

Compromised Function of Regulatory T Cells in Rheumatoid Arthritis and Reversal by Anti-TNF α Therapy

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Abstract

Regulatory T cells have been clearly implicated in the control of disease in murine models of autoimmunity. The paucity of data regarding the role of these lymphocytes in human autoimmune disease has prompted us to examine their function in patients with rheumatoid arthritis (RA). Regulatory (CD4⁺CD25⁺) T cells isolated from patients with active RA displayed an anergic phenotype upon stimulation with anti-CD3 and anti-CD28 antibodies, and suppressed the proliferation of effector T cells in vitro. However, they were unable to suppress proinflammatory cytokine secretion from activated T cells and monocytes, or to convey a suppressive phenotype to effector CD4⁺CD25⁻ T cells. Treatment with antitumor necrosis factor α (TNF α ; Infliximab) restored the capacity of regulatory T cells to inhibit cytokine production and to convey a suppressive phenotype to "conventional" T cells. Furthermore, anti-TNF α treatment led to a significant rise in the number of peripheral blood regulatory T cells in RA patients responding to this treatment, which correlated with a reduction in C reactive protein. These data are the first to demonstrate that regulatory T cells are functionally compromised in RA, and indicate that modulation of regulatory T cells by anti-TNF α therapy may be a further mechanism by which this disease is ameliorated.

Key words: T lymphocytes • tolerane • autoimmune disease • TNF α • cytokines

Introduction

Studies in rodents have provided firm evidence for the existence of a naturally occurring population of CD4⁺CD25⁺ professional regulatory/suppressor T cells, which, upon in vitro TCR-mediated stimulation, suppress the proliferation of effector T cells (1, 2). These cells appear central to the control of T cell homeostasis and in the modulation of immune responses to autoantigens, cancer cells, pathogens, and alloantigens (1, 2). In the periphery of young mice not prone to autoimmune diseases, regulatory T cells constitute a stable 10% of CD4⁺ T cells. This proportion appears to be reduced in mice genetically prone to autoimmune disease such as diabetes (3, 4). Transfer of regulatory T cells is able to prevent a wide range of experimental autoimmune diseases, including diabetes, experimental autoimmune encephalo-

myelitis, and colitis (3–6). In addition, depletion of regulatory T cells has been shown to exacerbate various experimental autoimmune diseases, including collagen induced arthritis (7). In humans, an analogous population of CD4⁺CD25⁺ regulatory T cells has been identified in the peripheral blood (PB; 8–11) and in the thymus (12, 13). In comparison to the wealth of evidence from animal models, much less is known about human regulatory T cells and their potential to suppress autoimmune disease in patients. One recent analysis of human regulatory T cells demonstrated a reduction in their numbers in the PB of newly diagnosed type-1 diabetic patients, suggesting that a deficiency in this subset could be responsible for the breakdown of tolerance in human diabetes (14).

Rheumatoid arthritis (RA) is a chronic inflammatory disorder that ultimately leads to the destruction of joint architecture. The pathogenic events that lead to the development of RA are not fully understood, although the pivotal role

The online version of this article contains supplemental material.

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Abbreviations used in this paper: CBA, cytometric bead array; PB, peripheral blood; RA, rheumatoid arthritis.

that proinflammatory cytokines (i.e., such as TNF α , IL-1 β , IL-6, etc.) play in the induction and maintenance of this disease is well documented (15). Moreover, these cytokines are important in the homeostasis of T lymphocytes (16), including regulation of the CD4⁺CD25⁺ regulatory T cell subset. In RA, the CD4⁺CD25⁺ regulatory T cell subset represents ~5–10% of the CD4⁺ T cell population, and this population has been shown to suppress the *in vitro* proliferation of autologous CD4⁺ T cells (17). Because proinflammatory cytokines are critical to the pathogenesis of RA, we postulated that regulatory T cells in active RA, although still capable of suppressing T cell proliferation, may be defective in controlling proinflammatory cytokine production. Therefore, we set out to investigate any changes in the function and/or number of regulatory T cells in the PB of patients with active RA and to determine if clinical response to anti-TNF α therapy results in changes in this cell population.

In this paper, we present evidence to suggest that regulatory T cells derived from patients with active RA are defective in their ability to suppress cytokine production and in their ability to convey a suppressive phenotype to CD4⁺ effector T cells. We go on to demonstrate that clinical response to anti-TNF α , but not conventional therapies, in RA patients is correlated with an increased number of PB regulatory T cells, suggesting a possible additional mechanism by which blockade of TNF α results in amelioration of RA.

Materials and Methods

Study Population. 27 patients with active RA, fulfilling the revised classification criteria of the American College of Rheumatology for RA, were evaluated before and after anti-TNF α therapy (Infliximab was given at a dose of 3 mg/kg *i.v.* at weeks 0, 2, 6, and at every 8 wk in combination with stable doses of methotrexate 7.5–15 mg/wk orally) and stable nonsteroidal anti-inflammatory drugs. Patients taking prednisolone were excluded from the study because steroids are known to affect lymphocyte function and CD25 expression (18). Only patients with a disease activity score of >5.1 were treated with anti-TNF α therapy. Response was defined as a drop in the disease activity score of >1.2. Patients responding to conventional dosages of methotrexate (15–25 mg/wk) were also included in this analysis.

Antibodies. The following Abs were used: FITC-conjugated anti-CD4 (RPAT4), Cy-Chrome-conjugated anti-CD25 (M-A251), and PE-conjugated anti-CD3 (UCHT1). Staining of MACS[®]-sorted T cells included the following: PE-conjugated, FITC-conjugated anti-CD3 (UCHT1); anti-CD4 (RPAT4); anti-CD25 (4E3); anti-CD28 (CD28.2); and anti-CTLA-4 (BNI3; all obtained from BD Biosciences). For T cell activation the stimulatory Abs, anti-CD3 (OKT3) and anti-CD28 (CD28.2; obtained from BD Biosciences) were used as indicated.

Cell Isolation. PBMCs were isolated by Ficoll-Paque Plus (Amersham Biosciences) gradient centrifugation. Cells were cultured in RPMI 1640 media supplemented with 2 nM L-glutamine, 5 mM Hepes, 100 U/ μ g/ml penicillin/streptomycin, 0.5 mM sodium pyruvate, 0.05 mM of nonessential amino acids (both obtained from Life Technologies), and 10% FCS (all obtained from BioWhittaker) in 96-well U-bottom plates (Nunc).

Non-CD4⁺ T cells were stained using a biotin antibody cocktail (10 μ l/10⁷ total cells), incubated for 10 min at 4°C, magnetically labeled with antibiotin microbeads (20 μ l/10⁷ total cells), incubated for 15 min at 4°C, washed twice, and depleted over a MACS[®] LD column. CD4⁺CD25⁺ T cells were directly labeled with anti-CD25 microbeads (10 μ l/10⁷ CD4⁺ cells), incubated for 15 min at 4°C, and positively selected using MACS[®] MS columns according to manufacturer's instructions (Miltenyi Biotec). T cell subpopulations of CD4⁺CD25⁺ T cells were used immediately after isolation. All the plate-bound anti-CD3 cultures received 10⁴ irradiated PBMCs. In separate experiments, cells were isolated using a MoFlo cell sorter after staining using FITC-conjugated anti-CD4 and Cy-Chrome-conjugated anti-CD25. The purities of the populations obtained using these two methods of cell isolation are shown in Fig. S1, available at <http://www.jem.org/cgi/content/full/jem.20040165/DC1>.

Cytokine Detection. For analysis of intracellular cytokine production T cells were stimulated with either 5 μ g/ml of soluble anti-CD3/anti-CD28 or 1 μ g/ml of plate-bound anti-CD3/irradiated PBMCs for 48 h. 2 μ M monensin was added for the last 5 h. Staining of CD4 and CD25 surface expression was performed. Cells were washed, fixed, permeabilized, and stained for detection of intracellular cytokines using PE-conjugated anti-IFN γ , TNF α , or IL-10. Alternatively, supernatants were collected, before the addition of monensin, and IL-2, IL-4, IL-5, IL-10, IFN γ , and TNF α levels were measured by the cytometric bead array kit (CBA kit; BD Biosciences), according to the manufacturer's instructions.

Proliferation Assay. To assess proliferation of different CD4⁺ subtypes, 10⁵ cells sorted of MACS purified T cells were incubated in complete medium with 1 μ g/ml of plate-bound anti-CD3, 1 μ g/ml of plate-bound anti-CD28, and 5 μ g/ml of soluble anti-CD28 or 5 μ g/ml of soluble anti-CD3/anti-CD28 in 96-well U-bottom plates (Nunc). After 5 d of culture, [³H]Tdr was added for the remaining 8 h of culture. Proliferation was measured using a liquid scintillation counter.

Flow Cytometric Analysis. Immunofluorescence staining was performed after washing the cells twice with PBS plus 0.5% human serum albumin. Cells were incubated for 20 min at 4°C with each mAb (5 μ g/ml, 10⁵ cells/test). After washing with cold PBS/human serum albumin, the indirectly labeled cells were incubated with FITC- and PE-conjugated second-step mAb for 20 min at 4°C, washed three times, and analyzed by flow cytometry (FACScalibur[™], CELLQuest[™] software; Becton Dickinson).

Statistical Analysis. Analysis for statistically significant differences was performed with Student's *t* test. *p*-values <0.05 were considered significant.

Online Supplemental Material. Fig. S1 shows the purity of the populations isolated using either a MoFlo cell sorter or a MACS[®] column as analyzed by FACS[®]. The clinical details of the patients studied are included in Table S1. Online supplemental material is available at <http://www.jem.org/cgi/content/full/jem.20040165/DC1>.

Results

CD4⁺CD25⁺ T Cells Isolated from RA Patients Are Anergic and Suppress the Proliferation of Effector T Cells. To test the hypothesis that CD4⁺CD25⁺ regulatory T cells isolated from active RA patients may be functionally defective compared with those isolated from healthy individuals, or from the same patients after anti-TNF α treatment, CD4⁺CD25⁺

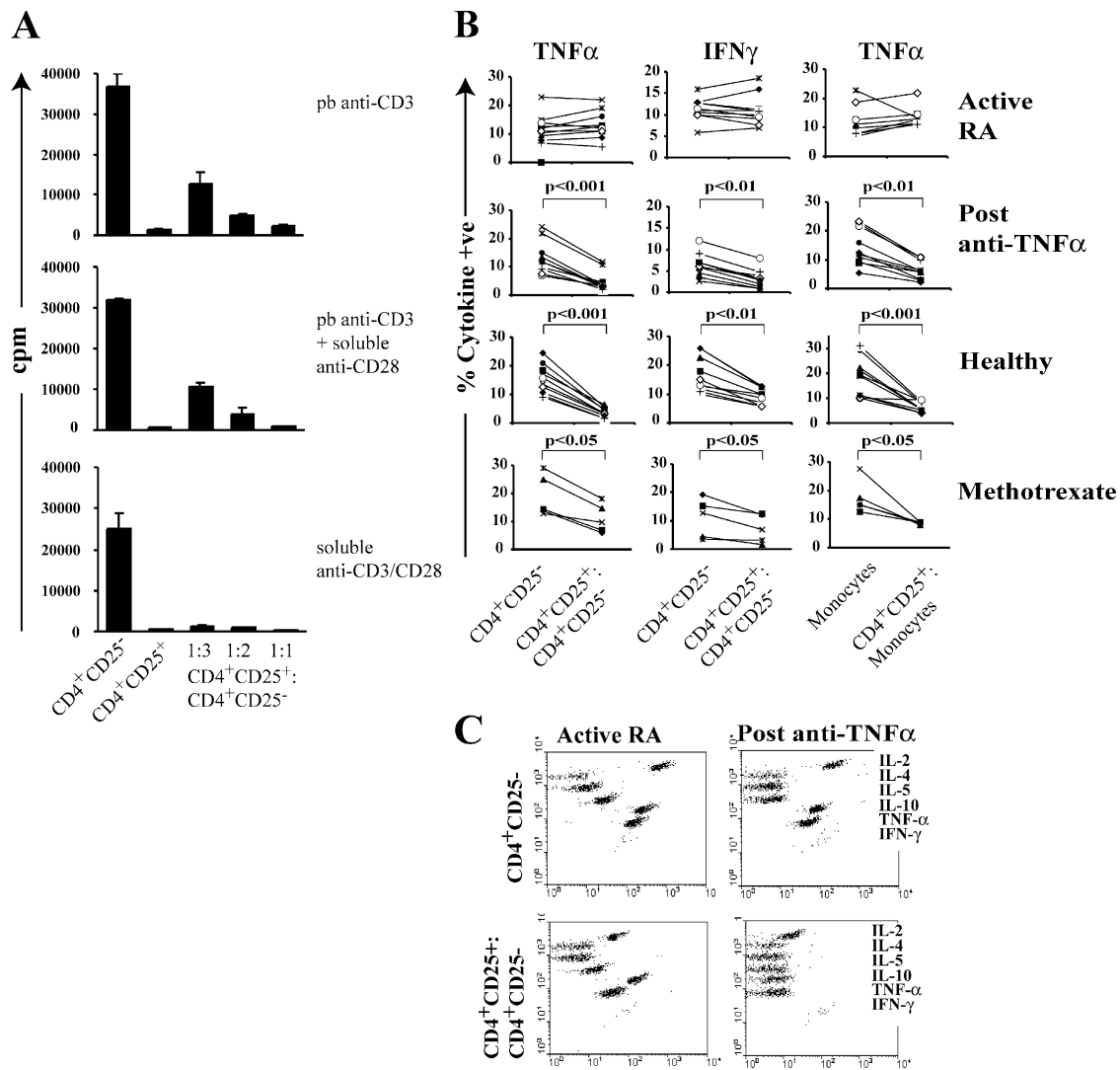


Figure 1. Regulatory T cells from the PB of patients with active RA can suppress proliferation but not proinflammatory cytokine production by effector T cells and monocytes. (A) PB was collected from patients with RA; MACS[®]-sorted CD4⁺CD25⁺ T cells and CD4⁺CD25⁻ T cells were cultured either alone or mixed at 1:3, 1:2, 1:1 ratio (10⁵ cells/well) and stimulated with 1 μ g/ml of plate-bound anti-CD3, 1 μ g/ml of soluble anti-CD3/5 μ g/ml of soluble anti-CD28, and 5 μ g/ml soluble anti-CD3/anti-CD28 for 48 h. Proliferation after 5 d was determined by [³H]Tdr incorporation. Results are expressed as mean \pm SEM of triplicate cultures. One out of five independent experiments is shown. (B) MACS[®]-sorted CD4⁺CD25⁺ and CD4⁺CD25⁻ T cells isolated from 10 patients before and after anti-TNF α therapy (3 mo) with 5 patients responding to methotrexate therapy or 10 healthy controls were cultured alone or mixed at a 1:1 ratio (10⁵ cells/well) and stimulated with 5 μ g/ml of soluble anti-CD3/anti-CD28 for 48 h. Monocytes were stimulated with 10 ng/ml LPS for 48 h. 2 μ M monensin was added for the last 5 h of culture. Staining of CD4 and CD25 surface expression was performed and, subsequently, the cells were washed, permeabilized, and stained with PE-conjugated anti-TNF α or anti-IFN γ . (C) Cytokines from the supernatants collected from the experiment (B) were measured by CBA. 1 out of 10 experiments is illustrated.

T cells were purified by MACS[®] sorting (as described in Materials and Methods) and cultured alone or mixed with CD4⁺CD25⁻ T cells. Three different stimuli were used to reveal any possible defect in the CD4⁺CD25⁺ T cell population in the PB of patients with RA. The results in Fig. 1 A show that CD4⁺CD25⁺ T cells isolated from active RA patients displayed an anergic phenotype and were able to inhibit the proliferation of effector CD4⁺CD25⁻ T cells in a dose-dependent mode when different T cell receptor signal strengths were used. CD4⁺CD25⁺ T cells isolated from active RA patients were capable of suppressing the proliferation of responder T cells to a similar level as found in

healthy individuals or in the same group of patients 3 mo after anti-TNF α treatment (unpublished data).

CD4⁺CD25⁺ Regulatory T Cells Isolated from RA Patients Do Not Suppress Cytokines Produced by Effector T Cells. As proinflammatory cytokines play an essential role in the pathogenesis of RA, next we assessed whether CD4⁺CD25⁺ regulatory T cells, isolated before and after anti-TNF α treatment, were able to suppress proinflammatory cytokine production by effector T cells. Similar to the suppressive effects that regulatory T cells have on the proliferation of effector T cells, the high levels of TNF α and IFN γ synthesized by the responder CD4⁺ T cells were

suppressed after coculture with CD4⁺CD25⁺ T cells derived from healthy or anti-TNF α -treated patients (Fig. 1 B). However, regulatory T cells isolated from patients with active RA failed to inhibit the production of these cytokines by CD4⁺CD25⁻ effector T cells. Similarly, TNF α production by monocytes, a key producer of this cytokine in RA, was also markedly inhibited by CD4⁺CD25⁺ T cells isolated from healthy individuals and patients with RA after treatment. No IL-10 production was detected in any of the samples analyzed (unpublished data). The response of CD4⁺CD25⁺ T cells isolated from patients responding to methotrexate treatment was included in this analysis. Although CD4⁺CD25⁺ T cells efficiently suppressed TNF α produced by monocytes, the ability to inhibit cytokines produced by effector T cells was less effective compared with CD4⁺CD25⁺ T cells isolated from anti-TNF α -treated patients (20–30% inhibition compared with 60–70% inhibition after anti-TNF α). To complement the results obtained by intracellular staining, cytokine production was also measured in the supernatants derived from the aforementioned experiments by CBA. In keeping with the results obtained from the intracellular staining, only regulatory T cells isolated from anti-TNF α -treated patients strongly suppressed TNF α and IFN γ released by effector CD4⁺CD25⁻ T cells upon anti-CD3/CD28 stimulation *in vitro*. A reduction in IL-2 production was detected in both groups. Comparable results were obtained when plate-bound anti-CD3 and irradiated PBMCs were used instead of soluble stimuli (unpublished data).

CD4⁺CD25^{high} T Cells from Active RA Patients Are Functionally Defective. The results described thus far are based on the use of populations of CD4⁺CD25⁺ T cells purified with magnetic beads, containing mixtures of CD25^{high} and CD25^{low} cells. It has been shown previously that amongst CD4⁺ T cells expressing CD25, only those expressing high levels of CD25 display regulatory function (10). To dissect which subset of CD4⁺CD25⁺ T cells (high or low) was responsible for the suppressive effect on cytokines released by the effector T cells, CD4⁺ T cells were sorted according to their CD25 expression (Fig. S1 A, available at <http://www.jem.org/cgi/content/full/jem.20040165/DC1>). Results in Fig. 2 A demonstrate that the suppressive effect on cytokine production resides in the CD4⁺CD25^{high} T cell fraction when isolated from anti-TNF α -treated patients. In contrast, the CD4⁺CD25^{high} T cells from patients with active RA were unable to suppress TNF α and IFN γ produced by CD4⁺CD25⁻ T cells. No differences were found in TNF α or IFN γ produced by CD4⁺CD25^{high} T cells isolated from patients before or after anti-TNF α treatment. Cytokines were also measured in the culture supernatants by CBA, and the results in Fig. 2 B reproduce the aforementioned findings. In agreement with the suppression of proliferation results shown in Fig. 1 A, regulatory T cells irrespective of their provenance strongly suppressed the production of IL-2 released by autologous effector T cells. No consistent changes in IL-5, IL-4, and IL-10 were found in the different samples analyzed (unpublished data). Together,

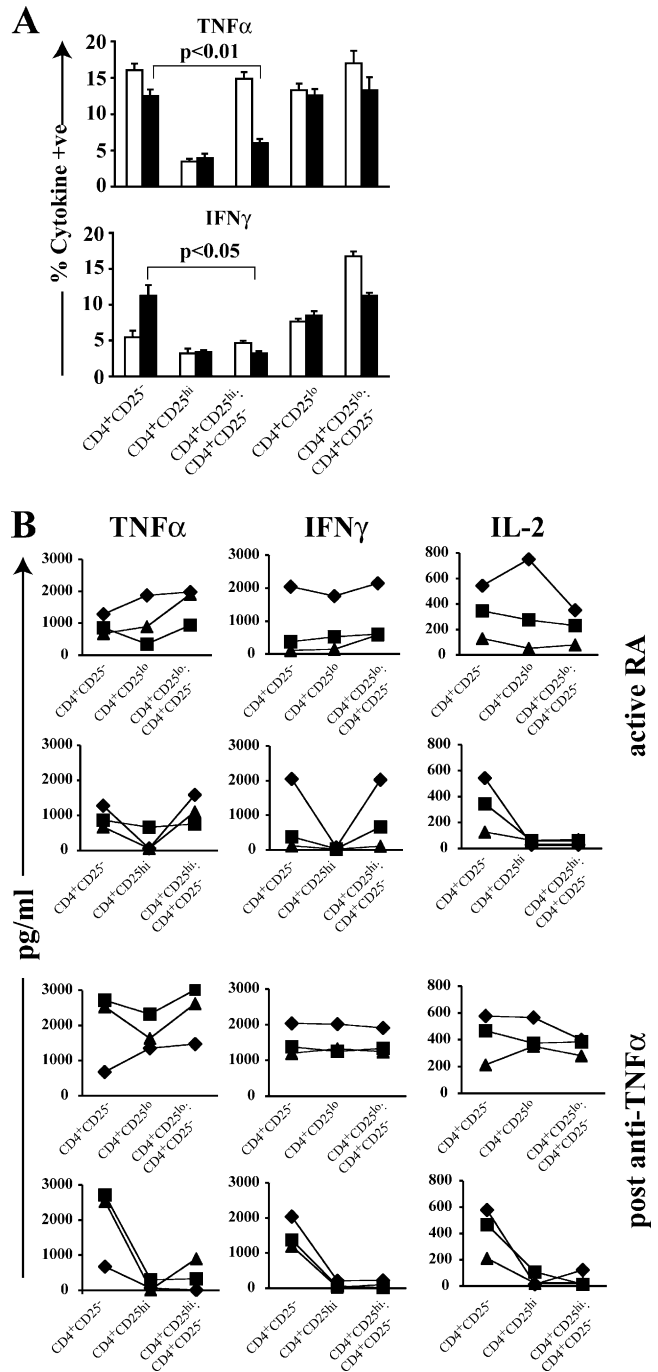


Figure 2. The regulatory defect resides within the CD4⁺CD25^{high} T cell population. (A) The CD4⁺CD25⁻, CD4⁺CD25^{low}, CD4⁺CD25^{high} population were FACS[®]-sorted (MoFlo) from an active RA patient before treatment (white columns) and a responding RA patient (black columns) receiving anti-TNF α therapy using the indicated gates as depicted in Fig. S1. The CD4⁺CD25^{high} and the CD4⁺CD25^{low} T cells were cultured alone or with CD4⁺CD25⁻ responder T cells (5×10^4 cells/well) and stimulated with 5 μ g/ml of soluble anti-CD3/anti-CD28 for 48 h. 2 μ M monensin was added for the last 5 h of culture. Cells were stained to detect intracellular TNF α and IFN γ in a similar fashion to those in Fig. 1 B. Mean \pm SEM of three patients before and after anti-TNF α therapy is shown. (B) Cytokines from the supernatants collected from the experiments from the three patients before and after anti-TNF α treatment (A) were measured by CBA and shown separately in each of the panels.

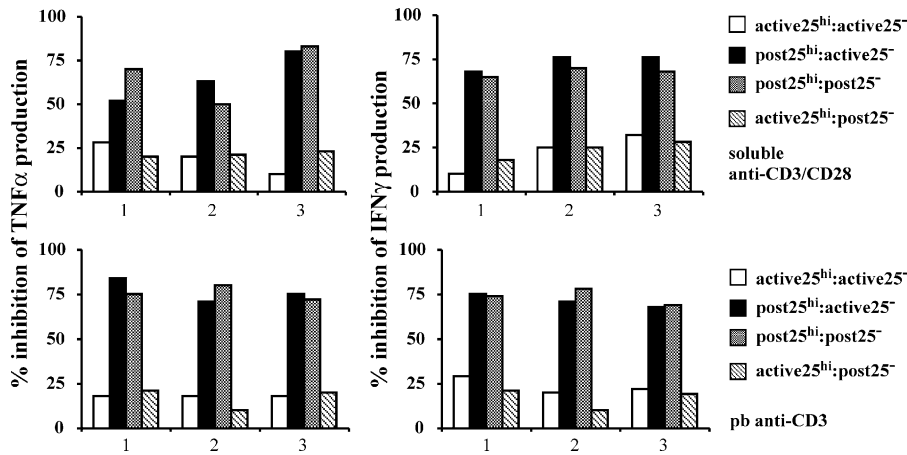


Figure 3. CD4⁺CD25^{high} T cells from patients with active RA fail to suppress cytokines produced by CD4⁺CD25⁻ T cells derived from the same patient either before or after anti-TNF α therapy. CD4⁺CD25^{high} and CD4⁺CD25⁻ T cells (5×10^4 cells/well) isolated from patients with active RA ($n = 3$) or from patients responding to anti-TNF α therapy ($n = 3$) were mixed and stimulated with 5 μ g/ml of soluble anti-CD3/anti-CD28 (top) or with 1 mg/ml of plate-bound anti-CD3 (bottom). Supernatants were analyzed by CBA. The results indicate the percentage of inhibition of the cytokine production relative to the CD4⁺CD25⁻ T cells stimulated alone. One out of two experiments is shown.

these results demonstrate that regulatory T cells isolated from patients with active RA are “compromised” at least in terms of their ability to suppress proinflammatory cytokine production by responder T cells as well as from monocytes.

Next, we investigated the possibility that effector T cells are resistant to the suppressive effect exerted by the regulatory T cells in patients with RA. CD4⁺CD25⁻ or CD4⁺CD25^{high} T cells from patients before therapy were cultured with either CD4⁺CD25^{high} T cells or with CD4⁺CD25⁻ T cells isolated 3 mo after therapy. The results in Fig. 3 show that CD4⁺CD25^{high} T cells from active RA patients were unable to suppress the production of cytokines released by effector T cells isolated after anti-TNF α treatment. In contrast, 3 mo after anti-TNF α therapy, CD4⁺CD25^{high} T cells regained their ability to inhibit IFN γ and TNF α released by autologous effector T cells from active RA patients. The same conclusion could be drawn whether the cultures were stimulated with soluble anti-CD3/anti-CD28 (Fig. 3, top) or plate-bound anti-CD3 (Fig. 3, bottom). Therefore, our data demonstrate that CD4⁺CD25^{high} T cells are functionally defective in RA patients and the lack of suppression is not due to effector T cell resistance.

In the next experiment, we wished to establish whether the recovery in function mediated by anti-TNF α therapy is cell contact dependent and cytokine independent. In coculture experiments, freshly isolated CD4⁺CD25⁻ T cells were separated in transwell chambers from CD4⁺CD25^{high} T cells. Prevention of cell contact abolished their suppressive capacity (Fig. 4 A). Next, we investigated whether addition or neutralization of TNF α in vitro affects regulatory T cells. The results in Fig. 4 B demonstrate that the addition of TNF α to the coculture system did not alter the suppressive function of regulatory T cells isolated after anti-TNF α treatment. In vitro neutralization of TNF α (Infliximab) was not sufficient to restore the defect in CD4⁺CD25^{high} T cell-mediated suppression (unpublished data).

Depletion of CD4⁺CD25⁺ T Cells from PB Isolated from Anti-TNF α -treated Patients Results in an Increase in TNF α Levels and in an Inhibition of IL-10 Production. Next, we evaluated how CD4⁺CD25⁺ T cell depletion influences

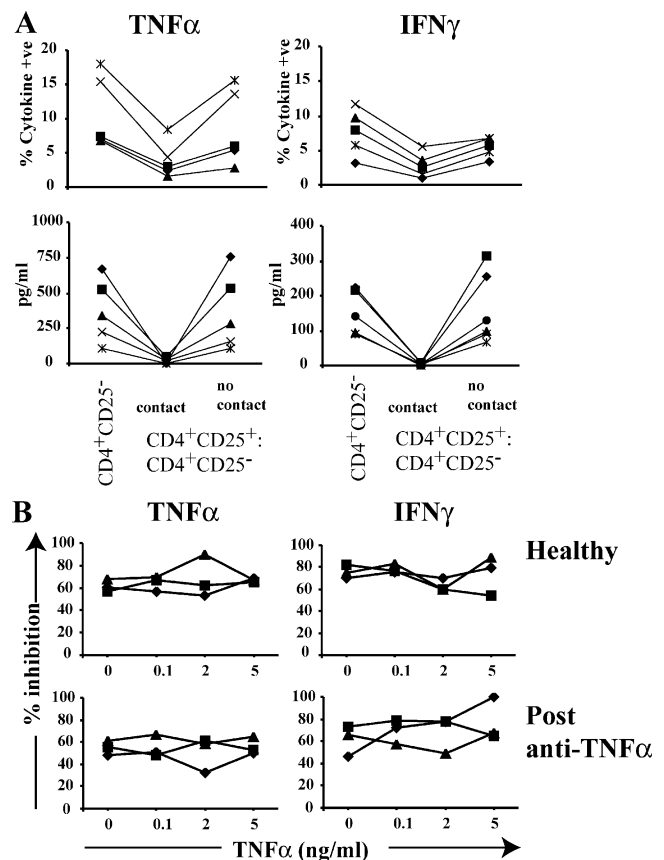


Figure 4. The inhibitory effect of CD4⁺CD25^{high} T cells requires cell contact and is not affected by the addition of TNF α in vitro. (A) CD4⁺CD25^{high} and responder T cells derived from patients responding to anti-TNF α therapy were stimulated with 5 mg/ml of soluble anti-CD3/anti-CD28 either with or without the use of a transwell membrane to prevent cell contact. (top) 2 μ M monensin was added for the last 5 h of culture, and cells were stained for detection of intracellular cytokine production. (bottom) Cytokines from the supernatants collected from the same experiment were measured by CBA. (B) CD4⁺CD25^{high} and CD4⁺CD25⁻ T cells isolated from healthy as well as responding patients were cultured 1:1 ratio, upon anti-CD3/anti-CD28 stimulation, in the presence of different concentrations of TNF α . The percentage of suppression of cytokine production was calculated in each individual. One out of two experiments is shown.

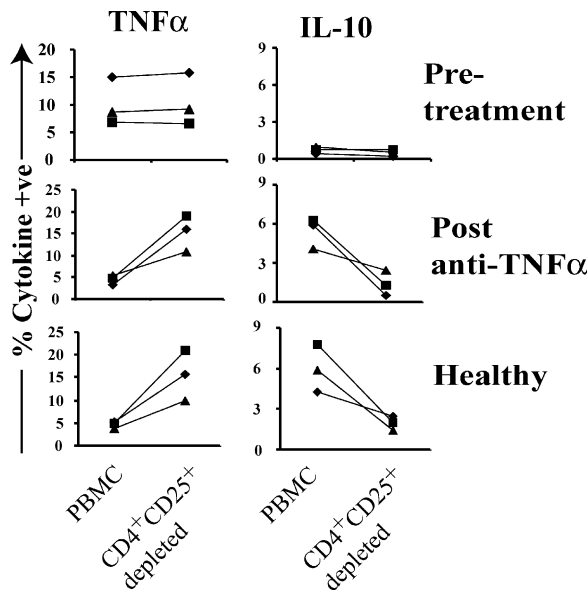


Figure 5. Effect of depletion of $CD4^+CD25^+$ T cells from PBMCs on $TNF\alpha$ and IL-10 production from the same patient before and after treatment. Total PBMCs or PBMCs depleted of $CD25^+$ cells (by MACS[®] sorting) were stimulated with 5 $\mu\text{g}/\text{ml}$ of soluble anti-CD3/anti-CD28 for 48 h. 2 μM monensin was added for the last 5 h of culture. Staining of CD4 and CD25 surface expression was performed. Cells were permeabilized and stained with PE-conjugated anti- $TNF\alpha$ or anti-IL-10. Results from three patients before and after therapy and three healthy individuals are shown.

the cytokine profile of PB before and after anti- $TNF\alpha$ treatment. PB from patients with active RA synthesized high levels of $TNF\alpha$, but no IL-10 (Fig. 5). After treatment, a reduced amount of $TNF\alpha$ and an increased number of IL-10-secreting cells were detected in PB. After depletion of $CD4^+CD25^{\text{high}}$ T cells from PB derived from patients with active RA, there was no change in the percentage of cells producing $TNF\alpha$ or IL-10, whereas a fivefold increase in $TNF\alpha$ and a >10-fold reduction in IL-10 production occurred when regulatory T cells were depleted from anti- $TNF\alpha$ -treated RA patients. Analysis of PB from healthy individuals gave similar results to patients responding to anti- $TNF\alpha$ therapy. These results provide additional evidence that regulatory T cells from patients with active RA are ineffective in terms of suppressing $TNF\alpha$ release and that this function is restored after treatment.

CD4⁺CD25⁺ Regulatory T Cells from Active RA Patients Lack the Ability to Convey Suppressor Activity to Effector T Cells: Restoration after Anti- $TNF\alpha$ Treatment. The generation of newly formed regulatory T cells may be a further mechanism by which regulatory T cells could control autoreactive T cells and the consequent inflammation. It has been shown recently that regulatory T cells, isolated from healthy individuals, convey a suppressive phenotype to “conventional” activated T cells (19). To explore this possibility in patients with RA, we tested the capacity of regulatory T cells, isolated before and after treatment, to convey a suppressive phenotype to $CD4^+CD25^-$ T cells. $CD4^+CD25^+$ T cells were isolated as previously men-

tioned and cultured 1:1 with the $CD4^+CD25^-$ T cell fraction in the presence of soluble anti-CD3/anti-CD28. After 3 d, $CD4^+CD25^+$ T cells were depleted, and the remaining negative fraction ($CD4^+CD25^-$) was cultured 1:1 with freshly isolated autologous $CD4^+CD25^-$ T cells for an additional 5 d. In agreement with results reported from Jonuleit et al. (19), the resulting $CD4^+CD25^-$ T cell fraction purified from healthy or anti- $TNF\alpha$ -treated patients suppressed the proliferation of freshly isolated autologous T cells (Fig. 6). In contrast, similarly prepared $CD4^+CD25^-$ T cells from patients with active RA showed no suppressive activity on freshly isolated T cells, suggesting that regulatory T cells from these patients are unable to imprint a “suppressive” phenotype onto the $CD4^+CD25^-$ T cells. As an additional control, we also depleted $CD4^+CD25^+$ T cells (which should represent the newly activated T cells) from the $CD4^+CD25^-$ T cells cultured alone, and replated with freshly isolated $CD4^+CD25^-$ T cells. No suppressive phenotype was acquired under these experimental conditions (unpublished data), confirming that this phenomenon is regulatory T cell dependent. These results demonstrate that regulatory T cells isolated from patients with active RA are unable to inhibit the production of proinflammatory cytokines and to induce the differentiation of additional populations of suppressor cells.

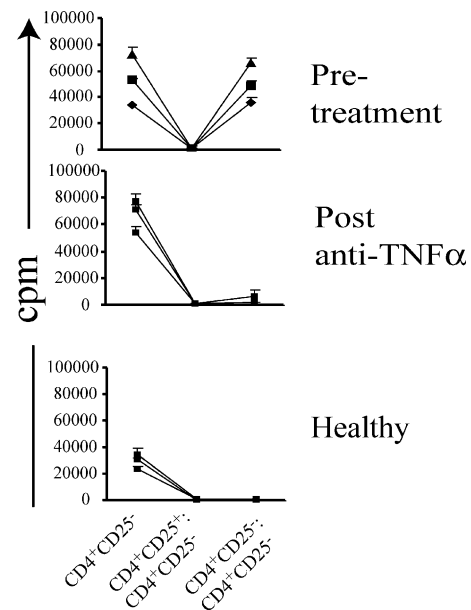


Figure 6. Only $CD4^+CD25^+$ regulatory T cells derived from patients treated with anti- $TNF\alpha$, but not from patients with active RA, convey a suppressive phenotype to effector T cells. MACS[®]-sorted $CD4^+CD25^+$ T cells and $CD4^+CD25^-$ T cells were cultured either alone or mixed at a 1:1 ratio (10^5 cells/well) and stimulated with 1 $\mu\text{g}/\text{ml}$ of soluble anti-CD3 and 2 $\mu\text{g}/\text{ml}$ anti-CD28. After 5 d of culture, $CD4^+CD25^+$ T cells were depleted and the remaining $CD4^+CD25^-$ T cells were replated 1:1 with freshly isolated autologous $CD4^+CD25^-$ T cells in the presence of anti-CD3 and anti-CD28 for an additional 3 d (third column). $^3\text{H}]Tdr$ was added for the final 8 h of culture (expressed as mean \pm SEM of triplicate cultures). Results from three patients before and after therapy and three healthy individuals are shown.

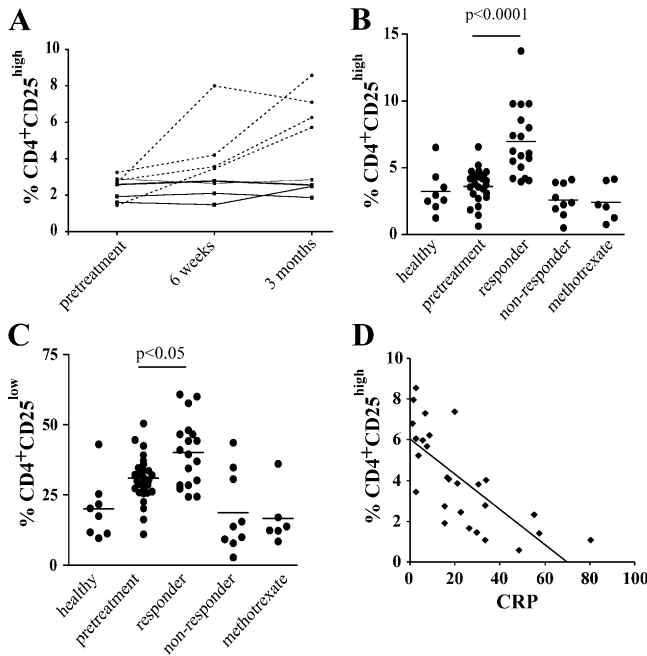


Figure 7. Increase in CD4⁺CD25^{high} T cells in the PB of RA patients responding to anti-TNF α therapy. (A) The percentage of CD4⁺ T cells expressing CD25^{high} was followed in four anti-TNF α responder (dashed line) and four nonresponder (solid line) patients with RA before and after treatment. (B) Analysis of larger group of patients treated with anti-TNF α ($n = 27$), methotrexate alone ($n = 6$), and healthy controls ($n = 8$). CD4⁺CD25^{high} and (C) CD4⁺CD25^{low} T cells (as defined in Fig. S1 A). (D) Scatter plot showing a significant correlation between the C reactive protein and the percentage of CD4⁺CD25^{high} T cells before and after treatment ($P < 0.001$, $r^2 = 0.5278$).

The Frequency of CD4⁺CD25^{high} T Cells Is Higher in Anti-TNF α -responding Patients Compared with the Same Patients before Treatment. Finally, we monitored the numbers of regulatory T cells in patients with RA, before and after treatment (Table S1, available at <http://www.jem.org/cgi/content/full/jem.20040165/DC1>). The expression of CD25^{high/low} on CD4⁺ T cells was initially examined in four responding and four nonresponding patients during the first 3 mo of treatment using FACS[®] analysis. Although the percentage of CD4⁺CD25^{high} T cells increased over time in those patients who responded to anti-TNF α therapy, there was no change in the percentage of CD4⁺CD25^{high} T cells in the four nonresponding patients (Fig. 7 A). The percentage of this population continued to rise in three out of the four responding patients 6 wk after the first infusion of Infliximab and remained stable after 3 mo of treatment (unpublished data). The subsequent analysis in a larger cohort of patients, including those responding to methotrexate therapy, revealed that the percentage of both CD4⁺CD25^{high/low} T cells was significantly increased in anti-TNF α -responding patients compared with the levels measured in those with active RA, methotrexate-treated patients, and healthy controls (Fig. 7, B and C). Active RA patients also showed an increased percentage of CD4⁺CD25^{low} T cells, which likely reflects increased activation of CD4⁺ T cells, and does not represent any changes

in the regulatory T cell population, in accordance with our (Fig. 2) and previously published data indicating that the regulatory CD4⁺ T subset is largely found within the CD25^{high} subset (10). The methotrexate-treated individuals were matched to the responding anti-TNF α -treated patients with respect to their response to treatment. Consistent with previous results, no reduction in numbers of regulatory T cells was measured in patients with active RA compared with healthy individuals (17), suggesting that numerical deficiency is unlikely to be responsible for any break in immune tolerance in RA, as has been suggested in some mouse models of autoimmune disease (3, 4), and in patients with type 1 diabetes mellitus (14). No differences in CD4⁺CD25^{high/low} expression were detected in patients with RA who failed to respond to anti-TNF α therapy compared with healthy controls. A significant correlation between the CRP, a measure of rheumatoid disease activity, and the percentage of CD4⁺CD25^{high} T cells (but not CD4⁺CD25^{low}) confirmed the relationship between a response to anti-TNF α therapy and an expansion in this cell population (Fig. 7 D). In agreement with previous papers, there was no significant change in the absolute numbers of CD4⁺ T cells in PBMCs before treatment and 3 mo after anti-TNF α treatment, indicating that the changes in percentages observed in CD4⁺CD25⁺ T cells reflected alterations in the absolute numbers of cells (20).

Discussion

The data presented here provide new insight into the biology of regulatory T cells within the context of a human autoimmune disease. CD4⁺CD25^{high} T cells isolated from patients with active RA, although still anergic, show compromised function as demonstrated by their inability to regulate proinflammatory cytokines released by effector T cells and monocytes. After Infliximab treatment, regulatory T cell-mediated suppression was restored to the level found in healthy individuals, whereas only a partial restoration was seen in regulatory T cells isolated from patients responding to methotrexate. Although it is well documented that Infliximab blocks both soluble and transmembrane TNF α , resulting in a strong inhibition of other proinflammatory cytokines, there is no unanimity about the effects of methotrexate on cytokine production in RA (21, 22). If proinflammatory cytokines are not efficiently suppressed in methotrexate-treated patients, this could have a deleterious effect on the function of regulatory T cells, thus explaining the different level of regulatory T cell-mediated inhibition in patients treated with these two therapies.

It is unclear why regulatory T cells isolated from RA patients are unable to suppress lymphocyte and monocyte cytokine production. One possibility is that the presence of TNF α as well as other proinflammatory cytokines may hinder the ability of regulatory T cells to prevent autoimmune disease. In a recent paper that examined the role of this cytokine with respect to regulatory T cells, TNF α impaired the ability of regulatory T cells to suppress disease in

the NOD mouse model of diabetes (4). These authors suggested that endogenous levels of TNF α might act centrally in the thymus to mediate these effects on regulatory T cells. Pertinent to their hypothesis is the recent observation that CD4⁺CD25⁺ T cells derived from the thymus of healthy donors have an increased expression of TNFR2 compared with CD4⁺CD25⁻ T cells (12), which might result in an increased susceptibility of regulatory T cells to the actions of TNF α . However, our in vitro data do not lend support to a direct effect of TNF α on regulatory T cells because, after exposure to a gradient of TNF α concentration alone, regulatory T cells were still viable and functionally active. These results indicate that more complex mechanisms are likely to operate in vivo. That regulatory T cells isolated from patients affected by chronic inflammatory disorders show altered function is not only peculiar to RA. Indeed, it has been reported recently that regulatory T cells isolated from the PB of patients with multiple sclerosis are functionally defective in terms of their ability to suppress proliferation and cytokines production by activated T cells (23). This finding, together with our data, might shed some light on the role that regulatory T cells play in controlling the maintenance of peripheral tolerance and in the prevention of human autoimmunity.

It has been speculated previously that the spreading of suppression from CD4⁺CD25⁺ T cells to responder T cells is an important mechanism by which regulatory T cells exert their effect in the maintenance of peripheral tolerance (19). This is an attractive explanation for how such small numbers of cells could prevent autoimmune disease. Our in vitro data suggest that, unlike regulatory T cells from healthy individuals, those derived from active RA patients cannot convey a suppressive phenotype to activated T cells. To our knowledge, this is the first time that this phenomenon has been shown to be impaired in an autoimmune disease. This defect could have a significant impact on the regulation of RA pathology because it is likely that the generation of newly formed (and fully functional) suppressor T cells is critical to control autoimmunity.

In searching for the mechanism by which these regulatory T cells act, we found that the suppression of cytokine production by regulatory T cells after treatment was contact dependent, and soluble factor independent as neutralization of IL-10 and TGF β did not alter their suppressive function (unpublished data). However, depletion of CD4⁺CD25⁺ T cells from treated PB led to a reduction in the number of IL-10-secreting cells. This suggests that the production of IL-10 may be dependent on the presence of regulatory T cells, but that its release is by another population such as a subset of suppressor cells that do not express CD25. It has been suggested that CD4⁺CD25⁺ T cells may actively promote the differentiation of Tr1 cells that mediate their suppression through production of IL-10 (24). As IL-10 is widely known for its antiinflammatory properties, it is tantalizing to hypothesize that the increase in this cytokine, previously reported in anti-TNF α -treated patients (20, 25), is orchestrated by regulatory T cells whose

function has been restored. Interestingly, we were unable to detect IL-10 in any of the T cell populations analyzed, suggesting that the production of IL-10 depends on the interaction of a variety of cell types (and/or their soluble products) present in whole PBMCs.

The other major finding described in our paper is the increased regulatory T cell number in RA patients treated with anti-TNF α , which significantly correlated with a reduction in CRP value. It is tempting to speculate that the increase in regulatory T cells in responding patients is important in the amelioration of disease and may help to differentiate between responder and nonresponder patients because the changes occur within 6 wk of initiation of therapy. It is conceivable that TNF α has a direct effect on regulatory T cell viability, such as the induction of apoptosis (26), which would explain the increased number of regulatory T cells after TNF α neutralization. As aforementioned, our in vitro data do not support this hypothesis. Moreover, we found no reduction in regulatory T cell numbers in patients with active RA compared with healthy donors, suggesting that neither apoptosis, nor any other direct effect on regulatory T cell numbers, are the primary mechanisms by which TNF α is acting. The lack of difference in CD25^{high} regulatory T cell numbers found in active patients, compared with healthy individuals, needs more careful study, as the CD25^{high} regulatory T cells derived from active RA could be "contaminated" by recently activated CD4⁺ T cells, which would mask the total number of regulatory T cells. Indeed, human CD4⁺CD25⁺ T cells are not a homogenous population and contain nonsuppressive fractions (10, 27). Of equal importance to the issues already raised is the possibility that an increase in regulatory T cells may have deleterious consequences, in particular an increased susceptibility to infections, which is a major issue in patients receiving anti-TNF α therapy (28).

Further studies are required to elucidate the mechanisms that underlie these observations in patients with RA, and to relate the clinical and immunological responses in patients receiving anti-TNF α therapy. Restoration of the function of regulatory T cells or transfer of fully competent regulatory T cells could be a useful therapeutic tool in the treatment of RA (29).

We thank Dr. L. Wedderburn for helpful comments on the paper.

This work was supported by the Arthritis Research Campaign and The Wellcome Trust.

The authors have no conflicting financial interests.

Submitted: 27 January 2004

Accepted: 18 June 2004

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