High Levels of Anti-Ganglioside Antibodies in Patients with Parkinson’s Disease Associated with Cognitive Decline

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Abstract

Background: Increasing evidence suggests that gangliosides act as important mediators in both demyelination and remyelination.

Objective: The purpose of the present study was to investigate the presence of IgM antibodies against GM1, GD1β and GO1β gangliosides in the sera of patients who suffered from Parkinson’s disease in correlation with the clinical parameters.

Method: The present research is based on the investigation of 44 patients (63.7-73.3 years) for anti-ganglioside antibodies and 44 healthy age-matched individuals, as normal controls, using Enzyme-Linked Immuno-Sorbent Assays.

Results: The patients revealed increased levels of the tested antibodies, compared to normal controls (p=0.0005). A correlation between IgM anti-GM1 and the level of cognitive impairment (Minimental State Examination, p=0.003; Unified Parkinson’s Disease Rating Scale I, p=0.013) was also noticed.

Conclusion: A peripheral neuroimmune response may occur in patients who suffer from Parkinson’s disease especially those with cognitive impairment. Further investigation is needed to establish a direct connection between that immune response and disease pathophysiology.

Keywords: Parkinson’s Disease; Gangliosides; Anti-Gm1; Anti-Gd1b; Cognitive decline

Introduction

In most of patients with Parkinson’s disease (PD), Lewy bodies embody the hallmark pathological finding of the disease consisted mainly of α-synuclein [1], which is the principal component of Lewy bodies. Several studies have revealed that α-synuclein’s misfolded deposits act as an inflammatory stimulator of microglia, which is further escalated by the production of superoxide anions and other neurotoxic factors (TNF-α, chemokines and autoantibodies), including anti-ganglioside antibodies [2-6]. However, according to other issues gangliosides seem to restrain the pathological aggregation of α-synuclein [7]. Gangliosides are acidic glycosphingolipids of plasma membranes [8,9]. Their hydrophobic ceramide is inserted into the lipid bilayer, while the hydrophilic headgroup consisting of neural sugar molecules and sialic acid is protruded into the extracellular space. The molecular structure of the gangliosides enable them to behave as autoantibody targets [9-11].

Gangliosides constitute 10-20% of the lipids of the neuronal membrane and they are detected especially in the synaptic and the axolemma membranes [12]. The most substantial gangliosides of the brain are GM1, GM2, GM3, GD1b, GT1b, GQ1b, GD1b/a. GM1 ganglioside consists 15% of the total gangliosides of the myelin in peripheral nerves. Their expression is cell-specific and is regulated during the development, while the quantity and the type of gangliosides undergo changes during the differentiation of the cell [12,13].

The diversity and complexity of gangliosides suggest that they are not biologically redundant, but they have unique role in thermperature adaptation, neuronal Ca2+-homeostasis, axonal growth, paranoidal of Ranvier stability, synaptic transmission and regulation of apoptosis [14-17]. Gangliosides are present in membranic rafts that are characterized by a high concentration of cholesterol and sphingolipids [12,18-20]. Membranic rafts also contain specific proteins such as G- Proteins and Kinas [21]. In membranic rafts gangliosides co-exist with protein-messengers such as Ca2+-channels and SNAP25, receptors (receptors of SNAP: S-nitro-N-acetyl-penicilamine) [22-26].

Increasing evidence suggest that gangliosides are involved in the adhesion between cells or cell layers, interact with ion channels [27-29] and are involved in signal transduction pathways (a) by interacting with receptor-tyrosine kinases (RTKs) such as of NGF (Neurotrophins Growth Factor Receptor) EGFGR (Epidermal Growth Factor receptor) and IGF (Insulin Growth Factor). Specifically, they either inhibit the dimerization and autophosphorylation of the receptors induced by specific ligands, or activate receptors signaling without ligand binding. Moreover, the activation or inhibition of RTKs is dependent on the glycan structure of gangliosides and cellular
gangliosides initially are detected in paraproteinaiemic neuropathies with gamopathies IgM (e.g. the disease Waldenstöm). The first clinical-serological association studied in detail was the immunoglobulin M (IgM) paraproteinaemic neuropathy with reactivity against MAG and the cross-reactive glycolipids, Sulfated Glucuronyl Paragloboside(SGPG) and its higher lactosaminyl homologue, sulfated glucuronyl lactosaminyl paragloboside (SGLPG) [9].

Chronic motor neuropathies were then identified in association with polyclonal or monoclonal IgM antibodies directed to GM1 and other Gal(β1-3) GalNAc-bearing glycolipids including GD1b and asialo-GM1. These antibodies are now known to be present in half of the patients suffered from MMN with conduction block. The IgM-paraprotein operates against gangliosides, labeled by the Neu5Ac-a2-8 Neu5Ac-disiaylo group (GD3, GD1b, GT1a, GT1b and GQ1b) [9]. Anti-GQ1b and anti-GT1b antibodies (polyclonal IgA, IgG, IgM) have been detected in 90% of patients with MFS. Particularly the isoform IgM was detected in chronic suffered patients and even in continuously high levels [9].

These antibodies also cross react with GD1b and / or GD3. They acquire the maximum titer during the period of the greater exacerbation of the disease and by the improvement of the patient they reduce their concentrations and return to normal levels [9]. Although the initiation of neurodegeneration and apoptosis in response to several extracellular factors has been widely reported, the regulatory mechanisms underlying the myelin damage remain incompletely understood. However, anti-ganglioside antibodies are reported as important immunological markers of neurodegeneration. In pathological stages, such as PD, ALS, GBS, Alzheimer’s disease (AD), Acute Motor Axonal Neuropathy (AMAN) and Motor Neuron Disease (MND), that are characterized by the gradual loss of specific populations of neurons, persistent immunological attack of microvascular endothelial cells by glycolipid-directed autoantibodies may lead to extensive cellular damages, resulting in an increased permeability across Blood-Nerve-Barrier (BNB) and/or Blood-Blood-Barrier (BBB) [44].

In the present study we investigated basically the levels of three anti-ganglioside antibodies (IgM type) in the sera of PD patients. As we have already investigated anti-GM1, anti-GD1b and anti-GQ1b antibodies in neurodegenerative disorders such as Myasthenia Gravis (MG), CIDP, GBS, MND, ALS, MS, AD, we forwarded our research also in patients with Parkinson’s disease. According to several studies [45] IgM-gangliosides are detected in acute phase, while IgG-gangliosides in chronic phases of several demyelinating diseases. As we attempted to study primarily the subacute, ongoing immune reaction, we focused our study on the estimation of IgM levels. The investigation of other ganglioside antibodies of alpha series, GM2, GM3, GD1a, GT1a is our next target of research in Parkinson’s disease. Moreover we focused on IgM antibodies against GM1, GD1b and GQ1b since they are the most widely ganglioside antibodies studied with ELISA [46-50]. In addition we attempted to correlate the results with the clinical parameters, for figuring out an existing possible correlation, eventually.

Researches in paraproteinaiemic neuropathies detected monoclonal antibodies against gangliosides, whereas in inflammatory neuropathies without accompanied paraproteinaiemies, they demonstrated polyclonal antibodies of isotypes IgG and IgM [9]. Antibodies against
Materials

Patients

We examined 44 patients with PD, (21 women, 23 men), (mean age: 63.7 ± 13.1 years for women and 73.3 ± 10.3 years for men) and 44 healthy individuals (20 females, 24 males) (mean age: 60.0 ± 11.8 years for women and 67.3 ± 10.3 years for men). The study subjects gave informed consent for their participation; their anonymity was preserved.

The diagnosis of the patients was based on the UK Brain Bank Criteria for Parkinson’s Disease [51]. The patients were unselected and consecutive from our PD outpatient clinic, having no prior history of peripheral neuropathy. The current neurophysiological investigation included also any peripheral neuropathy. Other exclusion criteria included the presence of: acute/chronic inflammation, infectious diseases, cancer, metabolic or other severe pathological disorders. ‘Healthy controls’ were age and gender-matched individuals, with normal neurological examination, MMSE>28/30 and no history of immune or neurological disease.

We recorded the demographic parameters (gender, age) of the patients and controls, disease duration, treatment, MMSE (Mini Mental State Examination Scale), UPDRS I/III (Unified Parkinson’s Disease Rating Scale). 59% (n=26) of the patients were tremor-(TD) and 41% (n=18) Bradykinesia-Dominant (BD). 41% (n=18) of the patients received levodopa plus agonists, 27% (n=12) were under levodopa monotherapy, 14% (n=6) received only agonists and 18% (n=8) were under therapy with MAO inhibitors and amantadine.

Samples

GM1, GD1b and GQ1b-IgM were determined in the sera of the patients and the healthy controls. Peripheral venous blood was centrifuged (10 min, 2000xg), the supernatants were frozen in aliquots and –400°C. Serum GM1, GD1b and GQ1b-IgM concentrations were determined by the use of commercial available ELISA kits: (IMMCO diagnostics Inc., USA).

Anti-GM1 IgM, anti-GD1b IgM, anti-GQ1b IgM

Assays

The presence of IgM antibodies against GM1, GD1b and GQ1b gangliosides was determined by ELISA, using 96-well microtiter plates coated with the individual ganglioside, according to the manufacturer’s instructions.

Serial dilutions were made (1:50-1:200) and each sample was analyzed in duplicate. A Positive and a Negative Control consisting of a serum sample, produced by the manufacturer, with high and low concentrations of IgM anti-ganglioside respectively, were included in the assay. The Negative Control should be <20 EU/ml. Levels of antibodies <20 EU/ml have been considered as negative, while positive samples have had concentrations >25 EU/ml. Intermediate levels between 20-25 EU/ml were characterized as borderline.

Statistical Analysis

MMSE scores were subdivided according to literature. Age groups were subdivided for statistical purposes, to ensure a sufficiently large sampling in each interval and approximately uniform distribution of subjects between intervals. We chose to divide them in the following intervals:

1. According to the age: Group 1 (38-57 years), group 2 (58-70 years), group 3 (71-87 years).
2. According to the scores in UPDRS III-scale: Group 1 (0-2), group 2 (2-9), group 3 (>10).
3. According to the UPDRS I scores: Group 1 (0-3), group 2 (4-6), group 3 (>7).
4. According to the MMSE scores: Group 1 (0-15/30), group 2 (16-25/30), group 3 (26-30/30).

Based on the ganglioside antibodies’ concentrations: group 1 (positive/>25 EU/ml), group 2 (intermediate borderline/20-25 EU/ml), group 3 (negative/<20 EU/ml). The subdivision was given by the manufacturer. The results were correlated with all the above mentioned parameters. For the statistical evaluation of the results we used the One-way-ANOVA (2-tailed with the Confidence Interval at 95%) of the SPSS 16.0. The Mann-Whitney U-test was used for the comparison between the patients’ and the controls’ anti-ganglioside antibodies’ results. One-way-ANOVA was also used to evaluate the differences between anti-ganglioside antibodies versus age, MMSE, UPDRS I and UPDRS III scores.

The x-square analysis was used, to compare the three antibodies’ levels with the type of provided treatment or TD/BD, (CI: 95 %).

Results

I) Anti-ganglioside antibodies in patients and healthy individuals

We examined the anti-GM1, anti-GD1b and anti-GQ1b-IgM serum levels of 44 PD patients setting the cut-off value >25 EU/ml (Table 1a).

The concentrations of the Positive controls were within the ranges indicated on the labels. Furthermore, our laboratory conducts anti-GM1, anti-GD1b and anti-GQ1b studies in GuillainBarré and chronic inflammatory demyelinating polyradiculoneuropathy patients, confirming the accuracy of the test. According to our results 68% of the patients revealed positive anti-GM1 IgM (mean 32.4 ± 5.9 EU/ml) compared to 70% of the healthy control group, who had negative anti-GM1 IgM (mean 14.6 ± 3.3 EU/ml), thus providing a statistically significant difference (U=670.5, Z=-8.326, p=0.0005).

34% of the patients had positive anti-GD1b IgM (mean 27.3 ± 1.6 EU/ml), while 25% were negative (mean 13.8 ± 2.8 EU/ml). 86% of the controls demonstrated negative anti-GD1b IgM (13.2 ± 3.6 EU/ml) (U=283.5, Z=-1.713, p=0.0005). 89% of PD-patients revealed negative anti-GQ1b IgM (mean 12.3 ± 3.4 EU/ml), while only 11% demonstrated borderline concentrations (mean 21.4 ± 2.1 EU/ml). 95% of the healthy individuals demonstrated negative anti-GQ1b IgM (mean 6.1 ± 4.5 EU/ml) (U=334.0, Z=-5.293, p=0.0005). The healthy control group hadn’t revealed any positive concentration of the three examined antibodies.

II) Anti-GM1, GD1b and GQ1b vs age, disability, treatment, cognitive decline and dominant symptoms of the examined patients

According to our research there was no significant correlation between the patients’ age (p>0.05) and the examined autoantibodies’
levels, although older patients seemed to have higher anti-GM1 IgM (31.2 ± 8.4 EU/ml).

We found significant correlation between elevated anti-GM1 IgM, the degree of cognitive impairment and the predominance of bradykinesia (Table 1b).

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<thead>
<tr>
<th>PD Group (n=44)</th>
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<tbody>
<tr>
<td></td>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>Anti-GM1 IgM (EU/ml)</td>
<td>32.4 ± 5.9 (68%, n=30)</td>
<td>17.5 ± 1.6 (16%, n=7)</td>
</tr>
<tr>
<td>Anti-GD1b IgM (EU/ml)</td>
<td>27.3 ± 1.6 (34%, n=15)</td>
<td>13.8 ± 2.8 (25%, n=11)</td>
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<tr>
<td>Anti-GQ1b IgM (EU/ml)</td>
<td>-</td>
<td>12.3 ± 3.4 (89%, n=39)</td>
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<th>Control Group (n=44)</th>
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<tr>
<td></td>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>Anti-GM1 IgM (EU/ml)</td>
<td>-</td>
<td>14.6 ± 3.3 (70%, n=31)</td>
</tr>
<tr>
<td>Anti-GD1b IgM (EU/ml)</td>
<td>-</td>
<td>13.3 ± 3.6 (86%, n=38)</td>
</tr>
<tr>
<td>Anti-GQ1b IgM (EU/ml)</td>
<td>-</td>
<td>6.1 ± 4.5 (95%, n=42)</td>
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**Table 1a:** Anti-ganglioside antibodies of PD patients vs healthy individuals. There was a significant difference (p=0.0005) of each antibody between patients and controls. *1: Displayed are the mean concentrations ± standard deviations for every ganglioside antibody of each group, as well as percentage and number (n) of subjects for each ganglioside antibody. EU/ml: Elisa Units per milliliter.

<table>
<thead>
<tr>
<th>MMSE</th>
<th>[p]*</th>
<th>0-15</th>
<th>16-25</th>
<th>26-30</th>
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<tr>
<td>Anti-GM1 IgM (EU/ml)</td>
<td></td>
<td>32.6 ± 6.6</td>
<td>33.3 ± 8.1</td>
<td>25.2 ± 6.0 0.003</td>
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<tr>
<td>Anti-GD1b IgM (EU/ml)</td>
<td></td>
<td>24.3 ± 4.4</td>
<td>23.4 ± 4.6</td>
<td>20.1 ± 6.1 NS</td>
</tr>
<tr>
<td>Anti-GQ1b IgM (EU/ml)</td>
<td></td>
<td>13.2 ± 4.1</td>
<td>13.4 ± 5.6</td>
<td>13.4 ± 4.1 NS</td>
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<thead>
<tr>
<th>UPDRS I</th>
<th>[p]*</th>
<th>0-3</th>
<th>4-6</th>
<th>&gt;7</th>
</tr>
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<tbody>
<tr>
<td>Anti-GM1 IgM (EU/ml)</td>
<td></td>
<td>26.1 ± 6.3</td>
<td>33.4 ± 8.7</td>
<td>27.7 ± 3.5 0.013</td>
</tr>
<tr>
<td>Anti-GD1b IgM (EU/ml)</td>
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<td>21.2 ± 6.2</td>
<td>23.3 ± 4.5</td>
<td>22.2 ± 4.8 NS</td>
</tr>
<tr>
<td>Anti-GQ1b IgM (EU/ml)</td>
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<td>13.8 ± 4.6</td>
<td>13.0 ± 4.4</td>
<td>12.2 ± 2.9 NS</td>
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<th>Dominant symptoms</th>
<th>[p]**</th>
<th>BD</th>
<th>TD</th>
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<tbody>
<tr>
<td>Anti-GM1 IgM (EU/ml)</td>
<td></td>
<td>31.3 ± 8.4</td>
<td>25.2 ± 6.3</td>
</tr>
<tr>
<td>Anti-GM1 IgM (EU/ml)</td>
<td></td>
<td>22.0 ± 8.2</td>
<td>20.4 ± 5.0</td>
</tr>
<tr>
<td>Anti-GM1 IgM (EU/ml)</td>
<td></td>
<td>15.2 ± 4.7</td>
<td>13.1 ± 4.1</td>
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</table>

**Table 1b:** Anti-ganglioside antibodies vs age, grade of cognitive decline, the disability and the main symptoms of the PD patients (tremor-/bradykininesia dominant). *1: Displayed are the mean concentrations ± standard deviations for every ganglioside antibody of each group, as well as the significance (p). MMSE: Mini-mental State Examination scale, UPDRS: Unified Parkinson’s Disease Rating Scale, BD: bradykinetic-dominant, TD: tremor-dominant, y: Years, NS: not significant. significance [p] with aANOVA, bChi-square. **2: Mean concentrations ± standard deviations. Older (71-87 years) and most impaired patients (MMSE 0-25/30) or mild impaired (UPDRS I 4-6) revealed higher anti-GM1 IgM (p<0.05). BD patients demonstrated also higher anti-GM1 IgM (p<0.05).
BD patients demonstrated increased anti-GM1 IgM (mean 31.3 ± 8.4 EU/ml), comparing to TD patients (p=0.0005). Anti-GD1b IgM and anti-GQ1b IgM were decreased and with no important difference between the two groups (p=0.05). Patients with mild cognitive impairment (MCI) (MMSE score 16-25/30) revealed the highest anti-GM1 IgM (mean 33.3 ± 8.1 EU/ml) (p=0.003). Based on the UPDRS I-scale, patients with scores 4-6 had higher anti-GM1 IgM (33.4 ± 8.7 EU/ml) (p=0.013).

Discussion

In the present study increased anti-GM1 IgM and anti-GD1b IgM (68% and 35% respectively) were determined in the serum of 44 PD patients, whereas only 9% of the patients revealed positive anti-GQ1b IgM. Healthy age-matched individuals didn’t demonstrate increased concentrations of the three anti-ganglioside antibodies (p=0.0005), indicating first that anti-GM1 and anti-GD1b antibodies are not associated to normal aging and secondly that these antibodies might play a significant role in the pathophysiology and pathogenesis of PD. No connection could be made between clinical parameters and anti-gangliosides in PD patients, emphasizing mostly its association to anti-GM1 IgM and anti-GD1b IgM in demented patients especially in older and severely mentally impaired individuals [55,59]. According to our recent results older demented patients with ages between 66-86 years revealed the most increased concentrations of anti-GM1 IgM (28.1-37.0 EU/ml) (F(2,101)=30.6, p=0.005). Moreover, seriously demented patients, with scores in the Mini-Mental State Examination scale of 0-18/30 revealed the highest levels of anti-GM1 IgM (37.9 ± 8.9 EU/ml) (F (2,101)= 83.3, p=0.005) [59]. Several NMR studies have been performed in the past concerning the Aβ conformational changes. Based on NMR spectroscopic studies of Mandal and Pettergrew [58], asialo-GM1 bound with Aβ peptide in a manner that might prevent β-sheet formation; ganglioside GT1b, however, did not show such a property. In addition, the interaction between gangliosides has been studied as well as the Aβ-peptide, in a membrane-mimic environment, dissolving the gangliosides asialo-GM1 and GT1b in SDS (sodium dodecyl sulphate) solution [58].

Gangliosides present a hydrophilic oligosaccharide chain, to which one or more sialic acids (N-acetylneuraminic acid) are attached and a hydrophobic ceramide, which binds the gangliosides to the plasma membranes [9-11]. Gangliosides’ binding induces Aβ peptide oligomerization. GM1 and GT1b have four sugar moieties in common, however, GT1b has three sialic molecules more compared to asialo-GM1 that doesn’t contain sialic rests [60].

According to this study, with the additions of sialic acid molecules, it is difficult to bind on the ganglioside-specific binding sites of Aβ-peptide. Asialo-GM1 and GM1 are able to bind Aβ and prevent by this binding the β-sheet formation [58]. Therefore, the loss of ‘protective’ GM1 and the increase of ‘unprotective’ GT1b during the senility, elevates the possibility of β-sheet formation and the resulting senile plaques [60-62]. Parkinson’s disease concerns the degeneration of dopaminergic neurons of SubstantiaNigra, caused by genetic, neurotoxic and several other factors, that induce oxidative damage and cell death. Increasing evidence suggest that inflammation is the fundamental process contributing to neuron death in PD, caused or triggered by brain injury, chemicals and infections [63].

Many researches attempted to explain the inflammatory pathways, which are probably activated resulting in the neurodegeneration, which occurs in Parkinson’s disease.

Reactive astrocytes and activated microglia play crucial role in neuroinflammation and the progressive neurodegeneration in PD. Glia normally act neuroprotective, however, given adverse stimulation, they contribute to damaging chronic neuroinflammation [1,2].

It is well known that many gangliosides (GM1, GD1b, asialo-GM1) have an epitope Gal(β1-3)GalNAc, which is common with the bacterial lipopolysaccharide (LPS) of Campylobacterjejunii. GM2 binds to a toxin produced by Clostridium perfringens. This epitope is the target of anti-ganglioside antibodies [64].

Previous researches elucidated the mechanism by which these autoantibodies act, in the most well studied neurodegenerative disorder of peripheral nervous system, Landry-Guillain-Barré [8,9]. Antibodies against gangliosides are reported in patients with severe axonal damage and are directed against the Gal(β1-3)GalNAc structure of the carbohydrate portion of the molecule, which is shared
by several glycoproteins in peripheral nerve. A typical infectious autoimmune polyneuropathy, is the Guillain-Barré syndrome. Patients with GBS elicit antibodies against the ganglioside GM1. By acute motor axonal neuropathy and Acute Motor and Sensory Axonal Neuropathy (AMSAN), two subtypes of GBS, it is known to be caused by antibodies to gangliosides on the axolemma, which target and facilitate the macrophages to invade the axon at the node of Ranvier.

About a quarter of patients with GBS have had a bacterial infection. The LPS from the bacterial wall contains ganglioside-like structures that activate B-cells to produce antibodies. These antibodies pass the BNB, opsonise cross-reactive antigens, fix complement and target macrophages to invade the periaxonal space or cause axonal degeneration [10,35,65-67].

In case of Parkinson’s disease we know that α-synuclein is an inflammatory stimulant for microglia that binds specifically to GM1 ganglioside, whereas GM2, GM3 and asialo-GM1 have a weaker bound on α-synuclein. This bound inhibits the fibrillation of α-synuclein and its pathological accumulation. It is possible that α-synuclein is recruited by GM1 to membranerraft regions in presynaptic terminals. In this context, perturbation of GM1raft association could induce changes in α-synuclein contributing to the pathogenesis of PD [2,68].

Commonly to Campylobacter in case of GBS, to C. pneumoniae or Helicobacter pylori in AD, previous researches demonstrated in case of PD, that in H.pylori-infected PD patients reduced L-DOPA absorption and increased clinical disability, whereas treatment of the infection resulted the increased L-DOPA and decreased clinical disability. H. pylori may not be directly involved in the pathogenesis of PD but the systemic influence could affect the progression and treatment, possibly by stimulating inflammation and autoimmunity [69,70].

Previous authors have demonstrated the pathogenetic role of activated microglia and the resulted neuroinflammation in both Alzheimer’s and Parkinson’s disease [3,5,67,1].

Microglia cells, also known as the phagocytes of the brain, seem to be the main contributors in the inflammatory process. During the inflammation the activated microglia produce large amounts of superoxide radicals, the major source of oxidative stress, chemokines, among them IL-1, IL-6 and TNF-a, as well as autoantibodies (maybe also anti-gangliosides), which are targeted against the myelin and could result the nerve degeneration. In addition, astrocytes secrete both inflammatory and anti-inflammatory molecules modulating the microglia activity [1,2]. The production of autoantibodies enhance the pathological formation of α-synuclein resulting again the neuroinflammation and neurodegeneration.

In our research the patients with the highest levels of anti-ganglioside antibodies suffered from idiopathic PD. Although the oldest patients revealed the highest concentrations of anti-GM1 IgM, no statistical important difference could be found. However, the association with the age or the disability of the disease, cannot be excluded because of the relative small number of the examined patients.

The connection of anti-GM1 IgM/IgG to the cognitive impairment was statistically important. In more recent reports Mandal et al. demonstrated with NMR studies, the interaction of membrane-bound α-synuclein with Aβ. The presence of multiple sites of interaction between α-synuclein and Aβ might be important in determining the overlapping patho-cascades of AD and PD seen in DLB [60]. Preventing the interaction of membrane-bound α-synuclein with Aβ peptide would be an important therapeutic research target. Various neuroprotective gangliosides may play an important role in preventing these interactions. We strongly believe that, by a co-existing cognitive decline the hypothesis of neuroinflammatory process and the resulting neurodegeneration is presumably much validated. In such a case the ganglioside GM1 may bind both to Aβ and α-synuclein, building complexes with these molecules which in turn might activate the neuroinflammatory process.

The biological effects of gangliosides in several neurodegenerative diseases of the peripheral as well as of the central nervous system may explain the interest of many authors, who propose them as potential therapeutics. Exogenous GM1 treatment has been used to treat symptoms of Parkinson’s disease, though both in human and animal models. Based on these studies, GM1 protects against nigrostriatal toxicity and associated motor symptoms induced by 1-methy-4-phenyl-1,2,3,6-tetrahydropyridine in mice and monkeys [72-76]. GM1 treatment restored cognitive and motor function and prevented decline in function in a 90 week trial in monkeys. In a placebo controlled study, Parkinson’s patients improved significantly after 16 weeks of GM1 treatment [77].

In addition to GM1, Schneider et al. [78] reported potential neuroprotective as well as neurorestorative roles for a synthetic ceramide analog L-threo-1-phenyl-2-decanoylamino-3-morpholino-1-propanol (L-PDMP), in mouse models of Parkinsonism. In contrast to the D-isomer, L PDMP treatment caused an increase in brain GM1 levels in Parkinson models. Thus, administration of L-PDMP in order to elevate endogenous brain GM1 levels might play a beneficial role as a potential neuroprotective or neurorestorative therapeutic factor in Parkinson’s disease. However, we need further studies in order to investigate the potential effects of exogenous administered gangliosides in the therapy of PD, at clinically relevant and safe concentrations.

Our results indicate anti-ganglioside antibodies (especially anti-GM1 IgM) as possible immunological factor of neurodegeneration in PD patients, especially those with co-existing mild cognitive decline. This is a new research field, which may be further evaluated, although the literature on this subject is limited and only assumptions can be made at present. A larger scale study that is going to include also other series of anti-ganglioside antibodies is being proceeded to establish a stronger interrelationship between the pathophysiology of PD and the activated immune response.

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References


