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9

Recovery from Infection

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If there is to be recovery from an infection it is first necessary that the multiplication of the infectious agent is brought under control. The microbe must decrease in numbers and cease to spread through the body or cause progressive damage. This is accomplished by immunological and other factors whose action is now to be described. The average multiplication rate of various microorganisms in the infected host as shown by doubling-times (Table 8.2) is nearly always longer than in artificial culture under optimal conditions. This in itself reflects the operation of antimicrobial forces. In the process of recovery from an infectious disease, damaged tissues must of course be repaired and reconstituted. Sometimes the microorganism is completely destroyed and tissues sterilised, but often this fails to take place and the microorganism persists in the body, in some instances continuing to cause minor pathological changes. The individual is nevertheless said to have recovered from the acute infection and is usually resistant to re-infection with the same microorganism. Persistent infections are dealt with in Ch. 10.

Immunological Factors in Recovery

The mechanisms of recovery from a primary infection are not necessarily the same as those responsible for resistance to re-infection (see below). For instance, antibody to measles is of prime importance in resistance to re-infection and susceptible children can be passively protected by the antibody present in pooled normal human serum. But, compared with CMI, antibody plays only a small part in the recovery from initial infection with measles virus. Antibody, CMI, complement, phagocytes and interferon are involved in the response to nearly all infections and without any doubt are together responsible for recovery.

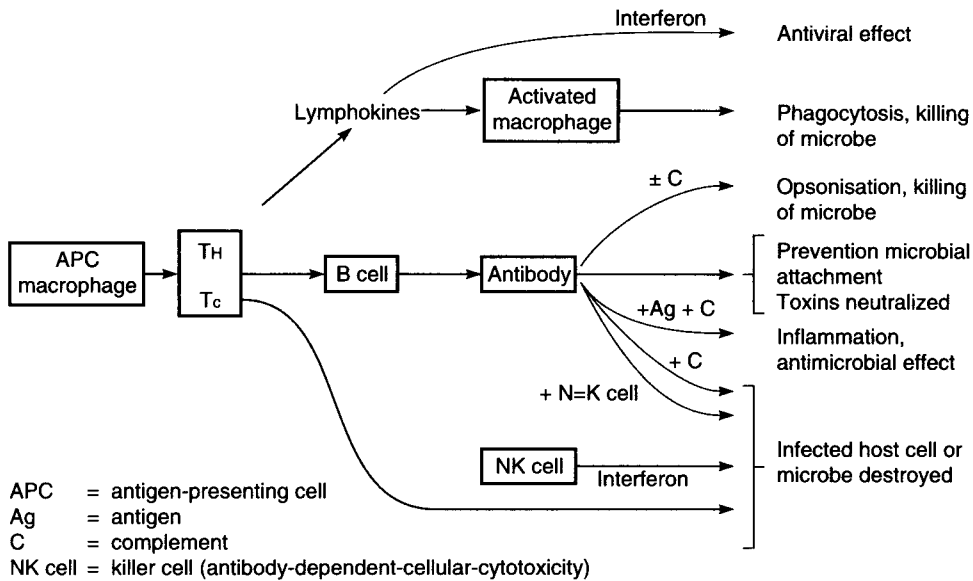


Fig. 9.1 Immune responses in infection.

They constitute a mighty antimicrobial pentad, whose action is illustrated diagrammatically in Fig. 9.1. In only a few instances, however, have the different components of this mighty pentad been dissected out and separately evaluated. All components normally operate together, and to some extent the attempt to make separate evaluations is rather like deciding on the relative importance of 2, 3 and 4 in producing the product 24. For instance, polymorphs play a vital role in recovery from many bacterial infections, but they necessarily operate in conjunction with antibody and complement. Macrophages play a vital role both in the induction and in the expression of CMI responses (see below). There are naturally occurring diseases in which one component is deficient or absent, and sometimes a component can be eliminated experimentally. More commonly the deficiency diseases are mixed in type, and experimentally it is often impossible to eliminate one component without also affecting the others. There has been some clarification and definition of the factors involved in recovery in the case of virus infections.

One major difficulty in assessing the importance of immune responses is that nearly all microorganisms are very complex, with large numbers of antigens. Various tests for antibody and CMI are carried out, but it is not often possible to test the response to a defined antigen, or to know precisely which antigens are important for infection and pathogenicity.

Antibody

The different types of antibody and the ways in which they have an antimicrobial action are listed in Ch. 6. Antibody actions against

Table 9.1. Antibody and CMI in resistance to systemic infections^a

Type of resistance	Antibody	CMI
Recovery from primary infection	Yellow fever	Poxviruses
	Polioviruses	e.g. ectromelia (mice)
	Coxsackie viruses	vaccinia (man)
		Herpes-type viruses
		Herpes simplex
		Varicella-zoster
		Cytomegalovirus
	Streptococci	LCM virus (mice)
	Staphylococci	Measles
	<i>Neisseria meningitidis</i>	Tuberculosis
<i>Haemophilus influenzae</i>	Leprosy	
Malaria?	Typhoid	
<i>Candida</i> spp.	Systemic fungal infections	
<i>Giardia lamblia</i>	Chronic mucocutaneous candidiasis?	
Resistance to re-infection	Nearly all viruses including measles	Tuberculosis
	Most bacteria	Leprosy
Resistance to reactivation of latent infection	Herpes simplex?	Varicella-zoster
		Cytomegalovirus
		Tuberculosis
		<i>Pneumocystis carinii</i>

^a Either antibody or CMI is known to be the major factor in the examples given. But in many other infections there is no information, and sometimes both types of immunity are important.

microorganisms are further discussed at the end of this chapter under 'Resistance to re-infection'.

In some infections antibody plays a major part in the process of recovery (see Table 9.1). For instance, viruses producing systemic disease, with a plasma viraemia (see p. 116), are controlled primarily by circulating antibody. This seems to be so in yellow fever or poliomyelitis virus infections. Children with severe hypogammaglobulinaemia are unable to form antibodies to poliovirus, and are about 10 000 times more likely than normal individuals to develop paralytic disease (which is generally of a chronic type) after live virus vaccination.* They have normal CMI and interferon responses, normal phagocytic cells and complement, but lack the specific antibody which must be produced if virus multiplication and spread to the CNS are to be inhibited.

Antibody on its own can neutralise virus infectivity. Such neutralising antibodies attach to specific neutralisation sites on surface proteins (poliovirus has four and influenza virus has five neutralisation sites) and only through these sites is the virus neutralised. Antibodies do

* Agammaglobulinaemics are also susceptible to pneumococcal infections. Theoretically, opsonisation of these bacteria should occur after activation of the alternate pathway (Ch.6), but antibody appears to be needed for optimal uptake and killing by phagocytes. Antibody may also be needed for lysis of virus-infected host cells after alternative pathway activation (see pp. 292-3).

attach to other sites but these are non-neutralising. Neutralising antibodies do not need to coat the virion and rarely inhibit attachment of the virion to the host cell receptor. In fact most kinetics of neutralisation are single hit, meaning that one virus particle is neutralised by one molecule of antibody. How can this be when an antibody (IgG) molecule (Mr 150 000) is less than the size of one of the hundreds of surface proteins of an enveloped virus like influenza? It is thought that antibodies usually act by interfering with uncoating, either by triggering a stage of uncoating prematurely or by preventing uncoating by cross-linking surface structures on the virion. For example some antibodies inhibit fusion (the first stage of uncoating). Still others inhibit later stages of uncoating from taking place. How they do so is not understood. Neutralising antibodies can be of the IgG, IgA or IgM immunoglobulin isotypes.

Antibody also promotes the uptake and digestion of virus by phagocytic cells, so that the virus-antibody complex is finally taken up and disposed of. Antibodies also act against viruses by clumping them, by destroying them with the help of complement, or by inducing inflammatory responses following their interaction with viral antigens (see Ch. 6).

Various bacteria have been shown to make specific attachments to epithelial surfaces and here secretory IgA antibodies are significant. IgA antibodies are formed in most infections of mucosal surfaces whether bacterial, viral or due to other microorganisms. They tend to prevent re-infection, but if formed early enough in the primary infection they could block the attachment of the microorganism to susceptible cells or cell surfaces (see Table 2.1) and thus interfere with the spread of infection. Their actual function in recovery, however, is doubtful. As was pointed out earlier, virus infections that are limited to epithelial surfaces and do not have a time-consuming spread of infection through the body, have incubation periods of no more than a few days. There is little opportunity for the slowly evolving immune response to play an important role in recovery, and virus replication is often inhibited before there has been a detectable IgA response. On the other hand, it must be remembered that antibodies (IgG or IgA) can be produced locally within two days after experimental respiratory tract infections, for instance, and they would not be detected routinely when bound to viral antigens at this stage. But interferon is produced by the first infected cell, and is likely to have an important local antiviral action. If the process of infection takes longer, then secretory IgA antibodies have more opportunity to aid recovery. When the intestinal protozoan *Giardia lamblia* causes symptoms, these are not seen until 6–15 days after infection. A role for secretory IgA antibodies is indicated because patients with a shortage of these antibodies show troublesome and persistent giardial infection.

Quite clearly, as discussed in Ch. 4, the antibody response to streptococci, staphylococci and various encapsulated bacteria such as the

pneumococcus is of particular importance. These are the common pyogenic (pus-forming) infections. For its antibacterial function, antibody needs to operate together with phagocytic cells and complement and, if either of these are missing, resistance to pyogenic infections is impaired. Children with agammaglobulinaemia suffer repeated infections with pyogenic bacteria.* The spleen is an important site of antibody formation, and when the spleen has been removed surgically, or rendered incompetent in children with sickle cell disease (see p. 334) there is increased susceptibility to such infections. On the other hand, many bacterial infections (tuberculosis, syphilis, typhoid, gonorrhoea) can persist or can re-infect in spite of the presence of large amounts of antibody. This is discussed more fully in Ch. 7, and it is a reminder of the frequent inability of antibodies to ensure recovery.

Antibodies are vital in recovery from diseases caused by toxins, such as diphtheria and tetanus. As soon as antibodies have been formed to neutralise the powerful toxins and prevent further tissue damage, recovery is possible; without antibodies the other antibacterial forces may operate in vain. In diphtheria the patient often recovers and is immune to the toxin without having controlled the infection itself, and remains a carrier.

Circulating antibodies are probably important in the recovery from infection with certain protozoa such as malaria. Here, in particular, antibody must be directed against the relevant stage of the microorganism (especially the merozoite) and also against the relevant antigen on the microorganism. Merozoites are the forms that specifically absorb to red blood cells and parasitise them, and protective antibodies coat the merozoite surface and inhibit this absorption, at the same time promoting phagocytosis by the reticuloendothelial system.

Host defences against fungi are less clearly defined but there are indications that CMI is more important than antibody. Disseminated infection with certain fungi (*Coccidioides*, *Histoplasma*) occurs even in the presence of high antibody titres, and in such cases there is usually no CMI demonstrable by skin tests (Table 6.5), suggesting that CMI matters most. Local infections with fungi elicit good CMI responses but poor antibody responses, and the patient recovers. Severe mucocutaneous candidiasis is seen in those with defective CMI, in spite of normal antibody production.

Small microorganisms such as viruses may have no more than one (HIV) or two different proteins on their surface. The surface of influenza virus, for instance, consists of 500 or more haemagglutinin trimers, interlaced with about 100 neuraminidase 4-mers. Antibodies to either antigen protect against infection, although the haemagglutinin is the

* Infants with congenital (inherited) forms of agammaglobulinaemia remain well until about nine months of age because the gift of maternal IgG via the placenta gives passive protection during this period.

major neutralisation antigen. Antibody to the neuraminidase inhibits its enzymic activity. It does not prevent infection of the cell, but prevents the dissemination of newly formed virus, and thus hinders the spread of infection. This occurs because neuraminidase is required to digest neuraminic acid receptors on the cell from which it has just emerged, and thus prevent the virus from attaching to the cell from which it has just emerged. One can begin to work out the mechanisms of antibody protection in a relatively simple microorganism of this sort.* Larger microorganisms, however, generally have many different proteins and carbohydrates on their surface. Some of these will be concerned with vital steps in the process of infection, and antibodies to specific neutralisation sites on these will be protective. Antibodies to other antigenic sites on these structures and even to some complete structures will not be protective, and when they are attached to the microbial surface may even physically interfere with (block) the action of protective antibodies. In addition, a large assortment of irrelevant antibodies are produced to internal components of the microorganism. Antibodies themselves differ in the firmness of the combination they make with antigens and may be of high or low avidity (see Glossary). Thus the quality of the antibody also matters. Protection by antibody is therefore a complicated matter, and if there is no protection in spite of the presence of large amounts of antibody, one has to ask first what components of the microbe these antibodies are combining with, and whether these antibodies have the relevant specificity for the job. Second, one needs to ask whether the antibody itself is of sufficient quality, and of the appropriate isotype.

Cell-mediated immunity

There is good evidence that cell-mediated immunity (CMI) is of supreme importance in recovery from a variety of microbial infections. These tend to be infections in which the microorganism replicates intracellularly (see Table 9.1). Tissue responses in the host bear the hallmarks of CMI involvement, the infiltrating cells consisting primarily of lymphocytes and macrophages. Macrophages are often infected. Delayed hypersensitivity is usually demonstrable by skin testing (Table 6.5). Infections of this nature include tuberculosis, brucellosis, tularaemia, syphilis, tubercloid leprosy (pp. 289–90) and leishmaniasis. Recovery is associated with the development of a vigorous CMI response, which also makes an important contribution to the pathology of the disease. As pointed out earlier, CMI develops in many other infections but is not very clearly associated with recovery. On infection with *Streptococcus pyogenes*, for instance, delayed hypersensitivity to the streptococcal products streptokinase and streptodornase develops, but it is less important than

* The haemagglutinin of influenza virus was the first envelope protein for which a three-dimensional structure was determined. Analysis with monoclonal antibodies defined five antigenic sites which mediate neutralisation, and their physical location. These are also the sites which undergo antigenic drift (p. 190).

Table 9.2. Immune defences appropriate to different types of infection

Type of infectious agent	Primary immune defence	Immune mechanism	Further possible immune defences	Examples
1. Multiplies inside tissue cells	Antibody rarely inhibits virus attachment but prevents entry or a later stage of infection. Entry of other microbes inhibited by coating with antibody	Antibody production (IgG, IgA, IgM)	Kill infected cell ^a	Most viruses Rickettsias, malarial merozoites
2. Multiplies inside phagocytes	Activate phagocytes and thus render them resistant to infection	T cells generate lymphokines	Kill infected ^a phagocyte	Certain viruses <i>Mycobacterium tuberculosis</i> <i>Leishmania</i> , trypanosomes (see Table 4.2)
3. Multiplies outside cells	Kill microbe extracellularly or intracellularly	Complement-mediated lysis ^b Opsonised phagocytosis and killing	Neutralise microbial toxins	Most bacteria Trypanosomes
4. Multiplies outside cells, but attachment to body surface necessary for invasion	Prevent attachment by coating microbial surface with specific antibody	Antibody production (mainly secretory IgA)	As under 3	Streptococci <i>Neisseriae</i> <i>E. coli</i> etc. (see Table 2.1, pp. 12–14)

^a Mechanisms are antibody + complement, ADCC, cytotoxic T cell, or natural killer cell (see Ch. 6).

^b NK cells (e.g. in *Toxoplasma gondii* infection) or T cells.

antibody in recovery from infection. An interesting distinction can be made between different types of infectious agent and the immune strategy most likely to be effective (Table 9.2).

The clearest picture about CMI in recovery comes from certain virus infections, particularly herpes viruses, poxviruses and measles virus, and it is first necessary to refer to important features of these infections which make the CMI response important. Antibodies neutralise free virus particles liberated from cells, but, despite the help of complement and phagocytes with Fc receptors, often fail to influence events in infected cells. Action on the infected cell seems necessary for recovery from the above virus infections. The destruction of cells infected with viruses takes place in various ways, but depends on the mechanism of virus maturation in the cell. Many viruses, such as poliovirus or papilloma viruses, replicate and produce fully infectious particles inside the cytoplasm. These particles are nucleocapsids, consisting of the nucleic acid with its protein coat (capsid), and are exposed to antibody when liberated from the cell (Fig. 9.2). Other viruses do not have to wait for cell disruption, but are liberated by a process of budding from the cell membrane. The viral nucleocapsid in the cytoplasm becomes closely associated with the cell membrane and acts as a nucleation point for the viral envelope proteins (Fig. 9.2). The virus particle finally matures by budding through the altered cell membrane, acquiring an envelope as it does so. Such viruses are referred to as 'enveloped' and include HIV, herpes viruses, myxo and paramyxo viruses etc. (pp. 384–5). There are two important consequences of this mechanism of virus maturation. First, virus can be released even though the cell remains alive and intact. Second, the foreign viral antigens appearing on the cell surface are recognised by the host and an immune response is generated with the infected cell as the target. The significance of this is that the infected cell can be destroyed before virus has been liberated,* and can also be destroyed in oncogenic and other virus infections in which virus is liberated from the cell over long periods.

Viral antigens are also formed on the cell surface during the replication of certain nonenveloped viruses such as adenoviruses. The surface antigens are not incorporated into the virus particle, but the infected cell bearing the antigens can be recognised and destroyed by immune mechanisms. Also, although destruction of infected host cells has long been considered a feature of viral rather than other infections, there is growing evidence that it is a possibility in certain other infections. Host cells infected *in vitro* with protozoa (*Plasmodia* and *Theileria*), with rickettsia (*Coxiella burnetii*) and probably with certain bacteria (*Listeria*) express microbial antigens on their surface and thus should be vulnerable to immune lysis.

* Viral antigens often appear on the cell surface very early in the replication process, many hours before progeny virus particles have been formed. These antigens can be identified by fluorescent antibody staining, or by the susceptibility of the infected cell to lysis after treatment with antiviral antibody plus complement. As many as five distinct viral antigens (glycoproteins) appear on the cell surface in the case of a large virus such as herpes simplex.

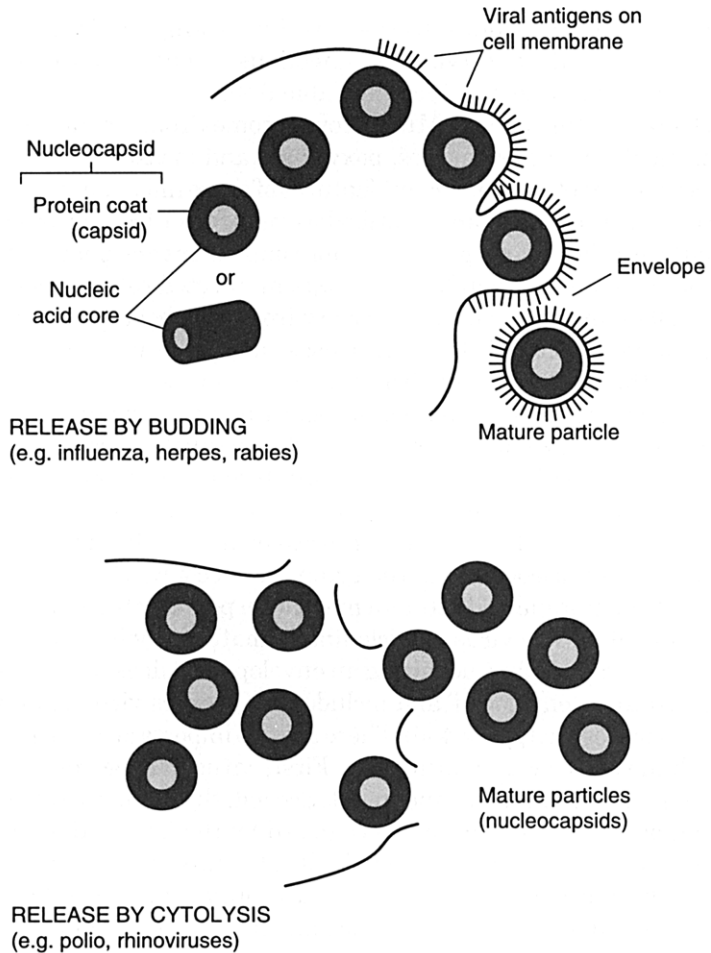


Fig. 9.2 Diagram to illustrate mechanisms of virus release from infected cell. Nucleocapsids may be spherical (herpes viruses) or tubular (influenza). Budding may also take place from nuclear membrane (herpes viruses) or from the membrane lining cytoplasmic vacuoles (coronaviruses, flaviviruses).

The immune mechanisms for the destruction of cells bearing foreign antigens on their surface can be summarised as 'burns' or 'pores', and are as follows:

- (1) The T cell receptors recognise only peptides in association with MHC class I proteins ($CD8^+$ T cells) or class II proteins ($CD4^+$ T cells) on the target cell surface. Any viral protein can be processed in this way, and often internal virion proteins or nonvirion proteins provide the major target for T cells. A specifically sensitised cytotoxic T cell (CTL) makes intimate contact with the target cell membrane and deposits 'pores' made of the protein perforin in the membrane of the target cell, making holes 40 nm in diameter that cannot be repaired, so that when the T cell moves away 30–60 s later there is a leakage of

cell components and K^+ ions, an influx of water and Na^+ ions, and the target cell swells up and dies. The T cell can kill again. Natural killer cells have a similar mode of action, but they do not have the same antigen-specific recognition system.

- (2) Macrophages, polymorphs, and also certain mononuclear cells (NK cells, see Ch. 6) which are not macrophages or typical T lymphocytes have the ability to destroy target cells with the assistance of specific antibody (ADCC). Antibody combines with antigen on the infected cell surface, and the killer cell attaches to the antibody-coated cells via the Fc receptor. The process is enhanced when complement is activated, the C3b molecules deposited on the cell surface being recognised by mononuclear cells that bear C3b receptors. The final killing mechanism is not clear, but the killer cell releases oxygen radicals (see p. 80) which 'burn' the target cell. The Fc receptors on eosinophils enable them to function in the same way and kill multi-cellular parasites such as schistosomes (see p. 77) after adhering in large numbers to the antibody-coated surface of these parasites.
- (3) Antibodies combine with antigen on the target cell surface, complement is activated locally, creating pores in the cell membrane very similar to those made by CTLs, and leading in the same way to cell disruption (see p. 165). This type of cell destruction generally needs much more antibody and in that sense is less efficient than the antibody-dependent destruction by mononuclear cells described under 2. The importance of complement in disease is indicated by natural complement deficiencies which exacerbate certain bacterial infections (*Neisseria*) but have no effect on the severity of virus infections.

In infections with herpes viruses (herpes simplex, varicella, CMV etc.), proteolytically processed peptides or virus antigens appear on the surface of infected cells 12–24 h before virus multiplication is completed, so that cells can be destroyed early in infection by T cells or by the other mechanisms listed above. Herpes viruses tend to spread directly from cell to cell without entering extracellular fluids, and antibodies cannot enter cells to neutralise virus. By acting directly on infected cells, immune cytotoxicity helps prevent this type of spread. Immune cytotoxicity has a similar action on cells infected with poxviruses and measles virus.

The sequence of events with herpes virus, poxvirus and measles virus infections appears to be as follows (as outlined in Ch. 6). At sites of virus multiplication, T lymphocytes, in the course of their normal movements through the body encounter viral peptides that are complexed with MHC proteins on the surface of a macrophage or other antigen-presenting cell. When a T cell encounters the antigen to which it is specifically sensitised, the CMI response is initiated. The T cell differentiates and divides to give fresh supplies of specifically sensitised T cells. These can react with any cell presenting the relevant peptide in association with a MHC molecule. Lymphokines are liberated to attract macrophages and other leucocytes and focus them onto the site of infection. Infected cells are

destroyed by cytotoxic T lymphocytes and other cells, and virus material and cell debris is phagocytosed and disposed of by activated macrophages. Similar events occur in lymph nodes to which virus or virus antigens have been brought by lymphatics.

The best way of discovering the function of a bodily mechanism or organ is to see what happens when it is removed (see also agammaglobulinaemia, p. 280). In experimental infections, CMI can be inactivated without affecting antibody or interferon responses, and changes in the disease are then studied. For instance, the selective removal of lymphocytes* in mice infected with ectromelia (mouse pox) virus has profound effects on the disease. The virus normally causes focal liver necrosis, and in CMI-depleted mice inflammatory responses in foci of liver infection are inhibited so that virus continues to grow, destroys hepatic cells, and proves fatal in spite of the presence of antibodies. If immune T cells are transferred to such an animal, there is a prompt cellular infiltration into foci of infection and inhibition of virus growth. Immune T cells react with viral antigens in tissues and focus macrophages onto the site of infection, inhibiting virus growth by the mechanisms described above and in Ch. 6.

A more defined depletion of T cells can be achieved by treatment with monoclonal antibodies specific for CD4 or CD8 proteins. Nowadays the method of choice is to use transgenic 'knockout' mice in which the gene encoding the protein of interest is inactivated at the DNA level. In this way mice with selected defects in host defence can be studied, such as mice lacking IFN- γ , TNF or their receptors; mice unable to produce IL-2, IL-4, IL-6, IL-10; or mice without CD8+ T cell function (a disrupted β_2 microglobulin gene rendering them incapable of presenting class I MHC molecules on the cell surface). Most of these gene knockout mice develop normally and remain well, but show increased susceptibility to intracellular infections caused by various viruses, bacteria or protozoa. But the picture is complex. Deleting one cytokine or cell function upsets a delicate network of antimicrobial forces. Often a different defence mechanism takes over the function of the one that has been deleted. In other words, there is a redundancy in host defence mechanisms, as might be expected as an evolutionary response to infectious agents that often evade or interfere with these mechanisms.

At the clinical level, albeit without the precise focusing achieved in the knockout mice, evidence for the importance of CMI in the control of infections comes from studies on patients with defective CMI. Very rarely, infants are born with an absent or poorly developed thymus gland (thymic aplasia or hypoplasia). Their T lymphocytes fail to differentiate and develop, giving rise to severe CMI deficiency. Although their T cell-dependent antibody response is also defective, they make a normal T cell-independent antibody response (mainly IgM). Congenital

* This was done in adult mice by treating them with antilymphocyte serum which lyses lymphocytes in association with endogenous complement.

immunodeficiencies are often mixed in nature with defects in CMI, antibody response or phagocytic cells; thymic aplasia, although so rare,* is a 'pure' deficit and gives some insight into the importance of CMI in infectious diseases. Affected infants show normal ability to control most bacterial infections, but a greatly increased susceptibility to infections with various viruses and certain other intracellular microorganisms. After measles infection, for instance, there is no rash but an uncontrolled and progressive growth of virus in the respiratory tract, leading to fatal giant cell pneumonia. Evidently the CMI response controls the infectious process and at the same time plays a vital role in the development of skin lesions. In the days when affected children were vaccinated against smallpox with vaccinia virus, the virus grew as usual in epidermal cells at the inoculation site to give an increasing zone of skin destruction. In normal infants there was an inflammatory response at the edges of the lesion after 6–8 days and this led to inhibition of virus growth, then scabbing and healing of the lesion. The infant with thymic aplasia, however, did not show this response and the destructive skin lesion continued to enlarge, occupying an ever-increasing area of the arm and shoulder. The infection could be controlled by local injection of immune lymphocytes from a closely related donor, but not by antibody. Infants with this type of immune deficiency also tend to suffer severe generalised infections with herpes simplex virus. In addition they show increased susceptibility to other intracellular microorganisms. When they are vaccinated against tuberculosis with live BCG vaccine, the attenuated bacteria, instead of undergoing limited growth with induction of a good CMI response, multiply in an uncontrolled fashion and may eventually kill the patient. The CMI response is therefore necessary for the control of infection with intracellular bacteria of this type.

There are two more clinical examples of the importance of CMI in recovery from nonviral intracellular infections. Leprosy, caused by *Mycobacterium leprae*, exists in a spectrum of clinical forms. At one end of the spectrum is tuberculoid leprosy. Here, the infection is kept under some degree of control, with infiltrations of lymphocytes and macrophages into infected areas such as the nasal mucous membranes. In the lesions there are very few bacteria and all the signs of a strong CMI response. Injection of lepromin (leprosy antigens) into the skin of the

* Mixed antibody and CMI deficiencies are commoner. The infants suffer from superficial *Candida albicans* infections, and commonly die with *Pneumocystis carinii* (see Glossary), pneumonia or generalised infections with vaccinia, varicella or measles. Immune deficiencies (mostly CMI) are seen in adults with Hodgkin's disease, or after immunosuppression for organ transplants. In these patients, who have encountered the common infections in early life, there is reactivation of persistent infections such as varicella-zoster, tuberculosis, herpes simplex, cytomegalovirus, warts and *Pneumocystis carinii* infection. Gram-negative bacterial pneumonia may also occur. In many immunodeficiencies the primary defect is unknown. Patients lacking adenosine deaminase, an enzyme in the purine salvage pathway, develop a severe combined immunodeficiency (SCID). Their lymphocytes fail to mature, macrophage activation is defective, and they die early as a result of infection unless given a bone marrow transplant.

infected patient gives a rather slowly evolving but strong delayed hypersensitivity reaction. This type of leprosy is called tuberculoid leprosy because the host response is similar to that in tuberculosis. At the other end of the leprosy spectrum* (lepromatous leprosy) there are very few lymphocytes or macrophages in the lesions and large numbers of extracellular bacteria. Associated with these appearances indicating less effective control of the infection, there is a weak or absent skin response to lepromin. Lepromin is a crude bacterial extract and the exact antigens to which the lepromatous patient fails to respond are not known.† Antibodies are formed in larger amounts than in tuberculoid patients and indeed may give rise to immune complex phenomena in lepromatous patients (see Ch. 8), but these antibodies fail to control the infection. The second clinical example of the importance of CMI in recovery concerns the disease chronic mucocutaneous candidiasis. Children with immunodeficiency disease sometimes develop severe and generalised skin lesions caused by the normally harmless fungus *Candida albicans*. Antibody to *Candida* is formed but the CMI response is often inadequate and these patients can be cured by supplying the missing CMI response. This can be given in the form of repeated injections of a mysterious 'transfer factor' (see Glossary). The CMI response may have additional antimicrobial effects in chronic infections with certain intracellular organisms. When the microorganism persists as a source of antigenic stimulation and the CMI-induced influx of mononuclear cells continues, a granuloma may be formed (see below). The focus of infection tends to be walled off, and this is often associated with the inhibition of microbial growth. Granulomas are a feature of respiratory tuberculosis, contributing to pulmonary fibrosis. Granulomas, however, can result from chronic accumulation of immune complexes as well as from chronic local CMI reactions (see Ch. 8).

Phagocytosis

Phagocytes play a central role in resistance to and recovery from infectious diseases (see pp. 63–72). In the old days physicians saw the formation of pus (see pp. 82–3) as a valiant attempt to control infection, and referred to it as 'laudable pus', especially when it was thick and creamy. An account of the antimicrobial functions of phagocytes and the consequences of phagocyte defects is given in Ch. 4.

Inflammation

Inflammation, whether induced by immunological reactions, tissue damage or microbial products plays a vital role in recovery from infection

* To some extent there is also a clinical spectrum in tuberculosis, according to the type of immune response, some (more susceptible) patients showing strong antibody responses and weak cell-mediated immune responses.

† Lymphocytes from patients show normal transformation responses to other mycobacteria such as BCG and *Mycobacterium lepraemurium* (see Ch. 7).

(see also Chs 3 and 6). Inflammation is necessary for the proper functioning of the immune defences because it focuses all circulating antimicrobial factors onto the site of infection. The circulating antimicrobial forces that arrive in tissues include polymorphs, macrophages, lymphocytes, antibodies, activated complement components, and materials like fibrin that play a part in certain infections.* The increased blood supply and temperature in inflamed tissues favour maximal metabolic activity on the part of leucocytes, and the slight lowering of pH tends to inhibit the multiplication of many extracellular microorganisms. The prompt increase in circulating polymorphs during pyogenic infections is caused in the first place by the release of cells held in reserve in the bone marrow, but there is also an increase in the rate of production. Monocyte release and production is controlled independently. At least four colony stimulating factors, all glycoproteins, control the mitosis of polymorph and macrophage precursors, and their final differentiation and activity. One of them is interleukin-3 (IL-3), which acts mainly on polymorph precursors. They are present in increased amounts in serum during infection, and in animals the serum levels are dramatically raised by the injection of endotoxin.

Circulating polymorphs show increased functional activity during pyogenic infections and readily take up and reduce a certain yellow dye (nitroblue-tetrazolium), forming dark blue deposits in the cytoplasm. An increase in the proportion of polymorphs showing this reaction reflects their increased activity, but the test is of no value in the diagnosis of pyogenic infections because of false positive and false negative results. In any case, increased reduction of the dye is not necessarily associated with increased bactericidal activity.

When inflammation becomes severe or widespread there is a general body response with the appearance of acute-phase proteins in the blood. (see p. 70). As a result two classical changes can be detected in the blood. The first is an increase in the erythrocyte sedimentation rate (ESR), and this is a clinically useful indication that inflammation or tissue destruction is occurring somewhere in the body. The exact mechanism of the increase is not understood. The second change is the appearance in the blood of increased quantities of a β -globulin synthesised in the liver and detected by its precipitation after the addition of the C carbohydrate of the pneumococcus. It is therefore called C-reactive protein.† Very small amounts are present in the blood of normal individuals, but there is a 1000-fold increase within 24 h of the onset of inflammation. After

* There have been numerous reports of antimicrobial factors present in normal serum. Doubtless some of these involved alternative pathway activation of complement, as in the case of pathogenic *Neisseria* (see below). Trypanocidal factors in normal human serum may be related to natural resistance to trypanosomiasis. It has been known since 1902 that *Trypanosoma brucei*, which is not infectious for man, is lysed by something present in normal human serum, whereas *Trypanosoma rhodesiensi* and *Trypanosoma gambiensi* which infect man and cause sleeping sickness, are relatively resistant. The trypanocidal factor has been shown to be a high density lipoprotein.

† C-reactive protein and other acute phase proteins are formed as a result of the action of mediators such as IL-1, IL-6 and TNF.

binding to substances derived from microorganisms and from damaged host cells, it activates the complement system, acts as an opsonin, and possibly serves a useful function. Both the ESR and C-reactive protein changes are nonspecific sequelae to inflammation of any sort, whether infectious or noninfectious.

When the infection is persistent, inflammation may become chronic, lasting weeks or months. Infections do not generally last for long periods if they induce acute polymorphonuclear inflammation; the battle between host and microbe is decided at an early stage.* Chronic inflammation depends on a constant leakage of microbial products and antigens from the site of infection. The type of infection that persists and causes chronic inflammation is generally an intracellular bacterial or fungal or chlamydial infection. In these infections there is a chronic CMI response, with proliferation of lymphocytes and fibroblasts in infected areas, a steady influx of macrophages and the formation of giant and epithelioid† cells. Episodes of tissue necrosis alternate with repair and the formation of granulation tissue, then fibrous tissue. It is a ding-dong battle between microorganisms and host antimicrobial forces. The resulting granuloma (see also above) can be regarded as an attempt to wall off the infected area. Chronic infections with chronic inflammation and granuloma formation include tuberculosis, syphilis, actinomycosis, leprosy, lymphogranuloma inguinale and coccidioidomycosis. Chronic viral infections are not associated with chronic inflammatory responses, probably because virus growth is often defective and no more than minute amounts of antigen are liberated.

Complement

Complement has been discussed and invoked on many occasions in Chs 6, 7, 8 and in this chapter. It should be remembered that some of the complement components are quite large molecules, and do not readily leave the circulation except where there is local inflammation. Complement can carry out antimicrobial activities in the following ways.

- (1) *Complement lysis*. Complement reacts with antibody (IgG and IgM) that has attached to the surface of infected cells or to the surface of certain microorganisms, and destroys the cell or microorganism after making holes in the surface membrane. Gram-negative bacteria are killed in this way, and also enveloped viruses such as rubella and parainfluenza (although as mentioned above lack of complement does not exacerbate these virus infections). Because of the amplification occurring in the complement system (see Ch. 6),

* Occasionally this is not so, and there is continued polymorph infiltration, as for instance in chronic osteomyelitis or a pilonidal sinus.

† Epithelioid cells are poorly phagocytic, highly secretory, and about 20 μm in diameter, whereas giant cells, formed by the fusion of macrophages, are up to 300 μm in diameter, containing up to 30 nuclei.

especially when the alternative pathway is also activated, antibody attached to the surface of a microorganism is more likely to induce complement lysis than it is to neutralise it. Complement lysis is therefore perhaps more important when antibody molecules are in short supply, early in the immune response. Bacteria with surface polysaccharide components can activate complement without the need for antibody (see 5, below), as can host cells infected with viruses such as measles. In the latter case alternative pathway activation by itself does not do enough damage to kill the cell, presumably because less severe membrane lesions can be repaired; antibody must also be present for lysis.

- (2) *Complement opsonisation.* Complement reacts with antibody attached to the surface of microorganisms, providing additional receptor sites for phagocytosis by cells bearing the appropriate complement receptors, like polymorphs or macrophages. Phagocytosis is also promoted by antibody attached to the microorganism because of the Fc receptors on phagocytes, but when complement is activated there are many more molecules of C3b present as a result of the amplification phenomenon. Therefore complement often has a more pronounced opsonising effect than antibody alone and for some bacteria, such as the pneumococcus, opsonisation actually depends on complement. Complement opsonisation is important when the antibody is IgM, because human phagocytes do not have receptors for the Fc region of IgM. Complement can also act as an opsonin though not always so effectively, in the absence of antibody (see 5, below).
- (3) *Complement-mediated inflammation.* Specific antibodies react with microbial antigens that are either free or on the surface of microorganisms. Following this antigen-antibody reaction, complement is activated, with generation of inflammatory and chemotactic factors (C3a and C5a). These substances focus antimicrobial serum factors and leucocytes onto the site of infection.
- (4) *Complement-assisted neutralisation of viruses.* In the case of viruses coated with antibody, complement adds to the mass of molecules on the virus surface and may hinder attachment of virus to susceptible cells. However, it has little effect on virus coated with non-neutralising antibody, and in general appears to be of little importance in human infections.
- (5) *Complement-assisted cell lysis.* C3b deposition on infected host cells not only opsonises (see above) but also augments cell-mediated cytotoxicity (ADCC, see p. 151).
- (6) *Complement opsonisation via alternative pathway.* Complement reacting with endotoxin on the surface of Gram-negative bacilli, with capsular polysaccharide of pneumococci etc., or with *Candida*, is activated via the alternative pathway (see p. 163) and C3b-mediated opsonisation takes place. It seems likely that this is important in natural resistance to infection.

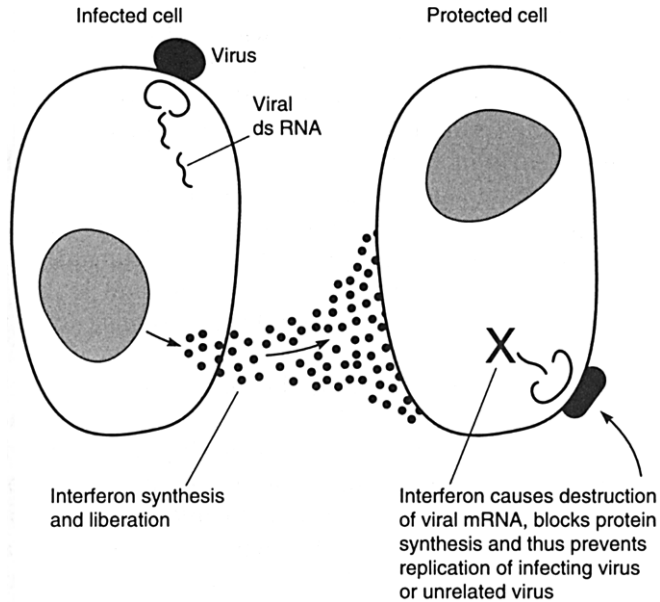


Fig. 9.3 Mechanism of induction and action of α and β interferon. Interferon attaches to its receptor on uninfected cell on right and protects it against virus infection. γ Interferon from T cells acts in the same way. Interferons also increase NK cell activity.

Unfortunately, there is little direct evidence that the above antimicrobial activities of complement are in fact important in the body. The rare patients with C3 deficiency develop repeated pyogenic infections, and C3-deficient mice show increased susceptibility to plague and to staphylococcal infections. Mice with C5 deficiency (controlled by a single gene) are more susceptible to *Candida* infection, probably because of inadequate opsonisation. Patients with C5–C8 deficiencies, however, are often particularly susceptible to disseminated or recurrent neisserial infection. In this case the bactericidal rather than the opsonising action of complement seem important. But observations on complement deficiencies are probably too limited to draw firm conclusions and there have been few clearly defined deficiencies. The system is a highly complex one, with alternative pathways, positive feedback amplification and multiple inhibitors. A similar complement system occurs in a wide range of vertebrates and it must be assumed that such a complex, powerful system confers some biological advantage, presumably by giving resistance to microbial infections.

Interferons

The interferons are cytokines, members of a family of cell-regulatory proteins produced by all vertebrates. There are three types of interferon: alpha (α), beta (β) and gamma (γ). Alpha and beta interferons are very similar, and are made by nearly all cells in the body, including epithelial

cells, neurons, muscle cells etc. in response to viral and other infections. Gamma interferon is produced by T lymphocytes following antigen-specific stimulation. All are cytokines with immunoregulatory functions as well as the antimicrobial action described below.

Viruses are the most important inducers of α and β interferon, the stimulus to the cell being the double-stranded RNA formed during virus replication (Fig. 9.3). Interferons act on uninfected cells, binding to a cell surface receptor and inducing the synthesis of a series of enzymes. These enzymes can prevent the replication of any virus destroying viral messenger RNA (by means of an induced ribonuclease), and by inactivating the polypeptide chain initiation factor. Interferons are exceedingly potent *in vitro*, being active at about 10^{-15} M. They have no direct action on virus itself and do not interfere with viral entry into the susceptible cell. The interferons produced by different species of animals are to a large extent species specific in their action.

Interferon liberated from infected cells can reach other cells in the vicinity by diffusion and establishes an antiviral state which protects them from infection.* A cell is thus protected from infection with all viruses for a period of up to 24 h. It would seem inevitable that interferon is important in recovery from virus infections, whether on epithelial surfaces or in solid tissues. Interferons, moreover, have other effects on host resistance. They activate NK cells, and control T cell activity by upregulating the expression of MHC proteins and thus the concentration of available peptide antigen. It has proved difficult to show conclusively that interferon is a vitally important part of the body's defence against viruses. If there were naturally occurring deficiencies in interferon production, or naturally occurring insensitivity to interferon, it would be possible to decide what interferon does, but deficiencies are not known to occur, partly because in humans there are about 12 genes encoding slightly different α interferons, although only one each for γ and β interferon.† However, interferon can be selectively inhibited in mice by treatment with antibody to interferon. When this is done, enhanced susceptibility to certain virus infections is observed. Interferon has also been given passively to experimental animals and can be effectively induced by the administration of a synthetic ds RNA preparation (poly I:poly C). Antiviral results are demonstrable in experimental infections, and are most clearly seen in infections of epithelial surfaces such as the conjunctiva or respiratory tract, and when treatment is begun before rather than after infection.

Interferon would seem to be the ideal antiviral chemotherapeutic agent for use in man, being produced naturally by human cells, nonimmunogenic

* Interferon is also induced by nonviral agents such as rickettsiae and certain bacteria, and will protect cells from various nonviral intracellular microorganisms.

† A study of 30 children who suffered from recurrent respiratory tract infections identified four with impaired interferon production. When these particular children were infected with common cold viruses, α interferon could not be detected in nasal washings. Their peripheral blood leucocytes also failed to produce α interferon on repeated testing *in vitro*, although γ interferon production was normal.

and active against a broad spectrum of viruses. However, it does cause influenza-like symptoms. So far, results in human patients have not been dramatic. For instance, volunteers infected intranasally with rhinoviruses and other respiratory viruses have been given either poly I:poly C or repeated very large doses of purified human interferon by the same route, but with disappointingly slight protection. However, it has proved useful in clearing up some cases of chronic hepatitis B infection, and is being used to treat hepatitis caused by the flavivirus, hepatitis C. HBV downregulates the expression of MHC class I proteins on infected hepatocytes, thus preventing CD8⁺ CTLs from destroying infected cells. By treating with α interferon, expression of MHC I proteins is upregulated and CTLs can act. Initially the patient becomes ill from the destruction of the liver, but eventually a virus-free liver regenerates. Here interferon is exercising its regulatory function rather than its antiviral effect. The most recent experimental approach is to create a strain of mice in which the γ interferon gene or its receptor has been inactivated or 'knocked-out' transgenically. In the absence of pathogens, mice developed normally, but they were more susceptible to the intracellular bacteria *Mycobacterium bovis* and *Listeria monocytogenes* and to vaccinia virus. The multiplicity of effects of this interferon was demonstrated by impairment in these mice of the functions of macrophages and NK cells, reduction of macrophage MHC class II proteins, uncontrolled proliferation of splenocytes, and a reduction in the amount of antigen-specific IgG2a. Further support for the importance of interferons in antimicrobial defences comes from the discovery that certain viruses have gene products that interfere either with the production (hepatitis B) or antiviral action (rotaviruses, adenoviruses) of interferon.

Multimechanistic Recovery: an Example

Although the host factors responsible for recovery have been described separately, they generally act together. Recovery is multimechanistic. As an example, Hormaeche's group in Newcastle have made extensive studies of the mechanisms involved in controlling *Salmonella* infections caused by *S. typhimurium* in mice, the most widely used model for typhoid-like disease caused by *S. typhi* in man. This embraces many of the features already dealt with in this chapter and anticipates some dealt with in Chapter 11. The system involves intravenous injection* of mice with organisms and, over a period of several days, estimation of the bacterial populations present in liver and spleen (the principal relevant components of the RES—see Glossary—whose mononuclear cells represent the main battleground in this infection). Sublethal infection proceeds in at least four distinct phases, schematically depicted in Fig. 9.4, and with some *Salmonella* this confers solid immunity to rechallenge.

* The events after oral infection are more complex, and less well understood. There are the extra features of bacterial entry into gut epithelial cells and transit through Peyer's patches, mesenteric lymph nodes and lymphatics, before the blood is invaded.

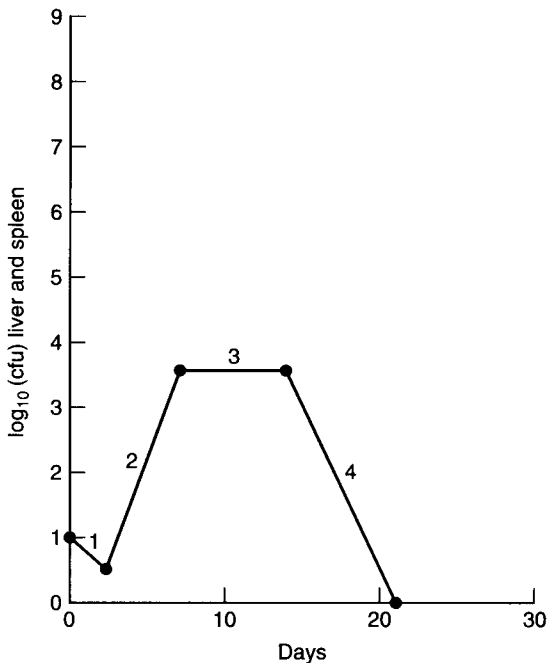


Fig. 9.4 The four phases of a sublethal salmonella infection in mice. Phase 1: initial inactivation of a large fraction of the challenge inoculum. Phase 2: exponential growth in the RES over the first week. Phase 3: Plateau phase in which growth is suppressed. Phase 4: Clearance of the organisms from the RES. cfu = colony-forming units.

Phase 1: Initial inactivation of the inoculum. This is a constant finding representing the transition from the *in vitro* to the *in vivo* phenotype. The decline is due to immunologically nonspecific uptake and destruction in macrophages of the RES. It is enhanced when animals are pretreated with opsonising antibody, as would be expected (see Fig. 5.4).

Phase 2: Exponential growth in the RES. This occurs during the first week with an estimated doubling time for *Salmonella* of ca. 2–5 h; killing rates are also slow. Three factors can affect phase 2. (i) Inoculum dose. By increasing the dose the pattern of phases 1 and 2 remains the same but raised to a higher level. When the inoculum reaches LD_{50} or higher (see Glossary) no phase 3 is observed; phase 2 continues till lethal numbers (10^8 – 10^9) are reached. With very high doses, the slope of phase steepens and the time to death shortens. (ii) Virulence of the bacteria. Increase in the slope of phase 2 is also a function of the virulence of the strain. (iii) Innate resistance of the host. A gene *ity* (immunity to *typhimurium*), expressed through macrophages controls phase 2. A similar situation exists for *Leishmania donovani*, *Mycobacterium tuberculosis* BCG, and *Mycobacterium lepraemurium*.

Phase 3 is essential for the host to survive. It is not mediated by T cells but requires continued production of TNF- α , which stimulates the production of IFN- γ . Studies with the *Listeria* model indicate that TNF- α is produced by macrophages which stimulate NK cells to release IFN- γ , which in turn activates newly recruited macrophages. It is of interest that during the plateau phase, mice show a manifest macrophage-mediated immunosuppression towards other antigens.

Phase 4 is the clearance phase which does require the presence of T cells, causing macrophage activation. CD8⁺ as well as CD4⁺ T cells are involved. Again host genes play an important role in this phase.

Temperature

In man the mean daily body temperature is 36.8°C with a daily variation of only 1.3°C, the maximum being at about 18.00 h, the minimum at about 03.00 h. This almost constant body temperature, like the almost constant level of blood sugar, illustrates Claude Bernard's dictum that '*La fixité du milieu intérieur est la condition de la vie libre*'. If the individual is to function steadily in spite of changes in the external environment, the internal environment must remain constant. The brain is one of the most sensitive parts of the body to departures from normality. At temperatures below 27.7–30°C people become unconscious, at 40.5°C or above they become disoriented and may be maniacal; above 43.3°C they are comatose. A rise in body temperature is one of the most frequent and familiar responses to infection, whether the infection is largely restricted to body surfaces (common cold, influenza) or is obviously generalised (measles, typhoid, malaria). During fever the appetite is often lost and headache may result from dilation of meningeal blood vessels. The temperature rise is largely due to an increase in heat production, and the raised metabolic rate, together with reduced food intake, results in a high excretion of nitrogen in the urine. There is rapid wasting of body fat and muscles if the fever is prolonged.

In infectious diseases there is a common mediator of the febrile response known as endogenous pyrogen (interleukin-1). It is present in inflammatory exudates and in the plasma during fever, and acts on the temperature-regulating centre in the anterior hypothalamus, resetting the body thermostat. Endogenous pyrogen is produced by macrophages and certain other cells, and as little as 30–50 ng causes fever in rabbits. It can be induced by immunological mechanisms. Fever is a common accompaniment of generalised antigen–antibody reactions. For instance, rabbits immunised with bovine serum albumin develop fever when injected with this antigen. Systemic virus infections such as the exanthems (see Glossary) are characterised by an asymptomatic incubation period during which virus replicates and spreads through the body, followed by a sudden onset of illness with fever. The febrile reaction is mainly due to the immune response to the virus; hence its relatively sudden onset a week or two after

infection. The CMI response (see below) as well as the antibody response is involved. Antigen–antibody reactions, in addition to causing fever, can also give rashes, joint swelling and pain, even glomerulonephritis (see Ch. 8). The first signs of illness in hepatitis B, before jaundice, are often ‘allergic’ in nature and mediated by antigen–antibody interactions, with fever, joint pains and fleeting rashes.

The generalised CMI response in the infected host is also a cause of fever, e.g. in tuberculosis, brucellosis and perhaps staphylococcal and cryptococcal infections. Tuberculin added to alveolar macrophages from an immunised animal generates endogenous pyrogen (interleukin-1). Also patients with chronic brucellosis develop fever when injected with 10 µg of purified brucella.

Certain bacterial products are pyrogenic. The peptidoglycan in the cell wall of staphylococci causes monocytes to liberate endogenous pyrogen. More importantly, endotoxins from Gram-negative bacteria also have this effect, as little as 2 ng of *Salmonella* endotoxin per kg causing fever in man. Endotoxin is present in the circulation during systemic infection with Gram-negative bacteria, but tolerance to endotoxin-induced fever develops quite rapidly, and endotoxin itself probably makes no more than a partial contribution to the febrile response, even in infections such as typhoid and dysentery. There is no good evidence that other microbial products or toxins cause fever other than by immunological mechanisms. In the old days before penicillin, pneumococcal pneumonia used to give one of the highest fevers known in man with dramatic and severe onset, the temperature often rising to 40°C within 12 h. These bacteria, however, have no endotoxin or other pyrogens and the mechanisms were presumably immunological.

In the case of influenza virus infection of ferrets, the best animal model for human influenza, there is a direct correlation between virulence and viral pyrogenicity. Endogenous pyrogen is released locally in the respiratory tract as a result of virus–phagocyte interaction. The viral determinants responsible have not been unequivocally identified, but the evidence points to the involvement of the haemagglutinin and/or neuraminidase surface glycoproteins of the virion.

Since fever is such a constant sequel of infection, it is natural to suppose that it has some antimicrobial function. Thomas Sydenham in the seventeenth century wrote that ‘Fever is a mighty engine which nature brings into the world for the conquest of her enemies’. Bodily functions are profoundly disturbed by fever. Metabolic activity is increased in phagocytic cells, and studies *in vitro* show that there are big increases in T cell proliferation and in antibody production at febrile temperatures. The evidence, however, is disappointing. Temperature-sensitive mutants of certain viruses are often less virulent, and experimental virus infections can sometimes be made more severe by preventing fever with antipyretic drugs. When fever is induced in infected animals by raising the environmental temperature there are also other complex physiological changes, making it difficult to interpret such experiments. In two bacterial

infections, gonorrhoea and syphilis, the microbes themselves are actually killed by febrile temperatures, but in the natural disease these temperatures are rarely reached. Before the introduction of antibiotics, patients with these two diseases were infected with malaria in order to induce body temperatures high enough to eradicate the infection (following which the malaria was treated with quinine).

Is fever, then, a purely accidental consequence of the immune response to an infectious agent and of little value to the host? Perhaps it would be wisest to reserve judgement. Fever is costly in energy and is an ancient bodily response, having evolved with the vertebrates over hundreds of millions of years. Perhaps one day some more convincing evidence will emerge to give substance to Sydenham's eloquent convictions.

Tissue Repair

Once the multiplication of the infecting microorganism has been controlled, and the microorganism itself perhaps eliminated from the body, the next step in the process of recovery is to tidy up the debris and repair the damaged tissues. Four examples will be given, in the skin, respiratory tract, liver and the foetus. At the molecular level a profusion of mediators are involved. Cytokines, because of their effects on cell growth and differentiation, play a part at all stages in the repair process.

In the skin

During recovery from a boil, for instance, the sequence of events is as follows. Superficial tissue debris, including necrotic epidermis, inflammatory cells and plasma exudate, dries off as a scab. This gives mechanical protection, acts as a barrier to further infection, and can be shed to the exterior after repair is completed. Below the scab, phagocytic cells clear up the debris and fibroblasts move in, multiply, and lay down a mucopolysaccharide matrix over the underlying intact tissues. New blood vessels are formed, and later on lymphatics, by sprouting of the endothelial cells of neighbouring vessels into the fibroblast matrix. The newly formed capillaries advance into the damaged zone at 0.1–0.6 mm a day. They are fragile and leaky, and there is a continuous extravasation of polymorphs, macrophages and fibroblasts into the matrix. As seen from the surface, each collection of capillary loops in the fibroblast matrix looks like a small red granule and this soft vascular material is therefore called granulation tissue. It bleeds easily and with its rich blood supply and abundant phagocytic cells is well protected against infection. Meanwhile, epidermal cells at the edges of the gap have been multiplying. The newly formed layer of cells creeps over the granulation tissue, and the epidermis is thus reconstituted. Fibroblasts in the granulation tissue lay down reticulum fibres, and later collagen. If the area of epidermal cell destruction is large, and when underlying sebaceous glands, hair follicles etc. are destroyed, a great deal of collagenous

fibrous tissue is formed to repair the gap. The newly formed collagen in fibrous tissue contracts and tends to bring the skin edges together. Contracting collagen can strangle an organ like the liver, but in the skin it merely forms a scar. A scar is a characteristic sequel to vaccination with BCG, or to a bacterial infection involving sebaceous glands, as seen in severe acne.

In the respiratory tract

After infection with a rhinovirus or influenza virus, there are large areas where the epithelial cells are destroyed, mucociliary transport is defective (see Ch. 2) and the underlying cells vulnerable to secondary bacterial infection. Phagocytic cells must now ingest and dispose of tissue debris, and the epithelial surface must be reconstituted by a burst of mitotic activity in adjacent epithelial cells. To some extent pre-existing cells can slide across the gap but repair depends on mitosis in cells at the edges. The process of repair takes several days, and the mechanism is the same whether the damage is caused by viruses, bacteria or chemicals. Epithelial regeneration is particularly rapid in respiratory epithelium, and also in conjunctiva, oropharynx and mucocutaneous junctions, but it is delayed if the infection continues. After chronic bacterial or chemical damage there is an increase in mucus-producing goblet cells in the respiratory epithelium, and sometimes impairment of mucociliary mechanisms, resulting in the condition called chronic bronchitis. As a rule, however, recovery is complete.

In the liver

During recovery from focal hepatitis, polymorphs and macrophages are active in areas of tissue damage, phagocytosing dead and damaged hepatic cells, Kupffer cells, biliary epithelial cells, inflammatory cells and microorganisms. As this proceeds neighbouring hepatic cells and bile duct epithelial cells divide to replace missing cells. This, together with cell movement and rearrangement leads to remodelling of the lobules and the restoration of normal appearances. If supporting tissues have been significantly damaged, and particularly if there are repeated episodes of necrosis, healing involves scar formation. When this is widespread it is referred to as cirrhosis, the bands of fibrous tissue dividing up the organ into irregular islands. The regenerating islands enlarge to form nodules, the fibrous tissue thickens and contracts and there is obvious distortion of structure, with circulatory impairment, biliary obstruction and liver dysfunction.

In most tissues, repair with restoration of structural integrity can be achieved by fibrous tissue formation. Recovery of function depends more on the ability of differentiated cells in damaged tissues to increase their numbers again and thus restore functional integrity. Liver cells or epithelial cells have a great capacity for mitosis, and the intestinal

epithelium, respiratory epithelium or liver can be restored to normal without great difficulty. In the case of cardiac muscle, striated muscle or brain, the differentiated cells show little if any mitotic capacity and destruction in these tissues results in a permanent deficit in the number of cells. This may be of no consequence in a muscle as long as firm scar tissue repairs the damage, but it may be important in the central nervous system. Anterior horn cells destroyed by poliovirus cannot be replaced, and if enough are destroyed there will be a permanent paralysis, although some restoration of function takes place by learning to use muscles more effectively and by the recovery of damaged anterior horn cells.

In the foetus

Tissue repair in the foetus is in some ways easier and in others more difficult. In general there is a very great capacity for repair and reconstitution of damaged tissues. Primitive mitotic cells abound, organs are in a state of plasticity, and in the developmental process itself tissue destruction and repair accompanies mitosis and construction. On the other hand, at critical times in foetal life, there is a programmed cell division and differentiation in the course of constructing certain major organs. If one of these organs is damaged at this critical time, the developmental process is upset and the organ is malformed. This is what happens when rubella virus infects the human foetus during the first three months of pregnancy. Depending on the exact organ system being formed at the time of foetal infection, there may be damage to the heart, eyes, ears or brain, resulting in congenital heart disease, cataract, deafness or mental retardation in the infant. Other infections (see Table 5.3) affect particularly the central nervous system of the foetus (toxoplasmosis, cytomegalovirus, syphilis) and sometimes bones and teeth (syphilis).

If the foetal infection is severe, as is the rule with vaccinia virus or with most bacteria, foetal death and abortion is the inevitable consequence. There are only a small number of microorganisms that infect the foetus and interfere with development without proving fatal. This type of nicely balanced pathogenicity is needed if the infected foetus is to survive and be born with a malformation. Even the infections that cause malformations (teratogenic infections) are sometimes severe enough to kill the foetus. In most congenital infections the microorganism remains present and is detectable in the newborn infant (cytomegalovirus, rubella, syphilis etc.), often persisting for many years. It is a striking feature of most teratogenic foetal infections (rubella, cytomegalovirus, toxoplasmosis) that the mother suffers a very mild or completely inapparent infection.

Certain microorganisms infect the foetus and damage developing organs, but are then eliminated from the body. The damaged organs are formed as best as possible, and at birth there are no signs that the malformation was caused by a microorganism. Tissues are sterile, and no inflammatory responses are visible histologically. Thus when a pregnant hamster is infected with K virus (a polyomavirus), there is infection

of the dividing cells that are to form the molecular layers constituting the bulk of the cerebellum. These cells are destroyed, the cerebellum therefore fails to develop normally, and the newborn hamster shows severe signs of cerebellar dysfunction, although it is perfectly well in every other way. The affected cerebellum is small and greatly depleted of cells, but there is no evidence of past microbial infection.

Resistance to Re-infection

Resistance to re-infection depends on the immune response generated during primary infection. Passive immunisation with antibody is known to protect humans against measles, hepatitis A, hepatitis B, rabies etc., and the passively acquired (maternal) immunity of the newborn child or calf to a great variety of infections is another example of the resistance conferred by specific antibody. Most resistance to re-infection is antibody-mediated (Table 9.1). IgG antibodies generally continue to be formed in the body for many years following the initial infection; IgA antibodies are less persistent than IgG antibodies. Even if antibody levels have sunk to undetectable levels, memory cells from the initial infection are often present in large enough numbers to give an accelerated (anamnestic) response within a few days of re-infection. This is especially important in infectious diseases with incubation periods measured in weeks because there is time enough for the anamnestic response to operate and terminate the infection during the incubation period, before production of clinical disease. Sometimes resistance to re-infection is maintained by repeated subclinical infections, each of which boosts the immune response. For instance, children catching rubella at school can re-infect their immune parents subclinically and this is detected by a rise in antibody levels. Resistance to rubella, diphtheria and perhaps other infectious diseases is maintained in this way.

Antibodies protect against infection in a number of ways (see pp. 151–2). For instance they attach to the microbial surface and promote its uptake by phagocytic cells, acting as opsonins. Other antibodies protect against reinfection by combining with the microbial surface and blocking attachment to susceptible cells or body surfaces. Microorganisms that need to make specific attachments are listed in Table 2.1. However, circulating IgG or IgM antibodies coat polioviruses, coxsackie viruses or adenoviruses, and act by interfering with viral uncoating (see above) rather than by blocking attachment to susceptible cells. Secretory IgA antibodies are particularly important because they can act on the microorganism before its attachment to a body surface. They do not act as opsonins; they do not lyse microorganisms because there is no complement on body surfaces, and in any case they fix complement poorly. But by preventing the attachment of microorganisms such as *Vibrio cholerae* to intestinal epithelium, the gonococcus to urethral epithelium, or chlamydia to the conjunctiva, IgA antibodies can ensure that these microorganisms are carried away in fluid secretions rather

than initiate infection. Acquired resistance to infection of the surface of the body is often of short duration. For instance, resistance to gonorrhoea or parainfluenza viruses following natural infection seems to last only for a month or so, and in childhood repeated infections with respiratory syncytial virus and *Mycoplasma pneumoniae* are common. Presumably the IgA antibodies that mediate resistance are short-lived and IgA memory cells do not generate a good enough or rapid enough secondary response.

Resistance to re-infection, since it is immunological in nature, refers especially to the antigenic nature of the original infecting microorganism. Resistance to measles or mumps means resistance to measles or mumps wherever or whenever they occur, because these viruses are of only one type (monotypic) immunologically.* Resistance to the disease influenza or poliomyelitis, however, depends on the separate acquisition of resistance to a number of distinct antigenic types of influenza or polio viruses. Resistance to streptococci depends on the acquisition of antibodies to the M protein in the bacterial cell wall, and since there are at least 10 types of M protein that circulate quite commonly in communities (40–50 types of M protein altogether), repeated infections with *Streptococcus pyogenes* occur as antibodies are gradually developed against the various types. Often, however, different serological types of a given microorganism show some overlap so that antibodies to one type can confer partial resistance to another.

When resistance to a disease appears not to develop, the possibility of multiple antigenic types must be considered. There are multiple antigenically distinct types of gonococcus, for instance, as discussed on p. 189, a fact that helps account for successive attacks of gonorrhoea. Numerous attacks of nonspecific urethritis are to be expected because of the variety of microorganisms that cause this condition. In one study 40% of attacks were due to chlamydia, but there are 12 known antigenic types.

Resistance to re-infection can also be mediated by CMI. The CMI response generated on primary infection lasts weeks or perhaps months rather than years, and there is an accelerated CMI response on re-infection, although less vigorous than in the case of antibodies. Nearly always a persistent infection is needed to give continued CMI resistance and infections showing this are usually intracellular in nature. For instance, resistance to re-infection with tuberculosis, syphilis and possibly malaria, depends on the active presence of the microorganism in the body, with continuous stimulation of the antibody and CMI responses. In most of these instances, resistance to re-infection is CMI-mediated.

* Differences between geographical strains may be demonstrable on genetic analysis, but antibody to one strain generally neutralises other strains. If these differences become marked they may be significant, and we may need to know, for instance, whether current vaccines protect against all strains of hepatitis B virus or rabies virus. Still smaller differences are detectable between viruses isolated from different individuals in a given geographical region. The differences are minor and generally insignificant, but can be useful as markers for tracing the source of epidemics. Ultimately, because viruses are so mutable, even the progeny in a given infected host may not be uniform, and should perhaps be regarded as a virus population. This is particularly true in HIV infections.

There are a few examples, however, such as measles, in which recovery from primary infection is largely due to CMI, but resistance to reinfection is attributable to antibody.

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