Differences in Serum Cytokine Levels in Acute and Chronic Autoimmune Thrombocytopenic Purpura: Relationship to Platelet Phenotype and Antiplatelet T-Cell Reactivity

By John W. Semple, Youli Milev, Donna Cosgrave, Meera Mody, Adriana Hornstein, Victor Blanchette, and John Friedman

Patients with both acute and chronic autoimmune thrombocytopenic purpura (AITP) have in vitro lymphocyte defects in the form of platelet-stimulated proliferation and cytokine secretion. A blinded study was performed to determine if these defects are related to serum cytokine levels and/or platelet antigen expression. Compared with controls, 53% of children with chronic AITP, but only 9% of those with acute AITP, had increased serum interleukin-2 (IL-2), interferon-γ, and/or IL-10; however, none of the patients had detectable serum levels of IL-4 or IL-6, cytokine patterns suggesting an early CD4+ Th0 and Th1 cell activation. In children with chronic AITP, the levels of serum IL-2 correlated with in vitro platelet-stimulated IL-2 production. Few (17%) patients with AITP showed platelet activation, as measured by CD62 expression, or abnormal expression levels of platelet membrane glycoprotein (GP) IIBIIa, but abnormal GPib levels were observed in one-third of children with AITP. In contrast to normal controls and patients with nonimmune thrombocytopenia, a significant number of children with acute (80%), chronic (71%), or chronic-complex (55%) AITP had GPib+ peripheral blood cells expressing HLA-DR. HLA-DR was variably coexpressed on distinct smaller and larger-sized GPib+ cell populations with CD41, CD45, CD14, CD80, and/or glycoporphin molecules. GPib+ cells isolated from spleens of patients with chronic AITP had high expression (49% ± 30%) of HLA-DR and splenic T cells had a high level of in vitro platelet-stimulated IL-2 secretion compared with controls. Platelet HLA-DR expression correlated inversely with platelet count, but not with therapy, serum cytokines, or in vitro lymphocyte antiplatelet reactivity. The results indicate that platelet HLA-DR expression is a common occurrence in patients with immune thrombocytopenia, whereas a large subpopulation of children with chronic AITP can be identified by increased serum cytokine levels and in vitro platelet-stimulated IL-2 secretion by lymphocytes, suggesting that differences exist in the immune pathogenesis of acute and chronic AITP, particularly at the level of platelet reactive T cells. © 1996 by The American Society of Hematology.

AUTOIMMUNE thrombocytopenic purpura (AITP) is a common immune-mediated bleeding disorder in which platelets are opsonized by autoantibodies and prematurely destroyed by the reticuloendothelial system. In children, both acute and chronic forms of the disease can be distinguished. Acute AITP in children is often preceded by viral or bacterial infections and generally resolves spontaneously within 6 weeks. Approximately 20% of children with acute AITP progress to the chronic form of AITP, defined as persistence of thrombocytopenia (platelet counts <150 × 10^9/L) for greater than 6 months. In contrast, AITP in adults is generally chronic and often requires treatment with immunosuppressive therapy or splenectomy. Although both acute and chronic AITP are immune-mediated, different pathogenetic mechanisms may be responsible; elucidation of such differences may permit identification of those children with acute AITP likely to develop the chronic form of the disorder.

Several studies have shown in vitro cellular immune defects in patients with both acute and chronic AITP, but little is known regarding serum cytokines in AITP and their relationship to the autoimmune pathogenesis. In addition, despite extensive study of platelet-associated immunoglobulins and complement, little is known of the platelet surface antigenic profile in AITP. Boshkov et al. reported a patient with acute AITP who had 39% of his platelets expressing HLA-DR; this amount declined as platelet counts increased. We examined the hypothesis that platelet membrane abnormalities and abnormal serum cytokine levels may play a role in the immune pathogenesis in patients with AITP, particularly with respect to in vitro platelet-stimulated T-helper (Th) cell activation. It was found that enhanced platelet HLA-DR expression was common to all the forms of AITP, whereas increased levels of interleukin-2 (IL-2), interferon-γ (IFN-γ), and/or IL-10 reflecting Th0 and Th1 cell activation were found primarily in the sera of patients with chronic AITP. These results suggest that differences exist in the immune reactivity of Th cells in a significant number of children with chronic AITP compared with those with acute AITP and that such differences may be useful in distinguishing the two forms of the disorder.

MATERIALS AND METHODS

Patients. Eleven children with acute idiopathic AITP, 23 children with chronic idiopathic AITP, and 11 children with chronic-complex AITP were tested. Twelve normal children and 13 normal adults were also tested. Eleven patients (2 with acute, 6 with chronic, and 3 with chronic-complex AITP) were examined on multiple occasions. The above samples were all tested blinded as to category/diagnosis. Table 1 summarizes the clinical data for the blinded study groups. Acute AITP was defined as thrombocytopenic purpura of abrupt onset, often within several weeks of a history of infection, in the absence of other identifiable causes of increased platelet destruction. Chronic AITP was defined as thrombocytopenia (platelet...
count <150 x 10^9/L) persisting greater than 6 months, normal or increased marrow megakaryocytes, and no secondary immune or nonimmune abnormality that could account for the thrombocytopenic state. Chronic-complex AITP was defined as chronic AITP associated with immune neutropenia and/or hemolytic anemia, often associated with other autoimmune disorders, eg, systemic lupus erythematosus, diabetes mellitus, dysgammaglobulinemia, or thyroid dysfunction. In addition, samples from 12 adult patients with nonimmune thrombocytopenia secondary to chemotherapy for acute leukemia were examined and samples from 16 normal healthy adult laboratory volunteers were tested as daily controls.

Preparation of peripheral blood mononuclear cells (PBMC), spleen cells, and platelets. For PBMC, heparinized blood was layered on a 1.077 g/mL Percoll cushion and centrifuged at 2,500g for 30 minutes and PBMC were aspirated from the top of the gradient and washed twice. Five children with chronic AITP underwent splenectomy during the study. Portions of the spleens were minced and crushed and fragments were allowed to settle in RPMI-1640. The spleen cell suspension in the supernatant was washed three times and platelets were analyzed directly from the suspension: splenic mononuclear cells were prepared by Percoll isolation as described above. For platelet antigen quantitation studies, peripheral blood was drawn into K<sub>2</sub>EDTA and immediately transferred into tubes containing 0.5 mL of a 0.5% paraformaldehyde (PFA) solution in saline to inhibit in vitro platelet activation during test manipulations. PFA-fixed platelets were isolated from platelet-rich plasma (PRP) as previously described. For three-color analysis of platelet populations, platelets were analyzed in whole blood.

Monoclonal antibodies used in platelet and lymphocyte phenotyping. Fluorescein isothiocyanate (FITC)-labeled anti-CD41 and anti-CD42b were obtained from BioCan Scientific (Toronto, Ontario, Canada) and FITC-labeled anti-human IgG and C3 were obtained from Organon Teknika (Scarborough, Ontario, Canada) or Immuno-corp Sciences Inc (Montreal, Quebec, Canada). Phycoerythrin (PE)-labeled antihuman IgM was obtained from Immunocorp Sciences. Briefly, the sera were diluted 1:2 in phosphate-buffered saline (PBS) and coated onto 96-well ELISA plates preadsorbed with an anticytokine antibody for 2 hours at 22°C. An enzyme-linked anticytokine antibody was then added for an additional 2 hours. Substrate conversion was measured at 450 nm. Standard curves were generated with titrations of recombinant cytokines and were used to quantitate the serum cytokines in picograms per milliliter ranges. In our hands, the sensitivity of the cytokine assays were as follows: IL-2, >62.5 pg/mL; IL-10, >31.25 pg/mL; IFN-γ, >50 pg/mL; IL-4, >12.5 pg/mL; and IL-6, >6.25 pg/mL.

In vitro antiplatelet reactivity. For determination of in vitro lymphocyte antiplatelet reactivity, 7-day antigen-presenting cell assays were performed. Normal platelets (or autologous platelets when available) were titrated into cultures containing 2 x 10<sup>7</sup> PBMC or splenic mononuclear cells in 96-well round-bottom plates and incubated at 37°C for 6 days. Human alloimmune platelets have no in vitro stimulatory activity for resting T cells derived from normal individuals (data not shown). Supernatants were removed for IL-2 determinations and the cells were pulsed with 1 μCi of [H]<sub>3</sub>thymidine for an additional 24 hours and incorporated radioactivity was measured. IL-2 production was measured by a bioassay using the IL-2-dependent cell line, CTLL, as previously described. The bioassay sensitivity was 0.1 U of IL-2 based on standard curves obtained with recombinant human IL-2 (GIBCO-BRL, Gaithersburg, MD).

**Analysis of results.** To correct for daily variations in the assays, samples from at least 3 normal healthy adults were processed identically to the blinded test samples and included with each day’s testing. Results were analyzed as absolute values and were presented as either absolute values or corrected for test variation by subtracting the mean daily control value (the delta [Δ] value). Normal ranges were established from the mean ± 2 SD of results with normal children (N = 12). Nonparametric tests were used to evaluate differences in means between groups. Regression analysis was used to test the significance of correlations between parameters.

**RESULTS**

**Serum cytokine levels.** A solid-phase ELISA was used to quantitate the levels of various cytokines in the sera of

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<th>Table 1. Clinical Data of Study Subjects</th>
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<td><strong>Subjects</strong></td>
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<tr>
<td>Age&lt;sup&gt;a&lt;/sup&gt; (mean ± SD)</td>
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<tr>
<td>Platelet count&lt;sup&gt;b&lt;/sup&gt; (mean ± SD)</td>
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<sup>a</sup> Age is in years (mean ± SD, with the range in parentheses).

<sup>b</sup> Platelets x 10^9/L (mean ± SD, with the range in parentheses), excluding patients in remission.

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Fig 1. Scatter diagram showing the (A) IL-2, (B) IL-10, and (C) IFN-γ serum cytokine levels in the patient and control groups. Cytokine levels were determined by ELISA and assay sensitivities were determined to be as follows: IL-2, >62.5 pg/mL; IL-10, >31.25 pg/mL; and IFN-γ, >50 pg/mL. Results are expressed as the cytokine concentration (in picograms per milliliter) of the sera samples. IL-4 and IL-6 results were negative in all the patients and controls (ELISA sensitivities: IL-4, >12.5 pg/mL; IL-6, >6.25 pg/mL; data not shown).

Fig 2. Scatter diagram showing (A) the IL-2 levels in the supernatants of platelet-stimulated PBMC from patient and control groups and (B) the correlation between in vivo and in vitro levels of IL-2. IL-2 levels in the supernatants were determined by a bioassay using CTLL cells, whereas those in serum were determined by ELISA. Results for in vitro-generated IL-2 are expressed as units per milliliter and were calculated from standard curves using recombinant IL-2.

The patients and controls. Figure 1 shows the levels of (A) IL-2, (B) IFN-γ, and (C) IL-10 in both patients and controls. Only 1 of 11 patients with acute AITP had significantly elevated levels of cytokines, i.e., IL-2 (1,750 pg/mL), IL-10 (320 pg/mL), and IFN-γ (500 pg/mL). However, in patients with chronic AITP, 9 of 17 patients had increased serum IL-2 (mean concentration, 360 pg/mL); 3 of the 9 also had elevated levels of IL-10 and 2 of these 3 patients had increased IFN-γ. Three other patients with chronic AITP only had elevated serum levels of IL-10. Three of seven patients with chronic-complex AITP had increased serum IL-2; 2 of these 3 patients also had elevated levels of IFN-γ and 1 of the 3 had detectible serum IL-10. The differences in the number of patients positive for serum IL-2 levels between acute and chronic AITP were significant (P < .001). Two children with chronic AITP were examined for serum cytokine levels on two occasions and were found to have consistent levels at both testing dates (e.g., for IFN-γ, 300 and 340 pg/mL for one child and 110 and 130 pg/mL for the second child). IL-4 and IL-6 serum levels were undetectable in the serum of all patients and controls in this study.

In vitro antithrombocyte T-cell reactivity. To assess whether PBMC from patients and controls produce IL-2 when stimulated with platelets in vitro, 7-day antigen-presenting cell (APC) assays were used. Figure 2 shows the levels of in vitro IL-2 secretion by platelet-stimulated PBMC from the patients. PBMC from 5 of 8 of children with acute AITP,
from 12 of 19 of those with chronic AITP, and from 5 of 9 of those with chronic-complex AITP proliferated and secreted measurable IL-2 upon platelet stimulation. Of the in vitro responding cultures, patients with chronic AITP consistently had higher levels of IL-2 (mean, 3.6 U) in the culture supernatants, whereas lower amounts were seen in the APC cultures from those patients with acute AITP (mean, 0.7 U) or chronic-complex (mean, 0.6 U). In 6 of 10 adult patients with chronic AITP (not otherwise included in this analysis), PBMC secreted IL-2 upon in vitro platelet stimulation (mean, 6 U). Splenic mononuclear cells from 4 of 5 patients with chronic AITP had the highest in vitro platelet-stimulated IL-2 production (mean, 12 U/mL). Figure 2B shows that in vitro antiplatelet T lymphocyte IL-2 secretion significantly correlated with the presence of increased serum IL-2 ($r = .975, P < .001$).

**Platelet phenotype.** A number of patients in each group had abnormal platelet phenotype results, compared with the number tested. Increased platelet-associated (PA)-IgG was the most common Ig detected, being present in 73% and 65% of children with acute and chronic AITP, respectively, and in 82% of those with chronic-complex AITP. Increased PA-C3 was observed in approximately half of children with AITP and increased PA-IgM and PA-IgA were less frequently observed (40% and 5%, respectively).

Figure 3A shows the individual $\Delta$ values by which the level varied from daily normal controls; the mean number of GPIbIIIa molecules per platelet for the daily normal controls was 47.1 $\pm$ 2.8 $\times 10^3$ molecules/cell ($N = 16$). Few patients with AITP (6 of 40 children overall) showed abnormal levels of platelet surface GPIbIIIa (CD41a). The overall mean $\pm$ SD levels ($\times 10^3$ molecules/platelet) of GPIbIIIa were 47.1 $\pm$ 3.2 for acute AITP, 45.8 $\pm$ 6.9 for chronic AITP, and 49.4 $\pm$ 3.9 for chronic-complex AITP; these levels were not different from the levels observed in normal children (47.0 $\pm$ 3.2) or normal adults (48.4 $\pm$ 1.6). Figure 3B shows the individual $\Delta$ values; the mean number of GPIb molecules per platelet for the daily normal controls was 19.9 $\pm$ 1.4 $\times 10^3$. Fifteen of 43 children with AITP overall had abnormal levels of GPIb (CD42b) and this was most common in those with acute AITP (5 of 11 children). Mean $\pm$ SD levels ($\times 10^3$) of GPIb were lower in normal children than in normal adults (18.2 $\pm$ 1.3 vs 20.2 $\pm$ 1.7, respectively; $P < .005$). The mean GPIb levels were 19.8 $\pm$ 4.9 for children with acute AITP, 20.9 $\pm$ 3.1 for those with chronic AITP, and 20.6 $\pm$ 2.7 for those with chronic-complex AITP; these were not different from normal adult values, but for chronic and chronic-complex AITP, the mean GPIb levels were increased from those of normal children ($P < .02$).

Platelet activation was assessed by CD62 (P-selectin; GMP140) expression. Immediate fixation in PFA was used to prevent in vitro platelet activation. Figure 3C shows the $\Delta$ values for platelets expressing CD62 for each individual; in normal children, the mean percentage of platelets expressing CD62 was 1.0% $\pm$ 1.5%. Only 17% of children with acute AITP and 13% of those with chronic AITP had an increase in platelets expressing CD62; an increase in platelets expressing CD62 was observed in 25% of children with chronic-complex AITP. Excluding 1 patient who had 35% of his platelets expressing CD62, the differences between patients with AITP and normal patients were not significant. When platelets were not fixed with PFA, 10% to 50% of the platelets from normal controls and from patients had increased expression of CD62.

Figure 3D shows the $\Delta$ values for the platelets expressing HLA-DR in children with AITP; in the daily normal controls, the mean proportion of platelets expressing HLA-DR was 0.08% $\pm$ 0.05%. Although in individual patients only small proportions of platelets expressed increased HLA-DR, most children with acute (80%), chronic (76%), or chronic-complex (55%) AITP exhibited a small but distinct increase in platelets expressing increased HLA-DR (defined as the mean channel fluorescence $> 2$ SD above the mean for the daily normal controls). In normal children and in normal adults, 0.09% $\pm$ 0.06% and 0.13% $\pm$ 0.12%, respectively, of platelets expressed HLA-DR ($P < .05$). In contrast, there was a 10-fold increase (1.1% $\pm$ 0.9%) of platelets from patients with acute, chronic (0.9% $\pm$ 0.8%), and chronic-complex AITP (0.9% $\pm$ 1.1%) expressing increased HLA-DR. Nonetheless, the majority of platelets remained HLA-DR$^-$. Compared with normal children, the increases observed in platelets expressing HLA-DR were significant ($P < .002$ v acute AITP, $P < .01$ v chronic AITP, and $P < .02$ v chronic-complex AITP). In 1 patient with acute AITP (not included in the calculations above), 24% of the platelets expressed HLA-DR. None of 12 patients with acute leukemia and non-immune thrombocytopenia showed an increased number of platelets expressing HLA-DR, compared with normal controls (data not shown).

Figure 4A through D shows a typical two-color flow cytometric analysis of PRP platelets derived from a healthy child (Fig 4A and C) and a child with chronic AITP (Fig 4B and D) with 0.07% and 5.0%, respectively, of GPIb$^+$ platelets expressing HLA-DR. Further characterization of HLA-DR$^+$ platelets was performed using three-color fluorescence. Figure 4E shows that GPIb$^+$ cells derived from the whole blood of a child with chronic AITP could be gated into three distinct populations based on size (forward light scatter; FSC) and a FITC-anti-GPIb threshold: GPIb$^+$ intact platelets (gate R1), GPIb$^+$ macroplatelets (gate R2), and GPIb$^+$ microparticles (gate R3). Microscopic examination of sorted populations showed that the macroplatelet gate R2 was composed of single, nonadherent cells that on Giemsa staining were erythrocytes. Figure 4F shows results with PE-labeled anti-glycophorin and PerCP-labeled HLA-DR antibodies of the ungated GPIb$^+$ cells; greater than 98% of the glycophorin-positive events were contained in gate R2. HLA-DR expression was virtually absent on the whole blood GPIb$^+$ cells from a healthy child control (0.06%; data not shown), but was increased (2.0%, $P < .001$) on the GPIb$^+$ cells from the child with chronic AITP (Fig 4F). Splenic GPIb$^+$ cells from the same child with chronic AITP had higher expression of HLA-DR (21%) compared with the whole blood platelets (2%). Spleens from 4 other children with chronic AITP had 49% $\pm$ 30% of their GPIb$^+$ cells expressing HLA-DR; each spleen showed higher HLA-DR expression than the corresponding peripheral blood platelets. Table 2 summarizes the three-color flow cytometric results of the three
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Correlations between the results. Overall, there was an inverse correlation of platelet count with proportion of platelets expressing HLA-DR, as shown in Fig 5A (correlation coefficient \( r = -0.5937 \), \( P < 0.01 \)). In individual patients studied over time, as the platelet counts improved (with or without therapy), the number of platelets expressing HLA-DR was reduced (\( r = -0.5531 \), \( P < 0.01 \); data not shown). On 9 of 10 occasions in which the platelet count increased, there was a decrease in platelet HLA-DR. On occasions in which the platelet count remained unchanged on subsequent testing, HLA-DR remained unchanged in 2 and increased in 1. One patient with chronic AITP (data not shown) was examined on 7 separate occasions (before and after IVIgG therapy, over the course of 7 months); the \( r \) value for relationship between HLA-DR expression and platelet counts in this patient was \( -0.5730 \) (\( P = 0.023 \)). Platelet HLA-DR expression was not correlated to serum IL-2 levels (\( r = -0.11 \), \( P \) = not significant [NS]; Fig 5B), and it did not correlate with the other serum cytokine levels (data not shown).

In a number of cases, patients had received therapy within the month before testing. Therapies included IVIg, anti-D, and steroids in patients with acute AITP (\( N = 6 \)); steroids, IVIg, and splenectomy in children with chronic AITP (N...
Fig 4. Flow cytometric analysis of HLA-DR expression on platelet populations prepared from washed PRP or whole blood. The upper panels show an FSC versus SSC dot plot of PRP platelets derived from (A) a healthy child and (B) a child with chronic AITP. The middle panels (C and D) represent the corresponding dot plots for HLA-DR/GP1b fluorescence of the ungated PRP platelet populations. Twenty thousand events were acquired in (A) through (D) and fluorescent markers were set on FITC- and PE-isotypic control antibodies. The lower panels show a typical three-color analysis of GP1b⁺ cells from the peripheral blood of a child with chronic AITP. (E) shows cells acquired through an FSC versus GP1b FL1 live gate. Gates (R1 through R3) were drawn around the clustered populations of cells. (F) shows the second (FL2; PE-antiglycophorin) and third (FL3; PerCP-anti-HLA-DR) colors of the ungated GP1b⁺ cells from (E). A summary of three-color fluorescent results for each gated population is shown in Table 2. The numbers indicate the percentage of cells in each quadrant. For clarity, only 2,000 events in each panel are shown.

Table 2. Three-Color Analysis of Gated Platelet Populations

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<tr>
<th>Marker</th>
<th>Gate R1: Intact Platelets</th>
<th>Gate R2: Macroparticles</th>
<th>Gate R3: Microparticles</th>
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<tr>
<td></td>
<td>Co</td>
<td>Pat</td>
<td>Pat Spl</td>
</tr>
<tr>
<td>GP1b⁺ '45'-DR⁺</td>
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<td>97</td>
<td>NT</td>
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<td>1</td>
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<td>1</td>
<td>0</td>
</tr>
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<td>GP1b⁺ '14'-DR⁺</td>
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Results are expressed as mean percentage of total cells within each gate (R1-R3) shown in Fig. 4E. Fifty thousand events were acquired for analysis. The relative size of the cells within each gate are shown in Fig 4E (there was no significant difference in GP1b⁺ cell size in control or patient groups).

Abbreviations: Co, GP1b⁺ cells from whole blood of healthy control children (N = 10); Pat, GP1b⁺ cells from whole blood of children with chronic AITP (N = 6); Pat Spl, GP1b⁺ splenic cells from children with chronic AITP (N = 4); NT, not tested.
because Boshkov et al. in 1992 described a single patient with acute AITP who had increased platelet HLA-DR expression, which declined with response to therapy, we investigated platelet HLA-DR expression in patients with different forms of AITP. Because platelet dysfunction and IgG-mediated platelet activation have been described in AITP and these functional changes may be reflected by changes in platelet membrane antigen expression, we performed a blinded study in children with acute and chronic AITP to quantitatively assess changes in specific and nonspecific platelet surface molecules and to relate them to changes in serum cytokine levels and to in vitro platelet-stimulated activation by T lymphocytes.

Patients with acute AITP differed from those with the chronic form of the disorder in that, in the former, few patients had increased cytokines, whereas many (53%) of the latter had increased levels of serum IL-2, IFN-γ, and/or IL-10. None of the patients tested had detectable serum levels of IL-4 or IL-6. The increased serum IL-2 significantly correlated with in vitro platelet-stimulated IL-2 production by T-helper cells. Thus, a population of children with chronic AITP may have abnormal in vivo T-cell activation causing accumulation of serum cytokines. Cytokine secretion patterns can distinguish CD4+ T-helper cells into Th1 and Th2 cells. Th1 cells primarily secrete IL-2 and IFN-γ and mediate DTH-like responses, whereas Th2 cells can secrete IL-4, IL-5, IL-6, and/or IL-10 and are superior in helping humoral responses, particularly IgE. A third group of T cells is termed Th0 cells and is thought to be less differentiated than Th1 and Th2 cells, because they can secrete most or all of the cytokines made by either cell type, particularly IL-2 and IL-10. Our results suggest that the pattern of cytokine levels in chronic AITP may reflect an early Th cell activation, i.e., primarily IL-2 secretion with some patients exhibiting Th0 or Th1 activation (IL2, IL-10, and/or IFN-γ). However, because IL-10 can be produced by other cell types and 3 of the patients with chronic AITP had elevated levels of only IL-10, it is unclear what the cellular source of this cytokine is in the patients with chronic AITP. Our in vivo results correlate with a recent report showing in vitro Th1 cytokine patterns in mitogen-stimulated CD2+ T cells from adult patients with chronic AITP.

IL-2 plays a pivotal role in human immune responses and increased serum IL-2 is reported in various autoimmune diseases. Hypersecretion of endogenous IL-2 may lead to autoaggression by a number of mechanisms, eg, by bypassing the need for T cell costimulation, by upregulating costimulatory CD80 molecules on B cells, or by the induction of other cytokines such as IFN-γ and IL-10. Increased IL-10 was also seen in a number of patients with AITP. IL-10 has potent immunostimulatory effects on human B cells and suppressive effects on monocytes/macrophages that leads to downregulation of inflammatory cytokines such as IL-6. We found no detectable levels of IL-6 in these patients. The ability of IL-10 to suppress the production of inflammatory cytokines suggests that it may have a strong anti-inflammatory role in vivo; although the role of IL-10 in chronic AITP is unclear, it may help in reducing antiplatelet reactivity and destruction. We are currently testing this hy-
pothesis, but, at the present time, it remains unclear whether the alterations in cytokines play a primary role in the etiology of AITP or are rather a reflection of an ongoing inflammatory and/or immune response.

We and others have previously reported that PBMC from patients with chronic AITP have enhanced platelet-stimulated IL-2 secretion in vitro. It was currently found that, in children with chronic AITP, serum cytokine levels correlated well with in vitro platelet-stimulated IL-2 production. In contrast, only 1 of 11 children with acute AITP had significant levels of serum IL-2, IL-10, and IFN-γ, despite the fact that about one-third of these patients also have PBMC that mediated weak (0.7 U) in vitro platelet-stimulated IL-2 reactivity. These observations may relate to different immune pathogeneses in the various forms of AITP. Acute AITP may be due to a cross-reactive immune response directed against an infectious agent, e.g., a virus, whereas chronic AITP may be generated by a more platelet-specific autoimmune pathogenesis, possibly at the level of T cells. In acute AITP, the lymphocyte immune response, although slightly cross-reactive to normal platelets in vitro, may be due to a stimulus that does not generate the same serum cytokine profile as the autoimmune response directed at the platelets themselves in the chronic form of the disorder. The enhanced serum cytokine levels, the increase in activated T cells, and the strong in vitro antiplatelet T-cell response in patients with chronic AITP may be due to a continually platelet-stimulated autoimmune response. We are currently studying these platelet-reactive T-cell responses at the clonal level.

A number of surface platelet-specific and nonspecific antigenic markers were quantitated in children with AITP and controls. Although some of the children with AITP in each group did exhibit abnormalities, in general, children with either the acute or chronic forms of AITP had platelets with normal expression of GPIIbIIIa and the CD62 activation molecule. These results support those of Chong et al., who reported that, in contrast to patients with consumptive thrombocytopenia, plasma P-selectin levels were not increased in patients with AITP. The low expression of surface GPIIbIIIa on normal platelets after thrombin or ADP stimulation and activation of the platelets (data not shown), suggesting that this pathway of endogenous release to the surface is not the likely mechanism. Furthermore, HLA-DR expression was of low levels, although statistically significant or it may indicate that other mechanisms are responsible for the expression. These mechanisms may include the passive adsorption of HLA-DR from membrane fragments of activated macrophages or possibly release of endogenous HLA-DR by the platelets themselves. However, the observed increases, although not sequestered or destroyed in the spleen, may have a potential relationship to platelet destruction in AITP and should be further studied. The inverse correlation of platelets expressing HLA-DR and the platelet count supports this hypothesis.

Although platelet HLA-DR expression was of low levels, 1 patient with acute AITP had a dramatic increase in platelet HLA-DR (24%) that was similar to that found by Boshkov et al. in acute AITP. However, because only 1 of 11 patients had a significant increase in platelet HLA-DR expression, it does not appear to be a common finding of acute AITP. The expression of HLA-DR on platelets was not correlated to serum cytokine levels. This may be due to either the number of patients being too low for statistical significance or it may indicate that other mechanisms are responsible for the expression. These mechanisms may include the passive adsorption of HLA-DR from membrane fragments of activated macrophages or possibly release of endogenous HLA-DR by the platelets themselves. However, we were consistently unable to show increased HLA-DR expression on normal platelets after thrombin or ADP stimulation and activation of the platelets (data not shown), suggesting that this pathway of endogenous release to the surface is not the likely mechanism. Furthermore, HLA-DR expression was not seen on young (as assessed by thiazole orange-detected RNA content) platelets from patients recovering from chemotherapy, suggesting that it is not the result of studying megakaryocytic platelets. On the other hand, the cells coexpressing GPIb and glycoporphin in patients with AITP may relate to the observations by Karpatic of increased red blood cell destruction in AITP.

Approximately 20% of children with acute AITP will progress to the chronic form of the disease. It would be beneficial if markers of this transition were available. Although Ware and Howard found no major phenotypic differences in T cells between children with acute and chronic AITP, functional analyses showed that the majority of platelet-reactive T-cell clones were derived from the children with chronic AITP. None of the platelet phenotypic markers investigated in the current report clearly distinguished the different clinical forms of AITP; however, we are observing
these children to determine if these results may have a predictive value for determining progression to chronic AITP. Increased serum cytokines, together with in vitro platelet-stimulated IL-2 production, may be important tests in examining differences in the pathobiology of the acute and chronic forms of AITP and may help predict which children with acute AITP will develop the chronic form of the disease.

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Differences in serum cytokine levels in acute and chronic autoimmune thrombocytopenic purpura: relationship to platelet phenotype and antiplatelet T-cell reactivity

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