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Inherited DOCK2 Deficiency in Patients with Early-Onset Invasive Infections

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Inherited DOCK2 Deficiency in Patients with Early-Onset Invasive Infections

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Inherited DOCK2 Deficiency in Patients with Early-Onset Invasive Infections


BACKGROUND
Combined immunodeficiencies are marked by inborn errors of T-cell immunity in which the T cells that are present are quantitatively or functionally deficient. Impaired humoral immunity is also common. Patients have severe infections, autoimmunity, or both. The specific molecular, cellular, and clinical features of many types of combined immunodeficiencies remain unknown.

METHODS
We performed genetic and cellular immunologic studies involving five unrelated children with early-onset invasive bacterial and viral infections, lymphopenia, and defective T-cell, B-cell, and natural killer (NK)–cell responses. Two patients died early in childhood; after allogeneic hematopoietic stem-cell transplantation, the other three had normalization of T-cell function and clinical improvement.

RESULTS
We identified biallelic mutations in the dedicator of cytokinesis 2 gene (DOCK2) in these five patients. RAC1 activation was impaired in the T cells. Chemokine-induced migration and actin polymerization were defective in the T cells, B cells, and NK cells. NK-cell degranulation was also affected. Interferon-α and interferon-λ production by peripheral-blood mononuclear cells was diminished after viral infection. Moreover, in DOCK2-deficient fibroblasts, viral replication was increased and virus-induced cell death was enhanced; these conditions were normalized by treatment with interferon alfa-2b or after expression of wild-type DOCK2.

CONCLUSIONS
Autosomal recessive DOCK2 deficiency is a new mendelian disorder with pleiotropic defects of hematopoietic and nonhematopoietic immunity. Children with clinical features of combined immunodeficiencies, especially with early-onset, invasive infections, may have this condition. (Supported by the National Institutes of Health and others.)
Combined Immunodeficiencies Comprise a Heterogeneous Group of Inherited Defects of the Immune System That Are Characterized by Quantitative or Qualitative Defects of T Lymphocytes. These Defects Are Associated with Primary or Secondary Defects of B Lymphocytes. In patients with combined immunodeficiencies, impairment of adaptive immunity causes increased susceptibility to early-onset, severe infections with a variety of viruses, bacteria, fungi, and parasites. Autoimmune manifestations, allergies, and cancers can also occur.

Identification of gene defects that cause combined immunodeficiencies has helped patients considerably, provided new and important insights into mechanisms governing T-cell development and function in humans, and led to an understanding of the molecular and cellular basis of common conditions, including autoimmunity, allergy, inflammation, and cancer. However, the specific molecular, cellular, and clinical features of many combined immunodeficiencies remain poorly defined.

Next-generation sequencing has revolutionized studies of human genetic diseases, enabling the identification of new causative genetic variations in an increasing number of patients with primary immunodeficiencies. Here we report on human dedicator of cytokinesis 2 (DOCK2) deficiency as a combined immunodeficiency in five unrelated patients of various ethnic origins. These patients presented with a distinctive clinical phenotype of early-onset, invasive infections that were associated with a broad spectrum of defects in hematopoietic and nonhematopoietic immunity.

**STUDY OVERSIGHT**

The study was approved by the institutional review boards of the Kuwait Ministry of Health, INSERM, Rockefeller University, the Medical University of Vienna, Ankara University Medical School, Boston Children’s Hospital, and Duke University School of Medicine. Written informed consent was obtained from the patients’ parents or guardians.

**CASE PATIENTS**

Pedigrees of the five unrelated index patients are shown in Figure 1A, and Figure S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org. Clinical and laboratory data are summarized in Table 1.

Patient 1, a boy born to consanguineous Lebanese parents, presented at 3 months of age with respiratory syncytial virus bronchiolitis, followed by recurrent episodes of pneumonia. At 5 months of age, severe T-cell lymphopenia and markedly reduced in vitro T-cell proliferation were observed (Table 1). At 9 months of age, after myeloablative conditioning with busulfan and fludarabine, he underwent T-cell–depleted haploidentical hematopoietic stem-cell transplantation (HSCT) from his father. He was well and was not receiving intravenous immune globulin replacement therapy 13 months after undergoing HSCT.

In the first 2 years of life, Patient 2, a girl born to nonconsanguineous Finnish parents, had recurrent otitis media, pneumonia, diarrhea, and three episodes of thrombocytopenia that resolved spontaneously. At 2.5 years of age, vaccine strain–related varicella developed, with liver and lung involvement and multiple pulmonary infiltrates, and the patient required ventilatory support.
A Family Pedigrees and Identification of DOCK2 Mutations

B Clinical Features in Patients with DOCK2 Deficiency

C DOCK2 Protein Domains and Synopsis of DOCK2 Mutations

D DOCK2 Protein Expression

1820

SH3
DHR-1
DHR-2

p.R751S
(Patient 3)
p.Q1224X
(Patient 2)
p.R1104W
(Patient 2)
p.R1104W
(Patient 2)

EBV-transformed
B cells

Patient

Control

Patient

1

Patient

3

Patient

1

Patient

2

DOCK2

GAPDH
<table>
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<tr>
<th>Variable</th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Patient 5</th>
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<tbody>
<tr>
<td>Age at evaluation</td>
<td>5 mo</td>
<td>2.5 yr</td>
<td>6.3 yr</td>
<td>1 yr</td>
<td>4 mo</td>
</tr>
<tr>
<td>Absolute lymphocyte count (cells/mm³ ×10⁻³)</td>
<td>1.22 3.9–9.0</td>
<td>1.24 2.3–5.4</td>
<td>1.1 1.9–3.7</td>
<td>2.3 3.6–8.9</td>
<td>4.4 3.9–9.0</td>
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<tr>
<td>Lymphocyte subset</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD3+ T (cells/mm³)</td>
<td>114 2500–5600</td>
<td>548 1400–3700</td>
<td>341 1200–2600</td>
<td>1173 2100–6200</td>
<td>830 2500–5600</td>
</tr>
<tr>
<td>CD4+ T (cells/mm³)</td>
<td>57 1800–4000</td>
<td>305 700–2200</td>
<td>176 650–1500</td>
<td>129 1300–3400</td>
<td>511 1800–4000</td>
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<td>CD45RA+CCR7+ (%)</td>
<td>4.0 76.7–91.4</td>
<td>0.4 65.2–84.8</td>
<td>NA NA</td>
<td>4.5 76.7–91.4</td>
<td>33.8 6.7–15.6</td>
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<td>CD45RA−CCR7+ (%)</td>
<td>16.0 6.7–15.6</td>
<td>19.2 10.5–23.2</td>
<td>NA NA</td>
<td>NA NA</td>
<td>44.5 1.1–5.3</td>
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<td>CD45RA−CCR7− (%)</td>
<td>78.0 1.1–5.3</td>
<td>79.8 2.9–9.8</td>
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<td>NA NA</td>
<td>44.5 1.1–5.3</td>
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<td>CD45RA+CCR7− (%)</td>
<td>8.5 0.1–1.9</td>
<td>0.6 0.2–3.0</td>
<td>NA NA</td>
<td>NA NA</td>
<td>17.2 0.1–1.9</td>
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<td>CD8+ T (cells/mm³)</td>
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<td>CD45RA+CCR7+ (%)</td>
<td>14.7 0.9–5.6</td>
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<td>NA NA</td>
<td>26.3 0.9–5.6</td>
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<td>CD45RA−CCR7− (%)</td>
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<td>74.0 3.4–38.2</td>
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<td>NA NA</td>
<td>9.8 1.3–19.5</td>
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<tr>
<td>CD45RA−CCR7− (%)</td>
<td>14.7 0.9–5.6</td>
<td>5.2 0.9–5.7</td>
<td>NA NA</td>
<td>NA NA</td>
<td>26.3 0.9–5.6</td>
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<tr>
<td>CD3−CD56−/CD16− (cells/mm³)</td>
<td>191 170–830</td>
<td>489 130–720</td>
<td>187 100–480</td>
<td>138 180–920</td>
<td>1539 170–830</td>
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<td>Immunoglobulin</td>
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<td>IgG (mg/dl)</td>
<td>350 172–814</td>
<td>788 424–1051</td>
<td>559 633–1280</td>
<td>821 821–904</td>
<td>413 164–558</td>
</tr>
<tr>
<td>IgA (mg/dl)</td>
<td>77 8.1–84.0</td>
<td>422 14–123</td>
<td>131 33–202</td>
<td>192 192–90</td>
<td>50 4.4–73.0</td>
</tr>
<tr>
<td>IgM (mg/dl)</td>
<td>24 33–108</td>
<td>37 48–168</td>
<td>82 48–207</td>
<td>31 31–126</td>
<td>170 27–101</td>
</tr>
<tr>
<td>IgE (IU/ml)</td>
<td>NA 2704 0.3–29.5</td>
<td>41 1–161.3</td>
<td>5.28 5.28–7.3</td>
<td>26 0.4–3.8</td>
<td></td>
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<tr>
<td>Serum antibody responses</td>
<td>NA</td>
<td>Nonprotective against tetanus toxoid, PRP, Streptococcus pneumoniae</td>
<td>No response to VZV</td>
<td>Response to HBV not detectable</td>
<td>Response to KLH not detectable</td>
</tr>
</tbody>
</table>
opathic of the chest showed a new pulmonary infiltrate (Fig. S2A in the Supplementary Appendix). A lung biopsy revealed granulomatous inflammation (Fig. S2B in the Supplementary Appendix) with acid-fast bacilli. Mycobacterium avium was cultured from the biopsy specimen, and human herpesvirus-6 DNA was detected. Immunologic investigations revealed T-cell and B-cell lymphopenia, defective in vitro T-cell proliferation, and a lack of specific antibody responses (Table 1), all of which were consistent with combined immunodeficiency. At the age of 3.8 years, after reduced-intensity conditioning with the use of treosulfan, fludarabine, and alemtuzumab, she underwent HLA-matched unrelated-donor HSCT. She was well 8 months after HSCT.

Patient 3, a boy born to consanguineous Turkish parents, had recurrent respiratory tract infections from the age of 3 months. At 6 years of age, he had two episodes of meningoencephalitis. On the basis of examination of the cerebrospinal fluid (1000 leukocytes per cubic milliliter, 74% of which were lymphocytes), high serum amylase levels (762 U per liter), and detection of mumps-specific IgM, this condition was presumed to be due to mumps virus infection that was concurrent with an outbreak of mumps at the child’s school. At the age of 6.3 years, severe varicella (Fig. 1B) with alveolar infiltrates developed, and child’s illness rapidly progressed to multiorgan failure and death. Laboratory studies during the patient’s hospitalization showed severe T-cell lymphopenia, impaired T-cell activation, and a lack of antibody responses to varicella–zoster virus (Table 1). A postmortem examination of the patient’s liver and lungs revealed coagulation necrosis, apoptosis, inflammatory infiltrates with neutrophils and monocytes, and nuclear inclusion bodies within pneumocytes; the latter findings were consistent with viral pneumonitis (Fig. S2C and S2D in the Supplementary Appendix).

Patient 4, a boy born to consanguineous Turkish parents, had neonatal-onset chronic diarrhea with mucus and recurrent episodes of fever and oral moniliasis. A liver biopsy, performed at 3 months of age because of persistently elevated aminotransferase levels, revealed macrovesicular steatosis, nonnecrotic eosinophilic granulomatous lesions, and lobular inflammation (Fig. S2E in the Supplementary Appendix). During hospital admission when the boy was 1 year of age,
growth failure (body weight, 4.5 kg [3.5 kg below the 3rd percentile] and length, 64 cm [9 cm below the 3rd percentile]), a nodular erythematous lesion at the site of bacille Calmette–Guérin vaccination, and hepatomegaly were detected. In addition, histopathological analysis of the colon revealed focal active colitis (Fig. 1B) that was associated with a paucity of B cells, plasma cells, and to a lesser extent T cells in the lamina propria of the colon. Immunologic investigations (Table 1) revealed T-cell lymphopenia and defective T-cell activation in response to phytohemagglutinin. Subsequently, multiple episodes of pneumonia due to parainfluenza virus type 3 and adenovirus developed. The patient had several episodes of cytomegalovirus reactivation and died from Klebsiella pneumoniae sepsis at 20 months of age.

Patient 5, a Hispanic boy born to nonconsanguineous parents from Honduras and Nicaragua, presented at the age of 4 months with interstitial pneumonia that responded to high-dose trimethoprim–sulfamethoxazole. Immunologic findings were consistent with combined immunodeficiency (Table 1). At 2 years of age, a rectal fistula developed. At 3 years of age, he received an HSCT from his HLA-identical brother after conditioning with myeloablative doses of busulfan and cyclophosphamide. This patient was well and was not receiving intravenous immune globulin replacement therapy 17.5 years after transplantation.

IMMUNOLOGIC ABNORMALITIES

In all five patients, T-cell lymphopenia and impaired in vitro T-cell activation in response to phytohemagglutinin were detected (Table 1). Maternal T-cell engraftment was ruled out in all the patients. More detailed immunologic analyses that were performed in Patients 1, 2, and 5 revealed a markedly reduced proportion of naive (CD45RA+CCR7+) CD4+ and CD8+ T lymphocytes that were associated with an increased proportion of effector memory (CD45RA–CCR7−) CD4+ T lymphocytes and of either effector memory or CD45RA+CCR7− TEMRA CD8+ T lymphocytes (Table 1). B-lymphocyte counts were reduced in Patients 2 and 4 (Table 1). Despite relatively normal serum levels of IgG and IgM, Patients 2, 4, and 5 had defective antibody production to T-cell–dependent immunization antigens (Table 1). Finally, in Patients 2 and 4, levels of T-cell–receptor excision circles, a marker of active thymopoiesis, were markedly reduced in dried blood spots obtained at birth (Table 1).

IDENTIFICATION OF BIALLELIC DELETEROUS MUTATIONS IN DOCK2

Whole-exome sequencing was performed to elucidate the genetic basis of the patients’ combined immunodeficiencies. Linkage analysis or homozygosity mapping were also performed in Patients 3 and 4, who were born to consanguineous parents. In Patients 1, 3, and 4, we selected genes harboring previously unreported homozygous variants, and in Patients 2 and 5 (for whom no parental consanguinity was known) we selected genes bearing two or more variants (Table S1 in the Supplementary Appendix). Biallelic mutations in DOCK2 were identified and confirmed by means of Sanger sequencing in all five patients (Fig. 1A). No other gene harbored biallelic mutations in two or more patients. Patients 1 and 4 were homozygous for DOCK2 dinucleotide insertions leading to frameshift and premature termination, Patient 3 was homozygous for a missense mutation, and Patients 2 and 5 were compound heterozygotes for different missense and nonsense DOCK2 mutations (Fig. 1A). Multiple sequence alignment showed that all of the three missense mutations affect evolutionarily conserved residues (Fig. S3 in the Supplementary Appendix). Intrafamilial segregation was consistent with autosomal recessive inheritance with complete penetrance (Fig. S1 in the Supplementary Appendix). Collectively, we identified seven distinct rare mutations in DOCK2 in five patients of various ethnic origins; four of these mutations led to premature termination, and three were predicted deleterious missense mutations affecting conserved residues of DOCK2 (Fig. 1C,
DOCK2 and Early-Onset Invasive Infections

Immunoblot analysis revealed no DOCK2 protein expression in T-cell lines obtained from Patient 1 and trace amounts in Patient 2; markedly reduced levels of protein were detected in Epstein–Barr virus–transformed B cells obtained from Patient 3 (Fig. 1D, and Fig. S4A in the Supplementary Appendix). No biologic specimens from Patients 4 and 5 were available; however, overexpression of streptavidin–hemagglutinin–tagged DOCK2 bearing the p.F744Cfs*27 mutation (present in Patient 4) showed expression of a truncated DOCK2 protein (Fig. S4B in the Supplementary Appendix) that lacks the DOCK homology region 2 domain that is critical for the DOCK2 guanine nucleotide exchange factor function.

Previous studies involving mice have shown that Dock2 is essential for Rac1 activation downstream of the T-cell receptor.8,9 In our study, after activation of polyclonal human T-cell lines with an anti-CD3 monoclonal antibody, guanine triphosphate–bound RAC1 was clearly detected in T cells from a healthy control and from Patient 2’s T cells (Panel B). Panel C and D show reduced levels of polymerized, filamentous actin (F-actin) in Patients 1 and 2, as revealed by phalloidin staining in T cells (Panel C) and B cells (Panel D). MFI denotes mean fluorescence intensity.

Figure 2. Defective RAC1 Activation, Lymphocyte Chemotaxis, and Actin Polymerization in Patients with DOCK2 Deficiency.

Panel A shows impaired RAC1 activation in T-cell lines from Patients 1 and 2 and Patient 2’s mother (as compared with those from a healthy donor [control]), after stimulation of the T-cell receptor with the use of anti-CD3 monoclonal antibodies. One-way analysis of variance with Bonferroni correction was used to calculate the P values. T bars represent the standard-deviation values of three independent experiments. P<0.001 for all comparisons. Panel B shows reduced T-cell and B-cell migration in response to CCL21 or chemokine (C-X-C motif) ligand 12 (CXCL12) in Patients 1 and 2 as compared with a healthy control. NS denotes not stimulated. Panels C and D show reduced levels of polymerized, filamentous actin (F-actin) in Patients 1 and 2, as revealed by phalloidin staining in T cells (Panel C) and B cells (Panel D). MFI denotes mean fluorescence intensity.

and Table S2 and Fig. S3 in the Supplementary Appendix).
mother, but not from Patients 1 and 2 (Fig. 2A, and Fig. S5 in the Supplementary Appendix).

Chemokine-mediated cell migration is critically important during lymphocyte development, immune surveillance of lymph nodes, and recruitment of immune cells to sites of inflammation. Previous experimental data suggested a role for DOCK2 in actin polymerization and chemotactic responses of T lymphocytes and B lymphocytes after chemokine stimulation.\(^{11,13}\) Indeed, the chemotactic response of T cells and B cells obtained from Patients 1 and 2 was profoundly impaired (Fig. 2B). Furthermore, chemokine (C-X-C motif) ligand 12 (CXCL12)–induced actin polymerization in T cells and B cells from Patients 1 and 2 was impaired and delayed (Fig. 2C and 2D). Baseline levels of polymerized actin (filamentous actin [F-actin]) were also reduced in DOCK2-deficient T lymphocytes and B lymphocytes from Patients 1 and 2 (Fig. 2C and 2D).

**DEFECTS IN NK CELLS AND NK T CELLS IN PATIENTS WITH DOCK2 DEFICIENCY**

Invasive viral infections were a prominent clinical feature in Patients 2, 3, and 4. Patients with DOCK2 deficiency had normal numbers of CD3− CD56+CD16+ NK cells (Table 1), and NK cells from Patient 2 had a normal immunophenotype (Fig. S6 in the Supplementary Appendix). However, NK cells from Patients 1 and 2 showed impaired degranulation after stimulation with the human erythroleukemia cell line K562 (Fig. 3A).

The ability of NK cells to lyse virus-infected and tumor-target cells correlates with the functionality of a variety of activating NK receptors interacting with distinct adaptor (DAP10 and DAP12) and signaling (CD3ζ, FcεRIγ) molecules.\(^{11-13}\) The triggering of activating NK receptors induces actin polymerization, activation of phosphatidylinositol-3-OH kinase, and phosphorylation of extracellular signal-regulated kinase (ERK) and mitogen-activated protein–ERK (MEK), ultimately promoting NK-cell cytotoxicity.\(^{14}\)

We analyzed NK-cell degranulation after engagement of CD16, NKP30 (NK-cell p30-related protein), or NKP46 (NK-cell p46-related protein) — all of which use CD3ζ and FceR1γ — or NKG2D (which recruits the DAP10 adaptor). We observed severely impaired degranulation in Patient 1 (Fig. 3B) and moderately impaired degranulation in Patient 2, probably corresponding to residual amounts of DOCK2 protein in Patient 2’s hematopoietic cells (Fig. S4A in the Supplementary Appendix). Degranulation was also impaired in Patient 2’s interleukin-2–activated polyclonal NK cells after engagement of NKP44 (NK-cell p44-related protein) (which uses DAP12) (Fig. S7 in the Supplementary Appendix). Furthermore, we observed reduced levels of F-actin in Patient 2’s NK cells after stimulation with anti-CD16 and anti-NKP46 monoclonal antibodies (Fig. 3C); these findings were reminiscent of observations in Dock2\(^{-/-}\) mice.\(^{15}\) These reduced levels possibly reflected impaired tonal signaling through antigen and chemokine receptors. Reduced phosphorylation of ERK1/2 and MEK and impaired actin polymerization were also detected in polyclonal NK cells from Patient 2 after cross-linking of NKP30, NKP44 (Fig. 3D), CD16, and NKP46. NK cells are also involved in cytokine production.\(^{16}\) After overnight stimulation with interleukin-12 and interleukin-18, the proportion of NK cells expressing interferon-γ was markedly reduced in Patient 2 (Fig. 3E).

Finally, the number of circulating NK T cells was severely reduced in Patients 1 and 2 (Fig. S8 in the Supplementary Appendix). Altogether, these data show that DOCK2 serves an essential role in NK and NK T-cell biology; these findings are consistent with similar observations in mice.\(^{17,18}\)

**IMPAIRED ANTIVIRAL INTERFERON RESPONSES IN PATIENTS WITH DOCK2 DEFICIENCY**

Human interferon-α/β and interferon-λ immunity has been suggested to be essential in host defense against viral infections.\(^{19}\) Plasmacytoid dendritic cells are the major source of interferon-α in human blood in response to enveloped viruses and synthetic toll-like receptor 7 and toll-like receptor 9 agonists.\(^{20}\) Previous studies involving mice have shown that Dock2 serves an essential function in regulating interferon-α production in plasmacytoid dendritic cells without perturbing development of these cells.\(^{17,21}\)

Although a normal proportion of circulating plasmacytoid dendritic cells was detected in Patient 2 (Fig. S9 in the Supplementary Appendix), the production of interferon-α and interferon-λ in the peripheral-blood mononuclear cells (PBMCs) in Patients 1, 2, and 3 after stimulation with herpes simplex virus type 1 (HSV-1) or vesicular stomatitis virus (VSV) was markedly impaired (Fig. 4A, and Fig. S10 in the Supplementary Appendix). By contrast, similar amounts of inter-
Figure 3. NK-Cell Cytotoxicity and Signaling Defects in Patients with DOCK2 Deficiency.

Panel A shows impaired NK-cell degranulation (as measured by CD107a surface expression) after stimulation with K562 cells in Patients 1 and 2, as compared with 10 healthy controls. Horizontal bars represent means, and T bars means ±SD. Panel B shows defective degranulation after triggering of activating NK-cell receptors in Patients 1 and 2, as compared with 6 healthy controls. Horizontal bars represent means, and T bars means ±SD. ND denotes not done. Panel C shows impaired actin polymerization after triggering of activating NK-cell receptors CD16 (top) and NKp46 (bottom). Panel D shows impaired extracellular signal-regulated kinase (ERK) and mitogen-activated protein–ERK (MEK) phosphorylation in NK cells from Patient 2 after triggering of activating receptors, as detected by means of flow cytometry. Panel E shows decreased interferon-γ production after NK-cell stimulation with interleukin-12 and interleukin-18 in Patient 2, as compared with a healthy control.

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**A** Impaired Interferon Production by DOCK2-Deficient PBMCs

- **Patient 1**
  - Interferon-α (pg/ml)
  - Interferon-λ (pg/ml)
  - Interleukin-6 (pg/ml)

- **Patient 2**

- **Patient 3**

**B** EMCV-Induced Cell Death of DOCK2-Deficient SV40 Fibroblasts and Rescue by Interferon alfa-2b

- **Control**
  - MOI 0.001
  - MOI 0.01
  - MOI 0.1

- **EMCV-Infected**
  - MOI 0.001
  - MOI 0.01
  - MOI 0.1

**C** Reconstitution of DOCK2 Expression after Lentiviral-Mediated Transduction

- **Control**
  - Patient 2
  - Patient 2+Mock
  - Patient 2+DOCK2

- **DOCK2**
- **GAPDH**

**D** Rescue of Virus-Induced Cell Death of DOCK2-Deficient SV40 Fibroblasts by Wild-Type DOCK2

- **Control**
  - Patient 2
  - Patient 2+Mock RFP
  - Patient 2+DOCK2 RFP
  - STAT1−/−
in hematopoietic cells, low levels of expression in the patients’ viral susceptibility. DOCK2 deficiency; this may also contribute to dritic cells may also be defective in patients with NK cells, and NK T cells, plasmacytoid den- 
ipation was detected in fibroblasts from Patients 1, 2, and 3 and from healthy controls. After infec-
tion with VSV or encephalomyocarditis virus, we found enhanced levels of viral replication and decreased viability of DOCK2-deficient SV40 fibroblasts (Fig. 4B, and Fig. S11 in the Supplementary Appendix); similar results were ob-
served in SV40 fibroblasts from patients with toll-like receptor 3 or signal transducer and ac-
tivator of transcription 1 deficiency (Fig. 4B, and Fig. S11 in the Supplementary Appendix), which affect the production of or the response to interferon-α/β and interferon-λ, respectively.

Both treatment with recombinant interferon alfa-2b (Fig. 4B) and lentiviral-mediated wild-type DOCK2 expression (Fig. 4C) protected DOCK2-deficient fibroblasts from virus-induced cell death (Fig. 4D). The DOCK2 mutations may therefore also impair cell-intrinsic, nonhematopoietic immunity, at least in fibroblasts and in response to some viruses.

**DISCUSSION**

In this study, we showed that biallelic mutations in DOCK2 were the molecular cause of a distinct-
tive type of combined immunodeficiency that is characterized by early-onset, invasive bacterial and viral infections; T-cell lymphopenia; impaired T-cell, B-cell, and NK-cell function; and defective interferon immunity in both hematopoietic and nonhematopoietic cells. Our results also indicate that this disease can be detected at birth with newborn screening for severe combined immunodeficiency (Table 1) and can be cured by means of HSCT (Fig. S12 in the Supplementary Appendix).

The observation that DOCK2 deficiency in humans leads to impaired RAC1 activation and to defects in actin polymerization, T-cell proliferation, chemokine-induced lymphocyte migration, and NK-cell degranulation confirms and extends similar observations in Dock2−/− mice. It also highlights the essential role of regulated actin dynamics for immune-cell function, a role that is also evident with respect to other combined immunodeficiencies involving defective actin polymerization such as the Wiskott–Aldrich syndrome, as well as with respect to deficiency of Wiskott–Aldrich syndrome protein–interacting protein (WIP), DOCK8 protein, the protein encoded by the Ras homologue family member H (RHOH), and macrophage-stimulating 1 growth factor (MST1) protein.

The occurrence of invasive viral infections, including disseminated vaccine-strain varicella,
was a prominent feature in patients with DOCK2 deficiency. Human antiviral immunity is critically dependent on intact T-cell function as well as on innate immune responses, as observed in patients with genetic defects affecting T-cell, NK-cell, NK T-cell, and dendritic-cell development, function, or both, or with mutations affecting production of (or response to) interferon-α, interferon-β, and interferon-λ in both hematopoietic and nonhematopoietic cells. We observed defective interferon-α/β and interferon-λ responses in both hematopoietic and nonhematopoietic cells in patients with DOCK2 deficiency. Plasmacytoid dendritic cells are the most potent interferon-α-producing cells. Severe reduction of splenic and lymph-node plasmacytoid dendritic cells and of their capability for interferon-α production were observed in Dock2−/− mice. Here we show impaired interferon-α and interferon-λ production in DOCK2-deficient PBMCs after stimulation with HSV-1 or VSV, possibly reflecting a defect of plasmacytoid dendritic cells. Therefore, we speculate that treatment with interferon alfa-2b might be beneficial in patients with DOCK2 deficiency who have severe viral infections.

Furthermore, our study suggests a role for DOCK2 in antiviral responses in nonhematopoietic cells. DOCK2 deficiency in nonhematopoietic cells may contribute to the pathogenesis of severe viral infections. Normalization of immunologic abnormalities and resolution of infections were observed in Patients 1, 2, and 5 after HSCT (Fig. S12 in the Supplementary Appendix). This finding implies that correction of hematopoietic cells may be sufficient to rescue the clinical phenotype, possibly by providing a source of cells producing interferon-α/β (e.g., plasmacytoid dendritic cells) and therefore complementing the defect in nonhematopoietic tissues.

K. pneumoniae sepsis was the cause of death in Patient 4. Susceptibility to invasive bacterial infections in patients with DOCK2 deficiency may reflect impaired function of neutrophil granulocytes in addition to impaired antibody production. Defective neutrophil chemotaxis has been reported in Dock2−/− mice. Because of a lack of primary material, we could not test whether a similar defect existed in the patients in our study.

Mutations in DOCK8, another member of the DOCK family of proteins, have been identified in patients with another form of combined immunodeficiency. Similarities and important differences have been observed between patients with DOCK2 deficiency and those with DOCK8 deficiency. Both conditions are characterized by recurrent bacterial and viral infections and are associated with T-cell lymphopenia, defective NK-cell function, aberrant NK T-cell survival and function, and impaired antibody responses. However, the natural course of DOCK2 deficiency appears to be more severe than that of DOCK8 deficiency. Although DOCK8 deficiency is characterized mostly by cutaneous viral infections, patients with DOCK2 deficiency have early-onset, life-threatening, invasive viral and bacterial infections. Furthermore, severe food allergies, eczema, and autoimmunity are commonly observed in patients with DOCK8 deficiency, whereas none of the patients with DOCK2 deficiency had such manifestations.

In summary, we have identified DOCK2 deficiency as a pleiotropic immunodeficiency leading to early-onset, invasive bacterial and viral infections. The broad spectrum of infections observed in patients with DOCK2 deficiency highlights the effect of DOCK2 function on several aspects of immunity and arouses possible concern about the application of new immunosuppressive agents targeting DOCK2.

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DOCK2 and Early-Onset Invasive Infections

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DOCK2 and Early-Onset Invasive Infections


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