

Folding proteins in fatal ways

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Human diseases characterized by insoluble extracellular deposits of proteins have been recognized for almost two centuries. Such amyloidoses were once thought to represent arcane secondary phenomena of questionable pathogenic significance. But it is now become clear that many different proteins can misfold and form extracellular or intracellular aggregates that initiate profound cellular dysfunction. Particularly challenging examples of such disorders occur in the post-mitotic environment of the neuron and include Alzheimer's and Parkinson's diseases. Understanding some of the principles of protein folding has helped to explain how such diseases arise, with attendant therapeutic insights.

One of the most satisfying moments in scientific investigation occurs when previously disparate phenomena of unclear origin are shown to arise from a common principle. During the past decade, numerous aetiologically distinct diseases have been linked by the likelihood that they result from the progressive misfolding of specific proteins into aggregates that can injure and kill cells. Together, these disorders inflict enormous personal and societal burdens, making it crucial to understand their genesis and to learn how to prevent them.

The amyloidoses have traditionally been defined as diseases in which normally soluble proteins accumulate in the extracellular space of various tissues as insoluble deposits of 10 nm fibrils that are rich in β -sheet structure and have characteristic dye-binding properties^{1,2}. There are many examples of secreted, circulating proteins that can, under abnormal circumstances, be converted in part to highly stable extracellular fibrils. These include immunoglobulins in primary systemic amyloidosis and multiple myeloma, amylin in the diabetic pancreas, and small soluble proteins of uncertain function such as the amyloid β -peptide (A β) in Alzheimer's disease.

Although the specific polypeptides that comprise the deposits are different for each amyloidosis, the disorders have several key features in common. Perhaps foremost among them is the ability of proteins that are highly soluble in biological fluids to be converted gradually to insoluble filamentous polymers enriched in β -pleated sheet conformation. The common structural motif of virtually all amyloid fibrils consists of cross- β -sheets in which the peptide strands are arranged perpendicular to the long axis of the fibre. Although it was once thought that relatively few proteins have this propensity, recent data suggest that many soluble proteins can, under certain circumstances, undergo this conversion. Of particular significance is the finding that globular proteins with diverse sequences that are not currently associated with a protein-folding disease (for example, muscle myoglobin) can undergo aggregation *in vitro* into fibrils indistinguishable from those found in the amyloidoses^{3,4}. This finding supports the concept that aggregation into β -sheet-rich fibrils is a generic property of polypeptide chains regardless of sequence⁵.

Another general feature of protein-folding disorders is the prolonged period before clinical manifestations appear. Although the age of onset of symptoms varies widely among the different diseases and even among cases of one disease, most of these disorders become noticeable in middle or late life. There is a prolonged preclinical phase during which

proteins misfold, build up and progressively compromise cellular and tissue function. A portion of this long prodrome derives from the energetic barriers to the formation of misfolded species, including the fact that nucleation — the initial development of very small, metastable oligomers of a protein — is a kinetically unfavourable requirement for fibrillogenesis^{6,7}. It seems that time, rather than great age, is required, in that some aggressive protein-folding disorders can occur in young and early middle-aged individuals. In such cases, time still has a role but the fibrillogenic process requires less time overall because particular biochemical circumstances promote accelerated nucleation. One striking example is Down's syndrome, in which patients with trisomy 21 develop abundant A β aggregates in the brain as early as the age of ten, owing to lifelong overexpression of the β -amyloid precursor protein (APP), which is encoded on chromosome 21. Similarly, inherited missense mutations in amyloid-prone proteins can markedly accelerate their misfolding and fibrillogenesis, producing earlier disease onset than occurs with the wild-type isoform. For example, senile systemic amyloidosis arises late in life from the aggregation of wild-type transthyretin, whereas familial amyloidotic polyneuropathy I generally arises in mid-life from the accelerated aggregation of mutant transthyretin.

In this review, I describe briefly three types of amyloidosis: systemic, organ-limited and intracellular. I then examine how aberrant protein folding may occur and how misfolded proteins may disrupt the cell.

Systemic amyloidoses

The list of secreted, circulating proteins that are capable of producing extracellular amyloid deposits in multiple organs is long and growing (Table 1). Amyloidoses can arise when other pathological conditions cause a sharp increase in the concentration of an amyloid-prone polypeptide, as occurs for the serum amyloid A (SAA) protein during the acute-phase response accompanying inflammatory disorders such as rheumatoid arthritis, or chronic granulomatous infections such as tuberculosis. A 76-residue proteolytic fragment of wild-type SAA can then accumulate, misfold, aggregate and be deposited in the connective tissue of multiple organs, including spleen, kidney and liver. Multiple myeloma is associated with the overproduction by plasma cells of monoclonal immunoglobulins that accumulate and form deposits (as holoproteins and/or proteolytic fragments) in the extracellular space of various tissues. Primary systemic amyloidosis also involves progressive multi-tissue deposition of immunoglobulin light chains and their fragments. In some systemic amyloidoses, the basis for an

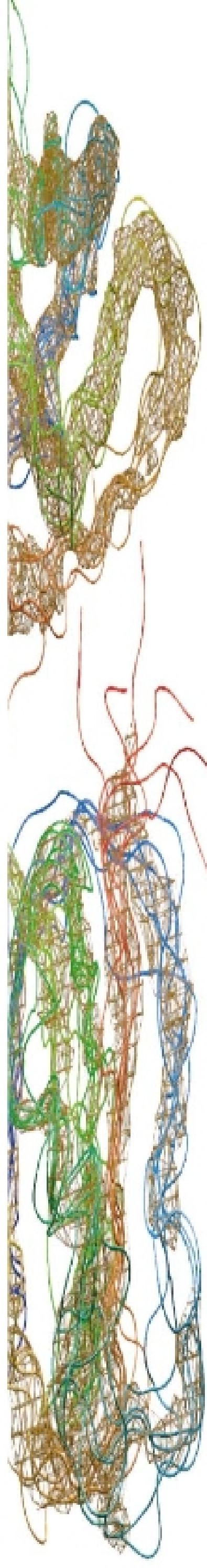


Table 1 Some members of the family of systemic extracellular amyloidoses

Clinical syndrome	Fibril subunit
Primary systemic amyloidosis	Intact immunoglobulin light chains or fragments thereof
Secondary systemic amyloidosis	Fragments of serum amyloid A protein
Familial Mediterranean fever	Fragments of serum amyloid A protein
Familial amyloidotic polyneuropathy 1	Mutant transthyretin and fragments thereof
Senile systemic amyloidosis	Wild-type transthyretin and fragments thereof
Familial amyloidotic polyneuropathy II	Fragments of apolipoprotein A-1
Haemodialysis-related amyloidosis	β_2 -Microglobulin
Finnish hereditary amyloidosis	Fragments of mutant gelsolin
Lysozyme amyloidosis	Full-length mutant lysozyme
Insulin-related amyloid	Full-length insulin
Fibrinogen α -chain amyloidosis	Fibrinogen α -chain variants

increased concentration of an amyloidogenic protein is a perturbation in its clearance. One striking example is haemodialysis-related amyloidosis, in which chronic haemodialysis can lead to progressive increase in β_2 -microglobulin in tissues because this amyloid-prone protein does not pass efficiently through the dialysis membrane and becomes highly concentrated in the post-dialysis serum of the patient.

In these and other systemic amyloid diseases, the precise reasons for selective tissue deposition and the mechanisms of cell dysfunction and organ failure are still under investigation (see below). Because systemic amyloid deposits can sometimes build up in very large amounts, it seems that they can cause injury in part by physical compression and microvascular compromise of adjacent tissue. However, as with the misfolded proteins that define certain neurodegenerative disorders (see below), the systemic extracellular amyloid fibrils and in particular their smaller, more diffusible precursor assemblies (oligomers and protofibrils) might also act in an amphipathic fashion to bind and perturb multiple cell-surface receptors and/or channels rather nonspecifically.

Organ-limited amyloidoses

The other broad class of amyloid disorders is that in which the fibrillogenic protein accumulates locally near its site of cellular production; that is, mostly in one organ (Table 2). Salient examples of this type include calcitonin deposition in medullary carcinoma of the thyroid, deposition of amylin in the pancreas in type II diabetes mellitus, deposition of atrial natriuretic factor in atrial amyloidosis of the heart, and A β deposition in Alzheimer's disease. Although these proteins enter the systemic circulation, their high local production in these conditions apparently leads to levels that exceed the critical concentrations for oligomerization and fibrillogenesis solely in that organ. In these disorders, the amyloid fibrils and their precursor aggregates are deposited in the extracellular space of the respective organs and somehow compromise local cell viability. However, there are also a growing number of diseases in which the accumulation of different misfolded proteins occurs intracellularly, particularly in the nervous system, as described in the next section.

Protein misfolding and age-related neurodegeneration

During the past two decades, there has been a marked transformation in our understanding of the causes and pathogenesis of age-related degenerations of the brain. Once fraught with mechanistic ignorance, this class of disorders has become recognized as likely to be mediated by the progressive accumulation of β -sheet-rich protein aggregates. A range of brain disorders of previously unknown cause now falls into this category (Table 3). The most common neurodegenerative disease, Alzheimer's, is the premier example of this. The second most common, Parkinson's, is increasingly considered to involve a protein-folding problem. Two special features of most of these disorders of the central nervous system are that the aggregates accumulate inside cells and that the ultrastructure of the aggregates is not the same as that of extracellular amyloid fibrils. This raises the

question of whether such disorders should be classified with the amyloidoses. But because the dye-binding properties (for example, birefringent labelling by Congo red), insolubility and X-ray diffraction pattern (high β -sheet content) of at least some of these deposits seem to be similar to those of classic amyloid fibrils, it is reasonable to consider them a special form of amyloidosis.

A wide variety of proteins of diverse sequence can form intraneuronal filamentous deposits. In Parkinson's disease, α -synuclein, a soluble cytoplasmic protein with a 'natively unfolded' structure, misfolds and accumulates in spherical filamentous masses (Lewy bodies) within selected neuronal cell bodies, particularly the dopaminergic and noradrenergic brainstem neurons whose premature death defines the disease biochemically. A recently recognized group of protein-folding diseases of the central nervous system are the polyglutamine repeat disorders, such as Huntington's disease and several forms of familial spinocerebellar ataxia⁸. Here, unstable DNA mutations in different genes result in the lengthening of glutamine stretches in the cognate proteins, which subsequently misfold and accumulate in the nuclei and cytoplasm of certain neurons. Although the appearance of microscopically detectable filamentous inclusions is variable and subtle compared with the robust formation of neurofibrillary tangles in Alzheimer's disease and Lewy bodies in Parkinson's disease, these highly stable, polyglutamine-rich proteins aggregate and gradually cause the dysfunction and death of their host neurons. It seems that the accumulation of misfolded proteins has particularly dire consequences in the post-mitotic milieu of the adult neuron.

Alzheimer's disease is virtually the only brain disorder that is defined by the accumulation of amyloid-forming proteins both extracellularly (A β) and intracellularly (tau). There has been lively debate about which of these, if either, has precedence in the pathogenic mechanism. The issue has been largely resolved by the finding that inherited mutations in APP, or in one of the proteases (called presenilin/ γ -secretase) that cleaves APP to release A β , cause aggressive, early-onset forms of Alzheimer's disease⁹. In contrast, inherited mutations in the tau protein do not produce Alzheimer's disease but cause the less common but equally devastating disorder, frontotemporal dementia with parkinsonism, in which tau-containing neurofibrillary tangles accumulate in the absence of extracellular amyloid¹⁰.

A remarkable example of protein misfolding causing neurodegeneration is that of the prion disorders. In humans, these include Creutzfeldt-Jacob disease and new-variant Creutzfeldt-Jacob disease, the latter being a human derivative of bovine spongiform encephalopathy ('mad cow disease'). These disorders are very closely related to a range of slowly progressive infectious diseases in certain lower mammals, including the defining disorder, scrapie, in sheep¹¹. Very rarely, the normal cellular prion protein (PrP) can undergo a change in its conformation that creates a metastable conformer, which can in turn bind and 'convert' another wild-type prion protein into this same pathological isoform. This misfolding process can apparently occur spontaneously at a very low frequency but occurs more readily if the protein bears certain missense mutations. Prion encephalopathies can thus be inherited, but they also occur in an infectious form: exposure of a healthy subject to small amounts of pathologically conformed but non-mutant prion protein (for example, through a corneal transplant from an individual with

Table 2 Some of the organ-limited extracellular amyloidoses

Clinical syndrome	Fibril subunit
Alzheimer's disease	Amyloid β -peptide
Spongiform encephalopathies	Full-length prion protein or fragments thereof
Hereditary cerebral haemorrhage with amyloidosis	Amyloid β -peptide or cystatin C
Type II diabetes	Amylin (islet amyloid polypeptide)
Medullary carcinoma of the thyroid	Procalcitonin
Atrial amyloidosis	Atrial natriuretic factor

Creutzfeldt–Jacob disease) can lead to progressive and fatal brain degeneration. Exactly how prion conversion and propagation of the disease occur is under study. One theory favours an ‘instructive’ dimerization of a scrapie-type prion protein conformer with a wild-type molecule that converts the latter to the former form; this can then be magnified geometrically to propagate the process. Alternatively, small oligomers of the scrapie-type conformer might serve as ‘seeds’ for the progressive addition and conformational conversion of wild-type monomers, in a mechanism akin to those postulated in systemic amyloidoses and Alzheimer’s disease. It should be emphasized that, like the prion protein, numerous amyloidogenic proteins can oligomerize and form toxic aggregates in their wild-type state, for example tau in Alzheimer’s disease and α -synuclein in idiopathic Parkinson’s disease.



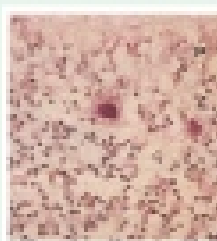
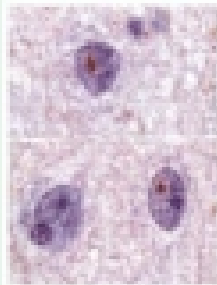
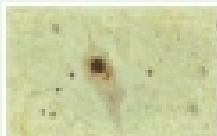
Mechanism of protein misfolding

A principal unanswered question about all of these disorders is the precise manner in which natively soluble proteins of distinct primary structure undergo partial unfolding and aberrant refolding to produce highly stable oligomers and polymers with novel properties. It is clear that supraphysiological concentrations, coupled with prolonged time and certain biochemical conditions, underlie the initiation of the oligomerization process. One instructive example that has

been studied in some detail is lysozyme, a protein that causes a fatal systemic amyloidosis only when it bears one of two inherited missense mutations, Ile 56→Thr or Asp 67→His. Crystallography of the wild-type and mutant variants revealed subtle but structurally significant changes at the interface between the α - and β -domains that suggest that this region is less constrained in both mutants¹². In agreement, circular-dichroism studies during conditions of heat denaturation that lead to fibril formation showed that both mutants are less thermostable. Moreover, near the midpoint of the heat-driven unfolding process, the mutants formed partly folded intermediates with considerable helical structure but no persistent tertiary interactions¹². Wild-type lysozyme unfolds into a partly structured intermediate only when thermal denaturation is performed at very low pH (ref. 13).

It seems that such partly folded forms, which have exposed hydrophobic regions and are therefore prone to self-aggregation, can exist in equilibrium with the native protein. In the case of the mutant lysozymes, the molten-globule-like intermediates have persistent structure in the α -domain but lack stable, native-type structure in the β -domain¹⁴. It has therefore been proposed that the transient, partly folded forms of the mutant lysozymes associate through their unstable β -domains. The emergence of stable β -structure through such intermolecular self-association might provide a template (seed) for the recruitment of additional peptide chains that ultimately form the hydrogen-bonded, mainly cross- β -sheet core structure of the insoluble amyloid fibril¹² (Fig. 1). In agreement with this model, the NMR structure of a domain of the prion protein (PrP(121–231)) indicates that amino acids that are mutated in inherited prion diseases are involved in the maintenance of the hydrophobic core¹⁵. Because microscopically visible fibril deposition is not an obligatory feature of the prion diseases, these principles are likely to apply also to pre-fibrillar, oligomeric assemblies of PrP and presumably other amyloidogenic proteins.

Table 3 Some human brain diseases characterized by progressive misfolding and aggregation of proteins

Disease	Protein	Locus	
Alzheimer’s disease	Amyloid β -protein Tau	Extracellular plaques Tangles in neuronal cytoplasm	
Frontotemporal dementia with parkinsonism	Tau	Tangles in neuronal cytoplasm	
Parkinson’s disease; dementia with Lewy bodies	α -Synuclein	Neuronal cytoplasm	
Creutzfeldt–Jakob disease; ‘mad cow disease’*	Prion protein (PrP ^{Sc})	Extracellular plaques Oligomers, inside and outside neurons	
Polyglutamine expansion diseases (Huntington’s disease, spinocerebellar ataxias, and so on)*	Long glutamine stretches within certain proteins	Neuronal nuclei and cytoplasm	
Amnionotrophic lateral sclerosis*	Superoxide dismutase	Neuronal cytoplasm	

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How do misfolded proteins cause cell dysfunction?

Perhaps even more complex than the mechanisms by which proteins misfold are the mechanisms by which they inflict cellular injury. This question once focused primarily on the mature, highly stable amyloid fibrils, but now attention has shifted to the apparent cytotoxicity conferred by metastable intermediates of the fibrillogenic process. In diseases in which unmistakable amyloid formation occurs, deposits of insoluble fibrils are in equilibrium with smaller, more diffusible assemblies that are invisible by light microscopy but can be detected by biochemical methods such as gel electrophoresis and size-exclusion chromatography. In the growing number of diseases in which protein misfolding and oligomerization occur but no definite amyloid fibrils are seen, these smaller diffusible assemblies might be responsible in part for cytotoxicity. Limited studies of such species in human-tissue extracts indicate that they might include dimers, trimers, tetramers and other larger oligomers. But most of the information about the properties of such intermediates has been gleaned from biophysical (*in vitro*) and cell culture studies of synthetic or recombinant versions of the amyloidogenic proteins. The concern here is that perhaps only a small proportion of these artificial assemblies closely resemble the natural oligomers that occur *in vivo*.

Mouse models that transgenically overexpress the polypeptide precursors of amyloid subunits *in vivo* offer another approach. One closely studied example is that of mice overexpressing mutant human APP as a model of the amyloidosis of Alzheimer’s disease. In some such mouse lines, presynaptic nerve terminals and neuronal cell bodies are decreased about 30% compared with non-transgenic controls at the age of 2–4 months, when concentrations of soluble A β are increasing but well before A β deposition (that is, amyloid plaque formation) has begun¹⁶. Comparisons of transgenic lines with different APP expression levels suggest that these decreases in presynaptic terminals are dependent on A β concentrations, not on the A β plaque burden¹⁷. This animal work fits nicely with growing evidence that