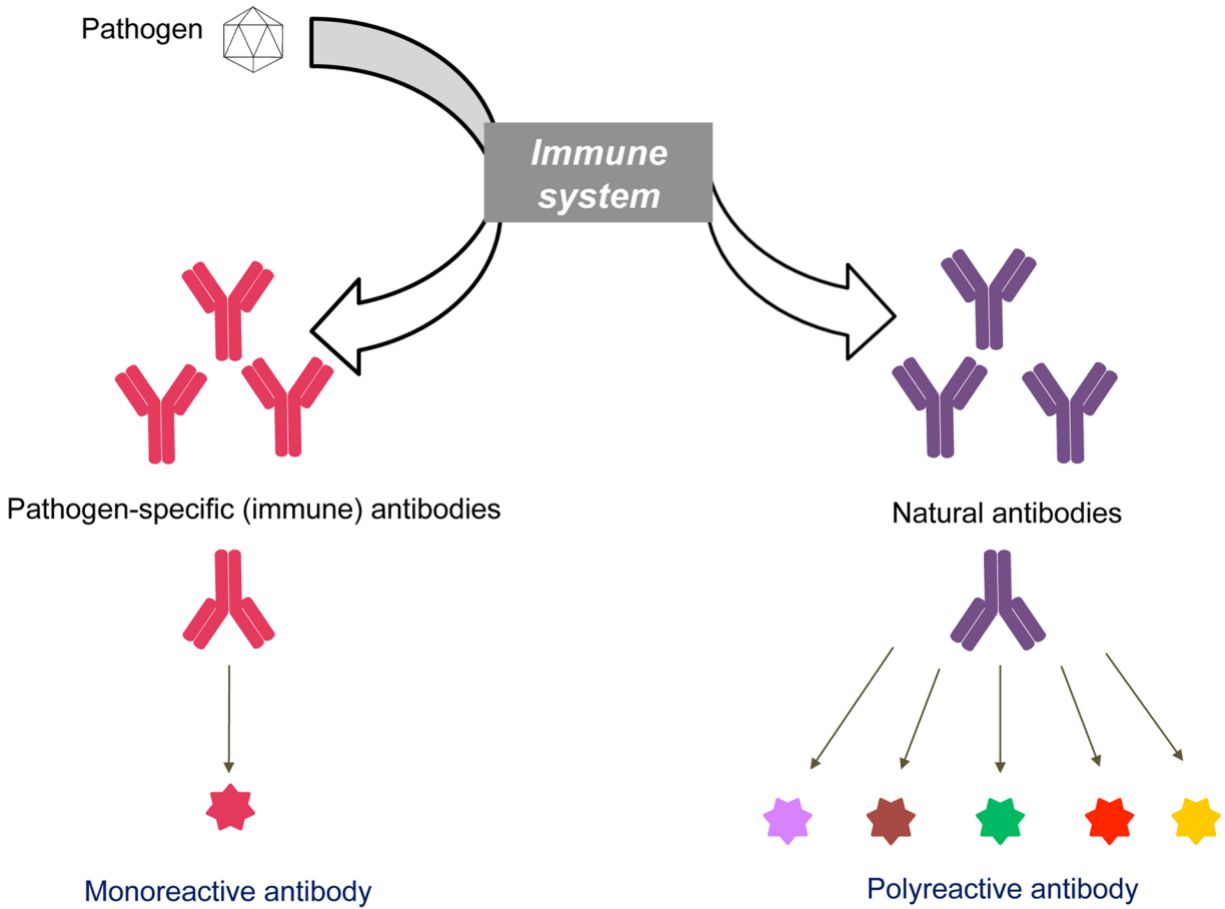


Figure. 2. Natural IgM in immune tolerance and homeostasis. nIgM can sustain immune equilibrium by acting as a first line of defense against invading pathogens, shaping the anti-microbial response, and by regulating the immune tolerance and homeostasis. nIgM confer protection against pathogens through direct neutralization, activation of the classical complement pathway, opsonization of pathogens and their phagocytosis by innate cells like dendritic cells (DC) and macrophages (MΦ), and transportation of antigens to secondary lymphoid organs for initiating the immune responses. In addition, nIgM can also shape the immune response to pathogens by regulating the T cell polarization and B cell class-switch. The role of nIgM in immune homeostasis involves recognition and clearance of apoptotic cells, altered cells and misfolded proteins, and regulation of disease-associated B cell clones and IgG antibodies. B, B cell; C1q, complement C1q (classical complement pathway); T, T cell. The figure is reproduced with modifications by permission from The Journal of Immunology, The American Association of Immunologists, Inc [53].

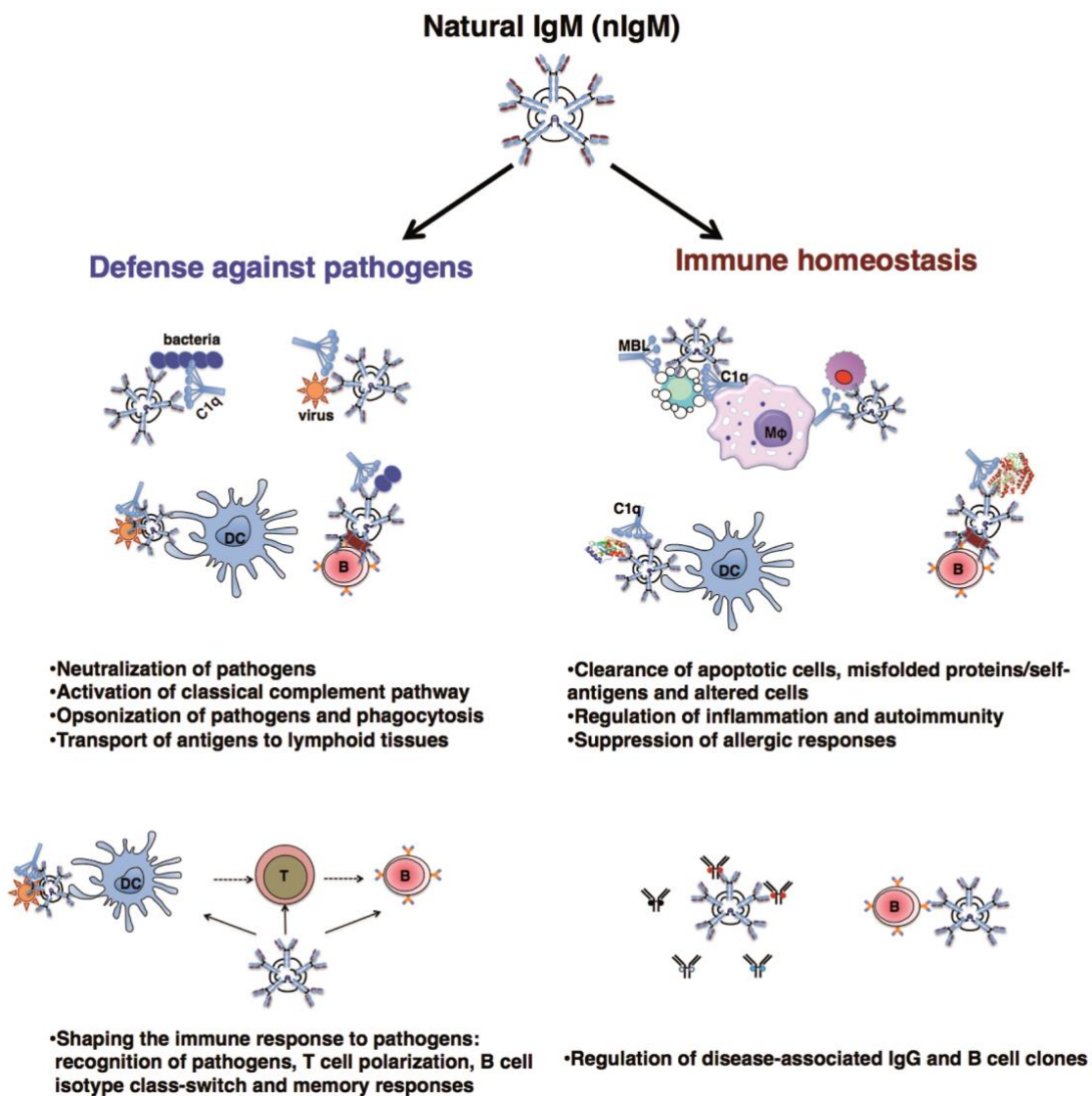


Figure. 3. The mechanisms of action of IVIG on various arms of autoimmune and inflammatory responses. The autoantigens endocytosed by the innate immune cells such as dendritic cells and macrophages are presented to the self-reactive T and B cells leading to the proliferation of autoreactive cells, production of inflammatory cytokines and autoreactive antibodies. IVIG targets different soluble and cellular compartments of the immune system to exert its therapeutic effects on diverse autoimmune diseases. IVIG neutralizes autoantigens and superantigens, and inhibits the activation of diverse innate immune cells such as dendritic cells, macrophages, monocytes, granulocytes and NK cells. Concerning the effector phase of autoimmune response, IVIG inhibits the activation and proliferation of effector T (Th1, Th17) and B cells while enhancing the expansion and function of regulatory T cells (Tregs). IVIG also induces expression of inhibitory FcγRIIB in a subset of macrophages and B cells. Further, IVIG saturates the neonatal Fc receptors (FcRn), modulates the cytokine network, induces apoptosis of immune cells, neutralizes pathogenic autoantibodies by anti-idiotypic interaction, inhibits the activation of complements and regulates the B cell repertoire. Abbreviations: ADCC, antibody-dependent cell-mediated cytotoxicity; FcγR, Fcγ receptors; NK, natural killer cell.

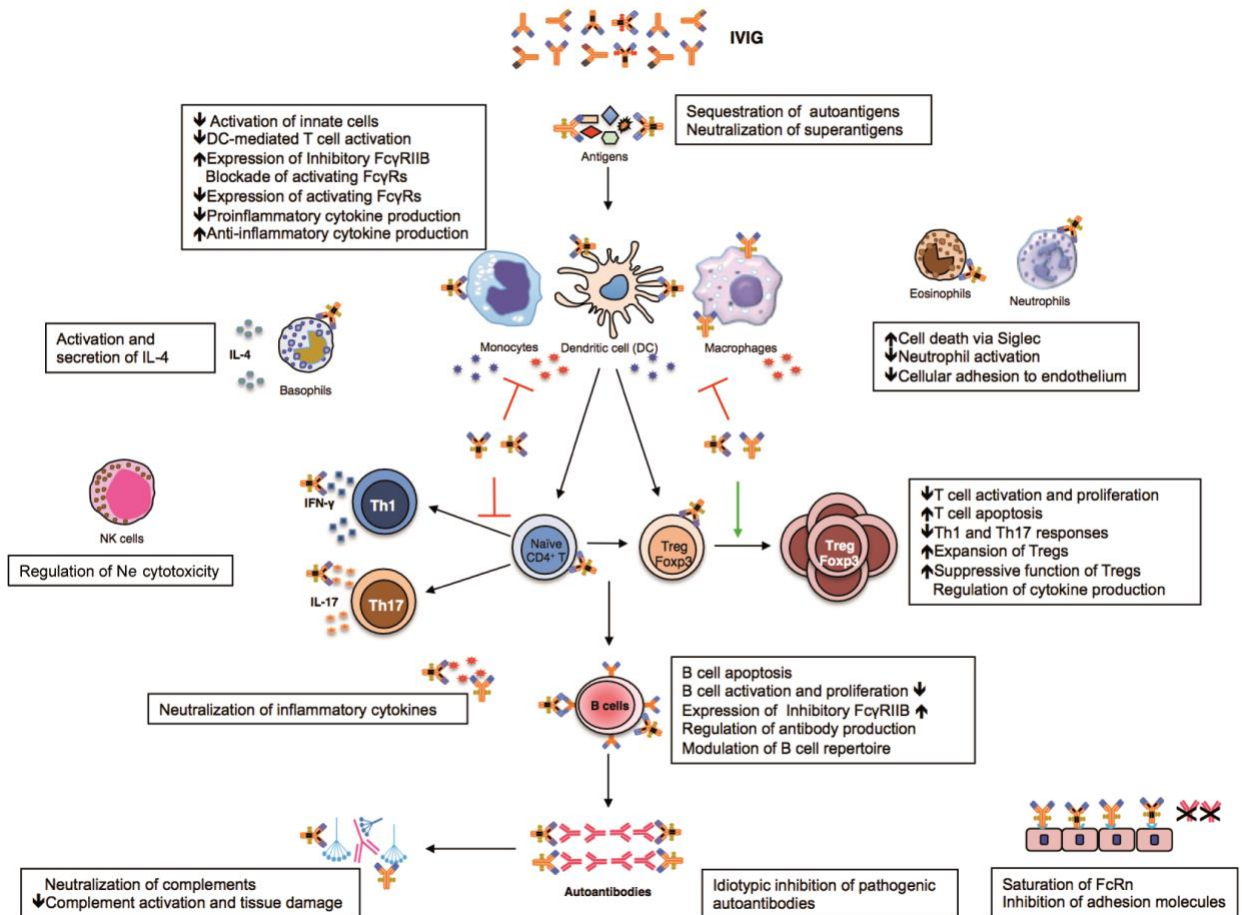


Table 1. Cellular source of natural antibodies (nAbs) in mice and humans

Property	Mice				Human	
	B1a	B1b	MZ B2	FO B2	B1-like	B2-like
Cell surface phenotype	IgM ^{high} , IgD ^{low} , CD19 ^{high} , B220 ^{low} , CD23 ⁻ , CD43 ⁺ , CD138 ^{+/-} , CD5 ⁺	IgM ^{high} , IgD ^{low} , CD19 ^{high} , B220 ^{low} , CD23 ⁻ , CD43 ⁺ , CD138 ^{+/-} , CD5 ⁻	IgM ^{high} , IgD ^{low} , CD19 ^{mid} , CD21 ^{high} , CD23 ⁻ , CD43 ⁻ , CD5 ⁻	IgM ^{low} , IgD ^{high} , CD19 ^{high} , B220 ⁺ , CD23 ⁺ , CD43 ⁻ and CD5 ⁻	CD20 ⁺ , CD27 ⁺ , CD43 ⁺ , CD70 ⁻ , CD38 ^{mod} , CD45RA ^{low} , CD5 ^{-/+}	CD20 ⁺ , CD27 ⁺ , CD43 ⁺ , CD70 ⁺ , CD38 ^{mod}
Development	Positive selection on self-antigen	Unclear pathway	Selection of weak self-reactive	Selection for non-self-reactive usually	Positive selection on self-antigen	Usually selection for non-self-reactive
Tissue distribution	Peritoneal cavity, pleural cavity, spleen, bone marrow, lymph nodes and blood		Spleen	Spleen	Blood, other locations?	Blood, lymph nodes and spleen
Self-renewing B1 cells	Mainly B1 cells from body cavities, but adult bone marrow as precursor		N/A	N/A	Yes	N/A
Spontaneous nAb secretion	Mainly B1 cells from spleen and bone marrow for IgM; and Intestinal mucosa and lung parenchyma for IgA		Nil	N/A	Yes	Nil
Induced nAb secretion	Mainly B1 cells from peritoneal cavity after CpG, LPS for IgM; and Intestinal mucosa and lung parenchyma for IgA			N/A	Yes	stimulus differentiated cells
Stimulus for response	BCR-independent, but need innate receptor or cytokine signals	BCR-dependent expansion	BCR-dependent expansion	BCR-dependent expansion	BCR-independent, and need innate receptor or cytokine signals	BCR-dependent expansion
Contribution to circulating nAbs	Mainly B1 cells from spleen and bone marrow for IgM; and Intestinal mucosa and lung parenchyma for IgA			N/A	unknown	N/A

N/A: Not applicable

Table 2. Therapeutic utility of IVIG in immunodeficiency, and autoimmune and inflammatory pathologies

Licensed FDA/EMA*	Off-label
<ul style="list-style-type: none"> • Primary immunodeficiencies [Eg. X-linked agammaglobulinemia (XLA), Common variable immunodeficiency (CVID)] • Secondary immunodeficiencies [Eg. B-cell chronic lymphocytic leukemia (CLL), Paediatric HIV infection] • Idiopathic thrombocytopenic purpura^a • Kawasaki Disease ^a • Chronic inflammatory demyelinating polyneuropathy ^a • Guillain–Barré syndrom^e^a # • Multifocal motor neuropathy^a • Bone marrow transplantation 	<ul style="list-style-type: none"> • Myasthenia Gravis^a • Autoimmune hemolytic anemia • Acquired immune thrombocytopenias • Juvenile idiopathic arthritis • Anti-phospholipid antibody syndrome • Lambert–Eaton syndrome • Dermatomyositis^a • Parvovirus B19-associated red cell aplasia • Anti-factor VIII autoimmune disease • Acquired von Willebrand disease • Autoimmune neutropenia • Steroid-dependent severe atopic dermatitis • Stiff person syndrome • Toxic epidermal necrolysis • Polymyositis • Multiple sclerosis • Rheumatoid arthritis and Felty’s syndrome • Systemic lupus erythematosus • Autoimmune skin blistering diseases ^a • Antibody-mediated rejection of the graft • Graft versus host disease^a • Autoimmune uveitis and birdshot chorioretinopathy • Streptococcal or staphylococcal sepsis and toxic shock syndrome • ANCA-positive systemic vasculitis • Graves ophthalmopathy

^a Indicates pathologies for which evidence for the clinical benefits of IVG has been obtained through controlled clinical trials.

* Licensed for use by US FDA and EMA, # Approved by European Medical agency (EMA) only

Table 3. Comparison of natural antibodies, immune antibodies and pathogenic autoantibodies

Feature	Pathogen-specific immune antibodies	Natural Antibodies (nAbs)		Pathogenic autoantibodies
		Pathogen cross-reactive	Self-reactive	
Develops following	Infection or immunization	Constitutive/Homeostasis	Constitutive/Homeostasis	Uncontrolled autoimmunity
Influence of external antigen on clonal diversity	Yes	Yes	No	Yes?
Source/Cells				
Mouse	B2*, also B1*	B1 mainly	B1 mainly	B2 mainly
Human	CD20 ⁺ CD27 ^{high} CD38 ^{high}	CD20 ⁺ CD27 ⁺ CD43 ⁺ CD70 ⁺ CD38 ^{mod}	CD20 ⁺ CD27 ⁺ CD43 ⁺ CD70 ⁺ CD38 ^{mod}	CD20 ⁺ CD27 ^{high} CD38 ^{high}
Somatic hypermutation	Present	Nil to minimum	Nil to minimum	Present
Isotypes	IgG mainly, also IgA, IgM, IgE	IgM mainly, also IgG and IgA	IgM and IgG, also IgA	IgG mainly, also IgM and IgA
T-cell dependence for induction	Yes	Nil to minimum	Nil to minimum	Yes
Affinity	Usually High	Low	Low	High
Avidity	High	High	High	High
Reactivity	Pathogen epitope specific	Self, cross-reactive to conserved epitopes	Polyreactive to self-antigens	Specific self-antigen
Examples of antigens	Influenza Hemagglutinin	Phosphorylcholine (PC)	HLA class I, CD4	Citrullinated protein antigens
Functional outcome	Prevention and control of pathogen-induced disease	Prevention of pathogen infection	Beneficial housekeeping tissue homeostasis functions	Inflammation and tissue destruction leading to disease

*B1: IgM^{high}, IgD^{low}, CD19^{high}, B220^{low}, CD23⁻, and CD43⁺; CD5⁺ (B1a) or CD5⁻ (B1b)

*B2: IgM^{low}, IgD^{high}, CD19^{high}, B220⁺, CD23⁺, and CD43⁻