Myelin Basic Protein–specific T Helper 2 (Th2) Cells Cause Experimental Autoimmune Encephalomyelitis in Immunodeficient Hosts Rather than Protect Them from the Disease

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Summary

Chronic inflammatory autoimmune diseases such as multiple sclerosis, diabetes, and rheumatoid arthritis are caused by CD4⁺ Th1 cells. Because Th2 cells antagonize Th1 cell functions in several ways, it is believed that immune deviation towards Th2 can prevent or cure autoimmune diseases. Experimental autoimmune encephalomyelitis (EAE) is a demyelinating disease used as a model for multiple sclerosis. Using an adoptive transfer system we assessed the role of Th1 and Th2 cells in EAE. In vitro generated Th1 and Th2 cells from myelin basic protein (MBP)-specific TCR transgenic mice were transferred into normal and immunodeficient mice. Th1 cells caused EAE in all recipients after a brief preclinical phase. Surprisingly, Th2 cells also caused EAE in RAG-1 KO mice and in αβ T cell–deficient mice, albeit after a longer preclinical phase. Normal or γδ T cell–deficient mice were resistant to EAE induced by Th2 cells. The histopathological features of this disease resembled those of an allergic process. In addition, disease induction by Th1 cells was not altered by coadministration of Th2 cells in any of the recipients. These findings indicate that MBP-specific Th2 cells have the potential to induce EAE and that the disease induced by previously activated Th1 cells cannot be prevented by normal lymphocytes nor by previously activated Th2 cells.

CD4 T cells can develop into Th1 and Th2 cells characterized by the production of different cytokines; whereas Th1 cells produce IFN-γ, TNF-β, IL-2, and low levels of IL-10, Th2 cells produce IL-4, IL-5, IL-13, and high levels of IL-10 (1, 2). Naïve T cells can be induced to differentiate into Th1 effector cells when stimulated in the presence of IL-12 and into Th2 effector cells when stimulated in the presence of IL-4 (3–5). In addition to the cytokine milieu, a number of other factors have been shown to influence the differentiation pathway of naïve CD4 T cells, including the affinity of the TCR for the antigen, the concentration of the antigen, and the type of antigen-presenting cell (reviewed in reference 2). Th1 and Th2 cells are known to antagonize each other in a variety of ways. For example, secretion of IL-4 by Th2 cells blocks differentiation of naïve cells towards the Th1 pathway. In addition, production of IL-4, IL-13, and IL-10 by Th2 cells may suppress many IFN-γ–induced macrophage functions. Conversely, Th1 cells secrete IFN-γ, which inhibits the proliferation of Th2 cells (1, 2).

In chronic inflammatory autoimmune diseases such as multiple sclerosis (MS)¹, diabetes and rheumatoid arthritis, pathogenic and protective roles have been ascribed to Th1 and Th2 cells, respectively (6–8). Experimental autoimmune encephalomyelitis (EAE) is a demyelinating disease of the central nervous system (CNS) widely used as an animal model for MS (9). When either Th1 and Th2 cell–derived cytokines or anti-cytokine blocking antibodies were administered to animals, the reported effects on the clinical course of EAE were conflicting. Using an adoptive transfer model, Racke et al. (10) showed that early treatment with IL-4 ameliorates EAE. Similarly, Brocke et al. (11) showed that anti–IL-12 treatment reversed the tolerance induced by an altered peptide ligand in another EAE adoptive transfer model. Furthermore, Leonard et al. (12) have shown that administration of IL-12 increases the severity of EAE, whereas anti–IL-12 antibodies confer protection in a PLP–specific adoptive transfer model of EAE. On the other

¹Abbreviations used in this paper: CNS, central nervous system; EAE, experimental autoimmune encephalomyelitis; MBP, myelin basic protein; MS, multiple sclerosis; PLP, proteolipid protein.
hand, administration of IFN-γ has also been shown to ameliorate EAE induced by antigen/adjuvant in SJL/J mice (13). According to Steinman (14), cytokines such as IL-4 and IL-10 have a effect opposite to tolerance when given systemically. Using a myelin basic protein (MBP)-specific adoptive transfer system, Cannella et al. (15) not only failed to prevent EAE by administration of IL-10 but actually worsened its clinical course. The aforementioned discrepancies are probably due to the fact that cytokines can affect the disease process at multiple stages, from alteration of levels of MHC expression to late effector functions of macrophages.

We assessed the role of Th1 and Th2 cells in EAE by transferring in vitro generated Th1 and Th2 cells from MBP-specific TCR transgenic mice into normal and immunodeficient mice. Th1 cells caused EAE in all recipients after a short preclinical phase. Surprisingly, Th2 cells also caused EAE in RAG-1 KO mice and in αβ T cell-deficient mice, albeit after a longer preclinical phase. Normal or γδ T cell-deficient mice were resistant to EAE induced by Th2 cells. Disease induction by Th1 cells was not reduced in any recipient by coadministration of Th2 cells. These findings indicate that MBP-specific Th2 cells have the potential to induce EAE and that disease induction by previously activated Th1 cells cannot be prevented by normal lymphocytes nor by previously activated Th2 cells.

Materials and Methods

Mice. The establishment of MBP Ac1-11-specific T cell receptor transgenic mice has been described elsewhere (16). The mice were made by injection of C57Bl/6 zygotes and subsequently were crossed with B10.PL (Jackson ImmunoResearch Labs., Inc., West Grove, PA) to incorporate the I.Au restriction element. H-2d/u mice were used in all experiments RAG-1 KO (17), TCR-α KO (18), and TCR-β KO (19), originally on 129X C57Bl/6 background, were crossed to B10.PL mice and the first generation intercrossed to obtain mice homozygous for the mutation as well as for H-2d.

Preparation of MBP-specific Th1 and Th2 Cells. Naive MBP-specific T cells were obtained from spleens of T/R + mice on a B10.PL genetic background. Spleen cells (1 × 10^6/ml) were cultured in the presence of the N. H3 terminus acetylated MBP peptide (MBP Ac1-17) and 100 U/ml of IL-12 (gift of Dr. M. Bower Gately, Hoffman-La Roche, Nutley, NJ) or 200 U/ml of IL-4 (PharMingen, San Diego, CA) following established procedures (3–5). The cultures were restimulated with peptide and syngeneic APC (no additional interleukins) on days 4 and 8.

Adoptive Transfer of EAE. Cells were washed with PBS and injected intravenously into recipient mice at day 11 of culture, when >90% of the cells in culture were blastic and positive for both Vp8.2 and CD4. EAE was graded as follows (20): level 1, limp tail; level 2, partial hind leg paralysis; level 3, complete hind leg paralysis; level 4, front leg weakness; level 5, moribund.

Cytokine Measurements. The concentration of cytokines in culture supernates was determined by ELISA using the antibodies BVD4-1D11 and BVD6-24G2 (PharMingen) for the detection of IL-4, antibodies JES5-2A5 and SXC-1 (PharMingen) for the detection of IL-10, antibodies R4-6A3 and XM11G2 (PharMingen) for the detection of IFN-γ, and Factor B test X kit (Genzyme Corp., Cambridge, MA) for the detection of TNF-α.

Cytokine mRNA expression in splenic lymphocytes and lymphocytes infiltrating the CNS was determined by RT-PCR. H-2d/u RAG-1 KO mice were injected with 1 × 10^7 Th2 cells. Forty days after injection, mice were anesthetized with ketamine and perfused with 100 ml of PBS containing 5 ml EDTA (PBS/EDTA) through the left ventricle of the heart. CNS lymphocytes were prepared by forcing the tissue through a steel sieve with a syringe plunger, and were subsequently purified by spinning through 38% Percoll (Pharmacia Biotec, Inc., Piscataway, N.J.). CD4-positive cells were purified by magnetic sorting with a SuperMACS (Miltenyi Biotec, Sunnyvale, CA) using beads directed to anti-mouse CD4 (Miltenyi Biotec). Cells were lysed in Trizol (MRC Inc., Cincinnati, OH) and total RNA was prepared following the manufacturer’s instructions. RNA was reverse-transcribed with Superscript (GIBCO BRL, Gaithersburg, MD) and PCR was performed using the Clontech primer pairs for IL-4 (product size 357 bp), IFN-γ (product size 365 bp), and IL-10 (product size 455 bp).

Radioisotopic Analysis. Th1 and Th2 cells (1 × 10^8) were incubated with 1 mc of sodium chromate (DuPont-NEN, Boston, MA) in 25 ml of complete medium. After 45 min at 37°C the cells were washed twice, resuspended in PBS and injected intravenously into RAG-1 KO mice. Whole organs from PBS/EDTA perfused mice were measured for radioactive content in a Packard gamma-counter.

Immunopathology. EAE was induced in RAG-1 KO recipients by both MBP-specific Th1 and Th2 cells. In this study we generated in vitro Th1 and Th2 cells expressing the transgenic MBP-specific TCR and studied the putative pathogenic and protective roles of these cells by adoptive transfer into various recipient mice. CD4 T cells from spleens of T/R + mice were stimulated with the MBP peptide in the presence of either IL-12 to generate Th1 cells or IL-4 to generate Th2 cells (3–5). After three rounds of stimulation, cells were harvested, washed, and injected intravenously into RAG-1 KO mice. Culture supernatants were analyzed to confirm the Th1 and Th2 phenotypes of the cells to be injected (Fig. 1 A). Transfer of 5 × 10^6 Th1 cells caused severe EAE in >90% of the recipients. Surprisingly, transfer of 5 × 10^6 Th2 cells also caused severe EAE in >90% of the recipient mice, although the onset of signs was delayed (Fig. 1 B). 50% of the maximum EAE score was reached at day 6 in Th1 cell recipients and at day 16 in Th2 cell recipients. Once initial symptoms were apparent, the speed of disease progression was the same regardless of the length of the preclinical phase. Coadministration of Th2 cells did not slow down the rapid onset of EAE caused by the injection of Th1 cells (Fig. 1 C).

Th2 Cell Preparations Do Not Contain Disease Causing Th1 Cells. Since disease induction by Th2 cells was unex-
RAG-1 KO recipient mice were injected intravenously with 10^6 Th1 cells. It was found that a small number of contaminant Th1 cells does not explain the high incidence of EAE in recipients of 5 x 10^6 Th2 cells. However, a small number of contaminant Th1 cells does not explain the high incidence of EAE in recipients of 5 x 10^6 Th2 cells. We therefore considered the possibility that some Th2 cells were converted into Th1 cells in vivo into Th1 cells. No evidence for such a conversion was obtained when cytokine mRNA was analyzed in extracts of spleens and brains of Th2 cell recipients which developed the disease: CD4+ T cells that were isolated from spleen and brain of Th2 cell recipients were found to produce IL-4 mRNA but not IFN-γ mRNA (Fig. 2). Moreover, we assessed whether we could convert in vitro the three times-stimulated Th2 cells into a Th1 phenotype by adding IL-12 or IFN-γ and observed no conversion, thereby confirming previous findings (21-23 and data not shown).

Unusually high numbers of polymorphonuclear cells and mast cells were found in the white matter of mice injected with either cell type. Th1 and Th2 cells home to the CNS with similar kinetics. Immunocompetent mice are resistant to EAE induced by Th2 cells. In all experiments described thus far, the MBP-specific T cells were injected into RAG-1 KO mice. Interestingly, when normal B10.PL mice were used as recipients, Th2 cells did not cause EAE, although Th1 cells caused the fast onset disease as in the RAG-1 KO recipients. mast cells were not found in the white matter of mice injected with either cell type.
Discussion

This study has shown that MBP-specific CD4 T cells which had been primed in vitro for IFN-γ production are capable of causing EAE upon transfer into normal or immunocompromised mice. Th2 cells failed to protect against Th1 cell-mediated EAE, and caused EAE by themselves when transferred to immunocompromised RAG-1 KO recipients. There were three main differences between disease induction by Th1 and Th2 cells. First, the appearance of first clinical signs was delayed by \( \sim 10 \) d in Th2 cell recipients as compared to Th1 cell recipients. Second, normal (i.e., RAG-1\(^+\)) mice were resistant to EAE induction by Th2 cells but not induction by Th1 cells. Third, an unusually high percentage of polymorphonuclear cells and mast cells was present in the CNS of RAG-1 KO mice into which Th2 cells had been transferred but this was not the case in RAG-1 KO mice that had received Th1 cells.

The mechanisms by which Th1 and Th2 cells induce EAE in adoptive recipient mice are unknown. Our data suggest that the difference in the duration of the preclinical phase is related to differences in interleukin production rather than to differences in the extravasation of cells from blood vessels into the brain parenchyma (Fig. 4). The crucial cytokines involved in disease induction may be IFN-γ and TNF-α in Th1 recipients and TNF-α in Th2 cell recipients. However, Ferber et al. recently showed that IFN-γ KO mice develop antigen-induced EAE with similar kinetics and severity as normal mice (24). An alternative view is that TNF is responsible for the inflammation caused by both Th1 and Th2 cells. TNF-α is present not only in Th1 culture supernatants, but also in Th2 supernatants, albeit at lower levels (Fig. 1 A). The higher amounts of TNF released by Th1 cells may cause a more rapid inflammation. The importance of TNF in EAE induction has been known for several years: for example, injection of anti TNF antibodies has been shown to inhibit EAE in adoptive transfer systems (25–26). Moreover, the encephalogenicity of some T cell clones has been positively correlated with the amount of TNF produced (27); in addition, a demyelinating disease has been described in a line of TNF-α transgenic mice in which the transgene is selectively expressed in the CNS (28).

**Table 1.** Susceptibility of Different Mouse Mutants to EAE Induced by Th1 or Th2 MBP-specific T Cells

<table>
<thead>
<tr>
<th>Host</th>
<th>Injected MBP-specific T cells</th>
<th>Th1</th>
<th>Th2</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAG-1 KO</td>
<td>Early onset</td>
<td>Late onset</td>
<td></td>
</tr>
<tr>
<td>TCR-α KO</td>
<td>Early onset</td>
<td>Late onset</td>
<td></td>
</tr>
<tr>
<td>TCR-β KO</td>
<td>Early onset</td>
<td>No EAE</td>
<td></td>
</tr>
<tr>
<td>B10.PL</td>
<td>Early onset</td>
<td>No EAE</td>
<td></td>
</tr>
</tbody>
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Early onset and late onset mean, respectively, that 50% of maximum EAE score was reached before or after day 10 after injection of \( 10^6 \) cells or more.
Using Th1 and Th2 cells derived from the same precursors and expressing identical MBP-specific TCR, we have not been able to obtain any evidence supporting the common assumption that Th2 cells protect mice against Th1 cell-mediated, inflammatory diseases (7, 8). A lack of protection by antigen-specific Th2 cells was also observed in a diabetes model (29) as well as in an EAE adoptive transfer model in which short-term polyclonal PLP-specific Th1-enriched and Th2-enriched cultures were administered (30). On the other hand, two reports have described protective effects of CNS-specific Th2 clones on EAE (31, 32). In these studies, disease was induced by antigen plus adjuvant, not by adoptive transfer of activated Th1 cells. It is possible that Th2 cells may prevent the generation of the more pathogenic Th1 cells from naive cells, but fail to counteract already activated Th1 cells. However, this explanation is unlikely since Kuchroo et al. described protection by PLP-specific Th2 cells even when administered after the appearance of the first signs of EAE, which is clearly too late if Th2 cells were to act by preventing the generation of Th1 cells (32). An alternative explanation is that Th2 populations generated under different conditions or from animals of different genetic backgrounds also differ in some of their properties, despite commonly secreting IL-4, IL-5, high levels of IL-10, and no IFN-γ. The importance of non-MHC-linked genes in determining a preferential Th1 or Th2 response has been established (6, 33). It is also possible that genetic differences account for quantitative or qualitative differences among Th2 populations.

Our results demonstrate that MBP-specific Th2 cells have the potential to cause EAE equivalent in morbidity to the disease caused by Th1 cells. The finding of large numbers of mast cells in the meninges of animals injected with Th2 cells is rather unusual. Some of the mast cells were partially degranulated (for instance, Fig. 3C, second arrow from top). Since the recipient mice are RAG-1–deficient, degranulation of mast cells in these animals is not mediated by IgE. Mast cells could affect the course of EAE by several means. Through release of histamine and other vasoactive substances they can affect the properties of the blood-brain-barrier, and through the action of proteases and other mediators, they may cause myelin damage (34–36).

The potential danger of therapies based on immune deviation from Th1 cells towards Th2 cells has been previously appreciated by others (30, 37, 38). Th2 responses are responsible for allergic diseases and at least one autoimmune condition, Omenn’s syndrome, a disease associated with severe immunodeficiency (39). Interestingly, we observed pathogenic Th2 cell effects only in association with T cell immunodeficiency. A clear protective effect against Th1 cell-mediated EAE was apparent when, instead of RAG-1 KO mice, normal mice were used as recipients. This protection depends on αβ T cells since αβ T cell–deficient recipients, but not γδ T cell–deficient recipients were susceptible to disease induction by Th2 cells.

The role of αβ T cells in the protective effect against Th2 cell–mediated EAE remains an interesting unresolved issue.

References