

Complement: a key system for immune surveillance and homeostasis

Daniel Ricklin¹, George Hajishengallis², Kun Yang¹ & John D Lambris¹

Nearly a century after the significance of the human complement system was recognized, we have come to realize that its functions extend far beyond the elimination of microbes. Complement acts as a rapid and efficient immune surveillance system that has distinct effects on healthy and altered host cells and foreign intruders. By eliminating cellular debris and infectious microbes, orchestrating immune responses and sending 'danger' signals, complement contributes substantially to homeostasis, but it can also take action against healthy cells if not properly controlled. This review describes our updated view of the function, structure and dynamics of the complement network, highlights its interconnection with immunity at large and with other endogenous pathways, and illustrates its multiple roles in homeostasis and disease.

A hidden connection is stronger than an obvious one.

—Heraclitus of Ephesus (535–475 BC)

Traditionally, complement has been primarily viewed as a supportive first line of defense against microbial intruders, quickly tagging and eliminating them and buying the adaptive immune response time to pick up momentum. Today, we know that complement truly lives up to its name and complements, or even orchestrates, immunological and inflammatory processes, extending far beyond simple elimination of danger. Research over the past decade has drawn a picture of how complement acts as an intricate immune surveillance system to discriminate among healthy host tissue, cellular debris, apoptotic cells and foreign intruders and tunes its response accordingly (Fig. 1a–c). Indeed, besides its obvious involvement in eliminating microbes, complement participates in such diverse processes as synapse maturation, clearance of immune complexes, angiogenesis, mobilization of hematopoietic stem-progenitor cells (HSPCs), tissue regeneration and lipid metabolism. This versatility becomes less surprising when one considers that complement represents one of the most ancient cornerstones of immunity and has tightly coevolved with phylogenetically younger pathways¹. Our understanding of the intricate network of effectors, receptors and regulators at the heart of complement has been continuously extended as new components have been discovered or experienced a resurrection, and new initiation pathways have been defined (Table 1). Structural and functional studies have provided unprecedented insight into the finely balanced machinery that underlies these versatile complement functions. However, it has also become clear that any trigger that tips this delicate balance between complement activation and regulation can induce self-attack (Fig. 1d).

Indeed, complement can contribute to various immune, inflammatory, neurodegenerative, ischemic and age-related diseases, and complement-targeted therapeutics have recently re-entered the spotlight of drug discovery efforts. Our Review highlights recent and emerging trends that better define complement's role in physiology and pathophysiology.

Complement initiation and amplification

Although complement is commonly depicted as a linear cascade of separate pathways, it is essentially a hub-like network that is tightly connected to other systems (Supplementary Fig. 1). Depending on the trigger, several initiation and regulatory mechanisms act together to produce an anticipated result in immune surveillance (Figs. 1 and 2).

The classical pathway is often referred to as antibody-dependent because it is strongly initiated by IgM or IgG clusters. However, the versatile pattern recognition molecule (PRM) C1q activates complement by recognizing distinct structures directly on microbial and apoptotic cells or through endogenous PRMs such as immunoglobulins and pentraxins (for example, C-reactive protein; CRP). As part of the C1 complex (C1q₂S₂), the proteases C1r and C1s are consecutively activated upon surface binding of C1q^{2,3}. C1s subsequently cleaves C4 into C4a and C4b, thereby exposing a previously hidden thioester and leading to covalent deposition of C4b on surfaces in the immediate vicinity of the activation sites (opsonization). By cleaving C4b-bound C2 into C2a and C2b, C1s also mediates the generation of the classical pathway C3 convertase (C4b2b), which can cleave C3 and initiate amplification and downstream effector functions. (On the basis of recent discussions in the field and to streamline fragment nomenclature for all the complement pathways, we designate the small, nonproteolytic C2 fragment as C2a and the protease segment as C2b. As a consequence, the classical pathway and lectin pathway C3 convertase is referred to as C4b2b, by analogy to the alternative pathway C3 convertase, C3bBb.)

In the functionally similar lectin pathway, mannose-binding lectin (MBL) and ficolins act as PRMs that predominantly recognize carbohydrate patterns. Each PRM assembles with MBL-associated serine proteases (MASPs) that share structural similarity with C1r and C1s. Of

¹Department of Pathology & Laboratory Medicine, University of Pennsylvania, Philadelphia, Pennsylvania, USA. ²Department of Microbiology & Immunology, Oral Health and Systemic Disease, University of Louisville, Louisville, Kentucky, USA. Correspondence should be addressed to J.D.L. (lambris@mail.med.upenn.edu).

Published online 19 August 2010; doi:10.1038/ni.1923

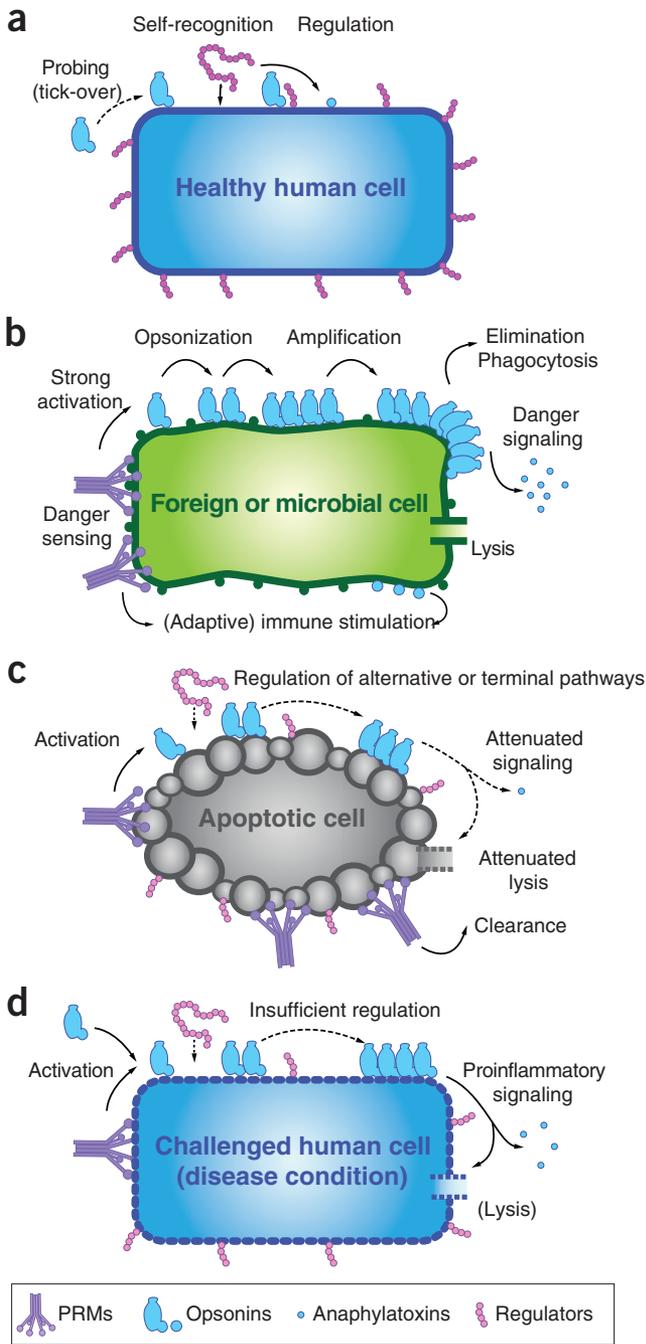


Figure 1 Immune surveillance functions of complement. (a) A constant low level of complement activation (tick-over) ensures occasional probing of healthy human cells, but the presence of surface-bound regulators and self-recognition by soluble regulators prevents any amplification of the response. (b) In the case of microbial intruders, a strong complement response is actively induced by pattern recognition proteins and amplified in the absence of regulators. Opsonization by complement fragments and proinflammatory signaling by anaphylatoxins recruit macrophages and enable phagocytosis, and the formation of a lytic membrane attack complex on cells such as Gram-negative bacteria leads to cell death. Finally, complement degradation products stimulate downstream immune responses. (c) Although pattern recognition proteins also recognize the surfaces of apoptotic cells, residual and recruited complement regulators hold amplification and terminal pathways in check. Thus, opsonization facilitates elimination of the cell without triggering danger signals and further immune responses. (d) This fine-tuned interplay between complement recognition, activation and regulation usually allows appropriate reactions to healthy, apoptotic and foreign cells; however, any imbalance can lead to an attack on host cells and trigger immune and inflammatory diseases. Although proinflammatory and immune signaling seems to be the driving force in most complement-mediated diseases, other processes such as TCC-mediated lysis may be involved (for example, of erythrocytes in the case of paroxysmal nocturnal hemoglobinuria).

and C3b. Cleavage of C3 exposes a reactive short-lived thioester moiety in C3b, which covalently attaches to amine and carbohydrate groups on the target surface. This initial tagging is quickly amplified on foreign cells but is immediately regulated on human cells. Moreover, the reactivity of the thioester moiety to specific carbohydrates might lead to preferential opsonization of foreign particles and represent a basic pattern recognition mechanism^{9,10}. The alternative pathway also includes a PRM-based initiation mechanism that resembles those found in the lectin pathway and classical pathway and involves properdin. Properdin recognizes several pathogen- or damage-associated molecular patterns (PAMPs and DAMPs, respectively) on foreign and apoptotic cells. Once bound, it initiates and propagates the complement response by attracting fluid-phase C3b to recognized surfaces¹¹ and allowing *de novo* convertase assembly, and by stabilizing C3 convertase complexes (C3bBbP)¹².

All surface-bound C3 convertases, regardless of origin, can induce the amplification branch of the alternative pathway by activating C3. The resulting C3b is rapidly deposited in the immediate vicinity of the activation and forms the major alternative pathway C3 convertase (C3bBb) in the presence of fB and fD, thereby creating an efficient cycle of C3 cleavage and convertase assembly that markedly amplifies the response. Despite its name, the alternative pathway might account for up to 80–90% of total complement activation, even when initially triggered by the classical pathway or lectin pathway¹³. Complement amplification can also occur in plasma when C3b forms dimeric complexes with IgG, which are partially protected from degradation and further stabilized by binding properdin¹⁴.

Amplification by the alternative pathway increases the density of deposited C3b and gradually leads to the formation of convertases that contain an additional C3b molecule (C4b2b3b or C3bBb3b) and shift the substrate specificity from C3 to C5. These C5 convertases cleave C5 into the anaphylatoxin C5a and fragment C5b. When C5b associates with C6 and C7, the complex becomes inserted into cell membranes and interacts with C8, inducing the binding of several units of C9 to form a lytic pore, the terminal complement complex (TCC; C5b-9_n; also known as the membrane attack complex)¹⁵.

Substitute routes of complement activation have emerged in recent years. Although it has long been known that proteases such as plasmin, thrombin, elastase and plasma kallikrein can cleave and activate C3, this extrinsic protease pathway (Fig. 2a) has gained more attention in the context of potential crosstalk between complement and coagulation

these, only MASP-2 cleaves both C4 and C2, generating the same C3 convertase as in the classical pathway. By contrast, MASP-1 cleaves C2 but not C4 and can supplement the lectin pathway response once initiated⁴, thereby increasing the efficiency of convertase formation^{5,6}.

In contrast to the classical pathway and lectin pathway, the alternative pathway represents three distinct but partially overlapping processes. The tick-over segment keeps complement alert and allows constant probing of cells^{7,8}. In its native form, C3, the central molecule of the alternative pathway, has few ligands and is relatively inert. However, a small fraction of the C3 molecules are hydrolyzed to C3_{H2O}, exposing new binding sites. The factor B (fB) protease binds C3_{H2O} and is cleaved by factor D (fD), generating an initial, mainly solvent-based C3 convertase (C3_{H2O}Bb) that activates complement by cleaving C3 into its active fragments, C3a

Table 1 Proteins involved in the core complement cascade

Pattern recognition	Alternative names	Function
C1q		Part of the C1 complex; recognizes surface-bound IgG, IgM, CRP and PAMP; initiates CP
MBL		Recognizes carbohydrate patterns; initiates LP
Ficolin-1	M-Ficolin	Recognizes carbohydrate patterns; initiates LP
Ficolin-2	L-Ficolin; Hucolin	Recognizes carbohydrate patterns; initiates LP
Ficolin-3	H-Ficolin; HAKA1	Recognizes carbohydrate patterns; initiates LP
Properdin	Factor P	Recognizes PAMP and DAMP; initiates AP; stabilizes AP convertases
CRP ^a		Recognizes DAMP and PAMP on apoptotic and microbial cells; binds C1q
CFHR-4	FHR-4	Recruits monomeric CRP to necrotic cells; facilitates activation of CP via C1q
Proteases	Alternative names	Function
C1r		Part of the C1 complex; cleaves C1s
C1s		Part of the C1 complex; cleaves C2 and C4
MASP-1		Binds to MBL/ficolins; cleaves C2 (but not C4); may cleave MASP-2 and C3; activates pro-FD; potential role in coagulation cascade?
MASP-2		Binds to MBL/ficolins; cleaves C2 and C4
MASP-3		Unknown (binds to MBL/ficolins, does not cleave C2 or C4)
C2		Part of the CP/LP convertases; cleaves C3/C5
Factor B	CFB	Part of the AP C3/C5 convertases; cleaves C3/C5
Factor D	CFD	Cleaves C3b-bound FB to form the AP C3/C5 convertases
Factor I	CFI	Degrades C3b and C4b
Complement components	Alternative names	Function
C3		Progenitor for anaphylatoxin C3a, opsonin C3b and signaling fragments (iC3b, C3dg, C3d); part of the AP C3 and all C5 convertases
C4		Progenitor for opsonin C4b; part of the CP/LP convertases
C5		Progenitor for anaphylatoxin C5a and C5b/TCC
C6		Part of TCC (membrane insertion)
C7		Part of TCC (membrane insertion)
C8		Part of TCC (induction of pore formation)
C9		Part of TCC (forms lytic pore)
Receptors ^b	Alternative names	Function
CR1	CD35; C3b/C4b-receptor	Binds C3b/iC3b; induces phagocytosis; accelerates decay of convertases; cofactor for fl
CR2	CD21; C3d-receptor	Binds iC3b/C3dg/C3d; lowers threshold for B-cell stimulation
CR3	CD11b/CD18; Mac-1; integrin $\alpha_M\beta_2$	Induces phagocytosis through interaction with iC3b; modulates IL-12 family in APCs
CR4	CD11c/CD18; p150/95; integrin $\alpha_X\beta_2$	Induces phagocytosis through interaction with iC3b
C3aR		Binds C3a; triggers proinflammatory signaling
C5aR	CD88	Binds C5a; triggers proinflammatory signaling
C5L2	GPR77	Binds C5a (strongly) and C5a ^{desArg} (weakly); might bind C3a/C3a ^{desArg} ; function not fully defined
CR1g	Z931g, VSIG4	Induces phagocytosis through interaction with iC3b/C3c; regulatory effect on C5 convertases
cC1qR	Calreticulin; collectin receptor	Recognizes bound C1q; induces phagocytic signaling through CD91
gC1qR	C1qbp (C1q-binding protein); p33	Recognizes C1q; potential role in phagocytosis and signaling; modulates IL-12 on APCs
C1qRp	(CD93 + unknown mediator)	Part of receptor complex that binds C1q and mediates phagocytosis
Regulators	Alternative names	Function
C1-INH	SERPIN1	Inhibits C1r/s and MASPs
sMAP	MAP19	Binds to MBL, competes with MASPs
MAP-1	MAP44	Binds to MBL/ficolins; inhibits C4 deposition
C4BP	C4-binding protein	Accelerates decay of LP/CP convertases; cofactor for fl
Factor H	CFH	Recognizes self-surfaces; accelerates convertase decay; cofactor for fl
FHL-1	Reconnectin, CFHL1	Accelerates convertase decay; cofactor for fl
MCP	CD46	Cofactor for fl
DAF	CD55	Accelerates decay of convertases
CFHR-1	FHR-1	Recognizes self-surfaces and C5; inhibits C5 cleavage and TCC formation
CD59	Protectin	Binds to C8 and C9; prevents assembly of TCC
Vitronectin	S-protein; S40	Binds to C5b-9; prevents assembly of TCC
Clusterin	Apolipoprotein J; SP-40,40	Binds to C7-C9; prevents assembly of TCC
Carboxypeptidase-N		Degrades C3a and C5a to their desArg forms

AP, alternative pathway; CFHR, complement factor H-related protein; CP, classical pathway; CR, complement receptor; LP, lectin pathway; Mac-1, macrophage-1 antigen. ^aAlthough CRP is the best-described representative mediator of this category, other pentraxins may exert similar functions; ^badditional receptors for C1q (for example, CR1, integrin $\alpha_2\beta_1$, murine SIGN-R1) have been proposed but not yet confirmed.

and have a number of crucial roles in immune responses and inflammation, which are discussed below and reviewed elsewhere^{26,27}.

C3a, and especially C5a, are powerful chemoattractants that guide neutrophils, monocytes and macrophages toward sites of complement activation. Thereby, they promote phagocytosis through the interaction of opsonins with complement receptors^{27,28}. Among these receptors, CR1 (CD35) is particularly relevant, as it interacts not only with C3b and C4b to promote neutrophil-mediated phagocytosis but also contributes to the regulatory degradation of its ligands by factor I (fI)²⁹. Thus, CR1 attenuates complement amplification by inactivating C3b and C4b, while simultaneously rendering the opsonins accessible to other complement receptors and promoting downstream immune responses. The integrin receptors CR3 (CD11b–CD18) and CR4 (CD11c–CD18) both bind to the iC3b fragment and contribute to phagocytosis, and CR3 also regulates cytokine responses, leukocyte trafficking and synapse formation.

Recently, another phagocytic receptor, the complement receptor of the immunoglobulin family (CRIg), has been identified. CRIg is exclusively expressed on certain tissue-resident macrophages and enhances phagocytosis by recognizing cell-bound C3b and iC3b^{28,30}. It is unique in that it also binds C3c, although whether this binding clears C3c or induces signaling has yet to be determined³¹.

Despite their structural similarity, CR1 and CR2 (CD21) have distinct but synergistic functions: CR1 is an important contributor to surface-bound iC3b and the only cofactor that induces further cleavage of iC3b to C3dg, both of which serve as CR2 ligands for B cell activation and differentiation^{32,33}. Besides initiating the complement cascade, PRMs also act as opsonins and participate in phagocytic and inflammatory signaling. Although several receptors for C1q have been described, their exact roles are not well defined. Originally designated cC1qR because of its ability to bind the collagenous part of C1q (and collectins such as MBL), cC1qR was later found to be identical to the secreted protein calreticulin and to require a transmembrane mediator, probably CD91, to induce phagocytosis³⁴. The C1q receptor of phagocytosis (C1qRp or CD93) seems to behave similarly, as it apparently does not bind C1q directly and might require an unidentified bridging molecule to form a phagocytic receptor complex³⁵. Finally, gC1qR, which interacts with the globular head domains of C1q, is involved in the regulation of cytokines (Fig. 2a). Notably, genetic deletion of either CD91 or CD93 in mouse macrophages does not substantially alter C1q-mediated phagocytosis^{36,37}, which underscores the complexity and potential redundancy of C1q interactions.

Complement regulation

Soluble and cell-bound complement regulators help to control complement attack and adjust its severity, propagation and endpoints to the cellular target³⁸ (Figs. 1a–c and 2b). In addition to C1 esterase inhibitor (C1-INH), a secreted glycoprotein of the serpin family that inhibits several proteases of the classical and lectin pathways, two other lectin pathway modulators have been identified: sMAP and MAP-1 are non-proteolytic splice products of the *MASP2* and *MASP1/3* genes, respectively, that apparently compete with MASPs for binding to MBL and ficolins. The C2 receptor inhibitor trispanning also binds to C2 and inhibits its activation by C1s³⁹. In the alternative pathway, activation in solution is mainly controlled by the abundant factor H (fH) and its truncated homolog, factor H-like protein 1 (FHL-1). fH mainly acts on C3 convertases in the alternative pathway, either competitively removing Bb from the C3bBb complex (decay acceleration) or serving as a cofactor for the fI-mediated degradation of C3b. Another fluid-phase regulator, C4b-binding protein (C4BP), has similar effects on classical pathway and lectin pathway convertases. Most importantly, fH, FHL-1 and C4BP also support complement regulation on human cells by engaging host-specific

surface patterns (such as sialic acid or glycosaminoglycans), thereby contributing to self-recognition and prevention of self-attack.

Most human cells also expose convertase regulators that act as decay accelerators, such as CR1 or decay-accelerating factor (DAF, also called CD55), or as cofactors for fI, such as CR1 and membrane cofactor protein (MCP or CD46)^{38,40}. Only a few C5-specific regulators have been described so far; whereas fH-related protein 1 directly binds C5 and inhibits C5 convertase activity, CRIg regulates the C3b-containing C3 and C5 convertases, although the physiological implications of this mechanism are unknown. A cell-based regulator, CD59, acts on TCC by preventing the formation of both sublytic and lytic complexes. In addition, TCC is controlled by soluble regulators such as vitronectin and clusterin. Finally, carboxypeptidase-N quickly converts anaphylatoxins to their desarginated forms; although this cleavage impairs signaling through the primary receptors C3aR and C5aR, it shifts the signaling pattern, as C3a^{desArg} and C5a^{desArg} themselves can trigger important functions, for example, during HSPC mobilization^{41,42} or lipid metabolism⁴³.

Structure and dynamics in complement

Complement must react quickly to potential danger but be selective enough to avoid wreaking havoc on the host. Molecular studies have provided a fascinating insight into how time, location, concentration and dynamics are used to achieve selectivity and orchestrate cascading events. For example, the highly abundant C3 can act as an omnipresent sentinel that has few endogenous ligands⁴⁴ but becomes transformed into one of the most versatile binding partners upon activation to C3b. Whereas the exposure of a highly reactive but short-lived acyl-imidazole moiety restricts deposition of C3b to immediate sites of activation, additional control mechanisms are responsible for keeping amplification through C3 convertases in check.

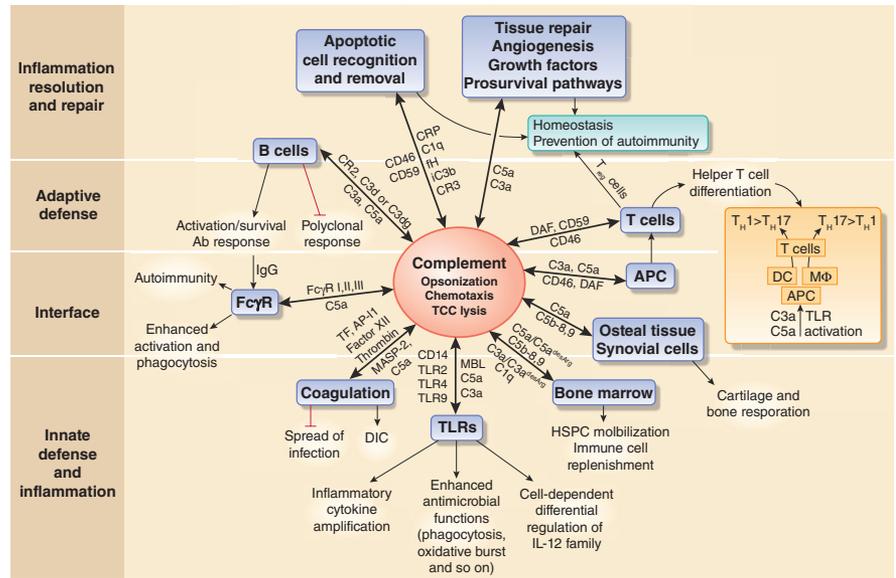
Structural studies of the C3 convertase have suggested that C3b bridges and orients the proteolytic Bb fragment of fB with C3 to allow cleavage of the substrate C3 (ref. 45). Moreover, the recent report of a C3b-fH complex⁴⁶ provided a molecular basis for important regulatory mechanisms; bound fH not only sterically interferes with contact areas of fB and Bb on C3b to accelerate convertase decay but also forms a joined binding pocket with C3b that allows fI to bind and cleave C3b, while stabilizing the domain arrangement of C3b during cleavage⁴⁶. This conversion disrupts domains involved in amplification but exposes complement receptor-specific binding sites, thereby facilitating downstream signaling steps. These and similar studies on other components have complemented our molecular picture of the initiation, amplification, regulation and signaling of complement and revealed that many of these proteins rely on dynamic rearrangements to fulfill their roles in these processes.

Interaction with microorganisms

When PAMPs are detected on invading microorganisms, one or several complement initiation pathways that aim to eliminate microbial intruders are triggered. As microbes normally lack complement regulators, the response is rapidly amplified by the alternative pathway and results in opsonization, proinflammatory signaling, mobilization of immune cells, phagocytosis and, on certain pathogens such as Gram-negative bacteria (mostly *Neisseria* species) or parasites, formation of TCC and subsequent cell lysis (Fig. 1b).

Given complement's central and early role in antimicrobial attack and the millennia of coevolution between microorganisms and this ancient component of immunity, it is not surprising that many pathogens have evolved counterstrategies to evade complement. Elaborate complement evasion mechanisms are found in bacteria, viruses, fungi and parasites²⁰. These strategies most commonly involve the nonactivating capture of

Figure 3 Integrative role of complement in host defense and homeostasis. The traditional functions of complement (in oval) and its orchestrating role in immunity and homeostasis are shown (key participating molecules are indicated next to the arrows). Complement regulates TLR signaling to coordinate innate defenses and potentiates coagulation to provide a mechanical barrier against the spread of invading bacteria. It also facilitates IgG-mediated phagocytic killing of microbes by reducing the threshold for FcγR activation and promotes specific IgG antibody responses through B cell activation. Complement regulation of APC TLRs influences the differentiation of T cells, which can also be affected directly by complement. Regulation of T helper cell differentiation by complement is complex; however, in the context of complement-TLR crosstalk, the anaphylatoxins can either promote or inhibit T_H1 or T_H17 cell development *in vivo*, depending on whether they act through DCs or macrophages (MΦ) as APCs. To replenish the immune system during infection or injury, complement regulates the mobilization of HSPCs from the bone marrow. Most or all of the mechanisms regulated by complement can also be involved in immunopathology, such as FcγR-mediated autoimmunity, disseminated intravascular coagulation (DIC) and inflammatory bone resorption (for example, through sublytic C5b-9 signaling). The functional repertoire of complement includes the resolution of inflammation through induction of regulatory T cells, noninflammatory clearance of apoptotic cells (which permit complement activation through loss of complement regulatory proteins) and promotion of tissue repair. Most complement interactions are bidirectional, in that the production and activation of complement proteins and receptors is regulated by other receptors or system components (for example, FcγRs, TLRs, thrombin).



complement initiators (such as immunoglobulins), inactivation or depletion of complement components by secreted proteases, recruitment of complement regulators to the pathogen surface or secretion of regulator mimics, molecular inhibition of convertase activity, interference with TCC formation, or competitive and antagonistic prevention of immune signaling (Supplementary Fig. 2)²⁰. Even more intriguingly, some pathogens take advantage of the complement system to enter cells by binding to cell-bound complement receptors and regulators, either through pathogen-expressed surface proteins or by ‘voluntary opsonization’ with complement fragments^{20,47,48}.

Removal of apoptotic cells

The role of complement is not limited to inductive and effector phases of immunity; it also contributes to the resolution of inflammation by promoting safe clearance of apoptotic cells and immune complexes through the cooperative action of its soluble PRMs, opsonins and receptors^{49,50}. Importantly, complement can differentiate between real threats and challenges that normally pose minimal danger: in contrast to a vigorous response against foreign intruders, removal of endogenous debris requires a much more tactful approach, in which complement avoids mechanisms downstream of C3 such as the inflammatory C5a-C5aR axis or TCC. Alterations in cell surface molecules during apoptosis allow dying cells to bind complement-related PRMs and become opsonized. The modified surfaces of apoptotic cells, which rapidly shed CD46 and CD59 (ref. 51), allow complement activation and their opsonization with C3b and C4b, followed by phagocytic cell uptake^{38,49}. However, residual regulators on the cell surface and in circulation tame subsequent complement amplification, thereby largely preventing the generation of danger signals (Fig. 1c). This activity depends on the classical pathway, as macrophages show reduced ability to take up apoptotic cells in individuals deficient in C1q, C4, C2 or C3 (ref. 52). Early stage effectors are preferentially used because the modified apoptotic cell surface acquires CRP and C1q together with fH^{38,53}. Specifically, CRP promotes the binding of C1q to apoptotic cells, amplifies classical pathway activation and recruits fH, which inhibits alternative pathway amplification and C5

convertase formation, thereby protecting cells from necrotic lysis and the host from unwarranted inflammation⁵³.

As a further safety mechanism, the clearance of apoptotic cells through iC3b opsonization and CR3 phagocytosis is accompanied by downregulation of interleukin 12 (IL-12) and a lack of oxidative burst in macrophages^{54–56} or by a reduction in the expression of co-stimulatory molecules and impaired maturation of dendritic cells (DCs)^{57,58}. Furthermore, even when the host sustains injury during an assault, complement can contribute to homeostasis by promoting tissue repair^{59,60} (Fig. 3).

Complement crosstalk with Toll-like receptors

To respond efficiently to danger, complement uses both pattern recognition and missing-self recognition strategies⁶¹, deploys its rapid cascade, and, importantly, communicates with other biological systems (Fig. 3). For example, it coordinates innate immunity in cooperation with Toll-like receptors (TLRs)⁶¹, helps to block the spread of infection by potentiating coagulation¹⁶, links the innate response to both humoral and cellular adaptive immunity⁶², and regulates the mobilization of HSPCs from bone marrow to replenish the immune system⁴¹. Both complement and TLRs are swiftly activated in response to infection or common microbial structures, such as lipopolysaccharides (LPS) or microbial CpG DNA. There is increasing evidence for extensive and bidirectional cooperation between the two systems, shaping the innate response through both synergistic and antagonistic crosstalk⁶¹. Concomitant detection of infection by distinct innate defense systems validates the presence of genuine danger, justifying and necessitating the amplification of the host’s antimicrobial and inflammatory response. For instance, complement synergistically enhances TLR-induced production of proinflammatory cytokines (tumor necrosis factor (TNF), IL-1β and IL-6) *in vitro* and *in vivo* through C3aR, and especially C5aR signaling⁶³. At least three TLRs (TLR2, TLR4 and TLR9) are involved in complement crosstalk, and their pathways converge with anaphylatoxin signaling at the level of mitogen-activated protein kinases (MAPKs), specifically Erk1/2 and Jnk⁶³. This crosstalk partially explains earlier observations that inhibiting C5a signaling



protects against sepsis induced by high doses of LPS or by cecal ligation and puncture (CLP) peritonitis⁶⁴. Reciprocally, activation of TLR induces the expression of complement components or receptors⁶⁵.

Intriguingly, C5a-induced TLR crosstalk might involve not only C5aR but also the enigmatic G-protein-independent C5L2, which might have both regulatory and proinflammatory roles^{23,61,66} (Fig. 2a). Thus, C5L2 is essential for the induction of high-mobility group box-1 (HMGB1), through which C5L2 contributes synergistically with C5aR to inflammatory lethality in CLP sepsis²³. At least *in vitro*, the induction of HMGB1 by C5a or LPS (or both) is diminished in *C5L2*^{-/-} but not *C5ar*^{-/-} macrophages²³. These findings suggest that C5L2 and TLR4 might cooperate in the induction of HMGB1, perhaps through signaling crosstalk involving the MAPK and phosphatidylinositol-3 pathways²³. Alternatively, C5L2 might act as a co-receptor for TLR4 activation.

Whether complement receptors associate with TLRs in functional multireceptor complexes is being investigated. Confocal microscopy and fluorescent resonance energy transfer experiments suggest that C5aR and TLR2 associate in activated macrophages⁶⁷. Furthermore, in the apparent absence of C5a, blockade or genetic ablation of C5aR inhibits TLR2-induced cytokine production in DCs, suggesting that C5aR has a C5a-independent effect on TLR2 signaling⁶⁸. MBL forms a functional complex with TLR2 in the phagosome and potentiates protective TLR2 signaling, at least in response to *Staphylococcus aureus*⁶⁹. However, the observation that CD14 blockade inhibits complement inflammatory activities in a human whole blood model⁷⁰ could reflect either inhibition of complement-TLR crosstalk (CD14 lacks a transmembrane signaling domain and signals through TLR4 or TLR2) or extracellular interactions of CD14 with complement receptors. CD14 can physically associate with CR3 (ref. 71), although it has not been shown to interact directly with anaphylatoxin receptors.

Complement's ability to cooperate with TLRs could even undermine host immunity, if these crosstalk interactions are induced by microbial cells. For example, the oral pathogen *Porphyromonas gingivalis* induces C5aR-TLR2 crosstalk that impairs nitric oxide-dependent killing in macrophages⁶⁷. Because this crosstalk inhibits only a subset of TLR2 signaling events⁶⁷, C5aR was characterized as a TLR modulatory receptor to distinguish it from TLR inhibitory receptors (such as IL-10R or TGF- β R), which inhibit most, if not all, inflammatory responses⁷². Moreover, although TLR2-induced transactivation of CR3 contributes to leukocyte trafficking⁷³, certain pathogens activate this TLR2 signaling pathway to exploit transactivated CR3 (refs. 47,48). Reciprocally, CR3 facilitates TLR2 or TLR4 signaling by promoting the recruitment of their sorting adaptor TIRAP⁷⁴. In summary, by cooperating with other innate receptors, complement receptors can diversify their pattern recognition and signaling or regulatory capacities, and these properties can be exploited by pathogens to undermine immune defense.

Interplay between complement and coagulation

Another crosstalk event that occurs early during infection is between complement and the coagulation system, apparently with the objective of enhancing local clotting and preventing microbial spread through the circulation¹⁶. Complement amplifies coagulation and inhibits fibrinolysis, mainly through C5a, which induces the expression of tissue factor⁷⁵ and plasminogen-activator inhibitor 1 (PA-I1)¹⁶. Moreover, MASP-2 can simultaneously activate complement and coagulation, the latter by generating thrombin from prothrombin⁷⁶. Reciprocally, components of the coagulation cascade amplify complement activation (see also the extrinsic protease pathway above and Fig. 2a); for instance, activated clotting factor XII can activate the classical pathway through C1 cleavage⁷⁷, whereas thrombin directly cleaves C5 and generates biologically active C5a (ref. 17).

These procoagulatory activities are counteracted by certain pathogens, which subvert the fibrinolytic system and cause disseminating infections⁷⁸. On the other hand, when the complement-coagulation crosstalk is activated systemically in an uncontrolled manner, as in sepsis, it can lead to life-threatening conditions such as disseminated intravascular coagulation⁷⁹. Additional aspects of this important crosstalk, such as the interplay between complement and platelet activation, have been covered elsewhere¹⁶.

Complementing humoral immunity

As alluded to above, C3dg functions as a natural adjuvant, as binding of C3dg-opsonized antigen to CR2 on the B cell co-receptor complex (CR2-CD19-CD81) has a strong co-stimulatory effect on B cells^{32,80} (Fig. 2a). Moreover, CR2 mediates antigen-independent signals that are necessary for B cells to survive in germinal centers⁸¹. CR1 and CR2 are the main receptors on follicular DCs for uptake and long-term retention of antigen, which contributes to B cell memory maintenance³². However, antibody responses to T-dependent antigens are impaired in mice with a B cell-specific CR1/CR2 deficiency (a single gene, *Cr1/2*, encodes both molecules), despite normal expression of both receptors on follicular DCs⁸². Therefore, the interaction of B cell-expressed CR2 and/or CR1 with C3 cleavage products is essential for antigen-specific antibody responses but not polyreactive antibody responses⁸³. Experiments in CR1/CR2-deficient mice have confirmed the importance of complement for antibody responses to both T-dependent and T-independent antigens, including protective humoral immunity to certain bacteria and viruses⁸⁴⁻⁸⁶. The anaphylatoxins also have regulatory effects on B cells, including suppression of B cell polyclonal responses (C3a)⁸⁷ and promotion of the migration of naive and memory B cells (C5a)⁸⁸.

Complement promotes the effector function of the antibody response in ways that far exceed its originally identified role as a heat-sensitive activity in serum, which complements that of antibody in causing bacterial lysis. At the interface between innate and humoral immunity, C5aR signaling lowers the threshold for Fc γ receptor activation by upregulating the expression of activating Fc γ receptors (Fc γ R I and III) and down-regulating the expression of the inhibitory Fc γ RIIB^{89,90}. Conversely, Fc γ R activation enhances the synthesis of C5 for C5a generation⁹⁰. This mutually reinforcing C5a-Fc γ R crosstalk (Fig. 2a) is important in infection as it promotes the clearance of microbial intruders by combining phagocytosis with the specificity of IgG antibodies. However, as IgG immune complexes have been implicated in autoimmune disorders (for example, rheumatoid arthritis), complement-Fc γ R crosstalk might exacerbate autoimmune pathology, as shown in a mouse model of autoimmune hemolytic anemia⁹⁰.

Regulation of T cell immunity by complement

Early reports that mice treated with anti-CR1/CR2 monoclonal antibodies (mAb) show impaired antibody but intact helper T cell responses⁹¹ could be interpreted as showing that C3 is not involved in T cell immunity. Similarly, CR1/CR2-deficient mice develop normal CD4⁺ and CD8⁺ T cell immunity and readily clear infection with influenza virus⁹²; however, pathogen-specific T cell responses are impaired in C3-deficient mice in a CR1/CR2-independent manner^{92,93}. C3 deficiency also results in impaired T cell responses in models of autoimmune disease and transplant rejection^{94,95}, at least in part because of lack of C3a and altered antigen-presenting cell (APC) function. For instance, C3aR-deficient DCs lose their ability to induce potent alloreactive CD4⁺ T cell responses⁹⁶. Moreover, C3a and C5a can be produced locally at the APC-T cell interface and can effectively determine the outcome of APC-T cell interactions^{62,97-99} (Fig. 3).

Experiments in mice that lack complement inhibitory proteins (DAF,

CD59) highlight an important regulatory role for complement in the development of T cell immunity^{62,100,101}. Interestingly, complement regulatory proteins exert both indirect (via APCs) and direct effects on T cells (Fig. 2a). For instance, DAF-deficient T cells show heightened cytokine responses and ligation of CD4⁺ T cells by CD59 downregulates their activation, whereas activation of CD46-ligated CD4⁺ T cells promotes their differentiation to a T regulatory 1 (T_H1) phenotype^{62,100,102}. Signaling in T cells mediated by CD46 and CD59 might contribute to the resolution of the immune response, thereby preventing immunopathology^{100,102}. Conversely, bacterial or viral pathogens that can directly engage these complement regulators may undermine T cell immunity as a survival tactic^{62,103}. For example, the M protein of *Streptococcus pyogenes* interacts with CD46 on human CD4⁺ T cells to induce a T_H1-like phenotype that suppresses bystander T cell activation¹⁰³.

Note that the effects of complement on helper T cell responses are influenced by tissue-specific microenvironmental conditions and timing variables. For instance, C5aR signaling protects the lungs against allergic asthma during the allergen-sensitization phase (C5a signaling at the DC–T cell interface leads to the induction of TGF- β and IL-10), whereas it drives a T_H2-mediated eosinophil and mast cell destructive response once allergic inflammation is established¹⁰⁴. Intriguingly, however, the protective role of C5aR signaling during the allergen-sensitization phase is countered by C3aR signaling¹⁰⁵, which contributes to T_H2-dependent airway hyper-reactivity¹⁰⁶. The emerging roles of IL-17 and the IL-17-producing helper T (T_H17) cells in asthma¹⁰⁷ and the ability of anaphylatoxins to regulate these responses in cooperation with TLRs^{68,108,109} suggest that complement's influence on this disease may be more complex than originally thought.

Impact of complement-TLR crosstalk on T cell responses

Recent work has focused on how complement-TLR crosstalk in macrophages and DCs regulates T cell immunity. The induction of C5aR (and, to a lesser extent, C3aR) signaling in TLR-activated macrophages selectively inhibits the transcription of genes that encode IL-12 family cytokines^{63,110,111} (Fig. 2a). These cytokines (IL-12, IL-23 and IL-27) have an important role in the activation and differentiation of distinct subsets of T cells. For example, IL-12 (a p35-p40 heterodimer) induces the differentiation of the T_H1 lineage from naive CD4⁺ T cells, whereas IL-23 (p19-p40) drives the expansion of the T_H17 subset¹¹². IL-27 (p28-EBI3) regulates the T_H1/T_H17 balance by limiting T_H17 development and favoring that of T_H1 (ref. 112). These regulatory effects might be relevant to the attenuation of T cell-mediated inflammatory tissue damage (inhibition of T_H1-mediated pathology by C5aR-TLR4 crosstalk). However, the relevance of this crosstalk becomes evident in microbial immune evasion. Specifically, *Leishmania major*, a macrophage intracellular pathogen, seems to benefit from C5aR-induced inhibition of T_H1 immunity¹¹⁰.

Similar inhibition of TLR-induced IL-12 production is seen when other complement receptors (gC1qR, CD46 and CR3) are activated concomitantly with TLR4 or TLR2 in mouse macrophages or human monocytes^{113–115} (Fig. 2a). These crosstalk pathways are likewise exploited by several pathogens to suppress T_H1 immunity and IL-12-IFN- γ -dependent clearance; these pathogens include hepatitis C virus, measles virus and *P. gingivalis*, which interact with gC1qR¹¹³, CD46 (ref 114) and CR3 (ref 116), respectively. However, when the same receptors are instead activated by their natural ligands, their crosstalk with TLR pathways can have important physiological roles. For instance, interactions between macrophage CR3 and iC3b-coated apoptotic cells inhibit IL-12, preventing unwarranted inflammation during apoptotic cell phagocytosis^{55,61}. Moreover, binding of C1q by gC1qR may represent a homeostatic mechanism for regulating T cell immunity; if so, this role would be con-

sistent with observations that C1q deficiency in humans and mice causes inflammatory autoimmune pathology¹¹⁷.

The crosstalk between complement and TLR that regulates IL-12 is dynamic and contextual, depending at least in part on the cell type involved. For example, activation of CD46 signaling in LPS-stimulated human DCs does not inhibit IL-12 production as it does in monocytes but rather promotes the expression of IL-12p35, IL-12-IL-23p40, and IL-23p19 (ref. 118). Moreover, in contrast to their effects on monocytes and macrophages, C5a and C3a do not inhibit TLR-induced IL-12 production in human or mouse DCs^{98,99,119}. Instead, these anaphylatoxins promote IL-12 production in LPS-stimulated DCs and favor the development of T_H1 responses, at least in a mouse model of allostimulation^{96,98,99}. These effects reflect the ability of both anaphylatoxins to inhibit immunosuppressive cAMP-dependent protein kinase A signaling, thereby releasing inhibitory constraints in DCs^{98,99}. By contrast, this pathway is not inhibited by the anaphylatoxins in macrophages or neutrophils^{67,79}. The findings from the allostimulation model are consistent with observations that *C3ar*^{-/-} and *C5ar*^{-/-} mice fail to mount T_H1 immune responses and succumb to *Toxoplasma gondii* infection⁹⁷. C3a and C5a are probably generated locally by both partners at the DC–T cell interface, leading to functional co-stimulation and differentiation of naive CD4⁺ T cells to T_H1 (refs. 96,97). Conversely, blockade or absence of C5aR in DCs prevents T_H1 differentiation, leading instead to enhanced TGF- β , IL-6 and IL-23 responses that promote differentiation of T cells to CD25⁺ Foxp3⁺ regulatory T cells and T_H17 cells *in vitro* and *in vivo*⁶⁸.

In contrast to DCs, TLR-activated macrophages require intact C5aR signaling to promote the differentiation of CD4⁺ T cells into T_H17 cells¹⁰⁹. *In vivo*, this T_H17-promoting crosstalk can induce experimental autoimmune encephalomyelitis or autoimmune arthritis and depends on synergistic induction of IL-6 by C5aR and several TLRs (TLR-2, -4 or -9)^{109,120}. Thus, in the context of TLR crosstalk, complement could conceivably either promote or inhibit the development of T_H1 or T_H17 cells, depending on the type of APC involved. By acting through DCs, complement favors T_H1 and inhibits T_H17, whereas by acting through macrophages, it favors T_H17 and inhibits T_H1 (Fig. 3). In general, complement can reduce the threshold for T cell polarization to either T_H1 or T_H17, depending on other concomitant environmental stimuli. Indeed, *Daf1*^{-/-} (but not *Daf1*^{-/-}*C3ar*^{-/-} or *Daf1*^{-/-}*C5ar*^{-/-}) T cells show considerably higher production of IFN- γ or IL-17 than wild-type controls in response to IL-12 or IL-23, respectively¹⁰⁸. In summary, complement exerts profound and complex effects on the initiation, differentiation and replenishment of immune responses (through HSPC mobilization⁴¹; Supplementary Fig. 3), necessitating a precise and contextual understanding of the signaling pathways involved.

Complement-related diseases

Although complement's involvement in pathophysiology was historically defined by observations in patients with complement deficiencies or dysfunctions^{121,122}, our knowledge has been boosted by improved animal models and genome-wide association studies (GWAS). The growing list of diseases that involve complement has fueled an interest in developing complement-targeted therapies^{123–125}. Despite challenges such as the high plasma concentrations of targets and a prevalence of protein-protein interactions, the first complement-directed drugs, including recombinant C1-INH (various manufacturers) for the treatment of hereditary angioedema and a therapeutic C5 antibody (Soliris, Alexion) for paroxysmal nocturnal hemoglobinuria, are already being marketed, with more candidates in clinical trials or preclinical development. Here we address some emerging aspects of complement in health and disease, while referring to specialized reviews for detailed coverage of its role in rheumatoid arthritis¹²⁶, asthma¹²⁷ and other diseases^{128,129}, or in complications aris-

ing from biomaterial-induced complement activation¹³⁰ (such as during hemodialysis¹³¹ or cardiopulmonary bypass surgery¹³²).

Inflammatory diseases

The accumulation and unsuccessful removal of cellular debris might contribute not only to autoimmune disorders such as systemic lupus erythematosus (often associated with C1q, C4 or C2 deficiencies)^{50,122} but also to various age-related and neurodegenerative diseases that have chronic inflammatory components. Age-related macular degeneration (AMD) has shown particularly strong ties to complement: this leading cause of blindness in elderly people of European descent has a complex etiology and produces geographic atrophy and neovascularization of the subretinal tissue that gradually leads to loss of central vision. After several complement components were detected in subretinal lipoprotein deposits (drusen)^{133,134}, GWAS identified polymorphisms in the *fH* gene as major risk factors for AMD^{135–138}. Meanwhile, additional polymorphisms and deletions that mostly affect the alternative pathway (including C3, *fB* and *FHL-1*) have been discovered, suggesting that disruption of the delicate balance between complement activation and regulation in the subretinal tissue might contribute to the progression of AMD. Although the pathogenesis of AMD is not fully understood, a slow but vicious cycle of tissue damage (for example, by oxidative stress), accumulation of debris, chronic complement activation and inflammation that perpetuates tissue damage seems to be at its heart¹³⁴. Given the strong association between AMD and complement and the high prevalence of the disease, it is not surprising that considerable complement-targeted drug development efforts are being directed toward AMD. Complement inhibitors are among the few promising options for treating the early, dry form of AMD and potentially preventing vision loss¹³⁹.

Excessive complement activation is also involved in two rare but severe kidney diseases that often culminate in end-stage renal failure. Both membranoproliferative glomerulonephritis type II (MPGN II; dense-deposit disease) and atypical hemolytic uremic syndrome (aHUS) progress aggressively and often manifest at a very young age. In both diseases, deficiencies and polymorphisms in components of the alternative pathway (including *fH*, C3, *fB*, *fI* and CD46) or autoantibodies that either neutralize regulators or stabilize the C3 convertase (nephritic factor) lead to excessive complement activation^{140,141}. Plasma infusion or plasma exchange therapy and renal transplantation are currently used to treat aHUS and MPGN II, but clinical trials involving treatment of patients with aHUS using complement inhibitors such as Soliris are being conducted to identify better therapeutic options^{125,141}.

There is also evidence that complement is involved in Alzheimer's disease, as both C1q and C3 recognize accumulating amyloid fibrils and induce persistent activation of complement. The release of anaphylatoxins might attract microglia and astrocytes that contribute to phagocytosis but can also be activated to release cytokines, proteases and reactive oxygen species (ROS), thereby contributing to inflammation and accelerating neuronal dysfunction¹⁴². Administration of a C5aR antagonist in a mouse model of Alzheimer's disease has substantially improved memory performance and reduced pathologic markers such as amyloid deposits¹⁴³. Complement might also exert protective effects during the early stages of Alzheimer's disease; certain complement regulators are upregulated early in the disease, and opsonization with C1q may facilitate clearance of damaged neurons. However, with increasing damage to the brain, the deleterious effects of complement seem to prevail.

Acute-phase disorders

In contrast to the diseases mentioned above, acute-phase disorders such as sepsis or ischemia-reperfusion injury trigger a more aggressive and distinctive complement response that can contribute to tissue dam-

age. In sepsis, severe infection with microorganisms can trigger acute inflammatory reactions associated with a storm of cytokines and other mediators, producing hypotension, multi-organ failure and death; this overwhelming immune response causes organ damage long after the triggers have been cleared. Given complement's role in first-line defense against microbial intruders, complement activity that contributes to control of the infection is clearly beneficial in the early stages of sepsis. However, complement, and especially C5a, can contribute to organ damage in combination with the cytokine storm in the later stages of sepsis^{79,144}. Thus, both the direct impact of C5a on immune cells and the induction of uncontrolled coagulation by C5a-mediated expression of tissue factor contribute to the devastating effects seen in sepsis (Fig. 4a). Therapeutic regimens that focus on early antimicrobial intervention and anti-inflammatory treatment during later stages therefore seem most appropriate, and inhibition of complement at the C3 level in a primate model of late-stage sepsis markedly improved organ preservation and other clinical parameters¹⁴⁵.

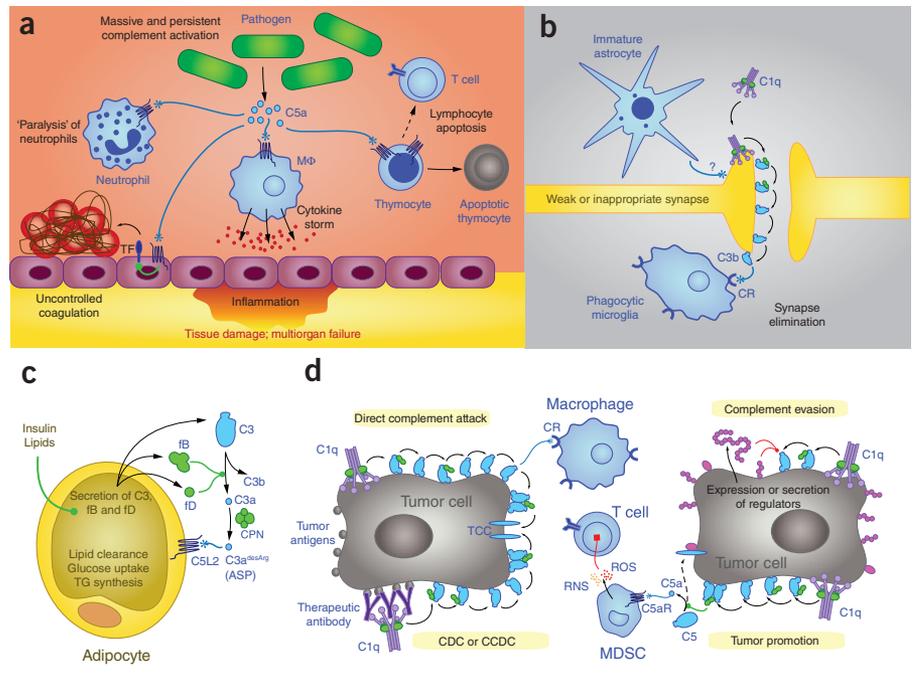
Complement-associated tissue damage is also seen in ischemia-reperfusion injuries related to myocardial infarction and stroke, or induced during procedures such as vascular surgery or organ transplantation. Reperfusion of tissue following temporary occlusion of the blood supply triggers inflammatory and immune responses, including complement activation, that can lead to self-attack, in which the contribution of individual pathways seems to depend on the affected organ¹⁴⁶. Complement-mediated recognition of damaged cells further activates the cascade and enhances anaphylatoxin release, fueling inflammation and recruiting immune cells. The ensuing release of ROS and other signals generates a vicious cycle of damage and inflammation. Several complement-directed therapies have achieved only limited success in treating ischemia-reperfusion injury, especially in myocardial infarction, but recent insights into the role of complement have suggested promising therapeutic strategies¹⁴⁶.

Immune connections to development and metabolism

There is growing evidence that, as in amphibians¹⁴⁷, complement contributes to the development and repair of mammalian tissue (in the resolution phase of inflammation). Both its role in the disposal of dead cells and the induction of growth factors that promote restoration of tissue homeostasis are considered important: C5a and C3a, for instance, induce expression of vascular endothelial growth factor, which is required for angiogenesis and tissue repair after injury⁶⁰. The repair-promoting function of complement is apparent in liver regeneration; anaphylatoxin-induced IL-6 and TNF pro-survival signaling promotes hepatocyte growth and proliferation¹⁴⁸, which is severely impaired in *C3^{-/-}*, *C3ar^{-/-}* and *C5ar^{-/-}* mice⁵⁹. However, C5 and C5a have been implicated as profibrotic factors in liver, lung and renal fibrosis^{148–150}, and a SNP in the gene for C5 is associated with liver fibrosis¹⁴⁹. Therefore, as in immunity, the role of complement in tissue repair involves a complex and delicate process that can produce undesirable outcomes.

Complement-mediated remodeling of synaptic connections in the developing nervous system is similarly a two-edged sword. Immature astrocytes can induce the elimination of improper synaptic connections through recognition by C1q and induction of C3b- or iC3b-mediated phagocytosis^{142,151} (Fig. 4b). The same process can be triggered by reactive astrocytes in the damaged or diseased brain, thereby contributing to the pathogenesis of neurological and neurodegenerative diseases. Complement has been linked not only to Alzheimer's disease (see above) but also to glaucoma¹⁵², Parkinson's disease¹⁵³, multiple sclerosis¹⁵⁴ and schizophrenia^{155,156}. Conversely, impaired complement activity early in development might be detrimental, given the surprising role for C3a-C3aR signaling in the control of neural crest migration during early

Figure 4 Emerging roles of complement in health and disease. Besides the more 'classical' roles of complement in the elimination of microbial intruders and clearance of apoptotic debris (Fig. 1b,c), complement has important roles in cell homeostasis and disease. (a) In sepsis, high levels of infectious microorganisms in the blood cause excessive complement activation with release of C5a that contributes to devastating effects ranging from immune depletion (for example, by paralyzing neutrophils and inducing apoptosis in lymphocytes) to severe inflammation (by triggering a cytokine storm) and disseminated coagulation (partly by inducing TF), all of which may culminate in tissue damage, multi-organ failure and death. (b) Complement is also important in synaptogenesis, where it eliminates weak or immature synapses. An unknown signal derived from immature astrocytes promotes recognition by C1q, which leads to opsonization with C3b and iC3b and facilitates complement receptor (CR)-mediated phagocytosis by activated microglia. (c) Although the role of the C5L2 receptor in the immune response is unclear, it seems to be important for lipid metabolism. Adipocytes secrete C3, fB and fD, and this expression can be promoted by stimuli such as insulin or lipids, leading to a higher turnover of the alternative pathway and generation of C3a, which is transformed into the C3a^{desArg} fragment (ASP). This fragment can induce lipid clearance, glucose uptake and triglyceride (TG) synthesis in adipocytes through C5L2 signaling. (d) Complement is likely to have a dual role in cancer. It contributes to protection through direct activation of complement or as part of the complement-dependent cytotoxicity (CDC) of tumor-directed therapeutic antibodies. However, many tumors escape complement attack by expressing and secreting complement inhibitors that largely prevent amplification, TCC formation or complement-mediated phagocytosis. The generation of C5a in the tumor microenvironment can attract myeloid-derived suppressor cells (MDSC) and induce the generation of reactive oxygen and nitrogen species (ROS and RNS, respectively) through the C5a receptor (C5aR), which impairs the tumor-directed effect of T cells.



embryogenesis¹⁵⁷. Complement, and specifically C3a, also has important regulatory effects on the differentiation and migration of neural progenitor cells¹⁵⁸, thereby affecting neurogenesis.

Complement is also involved in prostaglandin synthesis in bone, which is considered important for the metabolism and physiological remodeling of bone^{159–161}. In particular, subtle signaling by C5b-9 or C5b-8 activates phospholipase A2, releases arachidonic acid and induces the synthesis of prostaglandin E₂ in synovial cells or macrophages^{160,162}. However, certain autoimmune and inflammatory diseases involve complement-associated and prostaglandin-dependent bone immunopathology^{124,126,163–165}; both rheumatoid arthritis and periodontitis have been associated with a SNP in the gene for C5 that is linked to increased concentrations of C5 in the serum^{166,167}. Although these findings do not necessarily indicate that the C5b-9 pathway is involved, it is striking that CD59 deficiency causes enhanced cartilage and bone erosion in animal models, whereas it is reversed by C6 deficiency^{168,169}.

Although the immune and metabolic systems have evolved from common ancestors, functional links between these two central pillars of survival have only recently been drawn¹⁷⁰. Metabolic surplus may trigger inflammatory pathways and mediators (termed metaflammation)¹⁷⁰, which has been associated with obesity and type II diabetes¹⁷¹. The secretion of regulatory adipokines and crosstalk between adipocytes and macrophages are crucial in this context⁴³, and complement seems to be an important mediator of this process. Adipocytes are the main source of fD, and its mouse homolog, adipsin, is important for the differentiation of preadipocytes. Adipocytes also produce C3 and fB, and C3 is substantially increased after exposure to insulin or dietary lipid (Fig. 4c). C3 has been described as a strong marker of insulin resistance in an elderly population¹⁷². The local secretion of components of the alterna-

tive pathway triggers a higher turnover of C3 into C3b and C3a, which is readily processed to C3a^{desArg}. Intriguingly, C3a^{desArg} has been identified as the acylation-stimulating protein ASP, which has lipogenic activity and increases glucose uptake and triglyceride synthesis⁴³. Whereas recent studies suggest that C5L2, which is expressed on adipocytes and preadipocytes, is involved in metabolic processes (Fig. 4c), it is unclear whether it interacts directly with C3a^{desArg} (refs. 22,26,43). Importantly, C3^{-/-} and C5L2^{-/-} mice share a phenotype that is characterized by hypophagy, delayed lipid clearance and reduced triglyceride synthesis, and similar alterations in lipid metabolism were achieved after treatment of wild-type mice with neutralizing anti-ASP or anti-C5L2 mAbs. Anaphylatoxins may also have a direct effect on food intake regulation by the CNS; in mice, C3a promotes anorexia by influencing the prostaglandin E₂ pathway, whereas C5a stimulates food intake mediated by prostaglandin D and neuropeptide Y¹⁷³. Although additional studies are warranted, the effects of complement on food intake and lipid metabolism make it an interesting target for future basic and translational studies of metabolic diseases.

Dual role in cancer

On the basis of its involvement in immune surveillance and microbial defense, complement has long been assumed to have an active and beneficial role in the fight against malignant cells. PRMs, opsonins and effectors have been found on the surface of various tumor cells, suggesting that complement is substantially activated in the tumor microenvironment (Fig. 4d). Furthermore, complement-dependent cytotoxicity synergizes with tumor-directed antibody therapy¹⁷⁴. However, most persisting tumors express high amounts of membrane-bound complement regulators, mainly CD46, DAF and CD59, which prevent amplification and TCC

formation (Fig. 4d). In addition, soluble regulators such as fH, FHL-1 and C4BP can be recruited to or secreted by tumors, thereby contributing to the tumors' complement evasion strategy¹⁷⁴. Unexpectedly, the dogma that complement protects against tumors was further challenged when a recent study showed that classical pathway-induced generation of C5a in the tumor microenvironment leads to significant progression in tumor growth in a mouse model of cervical cancer¹⁷⁵. This mechanism is mediated by the effects of C5a on two subpopulations of myeloid-derived suppressor cells (MDSCs) that represent immature monocytes and neutrophils¹⁷⁵. In the cervical cancer model, C5a attracted neutrophil-like MDSCs to the tumor and induced the generation of ROS and reactive nitrogen species in monocyte-like MDSCs¹⁷⁵ (Fig. 4d), which interfere with the responses of T cells against tumor antigens¹⁷⁶. Treatment of tumor-bearing mice with a C5aR antagonist slowed tumor progression to a similar extent as the conventional drug paclitaxel¹⁷⁵. These findings suggest that C5aR-directed therapy has potential for use in certain cancers with an inflammatory component.

Conclusions and outlook

Our perspective on the human complement system has experienced a remarkable transformation during the course of a century. After the discovery of complement as a microbial defense system at the dawn of the 20th century, the following decades provided a wealth of information about its specific function in infection and immunity. The turn of the current century seems to be similarly significant, as we now begin to envision complement as a global mediator in immune surveillance, cell homeostasis and tissue development and repair (Fig. 3), and we eagerly await even deeper insights into these and other roles. Ongoing improvements in animal models, systems biology, GWAS, molecular and cellular techniques and clinical diagnostics will direct the field into new endeavors. At the same time, our deepening understanding of complement's involvement in various diseases is likely to yield promising treatment options. Complement has truly come out of hiding and shown fascinating connections we had never before imagined, and these hidden connections might indeed be stronger than the original, obvious ones.

ACKNOWLEDGMENTS

The scope of research into complement over the past decade makes it impossible to cover every important aspect; we have had to focus on certain areas, and we acknowledge the research that we could not mention specifically. We thank D. McClellan for editorial assistance and A. Tenner for comments. Supported by US Public Health Service grants CA112162, AI68730, AI30040, AI72106, EB3968, GM62134 (to J.D.L.), and DE015254 and DE018292 (to G.H.).

COMPETING FINANCIAL INTERESTS

The authors declare no competing financial interests.

Published online at <http://www.nature.com/natureimmunology/>.

Reprints and permissions information is available online at <http://npg.nature.com/reprintsandpermissions/>.

1. Sunyer, J.O., Zarkadis, I.K. & Lambris, J.D. Complement diversity: a mechanism for generating immune diversity? *Immunol. Today* **19**, 519–523 (1998).
2. Gaboriaud, C. *et al.* Structure and activation of the C1 complex of complement: unraveling the puzzle. *Trends Immunol.* **25**, 368–373 (2004).
3. Wallis, R., Mitchell, D.A., Schmid, R., Schwaebler, W.J. & Keeble, A.H. Paths reunited: Initiation of the classical and lectin pathways of complement activation. *Immunobiology* **215**, 1–11 (2010).
4. Chen, C.B. & Wallis, R. Two mechanisms for mannose-binding protein modulation of the activity of its associated serine proteases. *J. Biol. Chem.* **279**, 26058–26065 (2004).
5. Dobó, J. *et al.* MASP-1, a promiscuous complement protease: structure of its catalytic region reveals the basis of its broad specificity. *J. Immunol.* **183**, 1207–1214 (2009).
6. Rawal, N., Rajagopalan, R. & Salvi, V.P. Activation of complement component C5: comparison of C5 convertases of the lectin pathway and the classical pathway of complement. *J. Biol. Chem.* **283**, 7853–7863 (2008).

7. Bexborn, F., Andersson, P.O., Chen, H., Nilsson, B. & Ekdahl, K.N. The tick-over theory revisited: formation and regulation of the soluble alternative complement C3 convertase (C3(H2O)Bb). *Mol. Immunol.* **45**, 2370–2379 (2008).
8. Pangburn, M.K., Schreiber, R.D. & Muller-Eberhard, H.J. Formation of the initial C3 convertase of the alternative complement pathway. Acquisition of C3b-like activities by spontaneous hydrolysis of the putative thioester in native C3. *J. Exp. Med.* **154**, 856–867 (1981).
9. Pangburn, M.K., Ferreira, V.P. & Cortes, C. Discrimination between host and pathogens by the complement system. *Vaccine* **26** Suppl 8, I15–I21 (2008).
10. Sahu, A., Kozel, T.R. & Pangburn, M.K. Specificity of the thioester-containing reactive site of human C3 and its significance to complement activation. *Biochem. J.* **302**, 429–436 (1994).
11. Spitzer, D., Mitchell, L.M., Atkinson, J.P. & Hourcade, D.E. Properdin can initiate complement activation by binding specific target surfaces and providing a platform for de novo convertase assembly. *J. Immunol.* **179**, 2600–2608 (2007).
12. Fearon, D.T. & Austen, K.F. Properdin: binding to C3b and stabilization of the C3b-dependent C3 convertase. *J. Exp. Med.* **142**, 856–863 (1975).
13. Harboe, M. & Mollnes, T.E. The alternative complement pathway revisited. *J. Cell. Mol. Med.* **12**, 1074–1084 (2008).
14. Lutz, H.U. & Jelezarova, E. Complement amplification revisited. *Mol. Immunol.* **43**, 2–12 (2006).
15. Müller-Eberhard, H.J. The killer molecule of complement. *J. Invest. Dermatol.* **85**, 47s–52s (1985).
16. Markiewski, M.M., Nilsson, B., Ekdahl, K.N., Mollnes, T.E. & Lambris, J.D. Complement and coagulation: strangers or partners in crime? *Trends Immunol.* **28**, 184–192 (2007).
17. Huber-Lang, M. *et al.* Generation of C5a in the absence of C3: a new complement activation pathway. *Nat. Med.* **12**, 682–687 (2006).
18. Selander, B. *et al.* Mannan-binding lectin activates C3 and the alternative complement pathway without involvement of C2. *J. Clin. Invest.* **116**, 1425–1434 (2006).
19. Atkinson, J.P. & Frank, M.M. Bypassing complement: evolutionary lessons and future implications. *J. Clin. Invest.* **116**, 1215–1218 (2006).
20. Lambris, J.D., Ricklin, D. & Geisbrecht, B.V. Complement evasion by human pathogens. *Nat. Rev. Microbiol.* **6**, 132–142 (2008).
21. Cole, D.S. & Morgan, B.P. Beyond lysis: how complement influences cell fate. *Clin. Sci. (Lond.)* **104**, 455–466 (2003).
22. Ward, P.A. Functions of C5a receptors. *J. Mol. Med.* **87**, 375–378 (2009).
23. Rittirsch, D. *et al.* Functional roles for C5a receptors in sepsis. *Nat. Med.* **14**, 551–557 (2008).
24. Bamberg, C.E. *et al.* The C5a receptor (C5aR) C5L2 is a modulator of C5aR-mediated signal transduction. *J. Biol. Chem.* **285**, 7633–7644 (2010).
25. Scola, A.M. *et al.* The role of the N-terminal domain of the complement fragment receptor C5L2 in ligand binding. *J. Biol. Chem.* **282**, 3664–3671 (2007).
26. Klos, A. *et al.* The role of the anaphylatoxins in health and disease. *Mol. Immunol.* **46**, 2753–2766 (2009).
27. Haas, P.J. & van Strijp, J. Anaphylatoxins: their role in bacterial infection and inflammation. *Immunol. Res.* **37**, 161–175 (2007).
28. van Lookeren Campagne, M., Wiesmann, C. & Brown, E.J. Macrophage complement receptors and pathogen clearance. *Cell. Microbiol.* **9**, 2095–2102 (2007).
29. Krych-Goldberg, M. & Atkinson, J.P. Structure-function relationships of complement receptor type 1. *Immunol. Rev.* **180**, 112–122 (2001).
30. Helmy, K.Y. *et al.* CRlg: a macrophage complement receptor required for phagocytosis of circulating pathogens. *Cell* **124**, 915–927 (2006).
31. He, J.Q., Wiesmann, C. & van Lookeren Campagne, M. A role of macrophage complement receptor CRlg in immune clearance and inflammation. *Mol. Immunol.* **45**, 4041–4047 (2008).
32. Roozendaal, R. & Carroll, M.C. Complement receptors CD21 and CD35 in humoral immunity. *Immunol. Rev.* **219**, 157–166 (2007).
33. Carroll, M.C. Complement and humoral immunity. *Vaccine* **26** Suppl. 8, I28–I33 (2008).
34. Ogden, C.A. *et al.* C1q and mannose binding lectin engagement of cell surface calreticulin and CD91 initiates macropinocytosis and uptake of apoptotic cells. *J. Exp. Med.* **194**, 781–795 (2001).
35. Tarr, J. & Eggleton, P. Immune function of C1q and its modulators CD91 and CD93. *Crit. Rev. Immunol.* **25**, 305–330 (2005).
36. Lillis, A.P. *et al.* Murine low-density lipoprotein receptor-related protein 1 (LRP) is required for phagocytosis of targets bearing LRP ligands but is not required for C1q-triggered enhancement of phagocytosis. *J. Immunol.* **181**, 364–373 (2008).
37. Norsworthy, P.J. *et al.* Murine CD93 (C1qRp) contributes to the removal of apoptotic cells in vivo but is not required for C1q-mediated enhancement of phagocytosis. *J. Immunol.* **172**, 3406–3414 (2004).
38. Zipfel, P.F. & Skerka, C. Complement regulators and inhibitory proteins. *Nat. Rev. Immunol.* **9**, 729–740 (2009).
39. Inal, J.M. *et al.* Complement C2 receptor inhibitor trispanning: a novel human complement inhibitory receptor. *J. Immunol.* **174**, 356–366 (2005).
40. Kim, D.D. & Song, W.C. Membrane complement regulatory proteins. *Clin. Immunol.* **118**, 127–136 (2006).
41. Jalili, A. *et al.* Fifth complement cascade protein (C5) cleavage fragments disrupt the SDF-1/CXCR4 axis: Further evidence that innate immunity orchestrates the mobilization of hematopoietic stem/progenitor cells. *Exp. Hematol.* **38**, 321–332 (2010).
42. Ratajczak, M.Z., Reza, R., Wysoczynski, M., Yan, J. & Ratajczak, J. Modulation of the SDF-1-CXCR4 axis by the third complement component (C3)—implications for

- trafficking of CXCR4+ stem cells. *Exp. Hematol.* **34**, 986–995 (2006).
43. MacLaren, R., Cui, W. & Cianflone, K. Adipokines and the immune system: an adipocentric view. *Adv. Exp. Med. Biol.* **632**, 1–21 (2008).
 44. Sahu, A. & Lambris, J.D. Structure and biology of complement protein C3, a connecting link between innate and acquired immunity. *Immunol. Rev.* **180**, 35–48 (2001).
 45. Rooijackers, S.H. *et al.* Structural and functional implications of the alternative complement pathway C3 convertase stabilized by a staphylococcal inhibitor. *Nat. Immunol.* **10**, 721–727 (2009).
 46. Wu, J. *et al.* Structure of complement fragment C3b-factor H and implications for host protection by complement regulators. *Nat. Immunol.* **10**, 728–733 (2009).
 47. Oliva, C., Turnbough, C.L. Jr. & Kearney, J.F. CD14-Mac-1 interactions in *Bacillus anthracis* spore internalization by macrophages. *Proc. Natl. Acad. Sci. USA* **106**, 13957–13962 (2009).
 48. Wang, M. *et al.* Fimbrial proteins of *Porphyromonas gingivalis* mediate in vivo virulence and exploit TLR2 and complement receptor 3 to persist in macrophages. *J. Immunol.* **179**, 2349–2358 (2007).
 49. Flierman, R. & Daha, M.R. The clearance of apoptotic cells by complement. *Immunobiology* **212**, 363–370 (2007).
 50. Trouw, L.A., Blom, A.M. & Gasque, P. Role of complement and complement regulators in the removal of apoptotic cells. *Mol. Immunol.* **45**, 1199–1207 (2008).
 51. Cole, D.S., Hughes, T.R., Gasque, P. & Morgan, B.P. Complement regulator loss on apoptotic neuronal cells causes increased complement activation and promotes both phagocytosis and cell lysis. *Mol. Immunol.* **43**, 1953–1964 (2006).
 52. Gullstrand, B., Martensson, U., Sturfelt, G., Bengtsson, A.A. & Truedsson, L. Complement classical pathway components are all important in clearance of apoptotic and secondary necrotic cells. *Clin. Exp. Immunol.* **156**, 303–311 (2009).
 53. Gershov, D., Kim, S., Brot, N. & Elkon, K.B. C-reactive protein binds to apoptotic cells, protects the cells from assembly of the terminal complement components, and sustains an antiinflammatory innate immune response: implications for systemic autoimmunity. *J. Exp. Med.* **192**, 1353–1364 (2000).
 54. Lowell, C.A. Rewiring phagocytic signal transduction. *Immunity* **24**, 243–245 (2006).
 55. Kim, S., Elkon, K.B. & Ma, X. Transcriptional suppression of interleukin-12 gene expression following phagocytosis of apoptotic cells. *Immunity* **21**, 643–653 (2004).
 56. Mevorach, D., Mascarenhas, J.O., Gershov, D. & Elkon, K.B. Complement-dependent clearance of apoptotic cells by human macrophages. *J. Exp. Med.* **188**, 2313–2320 (1998).
 57. Morelli, A.E. *et al.* Internalization of circulating apoptotic cells by splenic marginal zone dendritic cells: dependence on complement receptors and effect on cytokine production. *Blood* **101**, 611–620 (2003).
 58. Verbovetski, I. *et al.* Opsonization of apoptotic cells by autologous iC3b facilitates clearance by immature dendritic cells, down-regulates DR and CD86, and up-regulates CC chemokine receptor 7. *J. Exp. Med.* **196**, 1553–1561 (2002).
 59. Markiewski, M.M. *et al.* The regulation of liver cell survival by complement. *J. Immunol.* **182**, 5412–5418 (2009).
 60. Nozaki, M. *et al.* Drusen complement components C3a and C5a promote choroidal neovascularization. *Proc. Natl. Acad. Sci. USA* **103**, 2328–2333 (2006).
 61. Hajshengallis, G. & Lambris, J.D. Crosstalk pathways between Toll-like receptors and the complement system. *Trends Immunol.* **31**, 154–163 (2010).
 62. Dunkelberger, J.R. & Song, W.C. Complement and its role in innate and adaptive immune responses. *Cell Res.* **20**, 34–50 (2010).
 63. Zhang, X. *et al.* Regulation of Toll-like receptor-mediated inflammatory response by complement in vivo. *Blood* **110**, 228–236 (2007).
 64. Guo, R.F., Riedemann, N.C. & Ward, P.A. Role of C5a-C5aR interaction in sepsis. *Shock* **21**, 1–7 (2004).
 65. Kaczorowski, D.J. *et al.* Pivotal Advance: The pattern recognition receptor ligands lipopolysaccharide and polyinosine-polycytidylic acid stimulate factor B synthesis by the macrophage through distinct but overlapping mechanisms. *J. Leukoc. Biol.* published online, doi: 10.1189/jlb.0809588 (22 April 2010).
 66. Chen, N.J. *et al.* C5L2 is critical for the biological activities of the anaphylatoxins C5a and C3a. *Nature* **446**, 203–207 (2007).
 67. Wang, M. *et al.* Microbial hijacking of complement-Toll-like receptor crosstalk. *Sci. Signal.* **3**, ra11 (2010).
 68. Weaver, D.J. Jr. *et al.* C5a receptor-deficient dendritic cells promote induction of Treg and Th17 cells. *Eur. J. Immunol.* **40**, 710–721 (2010).
 69. Ip, W.K.E., Takahashi, K., Moore, K.J., Stuart, L.M. & Ezekowitz, R.A.B. Mannose-binding lectin enhances Toll-like receptors 2 and 6 signaling from the phagosome. *J. Exp. Med.* **205**, 169–181 (2008).
 70. Lappégard, K.T. *et al.* Human genetic deficiencies reveal the roles of complement in the inflammatory network: lessons from nature. *Proc. Natl. Acad. Sci. USA* **106**, 15861–15866 (2009).
 71. Zarewych, D.M., Kindzelskii, A.L., Todd, R.F. & Petty, H.R. LPS induces CD14 association with complement receptor 3, which is reversed by neutrophil adhesion. *J. Immunol.* **156**, 430–433 (1996).
 72. Kagan, J.C. “Complementing” toll signaling. *Sci. Signal.* **3**, pe15 (2010).
 73. Harokopakis, E., Albzreh, M.H., Martin, M.H. & Hajshengallis, G. TLR2 transmodulates monocyte adhesion and transmigration via Rac1- and PI3K-mediated inside-out signaling in response to *Porphyromonas gingivalis* fimbriae. *J. Immunol.* **176**, 7645–7656 (2006).
 74. Kagan, J.C. & Medzhitov, R. Phosphoinositide-mediated adaptor recruitment controls Toll-like receptor signaling. *Cell* **125**, 943–955 (2006).
 75. Ritis, K. *et al.* A novel C5a receptor-tissue factor cross-talk in neutrophils links innate immunity to coagulation pathways. *J. Immunol.* **177**, 4794–4802 (2006).
 76. Krarup, A., Wallis, R., Presanis, J.S., Gal, P. & Sim, R.B. Simultaneous activation of complement and coagulation by MBL-associated serine protease 2. *PLoS ONE* **2**, e623 (2007).
 77. Ghebrehwet, B., Silverberg, M. & Kaplan, A.P. Activation of the classical pathway of complement by Hageman factor fragment. *J. Exp. Med.* **153**, 665–676 (1981).
 78. Bergmann, S. & Hammerschmidt, S. Fibrinolysis and host response in bacterial infections. *Thromb. Haemost.* **98**, 512–520 (2007).
 79. Ward, P.A. The dark side of C5a in sepsis. *Nat. Rev. Immunol.* **4**, 133–142 (2004).
 80. Dempsey, P.W., Allison, M.E., Akkaraju, S., Goodnow, C.C. & Fearon, D.T. C3d of complement as a molecular adjuvant: bridging innate and acquired immunity. *Science* **271**, 348–350 (1996).
 81. Fischer, M.B. *et al.* Dependence of germinal center B cells on expression of CD21/CD35 for survival. *Science* **280**, 582–585 (1998).
 82. Croix, D.A. *et al.* Antibody response to a T-dependent antigen requires B cell expression of complement receptors. *J. Exp. Med.* **183**, 1857–1864 (1996).
 83. Thornton, B.P., Vetvicka, V. & Ross, G.D. Function of C3 in a humoral response: iC3b/C3dg bound to an immune complex generated with natural antibody and a primary antigen promotes antigen uptake and the expression of co-stimulatory molecules by all B cells, but only stimulates immunoglobulin synthesis by antigen-specific B cells. *Clin. Exp. Immunol.* **104**, 531–537 (1996).
 84. Guinamard, R., Okigaki, M., Schlessinger, J. & Ravetch, J.V. Absence of marginal zone B cells in Pyk-2-deficient mice defines their role in the humoral response. *Nat. Immunol.* **1**, 31–36 (2000).
 85. Haas, K.M. *et al.* Complement receptors CD21/35 link innate and protective immunity during *Streptococcus pneumoniae* infection by regulating IgG3 antibody responses. *Immunity* **17**, 713–723 (2002).
 86. Da Costa, X.J. *et al.* Humoral response to herpes simplex virus is complement-dependent. *Proc. Natl. Acad. Sci. USA* **96**, 12708–12712 (1999).
 87. Fischer, W.H. & Hugli, T.E. Regulation of B cell functions by C3a and C3a^{desArg}: suppression of TNF- α , IL-6, and the polyclonal immune response. *J. Immunol.* **159**, 4279–4286 (1997).
 88. Ottonello, L. *et al.* rC5a directs the in vitro migration of human memory and naive tonsillar B lymphocytes: implications for B cell trafficking in secondary lymphoid tissues. *J. Immunol.* **162**, 6510–6517 (1999).
 89. Shushakova, N. *et al.* C5a anaphylatoxin is a major regulator of activating versus inhibitory Fc γ Rs in immune complex-induced lung disease. *J. Clin. Invest.* **110**, 1823–1830 (2002).
 90. Kumar, V. *et al.* Cell-derived anaphylatoxins as key mediators of antibody-dependent type II autoimmunity in mice. *J. Clin. Invest.* **116**, 512–520 (2006).
 91. Gustavsson, S., Kinoshita, T. & Heyman, B. Antibodies to murine complement receptor 1 and 2 can inhibit the antibody response in vivo without inhibiting T helper cell induction. *J. Immunol.* **154**, 6524–6528 (1995).
 92. Kopf, M., Abel, B., Gallimore, A., Carroll, M. & Bachmann, M.F. Complement component C3 promotes T-cell priming and lung migration to control acute influenza virus infection. *Nat. Med.* **8**, 373–378 (2002).
 93. Nakayama, Y. *et al.* C3 promotes expansion of CD8+ and CD4+ T cells in a *Listeria monocytogenes* infection. *J. Immunol.* **183**, 2921–2931 (2009).
 94. Kaya, Z. *et al.* Contribution of the innate immune system to autoimmune myocarditis: a role for complement. *Nat. Immunol.* **2**, 739–745 (2001).
 95. Marsh, J.E. *et al.* The allogeneic T and B cell response is strongly dependent on complement components C3 and C4. *Transplantation* **72**, 1310–1318 (2001).
 96. Sacks, S.H. Complement fragments C3a and C5a: The salt and pepper of the immune response. *Eur. J. Immunol.* **40**, 668–670 (2010).
 97. Strainic, M.G. *et al.* Locally produced complement fragments C5a and C3a provide both costimulatory and survival signals to naive CD4+ T cells. *Immunity* **28**, 425–435 (2008).
 98. Li, K. *et al.* Cyclic AMP plays a critical role in C3a-receptor-mediated regulation of dendritic cells in antigen uptake and T-cell stimulation. *Blood* **112**, 5084–5094 (2008).
 99. Peng, Q. *et al.* Dendritic cell function in allostimulation is modulated by C5aR signaling. *J. Immunol.* **183**, 6058–6068 (2009).
 100. Longhi, M.P., Harris, C.L., Morgan, B.P. & Gallimore, A. Holding T cells in check—a new role for complement regulators? *Trends Immunol.* **27**, 102–108 (2006).
 101. Wagner, C. *et al.* The complement receptor 1, CR1 (CD35), mediates inhibitory signals in human T-lymphocytes. *Mol. Immunol.* **43**, 643–651 (2006).
 102. Le Friec, G. & Kemper, C. Complement: coming full circle. *Arch. Immunol. Ther. Exp. (Warsz.)* **57**, 393–407 (2009).
 103. Price, J.D. *et al.* Induction of a regulatory phenotype in human CD4+ T cells by streptococcal M protein. *J. Immunol.* **175**, 677–684 (2005).
 104. Köhl, J. *et al.* A regulatory role for the C5a anaphylatoxin in type 2 immunity in asthma. *J. Clin. Invest.* **116**, 783–796 (2006).
 105. Zhang, X. *et al.* A protective role for C5a in the development of allergic asthma associated with altered levels of B7–H1 and B7–DC on plasmacytoid dendritic cells. *J. Immunol.* **182**, 5123–5130 (2009).
 106. Drouin, S.M., Corry, D.B., Hollman, T.J., Kildsgaard, J. & Wetsel, R.A. Absence of the complement anaphylatoxin C3a receptor suppresses Th2 effector functions in a murine model of pulmonary allergy. *J. Immunol.* **169**, 5926–5933 (2002).
 107. Finkelman, F.D., Hogan, S.P., Hershey, G.K., Rothenberg, M.E. & Wills-Karp, M. Importance of cytokines in murine allergic airway disease and human asthma. *J. Immunol.* **184**, 1663–1674 (2010).
 108. Liu, J. *et al.* IFN- γ and IL-17 production in experimental autoimmune encephalo-

- myelitis depends on local APC-T cell complement production. *J. Immunol.* **180**, 5882–5889 (2008).
109. Fang, C., Zhang, X., Miwa, T. & Song, W.C. Complement promotes the development of inflammatory T-helper 17 cells through synergistic interaction with Toll-like receptor signaling and interleukin-6 production. *Blood* **114**, 1005–1015 (2009).
 110. Hawlisch, H. *et al.* C5a negatively regulates toll-like receptor 4-induced immune responses. *Immunity* **22**, 415–426 (2005).
 111. la Sala, A., Gadina, M. & Kelsall, B.L. G_i-protein-dependent inhibition of IL-12 production is mediated by activation of the phosphatidylinositol 3-kinase-protein 3 kinase B/Akt pathway and JNK. *J. Immunol.* **175**, 2994–2999 (2005).
 112. Goriely, S., Neurath, M.F. & Goldman, M. How microorganisms tip the balance between interleukin-12 family members. *Nat. Rev. Immunol.* **8**, 81–86 (2008).
 113. Waggoner, S.N., Cruise, M.W., Kassel, R. & Hahn, Y.S. gC1q receptor ligation selectively down-regulates human IL-12 production through activation of the phosphoinositide 3-kinase pathway. *J. Immunol.* **175**, 4706–4714 (2005).
 114. Karp, C.L. *et al.* Mechanism of suppression of cell-mediated immunity by measles virus. *Science* **273**, 228–231 (1996).
 115. Marth, T. & Kelsall, B.L. Regulation of interleukin-12 by complement receptor 3 signaling. *J. Exp. Med.* **185**, 1987–1995 (1997).
 116. Hajishengallis, G., Shakhathreh, M.-A.K., Wang, M. & Liang, S. Complement receptor 3 blockade promotes IL-12-mediated clearance of *Porphyromonas gingivalis* and negates its virulence in vivo. *J. Immunol.* **179**, 2359–2367 (2007).
 117. Manderson, A.P., Botto, M. & Walport, M.J. The role of complement in the development of systemic lupus erythematosus. *Annu. Rev. Immunol.* **22**, 431–456 (2004).
 118. Vaknin-Dembinsky, A., Murugaiyan, G., Hafler, D.A., Astier, A.L. & Weiner, H.L. Increased IL-23 secretion and altered chemokine production by dendritic cells upon CD46 activation in patients with multiple sclerosis. *J. Neuroimmunol.* **195**, 140–145 (2008).
 119. Braun, M.C., Lahey, E. & Kelsall, B.L. Selective suppression of IL-12 production by chemoattractants. *J. Immunol.* **164**, 3009–3017 (2000).
 120. Hashimoto, M. *et al.* Complement drives Th17 cell differentiation and triggers autoimmune arthritis. *J. Exp. Med.* **207**, 1135–1143 (2010).
 121. Botto, M. *et al.* Complement in human diseases: lessons from complement deficiencies. *Mol. Immunol.* **46**, 2774–2783 (2009).
 122. Pettigrew, H.D., Teuber, S.S. & Gershwin, M.E. Clinical significance of complement deficiencies. *Ann. NY Acad. Sci.* **1173**, 108–123 (2009).
 123. Lachmann, P.J. & Smith, R.A. Taking complement to the clinic—has the time finally come? *Scand. J. Immunol.* **69**, 471–478 (2009).
 124. Ricklin, D. & Lambris, J.D. Complement-targeted therapeutics. *Nat. Biotechnol.* **25**, 1265–1275 (2007).
 125. Wagner, E. & Frank, M.M. Therapeutic potential of complement modulation. *Nat. Rev. Drug Discov.* **9**, 43–56 (2010).
 126. Okroj, M., Heinegard, D., Holmdahl, R. & Blom, A.M. Rheumatoid arthritis and the complement system. *Ann. Med.* **39**, 517–530 (2007).
 127. Zhang, X. & Kohl, J. A complex role for complement in allergic asthma. *Expert Rev. Clin. Immunol.* **6**, 269–277 (2010).
 128. Holers, V.M. The spectrum of complement alternative pathway-mediated diseases. *Immunol. Rev.* **223**, 300–316 (2008).
 129. Markiewski, M.M. & Lambris, J.D. The role of complement in inflammatory diseases from behind the scenes into the spotlight. *Am. J. Pathol.* **171**, 715–727 (2007).
 130. Nilsson, B., Korsgren, O., Lambris, J.D. & Ekdahl, K.N. Can cells and biomaterials in therapeutic medicine be shielded from innate immune recognition? *Trends Immunol.* **31**, 32–38 (2010).
 131. Kourtellos, I. *et al.* Complement anaphylatoxin C5a contributes to hemodialysis-associated thrombosis. *Blood* **116**, 631–639 (2010).
 132. Warren, O.J. *et al.* The inflammatory response to cardiopulmonary bypass: part 1—mechanisms of pathogenesis. *J. Cardiothorac. Vasc. Anesth.* **23**, 223–231 (2009).
 133. Mullins, R.F., Russell, S.R., Anderson, D.H. & Hageman, G.S. Drusen associated with aging and age-related macular degeneration contain proteins common to extracellular deposits associated with atherosclerosis, elastosis, amyloidosis, and dense deposit disease. *FASEB J.* **14**, 835–846 (2000).
 134. Anderson, D.H. *et al.* The pivotal role of the complement system in aging and age-related macular degeneration: hypothesis re-visited. *Prog. Retin. Eye Res.* **29**, 95–112 (2010).
 135. Edwards, A.O. *et al.* Complement factor H polymorphism and age-related macular degeneration. *Science* **308**, 421–424 (2005).
 136. Hageman, G.S. *et al.* A common haplotype in the complement regulatory gene factor H (HF1/CFH) predisposes individuals to age-related macular degeneration. *Proc. Natl. Acad. Sci. USA* **102**, 7227–7232 (2005).
 137. Haines, J.L. *et al.* Complement factor H variant increases the risk of age-related macular degeneration. *Science* **308**, 419–421 (2005).
 138. Klein, R.J. *et al.* Complement factor H polymorphism in age-related macular degeneration. *Science* **308**, 385–389 (2005).
 139. Gehrs, K.M., Jackson, J.R., Brown, E.N., Allikmets, R. & Hageman, G.S. Complement, age-related macular degeneration and a vision of the future. *Arch. Ophthalmol.* **128**, 349–358 (2010).
 140. Skerka, C. *et al.* Autoimmune forms of thrombotic microangiopathy and membranoproliferative glomerulonephritis: Indications for a disease spectrum and common pathogenic principles. *Mol. Immunol.* **46**, 2801–2807 (2009).
 141. Noris, M. & Remuzzi, G. Atypical hemolytic-uremic syndrome. *N. Engl. J. Med.* **361**, 1676–1687 (2009).
 142. Alexander, J.J., Anderson, A.J., Barnum, S.R., Stevens, B. & Tenner, A.J. The complement cascade: Yin-Yang in neuroinflammation—neuro-protection and -degeneration. *J. Neurochem.* **107**, 1169–1187 (2008).
 143. Fonseca, M.I. *et al.* Treatment with a C5aR antagonist decreases pathology and enhances behavioral performance in murine models of Alzheimer's disease. *J. Immunol.* **183**, 1375–1383 (2009).
 144. Markiewski, M.M., DeAngelis, R.A. & Lambris, J.D. Complexity of complement activation in sepsis. *J. Cell. Mol. Med.* **12**, 2245–2254 (2008).
 145. Silasi-Mansat, R. *et al.* Complement inhibition decreases the procoagulant response and confers organ protection in a baboon model of *E. coli* sepsis. *Blood* published online, doi: 10.1182/blood-2010-02-269746 (13 May 2010).
 146. Diepenhorst, G.M., van Gulik, T.M. & Hack, C.E. Complement-mediated ischemia-reperfusion injury: lessons learned from animal and clinical studies. *Ann. Surg.* **249**, 889–899 (2009).
 147. Tsonis, P.A., Lambris, J.D. & Del Rio-Tsonis, K. To regeneration...with complement. *Adv. Exp. Med. Biol.* **586**, 63–70 (2006).
 148. Markiewski, M.M., DeAngelis, R.A. & Lambris, J.D. Liver inflammation and regeneration: two distinct biological phenomena or parallel pathophysiologic processes? *Mol. Immunol.* **43**, 45–56 (2006).
 149. Hillebrandt, S. *et al.* Complement factor 5 is a quantitative trait gene that modifies liver fibrogenesis in mice and humans. *Nat. Genet.* **37**, 835–843 (2005).
 150. Addis-Lieser, E., Kohl, J. & Chiaromonte, M.G. Opposing regulatory roles of complement factor 5 in the development of bleomycin-induced pulmonary fibrosis. *J. Immunol.* **175**, 1894–1902 (2005).
 151. Schafer, D.P. & Stevens, B. Synapse elimination during development and disease: immune molecules take centre stage. *Biochem. Soc. Trans.* **38**, 476–481 (2010).
 152. Stevens, B. *et al.* The classical complement cascade mediates CNS synapse elimination. *Cell* **131**, 1164–1178 (2007).
 153. Loeffler, A., Camp, D.M. & Conant, S.B. Complement activation in the Parkinson's disease substantia nigra: an immunocytochemical study. *J. Neuroinflammation* **3**, 29 (2006).
 154. Ingram, G., Hakobyan, S., Robertson, N.P. & Morgan, B.P. Complement in multiple sclerosis: its role in disease and potential as a biomarker. *Clin. Exp. Immunol.* **155**, 128–139 (2009).
 155. Boyajyan, A., Khojetsyan, A. & Chavushyan, A. Alternative complement pathway in schizophrenia. *Neurochem. Res.* **35**, 894–898 (2010).
 156. Mayilyan, K.R., Weinberger, D.R. & Sim, R.B. The complement system in schizophrenia. *Drug News Perspect.* **21**, 200–210 (2008).
 157. Carmona-Fontaine, C. *et al.* C3 controls neural crest migration during embryo development. *6th Int. Conf. Innate Immunity* **44**, 36 (2009).
 158. Shiniyo, N., Stahlberg, A., Dragunow, M., Pekny, M. & Pekna, M. Complement-derived anaphylatoxin C3a regulates in vitro differentiation and migration of neural progenitor cells. *Stem Cells* **27**, 2824–2832 (2009).
 159. Raisz, L.G. Potential impact of selective cyclooxygenase-2 inhibitors on bone metabolism in health and disease. *Am. J. Med.* **110** Suppl 3A, 43S–45S (2001).
 160. Niculescu, F. & Rus, H. Mechanisms of signal transduction activated by sublytic assembly of terminal complement complexes on nucleated cells. *Immunol. Res.* **24**, 191–199 (2001).
 161. Raisz, L.G., Sandberg, A.L., Goodson, J.M., Simmons, H.A. & Mergenhagen, S.E. Complement-dependent stimulation of prostaglandin synthesis and bone resorption. *Science* **185**, 789–791 (1974).
 162. Nicholson-Weller, A. & Halperin, J.A. Membrane signaling by complement C5b-9, the membrane attack complex. *Immunol. Rev.* **12**, 244–257 (1993).
 163. de Pablo, P., Chapple, I.L., Buckley, C.D. & Dietrich, T. Periodontitis in systemic rheumatic diseases. *Nat. Rev. Rheumatol.* **5**, 218–224 (2009).
 164. Krauss, J.L., Potempa, J., Lambris, J.D. & Hajishengallis, G. Complementary Tolls in the periodontium: how periodontal bacteria modify complement and Toll-like receptor responses to prevail in the host. *Periodontol.* **2000** **52**, 141–162 (2010).
 165. McCoy, J.M., Wicks, J.R. & Audoly, L.P. The role of prostaglandin E2 receptors in the pathogenesis of rheumatoid arthritis. *J. Clin. Invest.* **110**, 651–658 (2002).
 166. Chai, L., Song, Y.-Q., Zee, K.-Y. & Leung, W.K. Single nucleotide polymorphisms of complement component 5 and periodontitis. *J. Periodontol. Res.* **45**, 301–308 (2010).
 167. Chang, M. *et al.* A large-scale rheumatoid arthritis genetic study identifies association at chromosome 9q33.2. *PLoS Genet.* **4**, e1000107 (2008).
 168. Fischetti, F. *et al.* Selective therapeutic control of C5a and the terminal complement complex by anti-C5 single-chain Fv in an experimental model of antigen-induced arthritis in rats. *Arthritis Rheum.* **56**, 1187–1197 (2007).
 169. Williams, A.S., Mizuno, M., Richards, P.J., Holt, D.S. & Morgan, B.P. Deletion of the gene encoding CD59a in mice increases disease severity in a murine model of rheumatoid arthritis. *Arthritis Rheum.* **50**, 3035–3044 (2004).
 170. Hotamisligil, G.S. Inflammation and metabolic disorders. *Nature* **444**, 860–867 (2006).
 171. Wellen, K.E. & Hotamisligil, G.S. Inflammation, stress, and diabetes. *J. Clin. Invest.* **115**, 1111–1119 (2005).
 172. Muscari, A. *et al.* Serum C3 is a stronger inflammatory marker of insulin resistance than C-reactive protein, leukocyte count, and erythrocyte sedimentation rate: comparison study in an elderly population. *Diabetes Care* **30**, 2362–2368 (2007).
 173. Ohinata, K. & Yoshikawa, M. Food intake regulation by central complement system. *Adv. Exp. Med. Biol.* **632**, 35–46 (2008).
 174. Markiewski, M.M. & Lambris, J.D. Is complement good or bad for cancer patients? A new perspective on an old dilemma. *Trends Immunol.* **30**, 286–292 (2009).
 175. Markiewski, M.M. *et al.* Modulation of the antitumor immune response by complement. *Nat. Immunol.* **9**, 1225–1235 (2008).
 176. Mantovani, A., Allavena, P., Sica, A. & Balkwill, F. Cancer-related inflammation. *Nature* **454**, 436–444 (2008).