BLOCKADE OF INTERLEUKIN-6 SIGNALING AUGMENTS REGULATORY T CELL RECONSTITUTION AND ATTENUATES THE SEVERITY OF GRAFT VERSUS HOST DISEASE

Xiao Chen¹,²
Rupali Das¹,³
Richard Komorowski⁴
Amy Beres¹,⁵
Martin J. Hessner³
Masahiko Mihara⁶
William R. Drobyski¹,²,³,⁵

From the Bone Marrow Transplant Program¹ and the Departments of Medicine², Pediatrics³, and Pathology⁴ and Microbiology⁵, Medical College of Wisconsin, Milwaukee, WI 53226; and Chugai Pharmaceuticals⁶, Shizuoka, Japan.

Running Title: Blockade of IL-6 Signaling Attenuates GVHD

Both X.C. and R.D. contributed equally to this work and share first authorship.

Scientific Category: Transplantation

Address correspondence to:
William R. Drobyski, M.D.
Bone Marrow Transplant Program
9200 West Wisconsin Avenue
Milwaukee, WI 53226
Phone: 414-456-4941, Fax: 414-805-4630, E-mail: wdrobysk@mcw.edu
Graft versus host disease (GVHD) is the major complication after allogeneic bone marrow transplantation and is characterized by the over production of proinflammatory cytokines. In this study, we have identified interleukin-6 (IL-6) as a critical inflammatory cytokine that alters the balance between the effector and regulatory arms of the immune system and drives a proinflammatory phenotype that is a defining characteristic of GVHD. Our results demonstrate that inhibition of the IL-6 signaling pathway by way of antibody-mediated blockade of the IL-6 receptor (IL-6R) markedly reduces pathological damage attributable to GVHD. This is accompanied by a significant increase in the absolute number of regulatory T cells (Tregs) which is due to augmentation of thymic-dependent and thymic-independent Treg production. Correspondingly, there is a significant reduction in the number of T_h1 and T_h17 cells in GVHD target organs, demonstrating that blockade of IL-6 signaling decreases the ratio of proinflammatory T cells to Tregs. These studies demonstrate that antibody blockade of the IL-6R serves to recalibrate the effector and regulatory arms of the immune system and represents a novel, potentially clinically translatable, strategy for the attenuation of GVHD.
INTRODUCTION

Graft versus host disease (GVHD) is the major complication associated with allogeneic stem cell transplantation. A prominent characteristic of GVHD is the presence of a proinflammatory milieu that is attributable to conditioning regimen-induced host tissue damage as well as secretion of inflammatory cytokines [e.g. interleukin-1 (IL-1), tumor necrosis alpha-α (TNF-α), interferon-γ (IFN-γ), interleukin-6 (IL-6)] by alloactivated donor T cells and other effector cell populations.1-3 These cytokines perpetuate GVHD through direct cytotoxic effects on host tissues,4-6 activation and/or priming of immune effector cells,7 and differentiation of proinflammatory T cell populations (i.e. T_{H1} and T_{H17} cells) from naïve T cell precursors.8,9 This inflammatory environment is also promoted by the absence of an effective regulatory T cell (Treg) response as both a relative and an absolute decline of Tregs in the peripheral blood and target tissues has been demonstrated in a majority of studies.8,10-12 The strong association between a proinflammatory milieu and the absence of an effective counter regulatory response suggests that the inflammatory environment prevents and/or inhibits Treg reconstitution during GVHD. How this occurs, however, is not well understood.

IL-6 is a pleiotrophic cytokine that is produced by a variety of cell types, including T cells, B cells, fibroblasts, endothelial cells, monocytes and keratinocytes.13 IL-6 is of particular interest with respect to GVHD biology since it occupies a unique position at the crossroads where the fate of naïve T cells to become either regulatory cells or proinflammatory T cells is determined. In the presence of IL-6 and transforming growth factor-β (TGF-β), naïve T cells differentiate into T_{H17} cells, whereas in its absence these same cells are induced to become Tregs.14,15 Furthermore, IL-6 produced by dendritic cells after activation through Toll-like receptors is able to inhibit the suppressive function of natural Tregs.16,17 Thus, IL-6 appears to have a pivotal role in directing the immune response towards an inflammatory phenotype and away from a regulatory response. The potential importance of IL-6 in GVHD is also supported by clinical studies that have shown that patients with elevated plasma levels of IL-6,18,19 as well as those with
a recipient or donor IL-6 genotype that results in increased IL-6 production,\textsuperscript{20,21} have an increased incidence and severity of GVHD.

Signaling through IL-6 occurs by the binding to a low affinity IL-6 receptor (IL-6R) which together induces homodimerization of gp130 and subsequent transduction of the intracellular signal.\textsuperscript{22} This membrane-bound IL-6R, however, is expressed only on hepatocytes and hematopoietic cells. Notably, the IL-6R can also be shed from the membrane generating a soluble form of the receptor which can complex with IL-6 and induce an intracellular response in cells that lack the membrane-bound IL-6R through a process called trans-signaling.\textsuperscript{23,24} Interference with the actions of IL-6 by administration of an IL-6R antibody that prevent binding of the cytokine to its receptor has been shown to be effective in the treatment of a variety of inflammatory disease such as rheumatoid arthritis,\textsuperscript{25,26} amyloidosis,\textsuperscript{27} and colitis.\textsuperscript{28} Whether inhibiting the actions of IL-6 affects the severity of GVHD or alters the proinflammatory milieu, however, has not been studied. In this report, we examined the effect that blockade of IL-6 signaling had on the pathophysiology of GVHD and on the ability of the host to reconstitute an effective regulatory T cell response.

**METHODS**

**Mice.** C57BL/6 (B6) (H-2\textsuperscript{b}), Balb/c (H-2\textsuperscript{d}), B6(C)-H2-Ab1\textsuperscript{bm12}/KhEgl (bm12) (H-2\textsuperscript{b}), B6.129S7-Rag-1 (B6 Rag-1) and IL-6 deficient (IL-6\textsuperscript{−−/−}) (B6 background) mice were bred in the Animal Resource Center (ARC) at the Medical College of Wisconsin (MCW) or purchased from Jackson Laboratories (Bar Harbor, ME). Thymectomized Balb/c mice were purchased from Jackson Labs. Foxp3\textsuperscript{EGFP} mice (backcrossed to the B6 background for six generations) in which the foxp3 gene is coupled to the enhanced green fluorescent protein (EGFP) were obtained from Dr. Calvin Williams (Medical College of Wisconsin, Milwaukee, WI) and have been previously described.\textsuperscript{29} All animals were housed in the
Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC)-accredited ARC of the Medical College of Wisconsin. Experiments were all carried out under protocols approved by the MCW Institutional Animal Care and Use Committee. Mice received regular mouse chow and acidified tap water ad libitum.

**Bone Marrow Transplantation.** Bone marrow (BM) was flushed from donor femurs and tibias with Dulbecco’s modified media (DMEM) (Gibco-BRL, Carlsbad, CA) and passed through sterile mesh filters to obtain single cell suspensions. BM was T-cell depleted in vitro with anti-Thy1.2 monoclonal antibody plus low toxicity rabbit complement (C-six Diagnostics, Mequon, WI). The hybridoma for 30-H12 (anti-Thy1.2, rat IgG2b) antibody was purchased from the American Type Culture Collection (Rockville, MD). Host mice were conditioned with total body irradiation (TBI) administered as a single exposure at a dose rate of 82 cGy using a Shepherd Mark I Cesium Irradiator (J.L. Shepherd and Associates, San Fernando, CA). Irradiated recipients received a single intravenous injection in the lateral tail vein of BM with or without added spleen cells. In some experiments, mice were transplanted with purified splenic CD4⁺ T cells that were isolated by positive selection using the MACS magnetic bead cell separation system (Miltenyi Biotech, Auburn, CA).

**Cell Sorting and Flow Cytometry.** Spleen and peripheral lymph node cells were collected from Foxp3EGFP mice and sorted on a FACSVantage with a DIVA option (Becton-Dickenson, Mountain View, CA) or a FACSaria. Spleen cells from transplant recipients were labeled with monoclonal antibodies (mAb) conjugated to fluorescein isothiocyanate (FITC), phycoerythrin (PE), or PE-Cy5.5 that were obtained from BD Biosciences (San Diego, CA). Cells were analyzed on a FACSCalibur flow cytometer with Cellquest software (Becton-Dickenson). Data were analyzed using FlowJo software (Treestar, Ashland, Oregon).
Reagents. Anti-IL-6R antibody (MR-16-1) is a rat IgG antibody that has been previously described. Animals received a loading dose of 2 mg intravenously on the day of transplantation and then were treated with 0.5 mg weekly by intraperitoneal injection. Antibody was re-suspended in phosphate-buffered saline (PBS) prior to injection. Rat IgG (Jackson Immunoresearch Laboratories, West Grove, PA) was used as a control and administered at the same dose and schedule as MR-16-1.

Histological Analysis. Representative samples of liver, colon, and lung were obtained from transplanted recipients and fixed in 10% neutral-buffered formalin. Samples were then embedded in paraffin, cut into five micron thick sections and stained with hematoxylin and eosin. A semiquantitative scoring system was employed to account for histological changes in the colon, liver, and lung as previously described. All slides were coded and read in a blinded fashion. Images were visualized with an Olympus BX45 microscope (Tokyo, Japan). Image acquisition was performed with an Olympus DP70 digital camera and software package.

Cytokine Analysis. Serum was collected from mice by retroorbital bleeds and analyzed on a Bioplex System (BioRad Laboratories, Hercules, CA) according to the manufacturer’s instructions. Soluble IL-6R was measured using a specific sandwich ELISA (R & D Systems, Minneapolis, MN). Concentrations of all other pro-inflammatory cytokines (IL-1β, TNF-α, IL-6, IL-17, G-CSF, and IFN-γ) in serum were measured using the multi-plex cytokine Bio-Rad assay system (Bio-Rad). All samples were run in duplicate.

Cell Isolation. To isolate lamina propria lymphocytes, pooled colons were incubated in Hank’s Balanced Salt Solution (HBSS) buffer (Gibco-BRL) supplemented with 2% fetal bovine serum (FBS), EDTA (0.05 mM) and 15 µg/ml dithiothreitol (Invitrogen, Carlsbad, CA) at 37°C for 30 min and subsequently digested in a solution of collagenase D (Roche Diagnostics, Mannheim, Germany, 0.15 mg/ml) in DMEM with 2% FBS for 75 min at 37°C. The resulting cell suspension was then layered on a 44%/67% Percoll gradient
Pooled liver and lung lymphocytes were isolated by collagenase D digestion followed by layering on a Percoll gradient as described above.

**Intracellular Cytokine Staining.** Lymphocytes isolated from spleen, liver and lung were stimulated with 50 ng/ml phorbol 12-myristate 13-acetate (PMA) (Sigma) and 750 ng/ml ionomycin (Calbiochem, La Jolla, CA) for 2 1/2 hours and then incubated with GolgiStop (BD Pharmingen) for an additional 2 1/2 hours. Cells were surface stained with PE Cy5.5 anti-CD4 and then intracellularly stained with PE-labeled antibody to IL-17 and FITC-labeled antibody to IFN-γ.

**Real Time q-PCR.** Liver, spleen and colon samples were harvested and immediately snap frozen in liquid nitrogen for RNA extraction. Total RNA was extracted from frozen samples using TRIzol reagent (Gibco-BRL). Real-time q-PCR was performed using Rotor-Gene 3000 (Corbett Research, Morelak, Australia), QuantumRNA 18S Internal Standards (Ambion, Austin, Texas), IL-6 primers (5’-TCCAATGCTCTCTAAGATAAG-3’, 3’-CAAGATGGAATTGGATGCTTG-5’), IL-6R (5’-CCTGTGTGGGGTCCAGAGG-3’, 3’-CTGCCAGATTCTCAGCAGCT-5’) and QuantiTect SYBR Green PCR Master Mix (Qiagen, Valencia, CA) according to the manufacturers' instructions. Synthesis of first-strand cDNA from 1 µg of RNA per animal was accomplished with random primers and Superscript II (Invitrogen) according to the manufacturers' instructions. Primers were purchased from Integrated DNA Technologies (Coralville, IA). Specificity for all q-PCR reactions was verified by melting curve analysis. Data were analyzed with the Rotor-Gene 3000 software using the cycle threshold for quantification. Relative gene expression data (fold change) between samples was accomplished using the mathematical model described by Pfaffl.34

**Statistics.** Group comparisons of spleen and T cell populations, cytokine levels, pathology scores, mean weights and gene expression data were performed using the Mann Whitney U test. A p value ≤ 0.05 was deemed to be significant in all experiments.
RESULTS

IL-6 and IL-6R levels are significantly increased during GVHD. In initial studies, we examined the temporal kinetics of IL-6 and sIL-6R production in the sera of mice undergoing syngeneic and allogeneic BMT. Lethally irradiated Balb/c mice were transplanted with either Balb/c BM and spleen cells (0.4-0.5 x 10^6) (syngeneic) or B6 BM and an equivalent number of B6 spleen cells (allogeneic) to induce GVHD. Cohorts of mice were sacrificed at weekly intervals and IL-6 levels were quantitated. These studies revealed that IL-6 was substantially increased in the sera of both syngeneic and allogeneic transplant recipients when compared to normal nontransplanted animals at all time points (Figure 1A). Within the first two weeks post BMT, no difference was observed in IL-6 levels between recipients of syngeneic versus allogeneic marrow grafts. However, whereas levels of IL-6 progressively declined in syngeneic recipients, levels remained consistently elevated in allogeneic recipients resulting in significantly higher values 21 and 28 days post BMT. Given the restricted expression of the membrane-bound IL-6R and the importance of trans-signaling in inflammatory responses, we also examined sIL-6R levels in syngeneic and allogeneic marrow transplant recipients. Quantitation of sIL-6R in serum revealed that levels were significantly increased (2-3 fold) in recipients of allogeneic versus syngeneic grafts at nearly all time points (Figure 1B).

To determine if similar findings were present in GVHD target organs, gene expression studies were performed to quantitate both IL-6 and total (i.e. membrane and soluble) IL-6R mRNA levels. We observed that IL-6 mRNA levels were significantly increased in the colon and liver of mice with GVHD when compared to syngeneic control animals (Figure 1C). This was in contrast to the spleen where no differences were observed at any of the time points examined. Notably, IL-6 mRNA levels were highest in the colon consistent with a prior report demonstrating markedly elevated levels of this cytokine in the colon microenvironment. Gene expression analysis of the IL-6R mRNA levels also demonstrated
significant increases in the colon and liver at several time points in recipients of allogeneic marrow grafts, but no difference in the spleen (Figure 1D). Whereas IL-6 mRNA levels were highest in the colon, IL-6R mRNA levels were most significantly increased in the liver where they were approximately 10-fold higher than either the spleen or colon. Collectively these results demonstrate that there is a marked increase in both IL-6 and IL-6R levels during the early stages of GVHD.

Absence of either recipient or donor-derived IL-6 is insufficient to protect animals from GVHD. Given the increase in IL-6 production observed in both the sera and specific GVHD target organs, we conducted experiments to determine the relative importance of recipient versus donor IL-6 production in GVHD pathophysiology. Cohorts of lethally irradiated wild type B6 or IL-6−/− mice were transplanted with Balb/c BM and 15 x 10^6 Balb/c spleen cells to induce GVHD. No difference in overall survival was observed between these two groups of animals (46% versus 62% at day 60, p=0.67) (Figure 2A). Moreover, serial weight curves demonstrated a similar pattern of weight loss indicating that absence of recipient-derived IL-6 had no protective effect on GVHD (Figure 2B). Reciprocal experiments were then performed to define the role of donor IL-6 production by transplantation of B6 or IL-6−/− BM and 0.5-0.7 x 10^6 splenocytes into lethally irradiated Balb/c animals. There was again no difference in overall survival between these two groups (44% versus 38%, p=0.85) (Figure 2C). Serial weight curves demonstrated no difference in weight loss over the first 5 weeks; however, surviving mice transplanted with IL-6−/− marrow grafts did have enhanced weight gain thereafter. This resulted in a statistically significant difference when compared to similar time points in recipients of B6 marrow grafts (Figure 2D). However, no difference in overall GVHD pathology scores was observed in surviving animals transplanted with wild type versus IL-6−/− marrow grafts (mean score 7.6 ± 1.9 versus 6.7 ± 0.9, p=0.93).

Blockade of IL-6 signaling attenuates GVHD severity and effects a significant increase in Treg reconstitution. We then conducted studies to determine whether more complete blockade of IL-6
signaling would result in greater protection of GVHD target organs from pathological damage. To address this question, we employed a monoclonal antibody that binds to both the membrane and soluble components of the IL-6R so that IL-6 signaling could be more effectively inhibited in vivo. Lethally irradiated Balb/c mice were transplanted with TCD B6 BM and spleen cells adjusted to yield a T cell dose of 0.7 x 10⁶ αβ T cells to induce lethal GVHD. Cohorts of mice were then treated weekly for four weeks with either anti-IL-6R or rat IgG isotype control antibody. Animals treated with anti-IL-6R antibody had significantly increased survival when compared to control antibody-treated mice (83% versus 20%, p=0.003)(Figure 3A). In order to understand the mechanism by which these mice were protected from GVHD lethality, we repeated these studies with a reduced T cell dose so that mice in all groups would survive and be able to be examined for immunological and pathological analysis. Moreover, since IL-6 has also been shown to play a pivotal role in directing naive T cell differentiation towards Th17 cells and away from Tregs,¹⁴,¹⁵ we examined this question using donor Foxp3EGFP mice so that Tregs could be definitively identified in recipient animals. In these studies, mice that received anti-IL-6R antibody had significantly less weight loss beginning approximately three weeks post transplantation (Figure 3B). Histological examination of GVHD target organs five weeks post transplantation revealed a significant reduction in pathological damage in the colon, liver and lung (Figures 3C and 3D) when compared to control antibody-treated mice, indicating that blockade of IL-6 signaling markedly attenuated GVHD severity in all target organs. This was accompanied by an increase in spleen cellularity (Figure 3E) and, most notably, a commensurate 12-fold increase in the number of Tregs (9.5 ± 3.1 x 10⁴) compared to mice administered the isotype antibody (0.78 ± 0.61 x 10⁴, p=0.0001) (Figure 3F). Examination of serum proinflammatory cytokines one week post-BMT revealed a significant increase in IL-6 levels in anti-IL-6R antibody-treated animals, but no difference in IFN-γ, IL-1β, TNF-α, G-CSF or IL-17 when compared to control mice (Figure 3G). The increase in serum IL-6 levels after anti-IL-6R antibody administration has been previously reported and is postulated to be due to a decrease in clearance as a consequence of circulating IL-6 being unable to bind to blocked IL-6 receptors.³⁵,³⁶
Attenuation of GVHD by blockade of IL-6 signaling is not dependent upon an intact thymus.

Immune reconstitution is a particular problem in older aged transplant recipients due, in part, to the involution of the thymus that limits the generation new T cells, including Tregs, and thereby constrains T cell repertoire complexity.\textsuperscript{37-39} Thus, we examined the effect of antibody blockade on GVHD protection under conditions where thymic function was absent. Lethally irradiated thymectomized Balb/c mice were transplanted with B6 Foxp3\textsuperscript{EGFP} BM and spleen cells and then administered either anti-IL-6R or isotype control antibodies. Mice treated with anti-IL-6R antibody had significantly less GVHD-associated weight loss (Figure 4A) and there was also reduced overall pathological damage with specific reductions in the colon and liver (Figure 4B). Coincident with the attenuation in organ pathology, there was a commensurate increase in splenic cellularity and total splenic CD4\textsuperscript{+} T cells (Figure 4C and 4D). Notably, animals treated with anti-IL-6R antibody also had a significant increase in the absolute number of splenic Tregs (3.3 ± 1.0 x 10\textsuperscript{4} versus 1.3 ± 0.6 x 10\textsuperscript{4}, p=0.012) (Figure 4E), indicating that the augmentation in Treg numbers occurring as a consequence of IL-6 signaling blockade was not dependent upon an intact thymus.

In vivo induction of CD4\textsuperscript{+} foxp3\textsuperscript{+} T cells from CD4\textsuperscript{+} foxp3\textsuperscript{−} T cells is negligible during acute GVHD.

The increased number of Tregs that we observed in thymectomized mice led us to investigate whether treatment with anti-IL-6R antibody enhanced the peripheral conversion of CD4\textsuperscript{+} foxp3\textsuperscript{+} T cells from conventional CD4\textsuperscript{+} foxp3\textsuperscript{−} T cells. To address this question, we first performed studies to determine the extent to which peripheral Treg conversion occurred during the course of acute GVHD. Experiments were conducted using a CD4\textsuperscript{+} T cell-dependent murine model in which lethally irradiated bm12 (allogeneic) or B6 (syngeneic) mice were transplanted with B6 Rag-1 BM (5-10 x 10\textsuperscript{6}) and equivalent numbers of sorted CD4\textsuperscript{+} EGFP-foxp3\textsuperscript{−} T cells (0.1-0.6 x 10\textsuperscript{6}) so that no natural Tregs were administered in the marrow graft inoculum and induced Tregs (iTregs) could be identified by their expression of EGFP. Cohorts of mice from each group were then sacrificed at 1 and 3 weeks post transplantation and the
absolute number and/or percentage of iTregs in the spleen, liver and colon was quantitated. Overall spleen cell numbers and total CD4+ T cells were increased in GVHD animals at both one and three weeks post transplantation due, in part, to the expansion of alloreactive CD4+ T cells (Figures 5A, 5B, 5E and 5F). The number of iTregs was also marginally increased at one week (Figure 5C), but by three weeks there was no difference when compared to syngeneic controls (Figure 5G). Similarly, although the mean percentage of CD4+ T cells which were EGFP-foxp3+ was also higher seven days post transplantation in GVHD mice (Figure 5D), no difference compared to syngeneic animals was observed by week three (Figure 5H). The most important aspect of these studies, however, was that the percentage of iTregs relative to total CD4+ T cell numbers was very low and averaged <1% at both time points. Examination of the colon and liver from these same animals also demonstrated that the mean percentage of CD4+ EGFP+ T cells in allogeneic recipients (n=3-4 mice/group) was 0.48% and 0.23%, respectively, at one week and 0.36% and 0.08%, respectively, at three weeks (data not shown). Collectively, these data demonstrated that the induction of CD4+ foxp3+ T cells from conventional CD4+ foxp3- T cells was negligible during acute GVHD.

Antibody blockade of the IL-6R augments conversion of CD4+ foxp3- to CD4+ foxp3+ T cells in the periphery. Experiments were then conducted to determine whether anti-IL-6R antibody administration enhanced the conversion of CD4+ foxp3+ T cells from CD4+ foxp3- T cells. To address this question, lethally irradiated Balb/c mice were transplanted with B6 Rag-1 BM cells and sorted CD4+ EGFP- T cells, and then treated with either anti-IL-6R or control antibody. Anti-IL-6R antibody-treated animals had a significant overall reduction in pathological damage when compared to control-treated mice (Figure 6A). Protection, however, was seen only in the colon whereas there was no statistically significant decrease in pathology scores in either the liver or lung. While there was no difference in spleen size or total number of CD4+ T cells between groups of mice (Figures 6B and 6C), we did observe that anti-IL-6R antibody administration significantly augmented the peripheral conversion of CD4+ foxp3- to CD4+
foxp3⁺ T cells. More specifically, there was a substantial increase in the percentage of iTregs (Figures 6D and 6E) as well as an eight-fold increase in the absolute number of these cells in the spleen in anti-IL-6R versus isotype antibody-treated mice (1.93 ± 0.37 x 10⁴ versus 0.24 ± 0.05 x 10⁴, p=0.002)(Figure 6F). Thus, blockade of IL-6 signaling enhanced the conversion of CD4⁺ foxp3⁺ T cells from CD4⁺ foxp3⁻ T cells without resulting in any statistically significant increase in the absolute number of CD4⁺ T cells.

**Anti-IL-6R antibody-induced increase in Tregs is associated with a significant reduction in proinflammatory T H1 and T H17 cells.** IL-6, in combination with TGF-β, has been shown to play a critical role in the differentiation of T H17 cells from naïve T cell precursors. Moreover, recent studies suggest that T H17 cells may contribute to the pathophysiology of GVHD, although their specific role relative to T H1 cells is still not well defined. We therefore conducted studies to determine whether blockade of IL-6 signaling affected the generation of T H17 and T H1 cells during GVHD. To address this question, lethally irradiated Balb/c mice were transplanted with wild type B6 BM and purified B6 CD4⁺ T cells and then treated with either control or anti-IL-6R antibody. Purified CD4⁺ T cells, which alone are able to induce GVHD in this strain combination, were employed to maximize the ability to detect expansion of T H1 and T H17 cells in the tissues of recipient mice. As we previously observed, blockade of IL-6 signaling resulted in improved overall weight curves (Figure 7A) in anti-IL-6R-antibody-treated mice. There was also a significant reduction in the total number of CD4⁺ T cells in the liver and lung in these same animals (Figure 7B). This was accompanied by a relative reduction in the percentage of CD4⁺ T cells secreting either IL-17 or IFN-γ with the exception of the liver where similar percentages of CD4⁺ IFN-γ⁺ cells were observed (Figure 7C). Coincident with the reduction in GVHD-associated weight loss, we also observed a significant decrease in the absolute number of CD4⁺IL-17⁺ T cells in spleen, liver and lung (Figures 7D-7F). CD4⁺ T cells secreting IFN-γ⁺ were also reduced in the liver and lung, although there was no significant difference in the absolute numbers of these cells in the spleen. Overall, these
studies demonstrated that blockade of IL-6 signaling significantly decreased the number of proinflammatory CD4+ T cells.

**DISCUSSION**

The re-establishment of effective regulation of alloreactive donor T cell mediated-inflammation is a major goal in the treatment of GVHD. A preponderance of prior studies, however, support the premise that the reconstitution of Tregs, which plays a pivotal role in regulating T cell-mediated alloresponses, is severely impaired in both acute and chronic GVHD. In fact, the progressive reduction in Treg numbers, which begins during acute GVHD, is a major factor responsible for the development of autoimmunity which is a defining characteristic of chronic GVHD. Why these cells fail to effectively reconstitute during GVHD has not been well understood. The current report now establishes that IL-6 is a critical cytokine that inhibits the reconstitution of Tregs post transplantation during GVHD. Furthermore, these studies reveal that both IL-6 and IL-6R levels are significantly increased in the sera and in specific target organs during the course of GVHD and that targeting of the IL-6/IL-6R complex by way of antibody blockade results in a reduction in GVHD severity.

The most significant observation was the finding that blockade of IL-6 signaling results in a marked increase in the absolute number of Tregs. Our data indicate that this occurs in both thymic-dependent and thymic-independent manners. With respect to the former, we observed that total Treg numbers in the spleen were three-fold higher in anti-IL-6R antibody-treated recipients with intact thymi as opposed to thymectomized mice (Figure 3E versus 4E). The most plausible explanation for this increase was that blockade of IL-6 signaling enhanced the de novo generation of Tregs in the thymus of these animals. Treatment with anti-IL-6R as opposed to control antibody, however, also augmented absolute Treg numbers in thymectomized mice indicating that de novo production of natural thymic-derived Tregs was
not an absolute requirement for GVHD protection to be observed. The fact that blockade of the IL-6R increased the number of Tregs in thymectomized recipients is an important finding that has potential clinical implications. Reconstitution of effective T cell immunity is a particular problem in older aged transplant recipients who comprise the majority of patients that require allogeneic stem cell transplants. These patients are also at increased risk of developing GVHD due, in part, to impaired thymic function occurring as a consequence of direct thymic damage from the conditioning regimen and/or age-related involution, both of which serve to limit the generation of new Tregs. While the increase in Treg numbers in anti-IL-6R antibody-treated mice was approximately three-fold less than in thymus intact animals, this was still sufficient to significantly attenuate GVHD-associated pathologic damage. Thus, these results suggest that blockade of IL-6 signaling may be a strategy to augment the establishment of peripheral tolerance in older patients with more limited ability to generate Tregs in the thymus.

Regulatory T cells defined by their expression of foxp3 have been classified into two distinct subsets that have different developmental pathways. The first termed “natural” Tregs represent 5-10% of CD4+ T cells, develop in the thymus and require costimulation through the CD28/B7 pathway to maintain their survival. Natural Tregs are most commonly characterized by the constitutive expression of CD25, CTLA-4, CD134, CD103 and glucocorticoid-induced tumor necrosis factor receptor (GITR) that are all markers of cell activation and reflect the continuous exposure of these cells to self antigens in the periphery. The second subset termed “induced” regulatory T cells (iTregs), are able to upregulate foxp3 after activation in the periphery, have variable CD25 expression and function in a cytokine-dependent fashion (e.g. IL-10). TGF-β has been shown to be a critical cytokine that promotes the conversion of conventional T cells into iTregs after ligation through the TCR along with appropriate costimulation. Prior studies have shown that IL-6 deleteriously affects the generation of iTregs induced by TGF-β by blocking foxp3 expression. This has been shown to occur by up regulation of the TGF-β inhibitor SMAD7. While a number of reports have examined the fate of natural Tregs during the course of GVHD, the role of iTregs in this disease has not been critically studied. In the current
report, we observed that conversion of CD4+ foxp3− T cells to CD4+ foxp3+ T cells in the spleen or selected target organs during GVHD was very limited and insufficient to prevent pathological damage. Administration of anti-IL-6R antibody, however, resulted in a significant increase in both the percentage and absolute number of these cells and this was associated with a marked reduction in overall GVHD. Notably, GVHD protection was observed only in the colon as there was no difference in pathology scores in either the lung or liver. This observation suggests that peripheral Treg conversion may be of particular importance in regulating alloimmune reactions in the gut and that IL-6 has a pivotal role in inhibiting this event. The elevated IL-6 mRNA levels in the colon (Figure 1C) are consistent with this interpretation. Moreover, an important role for IL-6 in the colon microenvironment is supported by recent studies demonstrating that IL-6 levels are significantly increased in this organ relative to other proinflammatory cytokines such as TNF-α, IFN-γ and IL-1β.

IL-6 has been shown to play a pivotal role in driving the differentiation of naïve T cells to become T\textsubscript{h}17 cells and in inhibiting the generation of CD4+ foxp3+ from CD4+ foxp3− T cells. We therefore examined whether anti-IL-6R antibody administration affected the number of IL-17-secreting CD4+ T cells which have been shown to be increased during GVHD.\textsuperscript{8} Our studies demonstrated that blockade of IL-6 signaling was associated with a significant reduction in these cells in the spleen, liver and lung. Thus, blockade of IL-6 signaling resulted in increased conversion in the periphery along with a corresponding decrease in T\textsubscript{h}17 cells. The inverse reciprocality in the numbers of these two T cell populations would suggest that blockade of IL-6 signaling was able to divert the differentiation of naïve T cells away from the T\textsubscript{h}17 cell lineage. We cannot exclude, however, that recently described IL-6-dependent plasticity which allows for the reprogramming of committed cells from regulatory to effector phenotypes might not also have been operative under these conditions.\textsuperscript{52} Notably, we observed that there was a significant reduction in the absolute number of CD4+ IFN-γ+ T cells as well in GVHD target organs. A similar observation has been made by Serada and colleagues in a model of experimental allergic
encephalomyelitis. A potential explanation for this observation is that the increase in Tregs as a consequence of anti-IL-6R antibody administration could have inhibited the induction of Th1 cells in both scenarios. This interpretation is consistent with data demonstrating that there is an increase in inducible Tregs and a decline in Th1 and Th17 cells in the absence of IL-6.

The results of this study also have clinical implications with respect to the use of Tregs to prevent GVHD in allogeneic stem cell transplant recipients. Current approaches are now focused on the ex vivo expansion of these cells so that they can be adoptively transferred into recipients post transplantation. However, there are several challenges with trying to implement this approach. First, defining the optimal regulatory T cell population is controversial and is constrained by the need to identify these cells based on CD25 expression which is also an activation marker. While expansion strategies have incorporated agents such as rapamycin to eliminate non-Treg CD4+ T cell populations, this approach does not completely remove them and thereby raises concerns that transplantation of an impure Treg population could potentially exacerbate GVHD toxicity. Secondly, Tregs that have the highest CD25 expression and thus the most suppressive capability in vitro are typically those that expand less well ex vivo. Consequently, achieving sufficiently large numbers of these cells for transplantation may be problematic. Our approach which employs administration of an anti-IL-6R antibody may be a way to circumvent these obstacles by augmenting the in vivo expansion of these cells. It should also be pointed out that blockade of IL-6/IL-6R interactions is currently a clinically feasible option. Tocilizumab is a humanized anti-IL-6R antibody that has been administered to patients with rheumatoid and juvenile arthritis and found to significantly ameliorate joint inflammation without any serious toxicity. Thus, formal testing of this premise is now a viable clinical option.

In summary, these studies demonstrate that the increased production of IL-6 during GVHD deleteriously affects the reconstitution of regulatory T cells and thereby adversely impacts the development of peripheral tolerance during this disease. Furthermore, IL-6 drives a proinflammatory phenotype that is
characterized by increased numbers of T<sub>H1</sub> and T<sub>H17</sub> cells in GVHD target organs which contribute to this inflammatory environment. Blockade of IL-6 signaling, on the other hand, significantly reduces GVHD-associated pathological damage by increasing Treg numbers and decreasing the absolute number of proinflammatory T cells. This serves to recalibrate the effector and regulatory arms of the immune system and thereby mitigate the severity of GVHD.
ACKNOWLEDGMENTS

This research was supported by grants from the National Institutes of Health (HL064603, HL081650 and AI078713) and by an award from the Midwest Athletes Against Childhood Cancer Fund (Milwaukee, WI).

AUTHOR CONTRIBUTIONS

X.C. designed and performed research, analyzed data and wrote the paper; R.D. performed research, analyzed data and wrote the paper; R.K. performed all pathological analysis; A.B. performed research; M.H. assisted with real time quantitative PCR studies; M.M. provided vital reagents; and W.R.D. designed and supervised research, analyzed data, and wrote the paper. The authors declare no conflict of interest.
REFERENCES

1. Hill GR, Crawford JM, Cooke KR, Brinson YS, Pan L, Ferrara JL. Total body irradiation and acute
graft versus host disease: the role of gastrointestinal damage and inflammatory cytokines. Blood.
1997; 90: 3204-3213.

2. Xun CQ, Thompson JS, Jennings CD, Brown SA, Widmer MB. Effect of total body irradiation,
busulfan-cyclophosphamide, or cyclophosphamide conditioning on inflammatory cytokine release
and development of acute and chronic graft versus host disease in H-2 incompatible transplanted


5. Mowat AC. Antibodies to IFN-γ prevent immunologically mediated intestinal damage in murine graft


regulatory T cell control of Th1 and Th17 cells is responsible for the autoimmune-mediated pathology

differentiated Th17 cells mediate lethal acute graft versus host disease with severe cutaneous and


FIGURE LEGENDS

Figure 1: **IL-6 and soluble IL-6R levels are increased during GVHD.** (A,B). Lethally irradiated (900 cGy) Balb/c mice were transplanted with Balb/c BM (10 x 10^6) and spleen cells (0.4-0.5 x 10^6) (syngeneic, white bars) or B6 BM (10 x 10^6) and an equivalent number of B6 spleen cells (allogeneic, black bars). Cohorts of animals (n=5-9/group) were sacrificed weekly and serum was analyzed for IL-6 and soluble IL-6R levels using either Bioplex or ELISA as described in Methods. Values for normal nontransplanted control mice (n=5) are depicted as a hatched bar. Data are derived from two independent experiments. (C,D). RNA was extracted from spleen, liver and colon tissues obtained from recipients of syngeneic (white bars) or allogeneic (black bars) marrow grafts (n=7-8 mice per tissue) at the indicated time points and gene expression of IL-6 (panel C) and total IL-6R (panel D) was analyzed by real time q-PCR as described in Methods. Values for normal nontransplanted control mice (n=5-6 mice/tissue) are depicted as a hatched bar. Data are derived from two independent experiments. Statistics: * p ≤ 0.05, ** p < 0.01.

Figure 2: **Absence of either recipient or donor-derived IL-6 is insufficient to protect mice from lethal GVHD.** (A,B). Lethally irradiated (1000 cGy) B6 (■, n=13) or IL-6−/− (□, n=13) animals were transplanted with 10 x 10^6 BM and 15 x 10^6 spleen cells from Balb/c mice. Overall survival (panel A) and the percentage of original body weight over time (panel B) are depicted. Data are cumulative results from four independent experiments. (C,D). Lethally irradiated (900 cGy) Balb/c mice were transplanted with 10 x 10^6 BM and 0.5-0.7 x 10^6 spleen cells from either B6 (■, n=16) or IL-6−/− (□, n=16) animals. Overall survival (panel C) and the percentage of original body weight over time (panel D) are depicted. Data are cumulative results from four independent experiments. Statistics: * p ≤ 0.05, ** p < 0.01.
Figure 3: **Antibody blockade of the IL-6R significantly attenuates the severity of GVHD.** (A). Lethally irradiated (900 cGy) Balb/c mice were transplanted with T cell depleted (TCD) B6 BM alone (10 x 10^6) (○, n=9) or together with B6 spleen cells adjusted to yield a T cell dose of 0.7 x 10^6 αβ T cells. Cohorts of mice that received adjunctive spleen cells were then treated with either rat IgG isotype control (■, n=15) or anti-IL-6R (MR-16-1) antibody (□, n=12) once weekly for four weeks beginning on the day of transplantation. Overall survival is depicted. Data are cumulative results from three independent experiments. (B). Lethally irradiated Balb/c mice were transplanted with TCD Foxp3^{EGFP} BM (10 x 10^6) and 0.4-0.5 x 10^6 Foxp3^{EGFP} spleen cells. Cohorts of mice were then treated with either rat IgG isotype control (n=12)(black squares/bars) or anti-IL-6R (MR-16-1) antibody (n=12) (white squares/bars) once weekly for four weeks beginning on the day of transplantation. Mice from both groups were sacrificed 34-37 days post-BMT. (B). The percentage of original body weight over time in mice from both groups is depicted. (C). Pathological damage in the colon, liver and lung using a semiquantitative scoring system as detailed in Methods. (D). Histology of colon, liver and lung from representative recipients treated with either isotype or anti-IL-6R antibody. In isotype control animals, colon shows extensive inflammation in the lamina propria, goblet cell depletion and crypt cell destruction, liver reveals portal triad inflammation with mononuclear cells and endothelialitis, and lung demonstrates perivascular and prebronchial cuffing with mononuclear cells. In anti-IL-6R antibody-treated mice, colon has normal appearing mucosa with no attendant inflammation, liver has reduced portal triad inflammation and lung demonstrates a similar reduction in perivascular and prebronchial cuffing. (E). Total spleen cellularity and (F) absolute number of splenic Tregs (CD4^+ EGFP^+) are shown. (G). Lethally irradiated (900 cGy) Balb/c mice were transplanted with TCD B6 BM plus 0.4 x 10^6 B6 spleen cells. Cohorts of transplanted animals were then treated with either isotype control (n=12) or anti-IL-6R antibody (n=12) on the day of transplantation. Mice were bled 6 days post transplantation and serum was assayed for proinflammatory cytokines. Data are presented as the mean ± SEM and are the cumulative results from three independent experiments. Statistics: * p ≤ 0.05, ** p < 0.01.
Figure 4: **Attenuation of GVHD by blockade of IL-6 signaling does not require an intact thymus.**

Lethally irradiated (900 cGy) thymectomized Balb/c mice were transplanted with Foxp3EGFP BM (10 x $10^6$) and 0.4 x $10^6$ Foxp3EGFP spleen cells. Cohorts of mice were then treated with either rat IgG isotype control (n=12) (black bars) or anti-IL-6R antibody (n=12) (white bars) once weekly for four weeks beginning on the day of transplantation. Animals were then sacrificed 46-48 days post transplantation. (A). The percentage of original body weight of mice over time from both groups is depicted. (B). Pathological damage in the colon, liver and lung using a semiquantitative scoring system as detailed in Methods. (C). Total spleen cellularity, (D) absolute number of splenic CD4+ T cells, and (E) absolute number of splenic Tregs are depicted. Data are presented as the mean ± SEM and are the cumulative results from three independent experiments. Statistics: * p ≤ 0.05, ** p < 0.01.

Figure 5: **In vivo conversion of CD4+ foxp3– T cells to CD4+ foxp3+ T cells is negligible during acute GVHD.** Lethally irradiated bm12 (1000 cGy) (n=8-11/group) (black bars) or B6 (1000 cGy) (n=8-12/group) (white bars) mice were transplanted with B6 Rag-1 BM (5 x $10^6$) and sorted CD4+ Foxp3EGFP T cells (0.6 x $10^6$). Cohorts of mice were sacrificed on either days 7-9 or day 20 post transplantation. Spleen cellularity (A,E), absolute number of splenic CD4+ T cells (B,F), percentage of CD4+ EGFP+ T cells in the spleen (C,G) and absolute number of CD4+ EGFP+ T cells in the spleen (D,H) are depicted. Data are presented as the mean ± SEM and are the cumulative results from two-three independent experiments. Statistics: ** p < 0.01.

Figure 6: **Antibody blockade of the IL-6R augments conversion of CD4+ foxp3– to CD4+ foxp3+ Tregs.** Lethally irradiated (900 cGy) Balb/c mice were transplanted with B6 Rag-1 BM (5 x $10^6$) and sorted CD4+ Foxp3EGFP T cells (0.2 x $10^6$). Cohorts of mice were then administered rat IgG isotype control (n=9) (black bars) or anti-IL-6R antibody (n=12) (white bars) once weekly for four weeks as described in Methods. Mice in both groups were sacrificed 26-36 days post transplantation. (A).
Pathological damage in the colon, liver and lung using a semiquantitative scoring system as detailed in Methods. (B). Total spleen cellularity and (C) absolute number of splenic CD4⁺ T cells are depicted. (D). Representative dot plot showing percentage of EGFP-foxp⁺ iTregs in the gated CD4⁺ T cell population from transplant recipients treated with either isotype control or anti-IL-6R antibody. (E). Percentage and (F) absolute number of iTregs in the spleen of animals administered control or anti-IL-6R antibody. Data are presented as the mean ± SEM and are the cumulative results from three independent experiments. Statistics: * p ≤ 0.05, ** p < 0.01.

Figure 7: Blockade of IL-6 signaling results in a significant reduction in proinflammatory T\(\text{H}1\) and T\(\text{H}17\) cells. Lethally irradiated (900 cGy) Balb/c mice were transplanted with B6 BM (5 x 10⁶) and purified B6 CD4⁺ T cells (0.3 x 10⁶). Cohorts of mice were then administered rat IgG isotype control (n=8) (black bars) or anti-IL-6R antibody (n=8) (white bars) for four weekly injections as described in Methods. Mice in both groups were sacrificed 28-29 days post transplantation. (A). The percentage of original body weight of mice over time from both groups is depicted. (B). Absolute number of CD4⁺ T cells in the spleen, liver and lung of animals treated with either isotype control or anti-IL-6R antibody. (C). Representative dot plot depicting the percentage of IL-17 and/or IFN-\(\gamma\)-secreting cells within the gated CD4⁺ T cell population. (D-F). Absolute number of CD4⁺ IFN-\(\gamma\)⁺ or CD4⁺ IL-17⁺ T cells present in the spleen, liver or lung of animals treated with either isotype control or anti-IL-6R antibody. Data are presented as the mean ± SEM and are the cumulative results from two independent experiments. Statistics: * p ≤ 0.05, ** p < 0.01.
Figure 1

A. IL-6

B. IL-6R

C. Spleen IL-6

D. Spleen IL-6R

E. Liver IL-6

F. Liver IL-6R

G. Colon IL-6

H. Colon IL-6R

Legend:
- ** Syngeneic
- Allogeneic
- Normal

Fold Increase over 18 S

pg/ml
Figure 2

A

Percent Survival

Day Post Transplantation

B

Percent Original Body Weight

Day Post Transplantation

C

Percent Survival

Day Post Transplantation

D

Percent Original Body Weight

Day Post Transplantation
Figure 3

A. Percent Survival vs. Day Post Transplantation

B. Percent Original Body Weight vs. Day Post Transplantation

C. Pathology Score

D. Histological images of Colon, Liver, and Lung

E. Cell Number (x 10^6)

F. Cell Number (x 10^4)

G. Cytokine levels (pg/ml)

Legend:
- Black squares: Isotype
- White squares: Anti-IL-6R

** P < 0.01
** P < 0.001
Figure 4

A) Percent Original Body Weight over Day Post Transplantation

B) Pathology Score for Total, Colon, Liver, and Lung

C) Spleen Cell Number (x 10^6)

D) CD4+ Cell Number (x 10^5)

E) Tregs Cell Number (x 10^4)
Figure 5

Day 7-9

A. Spleen

B. CD4+

C. CD4+ EGFP+

D. CD4+ EGFP+

Day 20

E. Spleen

F. CD4+

G. CD4+ EGFP+

H. CD4+ EGFP+
Figure 6

A. Pathology Score

B. Spleen

C. CD4+

D. Isotype Ab

E. EGFP-foxp3+

F. EGFP-foxp3+
Figure 7

A. Percent Original Body Weight over time post transplantation.

B. CD4+ cell counts in different organs.

C. Flow cytometry analysis of IL-17 and IFN-γ expression in Spleen, Liver, and Lung.

D. Cell number counts in Spleen.

E. Cell number counts in Liver.

F. Cell number counts in Lung.

** Indicates significant differences compared to control.
Blockade of interleukin-6 signaling augments regulatory T cell reconstitution and attenuates the severity of graft versus host disease