Autoinflammatory diseases are a relatively new category of conditions that differ from autoimmune diseases. Although both kinds of illnesses happen when the immune system attacks the body’s own tissues, they occur by different processes.

The NIH’s National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), along with researchers from other parts of NIH and from around the globe, played a vital role in differentiating between the two groups of diseases, discovering the molecular causes for autoinflammatory diseases, and identifying and testing treatments. For more information about studies at the NIH for patients who have periodic fever syndromes or other autoinflammatory diseases, visit http://niams.nih.gov/Research/Ongoing_Research/Branch_Lab/Clinical_Director/default.asp#fever

THE INNATE AND ACQUIRED IMMUNE SYSTEM

Your immune system defends you against infection. It has two parts: the acquired and the innate immune systems. The acquired (or adaptive) component develops over time. It produces antibodies that “remember” invaders and can fight them if they return. In autoimmune disease, antibodies and adaptive immune cells target the body’s own healthy tissues by mistake. The more primitive innate (or inborn) immune system causes the heat, redness, and swelling that we associate with acute inflammation. In autoinflammatory diseases, the innate immune system reacts uncontrollably and for unknown reasons.

AUTOINFLAMMATORY DISEASES: THEN AND NOW

THEN (pre-1980s)

- The rarity of periodic fever diseases meant that even the most expert researchers would study only a few patients.
- Patients received medical care from their local doctors.
- Diseases were differentiated by symptoms or affected populations.
- Patients were treated with non-specific therapies such as steroids.
- Conditions affecting children often were fatal. Those who survived were left with severe disabilities.

NOW

- The global nature of research allows investigators to study many patients and make reliable conclusions about diseases.
- The NIH Clinical Center offers specialized care that patients from around the world can access.
- Genetic testing has revealed that many share common mechanisms.
- Treatments address the underlying molecular pathways that cause the symptoms.
- Early diagnosis and consistent treatment can prevent the devastating consequences of repeated episodes of inflammation.
Researchers described an Irish family with FMF symptoms. Unlike FMF, these patients responded to steroids and the disease could be inherited from one parent. Researchers called the disease familial Hibernian fever.1

1970s

Colchicine—a medication approved to treat gout—became the standard treatment for FMF. It prevents painful fevers and potentially fatal kidney damage.2

1982

Researchers described an Irish family with FMF symptoms. Unlike FMF, these patients responded to steroids and the disease could be inherited from one parent. Researchers called the disease familial Hibernian fever.3


Researchers identified the genetic defect that causes FMF. They named the gene MEFV (Mediterranean fever).4

1999

Researchers studying families with FMF-like symptoms despite having normal MEFV, including some with familial Hibernian fever, discovered that mutations in the gene for TNF receptor 1 were causing dysregulated inflammation. They named the disorders TRAPS (TNF receptor-associated periodic syndrome).5

The 1997 and 1999 findings led NIH investigators to propose the term “autoinflammatory diseases” to distinguish these diseases from autoimmune diseases. Since then, investigators around the globe have uncovered the genetic basis for ~3 dozen autoinflammatory diseases.

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2002

Researchers determined that an often fatal disease called NOMID (neonatal-onset multisystem inflammatory disease) is related to two milder periodic syndromes. Defective IL-1 signaling causes all three diseases.6

2009

Investigators diagnosed FMF in people carrying only one defective copy of the MEFV gene. This changed the treatment recommendations.4

The autoinflammatory syndrome DIRA (deficiency of the IL-1 receptor antagonist) was discovered at NIH. Patients responded well to anakinra.9

2011

Studies of autoinflammatory patients who did not respond to anakinra led to the discovery of CANDLE (chronic atypical neutrophilic dermatosis with lipodystrophy and elevated temperature). Gene expression patterns suggested dysregulation of a different innate immune system component.10

2012–2013

Anakinra works for children with NOMID over the long-term.11 The 2012 study contributed to FDA approval of anakinra as a treatment for NOMID in 2013.

The success of drugs targeting IL-1 to treat NOMID and DIRA has encouraged their use in other autoinflammatory syndromes, including FMF, TRAPS, and other conditions that are not genetically well-defined.12

2015

NIH researchers discovered SAVI (STING-associated vasculopathy with onset in infancy), which is similar to CANDLE.13 The genetic and molecular insights gained from CANDLE and SAVI patients allowed NIH to develop a treatment protocol using a new class of drugs.
IMPACTS OF STUDYING RARE AUTOINFLAMMATORY DISEASES

KNOWLEDGE

• Genetic studies of FMF and TRAPS defined a new class of diseases. By 2016, approximately 3 dozen autoinflammatory diseases had been identified.14

• Studying autoinflammatory diseases revealed the inner workings of the innate immune system.15

• Rare autoinflammatory diseases are teaching us about the innate immune system’s role in more common diseases. For example, SAVI is providing insights about lupus.16

HEALTH

• An NIH study contributed to FDA approval of anakinra as the first treatment for NOMID.17 If left untreated, NOMID can lead to hearing and vision loss, cognitive impairment, physical disability, and death.

• Anakinra benefits patients with DIRA.18

• NIH scientists discovered a link among hard-to-treat disorders characterized by inflammation and fat loss.19 Several drugs act on the molecular pathway that is altered in CANDLE and SAVI. Patients can enroll in a compassionate use trial at the NIH Clinical Center.

MORE ABOUT CERTAIN AUTOINFLAMMATORY DISEASES

FMF (Familial Mediterranean fever): FMF occurs most commonly in people of Jewish, Armenian, Arab, and Turkish backgrounds; between 1 in 200 and 1 in 1,000 people in these populations have FMF.20 Although colchicine helps, some people respond better to IL-1 inhibitors. This suggests that FMF is more complicated than previously thought.21

TRAPS (TNF receptor-associated periodic syndrome): TRAPS, which includes familial Hibernian fever, affects more than 1,000 people worldwide.22 Symptoms resemble FMF, but TRAPS is caused by mutations in the gene for TNF receptor 1. Drugs that interfere with TNF sometimes help. Because some patients respond to drugs that affect IL-1 activity, NIH researchers are examining the link between defective TNF receptor 1 molecules and IL-1-mediated diseases.23

NOMID (neonatal-onset multisystem inflammatory disease): Fewer than 100 people worldwide have NOMID. 53 participated in the NIH-led trial that contributed to the FDA approval of anakinra as a treatment for NOMID.24

DIRA (deficiency of the IL-1 receptor antagonist): Although mutations that cause DIRA are rare, as many as 2.5 percent of people in northwest Puerto Rico are carriers; approximately 1 in 6,300 babies born in this region have DIRA. Mutations also are more common in individuals of Dutch descent. Anakinra is effective.

CANDLE (chronic atypical neutrophilic dermatosis with lipodystrophy and elevated temperature) and SAVI (STING-associated vasculopathy with onset in infancy): Some children have defects in immune processes that are controlled by proteins called type 1 interferons. They may benefit from a compound that acts on interferon signaling.

Read more at http://www.niams.nih.gov/Health_Info/Autoinflammatory/

For references, supplementary information, and more on the impact of NIH, please visit http://www.nih.gov/impact