

Transmission Properties of Pathogenic Protein Agents in Human Prion Disease and Neurodegenerative Diseases

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Abstract

Prion diseases are transmitted by the protein agent that can transfer its distinct misfolded structure to its normal counterparts and form insoluble aggregates in the nervous system. Recent findings led to the emergence of the prion paradigm of the protein agents that underlie neurodegenerative diseases such as Alzheimer's disease (AD) and Parkinson's disease (PD). This review will discuss current knowledge concerning both human prion diseases and prion-like transmission properties related to neurodegenerative diseases.

Keywords: Prion; Creutzfeldt-Jakob disease; neurodegenerative disease; Alzheimer's disease; Parkinson's disease

Abbreviations: AD: Alzheimer's Disease; PD: Parkinson's Disease; TSEs: Transmissible Spongiform Encephalopathies; CJD: Creutzfeldt-Jakob Disease; GALT: Gut Associated Lymphoid Tissue; BSE: Bovine Spongiform Encephalopathy; FDCs: Follicular Dendritic Cells; PRNP: PRion Protein; LSPCs: Liposome-siRNA-Peptide Complexes

Introduction

The term prion was introduced by Prusiner [1] in 1982 "to denote a small proteinaceous infectious particle which is resistant to inactivation by most procedures that modify nucleic acids". The infectious nature of a prion is that it can be transmitted between individuals. Once in the new host, the prion acts as a template to transfer its distinct misfolded secondary structure to its normal counterparts and form insoluble aggregates in the nervous system [2,3]. Although no infectivity between individuals has been found to date in neurodegenerative diseases such as Alzheimer's disease (AD) and Parkinson's disease (PD), in particular through peripheral inoculations, these diseases exhibit prion-like characteristics in terms of propagation of abnormally folded conformation of protein agents in the same individual, then formation of protein aggregates in the nervous system. In recent years, more discoveries were made in this field and provide new insights about prion diseases and their association with other neurodegenerative diseases [4-6]. Our primary aim in this present review is to provide an overview of recent advances in the understanding of both prion diseases and prion-like transmission properties, or "prion paradigms" of AD and PD. Given that over 330,000 articles were found from our

search by keywords on PubMed, we regret if some important findings are overlooked.

Human Prion Disease

Transmissible spongiform encephalopathies (TSEs) are a group of rare degenerative fatal brain diseases characterized by the "spongy" appearance of the tissues in the nervous system by microscopic holes as the result of apoptotic neurons surrounded by vacuoles and reactive astrocytes [7]. TSEs affect many animals, including humans, cows, goats, minks, cats, lemur, and sheep [8,9]. In humans, Creutzfeldt-Jakob Disease (CJD) is the most well-known form of TSE with different etiological subtypes.

The vast majority of CJD cases are caused by a pathogenic conformational change of the prion protein coded by the PRNP gene, [10-12] including either sporadic CJD (sCJD) which may be influenced by PRNP polymorphisms [11-13] or inherited familial CJD (fCJD), caused by an autosomal dominant germ line mutation. Some CJD cases are acquired, including iatrogenic CJD (iCJD), typically from medical treatments with prion-contamination, such as grafts of dura matter or cornea from cadavers with undiagnosed CJD. Other iCJD cases have been

acquired through hormone treatments or blood transfusions from infected human sources [14-16].

Variant CJD (vCJD) has been a recent emergent in the European countries, which is suspected to be acquired through food contaminated with bovine prion (from mad cow disease). It exhibits similarities to Kuru, a disease among the Fore tribe of Papua New Guinea who are infected via funerary cannibalism [17-19]. The status of all types of CJD is closely monitored by the National Creutzfeldt-Jakob Disease Surveillance Unit in the United Kingdom. In 1994, the first case of vCJD was identified in the United Kingdom and it was linked to the epidemic of bovine spongiform encephalopathy (BSE) in cattle [20]. CJD affects about one in every one million people per year, worldwide [21]. Among them, most cases were sCJD, and by 2011 almost 200 cases were vCJD from the bovine origin, most of which occurred in the United Kingdom and other European countries [22].

The transmissible agent of CJD, the prion protein (PrP), is a membrane glycosyl phosphatidyl inositol-anchored glycoprotein encoded by the gene PRNP located on chromosome 20 [23,24]. The pathogenic PrP is designated as PrP-TSE or PrPSc (scrapie), which is converted through a posttranslational process from a normal cellular PrP, designated as PrPC (cellular or normal PrP) [3]. PrP mRNA is highly expressed in various neuro ectodermal tissues such as the brain, as well as the heart, lungs, skeletal muscles, lymphoid tissues and subsets of maturing B cells, and intestinal epithelium [24-29]. The physiological role of PrPC is not clearly defined. Some reports suggest that PrPC functions in cell signaling pathways and synaptic connections [30-32]. In contrast, PrPSc has been found in the nervous system, muscle, placenta, intestines and secondary lymphoid organs [8]. In particular, PrPSc was detected in the brain tissue of all patients, while its deposition outside of the nervous system was also detected in spleen and muscle samples from about one third of patients who usually had a significantly longer duration of disease [33]. PrPSc exists in different strains which exhibit variation in physical, chemical and biological properties such as conformation, sensitivity to protease, conversion rate, aggregation, infectivity, and rate of disease progression [34-39].

Numerous studies show that the prion can be transmitted through cell culture, [40-46] cerebral inoculation, [47-57] and even peripheral inoculation [49,56,58-63]. The natural transmission pathway of a prion, in particular the pre oral infection, is currently a focus of research in order to find efficient infection control strategies against TSEs in both humans and other animals.

Substantial evidence suggests that the three key steps of prion disease transmission are through intestinal uptake, lymphoid accumulation and neuro invasion [64-67]. First, epithelial M cells (also called microfold cells) overlying the sub epithelial lymphoid follicles in the gastrointestinal tract have been recognized as a major entry site for prions [68,69]. These cells are specialized for antigen sampling and initiate immune

responses in the gut associated lymphoid tissue (GALT), also known as Peyer's patch [70].

Prion was detected in the follicular dendritic cells (FDCs) in small intestinal GALT, but not in large intestinal GALT, before it spread to lymphoid and nervous tissues [69,71-74]. Experimental depletion of M cells blocked neuro invasion and disease development after oral prion exposure [75]. The absorption mechanism of prion through the M cells is transcytosis, partly eased by the beta-sheet structure of PrPSc [65,76]. Animal experiments showed that the transcytosis of incorporating prions in the epithelial cells followed with the transport to Peyer's patches occurred within hours [77,78].

The second step, lymphoid accumulation, may take several days after inoculation to spread further to mesenteric lymph nodes and the spleen, and may take several weeks to reach the peripheral nervous system [77,78]. One study showed cholesterol homeostasis, temperature, and the degradation power of macrophages are the main factors which influence the early transient accumulation of PrPSc in the first 8-12 hours post-exposure [79]. High levels of PrPC expression is found in entero endocrine and enteric nervous systems, therefore prion amplification may occur at the same time of absorption [29,80,81].

The spleen is a critical site for prion accumulation. Splenectomies reduce the prion's infection efficiency [82]. Presence of peripheral PrPSc was also found in tonsillar tissue [83], the liver and the kidney [84]. The third step, neuroinvasion, is mediated by the autonomic nervous system, from the sympathetic nerves connected to the spleen and mesenteric lymph nodes to the spinal cord and eventually reaching the brain. Among the peripheral glial cells expressing PrPC, glial cells in the enteric system [85] and in the dorsal root ganglion have a permissive role in the neuroinvasion, but Schwann cells do not [86,87]. In the central nervous system, astrocytes and meningeal fibroblasts internalize PrPSc more efficiently than neurons and promote intercellular transfer of prion to neurons by cell-cell contact [40,44,46].

Other than the GI tract, alternative entry pathways of prions have also been identified, such as transports via skeletal muscle cells and papillae in the tongue [88,89], and via the olfactory nerve to the olfactory bulb through oral and nasal mucosa [90-95] as lesions of the olfactory epithelium accelerated prion neuroinvasion and disease onset [96]. In addition to food, other infectious pathways, particularly in non-human animals, include mites [97], fly larvae and pupae [98], saliva (via the oral route) and blood (via transfusion) [99], gingival scarification [100], pharyngeal tonsil [101,102], and skin scarification of skin or gums [103]. In human CJD patients, prion protein was detected in nasal brushings with very high sensitivity and specificity [104], suggesting this venue may need to be addressed to prevent human CJD transmission.

To date, there is no approved treatment for TSEs. The process of clinical trials has been challenging due to the limited number of patients and ethical concerns to recruit control subjects. Therapeutic chemical drug trials in human TSEs involved antimicrobial, anti-inflammatory and analgesic substance classes [105], as well as polyanionic and polycyclic compounds with hope to prevent the conformational conversion [106]. Several novel approaches involved biological treatments. Immunotherapy tested on animal models, including immunization with vaccines and passive immunization with antibody transfers [107], showed some promising outcomes in slowing disease progression or increasing lifespan, but did not prevent the onset of the disease. One approach targets heparan sulfate which facilitates prion infection and PrPSc formation.

Over-expression of heparanase, an enzyme utilized to degrade cellular heparin sulfate, resulted in decreased levels of PrPSc within cultured cells and delayed prion disease onset and progression in infected transgenic mice [108]. Another experiment utilized the presence of heterologous proteins (hamster prion vs. murine scrapie) to inhibit the prion conformation conversion process and found reduced pathology and delayed onset of symptoms [109]. In addition, RNAi or liposome-siRNA-peptide complexes (LSPCs) have been used in experiments to knock down PrPC expression in neuroblastoma cell cultures [110-112]. Although the delivery of lentivirus encoding PrP shRNA has been a limiting factor in efficacy *in vivo*, the recent development of lipid nanoparticle (LNP) may provide a more efficient delivery method of siRNA across the blood-brain barrier [113].

5.1. Prion association of neurodegenerative diseases

Several neurodegenerative diseases share similar pathological characteristics of abnormal folding of protein agents. Most of the research efforts have been focused on proteins amyloid-beta (A β), tau, and α -synuclein (α -syn), since these proteins correspond to AD and PD, the two most prevalent neurodegenerative diseases in elders. In recent years, the prion paradigms of these proteins emerged as these protein agents show cell-cell transmissibility like prion PrP in many research studies.

AD is the most prevalent cause of dementia [114]. The hallmark characteristic of AD pathology is the plaque aggregation of abnormally folded amyloid-beta (A β) proteins in the extracellular space and intracellular fibrillary tangles of phosphorylated tau protein. The major risk factors of AD include age, apolipoprotein E ϵ 4 (APOE) gene (over 60% of AD patients have at least one allele) and sex (60% of AD patients are female) [115,116].

Plaques are formed by A β 1-40/1-42 peptides, cleaved by β - and γ -secretases. The progression of AD implies that A β may propagate its abnormal folding in the brain. A β deposition was identified to spread in the brain in 5 phases: the neocortex

(phase 1), allocortical regions (phase 2), diencephalon nuclei, striatum, and the cholinergic nuclei of the basal forebrain (phase 3), brain stem nuclei (phase 4), and eventually the cerebellum (phase 5) [117]. Cumulative evidence suggests synapse failure and neural dysfunction in AD is due to the toxicity which impairs neurons that start with small diffusible A β oligomers before the formation of plaque [118-122]. It is worthy to note a recent report challenges this hypothesis by showing that A β 42 immunization cleared amyloid plaques but failed to prevent the progression of neurodegeneration [123].

The oligomer cascade hypothesis states that the A β oligomers are accumulated intracellularly in the small cytoplasmic granules located within neurites and synapses [119,124,125], and then secreted from the neurons [126]. The secretion and spread of A β oligomers pathology led to speculation of its prion-like propagation, which is supported by experiments with cell cultures [126-131]. Many studies also show that only intracerebral inoculation, but not oral, intravenous, intraocular, or intranasal ways induced cerebral β -amyloidosis in animal models [132-140], specifically in rat [141] as well as in primates [142].

In 2015, several reports showed intriguing links between AD and CJD in CJD patients. Two reports showed the majority of patients with iCJD who received prion-contaminated c-hGH treatments exhibited various levels of A β deposits in the gray matter of the brain, as well as in the blood vessel walls [4,5], increasing the possibility that the A β might be transmitted from a peripheral route. However, another report showed 17% of 266 prion disease cases (mostly sCJD) showed concurrent extracellular A β plaques. [6] The majority of these concurrent plaques were seen in sCJD patients (42 cases).

These cases suggest that PrPSc and A β may have some intrinsic association even though it is not passed between individuals. Putative explanations are that PrPC may act as a high-affinity receptor of A β , or it regulates the cleavage of the amyloid precursor protein through β -secretase [143,144]. These alternative hypotheses are not exclusive as the frequency of A β seen in these iCJD cases (50%) is significantly higher than the frequency in age-matched sCJD cases (10% and 17% in two reports) [5,6,145].

The appearance of intracellular fibrillary tangles formed by phosphorylated tau proteins is another defining feature of AD, and is seen in other neurodegenerative disorders [146-148]. Buildup of A β over decades can trigger tau aggregation [149,150]. Although not as many studies on A β , some studies have shown that tau can be transmitted from human patient brain homogenates or synthetic tau fibrils, to cell culture or transgenic mice expressing human tau protein [151-162].

Three main types of diseases are categorized as α -synucleinopathies: PD, dementia with Lewy bodies (DLB), [163-165] and multiple system atrophy (MSA) [166-168].

These are neurodegenerative diseases which share common pathological hallmarks of deposition of intracellular α -syn aggregates within inclusions (Lewy bodies and Lewy neurites) in neurons and glia [169]. Among the diseases, PD is the most common movement disorder, prevalent in 1% of the world population over age 60 [170,171].

The known risk factors of PD include mutations in several genes, such as SNCA, LRRK2, and GBA, and environmental toxins such as pesticides [172]. In DLB patients, Lewy body-related pathology is distributed from the brain stem to the cerebral cortex and is often associated with concurrent Alzheimer's disease pathology [163-165]. MSA is a neurodegenerative disorder characterized by a combination of autonomic dysfunction, cerebellar ataxia and Parkinsonism [166-168].

The protein underlying these diseases is α -syn, a protein that is soluble in its monomer and oligomer forms, but becomes insoluble when the oligomer undergoes fibrillation within neurons and glia [173]. The pathology of PD can spread through the brain, with 6 stages proposed by Braak [174]: the medulla oblongata/pontine tegmentum and olfactory bulb/anterior olfactory nucleus in presymptomatic (stages 1-2), the substantia nigra and other nuclear grays of the midbrain and forebrain in symptomatic (stages 3-4), and the mature neocortex in the end (stages 5-6).

The propagating pathology suggests the prion-like property of α -syn in the brain, which is supported by clinical reports and animal experiments. Two independent clinical reports showed that grafted healthy neurons gradually developed the same pathology of Lewy bodies containing α -syn aggregates 11-16 years after transplantation, in three recipients with pre-existing PD [175,176]. Prion-like propagation of α -syn was also observed in many experiments with cell cultures [177-185] and animal experiments [179,183,186-197].

The spread of disease may be initiated from a peripheral site shown by an intramuscular injection in mice [198]. The proposed model of intracellular α -syn transfer involves an exocytotic secretion and entry of the recipient cell through simple diffusion or lipid raft-mediated endocytosis [199,200]. Growing evidence showed monomeric and oligomeric, but not fibrillary form of α -syn can propagate along neural pathways [176,201-203]. A recent report in 2016 suggests that α -syn exists in a "continuum" of species with various numbers of monomers and molecular weights. Mature α -syn fibrils and stable elongated oligomers composed of more than 15 α -syn monomers have seeding capacity, while low-molecular weight and unstable oligomers do not [204]. Another report in 2016 showed very high numbers of seeds and cellular stress which are two necessary conditions for seeding [205]. Synergistic effects between α -syn and tau to promote fibrillation of both proteins have been observed in multiple studies [206,207]. Tau shifted the pattern of α -syn aggregation and increased the toxicity of α -syn [208].

Conclusion

To date, prion PrP is the only protein agent that was found to transmit diseases between individuals by acting as a template to transfer its misfolding to its normal counterparts and form insoluble aggregates in the nervous system. However, with a growing body of evidence, the recently emerging "prion paradigm" connects the pathological hallmarks of common neurodegenerative diseases with the transmission property of prion protein.

If $A\beta$, tau, or α -syn may be transmitted through peripheral pathways in clinical settings, many clinical procedures will need to be re-examined when human proteins are transferred between individuals such as blood transfusion, or even the clinical sterilization methods as they resist formaldehyde or a commonly used disinfectant per acetic acid. [209,210] Many reports (recent examples in the last three years are summarized in Table 1), with cell culture and transfusion, support the association which may provide the basis of further understanding of the pathologies and therapeutic developments of these diseases.

Table 1: Propagation of Proteins in Experimental Systems.

Protein Agent	Transmission Method	Reports
Prion	Cell Culture	Multiple reports [41-46]
	Cerebral	Multiple reports [47-57,211]
	Peripheral	Multiple reports [49,56,58-63]
A-beta	Cell Culture	Multiple reports [127-131]
	Cerebral	Multiple reports [131,139,140]
	Peripheral	Two reports in iCJD patients [4,5]
Tau	Cell Culture	Multiple reports [152,159-161]
	Cerebral	Multiple reports [155-158,160,161]
	Peripheral	N/A
alpha-syn	Cell Culture	Multiple reports [180-185]
	Cerebral	Multiple reports [183,190,192-195,197]
	Peripheral	Intramuscular injection in mice [198]

Conflict of Interest: None

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