Decreased sensitivity to 1,25-dihydroxyvitamin D3 in T cells from the rheumatoid joint

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Abstract
1,25-dihydroxyvitaminD3 (1,25(OH)2D3), has potent anti-inflammatory effects, including suppression of IL-17+ and IFNγ+ T cells implicated in rheumatoid arthritis (RA), but efficacy at the site of active disease is unclear. To investigate this, T cells from synovial fluid (SF) and paired blood of patients with active RA were studied. 1,25(OH)2D3 had significantly less suppressive effect on Th17 cells (IL-17+IFNγ+) and Th17.1 cells (IL-17+IFNγ+) from SF compared to those from blood, and had no effect on SF CD4+ or CD8+ IFNγ+ T cell frequencies. Memory T cells (CD45RO+) predominate in SF, and 1,25(OH)2D3 had less effect on memory T cells relative to naïve (CD45RA−) T cells. RT-PCR and flow cytometry showed that this was not due to decreased expression of the vitamin D receptor or its transcription partners in memory T cells. Further studies using stimulated CD4+ T cells sorted according to IL-17 and IFNγ expression confirmed the ability of 1,25(OH)2D3 to suppress pre-existing cytokines. However, 1,25(OH)2D3 was most effective at suppressing de novo IL-17 and IFNγ induction. Correspondingly, T cell responses to 1,25(OH)2D3 correlated directly with capacity for phenotype change, which was lower in cells from SF compared to blood. These findings indicate that anti-inflammatory effects of 1,25(OH)2D3 in active RA are impaired because of reduced effects on phenotype-committed, inflammatory memory T cells that are enriched in SF. Restoration of 1,25(OH)2D3 responses in memory T cells may provide a new strategy for treatment of inflammatory diseases such as RA.

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1. Introduction
The active form of vitamin D, 1,25-dihydroxyvitamin D3 (1,25(OH)2D3) promotes anti-inflammatory responses in a diverse array of cell types, supporting the potential use of vitamin D in the prevention and/or treatment of inflammatory disorders [1,2]. In previous studies we have shown that anti-inflammatory actions of vitamin D may occur indirectly through localized synthesis of 1,25(OH)2D3, and reduced expression of major histocompatibility and co-stimulatory molecules by antigen-presenting dendritic cells (DCs), monocytes and macrophages [3–6]. However, 1,25(OH)2D3 can also act directly on T-lymphocytes (T cells), inhibiting their proliferation [7], especially under conditions of weak co-stimulation [8], and suppressing their production of pro-inflammatory cytokines such as IFNγ, IL-17 and IL-21 [9–13], whilst promoting their expression of regulatory markers including CTLA4, FoxP3, and IL-10 [13], even in the presence of pro-inflammatory cytokines [14]. Crucially almost all of these observations have stemmed from experiments using T cells from the blood of healthy donors and much less is known about the effects of 1,25(OH)2D3 in established inflammatory disease, especially its effects upon T cells from inflamed compartments such as the joint of a patient with rheumatoid arthritis (RA).

Epidemiology suggests that many autoimmune diseases and

Please cite this article in press as: L.E. Jeffery, et al., Decreased sensitivity to 1,25-dihydroxyvitamin D3 in T cells from the rheumatoid joint, Journal of Autoimmunity (2017). https://doi.org/10.1016/j.jaut.2017.10.001
common chronic inflammatory diseases such as RA are associated with vitamin D-deficiency [15–17]. Vitamin D metabolites such as 1,25(OH)2D3 may therefore provide an alternative strategy for the prevention and/or treatment of RA [18], possibly as an adjunct to existing RA therapies [8]. Previous studies have highlighted aberrant metabolism of vitamin D in disease-affected synovial fluid (SF) from RA patients [19], but the impact of 1,25(OH)2D3 on T cells from the site of inflammation, the inflamed joint, has yet to be studied.

IFNγ + Th1 cells and IL-17 + Th17 cells are regarded as important mediators of chronic synovial inflammation. Increased levels of their hallmark and differentiating cytokines are found in the serum and synovial fluid of patients relative to controls [20], and elevated frequencies of both have been detected in the blood and joints of RA patients [21]. IFNγ produced by Th1 cells promotes APC maturation whilst IL-17 has pleiotropic effects, driving fibroblast-like synoviocytes (FLS) to release pro-inflammatory cytokines and chemokines [22], that further amplify the inflammation by facilitating the recruitment and retention of immune cells, including CCR5+CXCR3+ Th1 cells [23,24] and CXCR6+ Th17 [25,26] cells into the joint. IL-17 from Th17 cells also promotes cartilage and bone resorption by stimulating MMP release from FLS [22] and the induction of RANKL on FLS and osteoblasts leading to activation of RANK + osteoclasts [27]. The ability of 1,25(OH)2D3 to affect T cell function is important in RA, as T cells accumulate in the RA synovium and genetic risk factors for RA are largely related to T cell function [25]. The aim of the current study was to investigate further the potential use of vitamin D as a therapy for RA, by determining whether anti-inflammatory effects of 1,25(OH)2D3 are achievable on T cells from the site of inflammation.

2. Materials and methods

Patients were recruited for the study if they fulfilled 1987 ACR criteria for RA [28]. All patients and age and gender-matched healthy controls gave full written consent. Patient demographics are summarized in Table 1. Ethical approval for the work was granted by Solihull Research Ethics Committee (REC reference number 07/Q2706/2) and the University of Birmingham Ethics Committee (ERN_14-0446). For naïve and memory T cell comparison studies, as well for as cytokine-expression cell capture experiments, ethical approval was granted by Solihull Research Ethics Committee (REC reference number 1792/0) and the University of Birmingham Ethics Committee (ERN_16-0013). For experiments using isolated CD45RA-CD4+ naïve T cells, CD45RO+CD4+ memory T cells and CD14+ monocytes, cells were enriched by negative selection using cell separation reagents (StemCell Technologies and Biologend). For 24 h post-stimulation analysis of gene expression, T cells were stimulated with anti-CD3 (0.5 µg/ml, clone OKT3) at 2.5 × 105 cells/ml. 1,25(OH)2D3 was added to cultures at 100 nM and ethanol used as a vehicle control at 0.1%. At seven days, cells were restimulated with PMA/ionomycin in the presence of brefeldin A for cytokine expression analysis by flow cytometry.

Table 1

Table 2.1: Patient Demographics: Disease activity score 28 based upon C Reactive Protein (CRP) (DAS28 (CRP)); Erythrocyte sedimentation rate (ESR); Rheumatoid Factor (RF); anti-cyclic citrullinated peptide antibody (anti-CCP); conventional synthetic and biological disease modifying anti-rheumatic drugs (csDMARDs/bDMARDs).

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17-PE and CD3-PerCP for 15 min on ice with addition of IFNγ-APC during the final 10 min. After washing, Th17, Th17.1, Th1 and cytokine double-negative (DN) populations were collected into RPMI by FACS. Sorted T cells were then stimulated with negatively enriched (StemCell Technologies) and CD14⁺ FACS-purified allogenic monocytes at 1:4 ratio and 0.5 μg/ml anti-CD3 (OKT3) for 2 days in the presence of 40units/ml IL-2 (Immunotools) ± 100 nM 1,25(OH)₂D₃. Cell purities were >99% for Th17, Th1, DN and monocytes and >90% for Th17.1 cells.

2.3. Flow cytometry

CD45-RO⁺ frequencies were assessed directly ex vivo by surface staining at 4 °C in PBS with antiCD45RO-FITC, CD3-PE and CD4-APC (all from BD Biosciences). For post-stimulation cultures, cells were labelled with near-IR LIVE/DEAD fixable dead cell stain (Molecular Probes, Life Technologies) before fixation. For analysis of regulatory markers: CTLA-4, Foxp3 and CD25, cells were fixed, permeabilised and stained with ebioscience/Thermo Fisher Foxp3 staining buffers according to the manufacturer’s instructions. For analysis of cytokine expression, PMA/ionicmycin-stimulated cells were fixed with 3% paraformaldehyde in PBS for 12 min followed by a 5-minute wash with PBS under centrifugation. Fixed cells were permeabilised with 0.1% saponin (Acros Organics) prepared in PBS and stained with IL-17-PE, IFNγ-e+50, IL-21-APC, CD3-PerCP, CD4-FITC. For all studies cells were acquired on a Dako Cyan flow cytometer (Dako Cytomation) and data analysed using FlowJo software (Tree Star version 8.8.6). All antibodies were purchased from ebioscience/Thermo Fisher or BD Biosciences and expression quantified relative to the appropriate isotype control.

2.4. Quantitative real-time PCR

Total RNA was extracted by phenol/chloroform method after cell lysis in TRizol (Life Technologies/Invitrogen). 0.3–0.5 μg RNA was reverse transcribed with random hexamers using TaqMan reverse transcription reagents (ThermoFisher/Applied Biosystems). Quantitative real-time PCR for 18S rRNA, VDR, RXR, DRIP-205, NcoA1, NcoR1 and NcoR2, IL-17 or IFNγ was then performed on an Applied Biosystems 7900 machine using assays on demand from Applied Biosystems: 18S rRNA, (4319413E); VDR (Hs00172113_m1); RXR (Hs01045450_m1), NcoR2 (Hs00169555_m1), DRIP205 (Hs01062349_m1), NcoA1 (Hs00186661_m1); IL-17 (Hs99999082_m1) and IFNγ (Hs00989291_m1). Amplification of cDNAs involved incubation at 50 °C for 2 min and 95 °C for 10 min followed by 40 cycles of 95 °C for 15 s and 60 °C for 1 min. VDR mRNA expression was then calculated relative to 18S rRNA using the delta Ct method as described previously [30].

2.5. Statistical analysis

GraphPad Prism 5.0a software (GraphPad) was used for graphical summary and statistical analysis. For analysis of normality and Q-Q plot inspection SPSS statistics version 22 was used. Non-parametric Wilcoxon tests were used to test significance between two conditions. To test interactions between 1,25(OH)₂D₃ and cell source location repeated measures two factor within subject analysis with Huynf-Feldt correction was performed. The Shapiro-Wilk normality test and inspection of normal Q-Q plots were used to confirm that the data could be tested with these parametric models. For data sets that did not pass the normality test (VDR mRNA) the data were log₁₀ transformed, since by this transformation the residuals from the mean became normally distributed.

3. Results

3.1. Anti-inflammatory effects of 1,25(OH)₂D₃ are reduced in synovial fluid T cells

To determine whether T cells from patients with active RA are sensitive to the anti-inflammatory effects of 1,25(OH)₂D₃, peripheral blood mononuclear cells (PBMC) from the blood of healthy controls and established RA patients, as well as synovial fluid (SF) mononuclear cells (SMFC) from RA patients, were stimulated with anti-CD3 in the presence or absence of 1,25(OH)₂D₃ for seven days and the frequency of CD4⁺ T cells expressing IL-17 or IFNγ measured by flow cytometry (Fig. 1A and B). 1,25(OH)₂D₃ decreased IL-17⁺ and IFNγ⁺ T cell frequencies in HC and RA PBMCs. It also reduced frequencies of IL-17⁺ + T cells in SFMC cultures. However, 1,25(OH)₂D₃ had no effect on the frequency of IFNγ⁺ + T cells in SFMCs (Fig. 1B). Further classifying CD4⁺ T cells according to their combined expression of IL-17 and IFNγ revealed significantly greater suppressive effects of 1,25(OH)₂D₃ on Th17 (IL-17⁺+IFNγ⁺) and Th17.1 (IL-17⁺+IFNγ⁺) T cells in RA blood relative to SF, whilst Th1 (IL-17⁻IFNγ⁻) frequencies were not affected by 1,25(OH)₂D₃ in blood or SF (Fig. 1C). Thus Th17 and Th17.1 populations from the inflamed joints of RA patients are less sensitive to the anti-inflammatory effects of 1,25(OH)₂D₃ than equivalent circulating T cells. Similar results were also obtained with CD8⁺ T cells (Fig. S1), where 1,25(OH)₂D₃ decreased IL-17⁺ + CD8⁺ frequencies in HC and RA PBMC, as well as SFMC. However, 1,25(OH)₂D₃ had no effect on the frequency of IFNγ⁺ + CD8⁺ T cells in RA PBMC or SFMC.

3.2. Effects of 1,25(OH)₂D₃ are greater on blood naïve versus memory T cells

Consistent with previous studies [31], only 47% (±12%) T cells isolated from blood were memory (CD45RO⁺). By contrast, 98% (±2%) SF T cells were CD45RO⁺ (Fig. 52). We therefore determined whether the decreased effect of 1,25(OH)₂D₃ upon SF T cells could be attributed to differences between memory and naïve T cells. As shown in Fig. 2A and Fig. S3, IL-17⁺ and IFNγ⁺ T cells were more abundant in memory T cell populations. Treatment with 1,25(OH)₂D₃ suppressed IFNγ⁺ and IL-17⁺ frequencies in both naïve and memory subsets. For IL-17, 1,25(OH)₂D₃ had equal effect on naïve and memory T cells whereas the effect of 1,25(OH)₂D₃ on IFNγ expression was greatest for naïve T cells (Fig. 2B). 1,25(OH)₂D₃ also had greatest effect upon IL-21 and CTLA-4 expression in naïve T cells compared to memory T cells, with 1,25(OH)₂D₃ inducing CTLA4 in naïve T cells but having no effect on memory T cells (Fig. 3B and Fig. S3).

As it is unclear how many rounds of stimulation circulating memory T cells have experienced in vivo, we also compared the effect of 1,25(OH)₂D₃ on naïve and memory T cells during sequential rounds of stimulation (Fig. S4). Analysis of three cytokines (IL-17, IFNγ, and IL-21) showed that 1,25(OH)₂D₃ was more effective in naïve versus memory T cells at the first round of stimulation, but this difference in sensitivity was lost following the second round of T cell stimulation. These data support the concept that induction of a memory T cell phenotype reduces the anti-inflammatory effects of 1,25(OH)₂D₃ on T cells, which may in part explain the differences in 1,25(OH)₂D₃ responses between blood and SF T cells.

3.3. 1,25(OH)₂D₃ signaling components in naïve versus memory T cells

To investigate the underlying basis for reduced 1,25(OH)₂D₃ responsiveness in memory versus naïve T cells, expression of the
nuclear vitamin D receptor (VDR), its retinoid X receptor (RXR) heterodimer partner, as well as associated activator/repressor proteins was assessed. RT-PCR analyses and flow cytometry showed similar low levels of VDR in unstimulated naïve and memory T cells, with VDR expression increasing in both T cell populations following stimulation (p < 0.05 for mRNA and protein in stimulated naïve and memory T cells) (Fig. 3A). Similar to VDR, unstimulated naïve and memory T cells showed comparable low expression of RXR, but only memory T cells showed induction of this receptor upon stimulation (Fig. 3B). In addition to VDR and RXR, several co-regulators participate in 1,25(OH)2D3-mediated transcriptional responses, and these factors may contribute to variable responses to 1,25(OH)2D3 [32]. However, analysis of mRNAs for the co-enhancers DRIP205 and NcoA1, and co-repressors NcoR1 and NcoR2, showed no difference in expression between naïve and memory T cells (Fig. 3C). The decreased 1,25(OH)2D3 responsiveness of memory versus naïve T cells could therefore not be attributed to impaired expression of VDR or its signaling partners.

### 3.4. Effects of 1,25(OH)2D3 in SF versus blood memory T cells

To determine whether decreased responses to 1,25(OH)2D3 in SF compared to blood T cells involve differences between memory T cells from the two compartments, matched CD45RO + CD4+ memory T cells from paired blood and SF of RA patients were stimulated in the presence or absence of 1,25(OH)2D3. Flow cytometry for IFNγ and IL-21 showed decreased anti-inflammatory effects of 1,25(OH)2D3 in SF versus blood memory T cells, whilst a non-significant trend was observed for IL-17 (Fig. 4A). Flow cytometry and RT-PCR revealed enhanced VDR expression in unstimulated memory T cells isolated from SF relative to those obtained from blood (Fig. 4B and C), consistent with their more activated (CD69+) phenotype (Fig. 4D). VDR expression increased following memory T cell stimulation (p < 0.001 for stimulated versus unstimulated cells), but there was no significant difference in VDR expression between stimulated blood and stimulated SF cells (Fig. 4B). By contrast, mRNA for RXR did not differ in blood versus SF memory T cells in the stimulated or unstimulated state (Fig. 4B). The co-regulators DRIP205, NcoA1, NcoR1 and NcoR2 also showed elevated expression in unstimulated memory SF T cells (Fig. S5), similar to that observed for VDR. Collectively these data indicate that SF memory T cells are less affected by 1,25(OH)2D3 than memory T cells from blood, but this is not due to impaired expression of VDR or its signaling partners.

### 3.5. Effects of 1,25(OH)2D3 on Th17, Th17.1 and Th1 cells

To date, reported anti-inflammatory effects of 1,25(OH)2D3 have been based on data from mixed cultures of cytokine-expressing and non-expressing T cells. Further studies were therefore carried out to determine the effects of 1,25(OH)2D3 on T cells expressing specific cytokines. By combining anti-IL-17-PE and anti-IFNγ-APC cytokine detection reagents, live T cells were labeled according to their expression of IL-17 and/or IFNγ, and Th17, Th17.1, Th1 populations quantified by frequency in respective gate under untreated, 1,25D conditions. Significance was tested by repeated measures two-way ANOVA. ns — non-significant, * — P < 0.05, ** — P < 0.01, *** — P < 0.001.
and IFNγ (DN). RT-PCR analysis of IL-17 and IFNγ mRNA in the sorted populations confirmed cytokine purity of the sorted cells (Fig. S6). The Th17, Th17.1 and Th1 T cells generated in this manner were then re-stimulated in the presence or absence of 1,25(OH)₂D₃ for two days. In vehicle-treated re-stimulated populations, we observed plasticity of phenotype between Th17, Th17.1 and Th1, including the generation of T cells double negative for IL-17 and IFNγ (Fig. 5A). Th17 cells could give rise to IFNγ-expressing T cells, and Th1 cells could induce IL-17 expression. DN cells could also give rise to IL-17 and IFNγ (Fig. 5A).

Treatment with 1,25(OH)₂D₃ reduced expression of IL-17 or IFNγ in T cells pre-committed to Th17 and Th1 phenotypes respectively,

**Fig. 2. Effects of 1,25(OH)₂D₃ are greater on naïve than memory T cells.** Naive and memory CD4⁺ T cells were purified from the peripheral blood of healthy controls and stimulated with autologous monocytes and anti-CD3 in the presence or absence of 1,25(OH)₂D₃ (+1,25D). Frequency of cells expressing IL-17, IFNγ and IL-21 was quantified at seven days and expression of CTLA-4 and Foxp3 measured at four days by flow cytometry. (A) Frequencies of cytokine positive cells and CTLA-4 median fluorescence intensity (MFI) summarised for n = 6 donors for vehicle (closed symbols) and 1,25(OH)₂D₃ (+1,25D)-treated cells (open symbols). (B) The effect of 1,25(OH)₂D₃ on IL-17, IFNγ and IL-21 was compared for naïve and memory T cells by frequency of positive cells under untreated/1,25D conditions. A lower frequency limit of 0.001% was used for these calculations. 1,25(OH)₂D₃ effect on CTLA-4 was estimated by MFI under 1,25D/untreated conditions. Significant differences were tested using Wilcoxon matched pairs tests. ns = non-significant, * − P < 0.05, ** − P < 0.01, *** − P < 0.001.
but 1,25(OH)₂D₃ had a much greater inhibitory effect on de novo expression of IL-17 or IFNγ (Fig. 5A and B). In Th17 cells, 1,25(OH)₂D₃-sensitivity was greater for IFNγ than IL-17, whilst the opposite response was observed in Th1 cells. Moreover, 1,25(OH)₂D₃ actively suppressed the development of Th17, Th17.1 and Th1 populations from DN T cells, but had little effect on IL-17 or IFNγ expression in Th17.1 T cells that had pre-existing expression of both IL-17 and IFNγ (Fig. 5B).

3.6. Capacity for phenotype change is low in SF T cells

Further studies were carried out to determine if the impaired response to 1,25(OH)₂D₃ observed for SF versus blood T cells was due to differences in T cell phenotype commitment and plasticity. This was carried out by comparing the cytokine profiles of blood and SF T cells ex vivo and after stimulation. There were few IL-17+ T cells in blood ex vivo and these were almost exclusively Th17 (Fig. 6A, B and D). IL-17 expression was also low in SF, but this was evenly distributed across Th17 and Th17.1 populations (Fig. 6D). Compared to IL-17, considerably more T cells expressed IFNγ ex vivo in blood and SF, however, the frequency of IFNγ+ cells was much higher in SF compared to paired blood. Culture of T cells from blood for 7 days resulted in significant expansion of IL-17+ T cells (12-fold) (Fig. 6C), with the Th17.1 population showing greatest fold change (50-fold) (Fig. 6D). IFNγ+ Th1 cells from blood showed no change in frequency from ex vivo to 7 days of culture (Fig. 6A and D). In contrast to blood, culture of T cells from SF resulted in only a 2-fold induction of Th17 T cells and a 4-fold induction of Th17.1 T cells, with Th1 cells (the largest fraction of IFNγ+ T cells in SF), again showing no change in frequency from ex vivo to 7 days of culture (Fig. 6D).

The capacity for expansion of IL-17+ T cells during culture correlated directly with the ability of these cells to respond to 1,25(OH)₂D₃, with Th17 and Th17.1 cells from blood being more effectively suppressed by 1,25(OH)₂D₃ than their SF counterparts (Fig. 7). By contrast, the lack of phenotype plasticity shown for Th1 cells and cells from SF (Fig. 6A–D), was associated with lower sensitivity to 1,25(OH)₂D₃ (Fig. 7). The lack of an anti-inflammatory response to 1,25(OH)₂D₃ in SF T cells therefore appears to be due to the limited phenotype plasticity exhibited by these cells.

4. Discussion

Vitamin D metabolites such as pro-hormone 25-hydroxyvitamin D (25OHD) and active 1,25(OH)₂D₃ are detectable in SF from RA patients [19,33], and monocytes isolated from SF have been shown to actively synthesize 1,25(OH)₂D₃ from 25OHD [19,34]. Thus, there is significant potential for elevated concentrations of 1,25(OH)₂D₃ within inflamed joints. In addition, VDR is broadly expressed and present within cells from synovial tissue and fluid [35] indicating that different components of the inflamed joint have the capacity to respond to 1,25(OH)₂D₃, in an in situ or paracrine fashion [18]. As recently summarized [18], multiple in vitro studies also demonstrate anti-inflammatory effects of 1,25(OH)₂D₃ upon the immune cells that contribute to RA pathology. However, these studies have focused on cells from the blood of healthy controls or RA patients. The extent to which anti-inflammatory responses to 1,25(OH)₂D₃ also occur in immune cells from inflamed tissue is still poorly understood, but is nevertheless crucially important when considering the potential use of 1,25(OH)₂D₃ as a therapy for inflammatory diseases.

Th1 and Th17 cells are believed to contribute to inflammatory
conditions such as RA [36], and are both recognized inhibitory targets for 1,25(OH)2D3. Vitamin D supplementation may prevent, slow or reverse inflammatory disease by inhibiting these T cell subsets. The current study addressed the question of 1,25(OH)2D3 responsiveness in T cells from inflamed tissues.

Initial experiments (Fig. 1) utilized PBMC and SFMC cultures that included mixtures of cells including different types of T cells and antigen-presenting cells such as dendritic cells (DC). In this setting, and in vivo, the overall effect of 1,25(OH)2D3 on T cells may involve indirect pathways of immunosuppression. For example, indirect suppression of IL-17/IFNγ effector T cell frequency by 1,25(OH)2D3 may occur via promotion of regulatory T cell (Treg) development [37]. In supplementary studies FoxP3+CD25 Treg were found to be more abundant ex vivo in SFMC relative to PBMCs (Fig. S7A) but there was no difference between the frequency of FoxP3+CD25 cells in PBMC and SFMC cultures after CD25 stimulation (Fig. S7B). Interestingly, 1,25(OH)2D3 increased expression of CD25 in both PBMC and SFMC and CTLA-4 in SFMC alone (Fig. S7B). However, in contrast to PBMC, 1,25(OH)2D3 did not increase FoxP3+CD25 T cell frequencies in SFMC. It is therefore possible that the suppressive effect of 1,25(OH)2D3 upon CD4 T cell IL-17 and IFNγ in PBMC cultures relative to SFMC involves, in part,
enhancement of Treg differentiation and therefore stronger 1,25(OH)2D3-mediated effector T cell immunosuppression PBMC relative to SFMC. 1,25(OH)2D3 also has profound effects on antigen presenting cells (APC) such as dendritic cells (DC) that may indirectly impact T cell function [38]. It is also important to recognize that APC are the main source of active 1,25(OH)2D3 from precursor 25(OH)D3 for T cells in vivo [5,6]. Thus, the potential contribution of DC to altered 1,25(OH)2D3 sensitivity of T cells from synovial fluid is likely to be highly complex and warrants detailed future study that considers responses to 1,25(OH)2D3 and 25(OH)D3. By isolating T cells from SFMC and PBMC we were able to clearly demonstrate that the lack of anti-inflammatory response to 1,25(OH)2D3 in mixed cell cultures of SFMC involves, at least in part, an intrinsic insensitivity to 1,25(OH)2D3 by CD4+ T cells at the inflamed site. We therefore predict that similar T cell insensitivity to 1,25(OH)2D3 occurs in vivo within the inflamed joints of RA patients. Conversely, the lack of effect of 1,25(OH)2D3 on IFNγ production by CD8+ T cells even in PBMC may reflect the fact that the IL-17+IFNγ+ population of IFNγ+ cells that is the principal target for 1,25(OH)2D3 is minimal in CD8+ T cells relative to CD4+ T cells, even under control conditions (Fig. S1).

Both naïve (CD45RA+) and memory (CD45RO+) T cells were able to respond to 1,25(OH)2D3, but inhibition of inflammatory cytokines was more pronounced for naïve T cells, and became less effective upon transition from naïve to memory. These findings suggest that variations in the proportion of naïve to memory T cells play a key role in defining the anti-inflammatory impact of 1,25(OH)2D3 in vivo, especially at the inflammatory site where memory T cells are the dominant T cell type [31]. Furthermore, whilst naïve to memory transition accounted for most of the loss in 1,25(OH)2D3 effect upon SF T cells, comparing memory T cells from blood with those from SF revealed a further decline in 1,25(OH)2D3 sensitivity in SF cells. Collectively, these data indicate that analysis of 1,25(OH)2D3-responses using T cells from blood, even blood from RA patients, may over-estimate the ability of vitamin D to regulate inflammatory T cells in disease-affected synovial fluid.

Th17 and Th1 T cell subsets not only play a critical role in the pathophysiology of inflammatory diseases such as RA, they are also pivotal to host responses to infectious pathogens such as Mycobacterium tuberculosis [39]. In this setting, 1,25(OH)2D3 is proposed to be less effective in the early stages of infection, where T cells are not chronically activated and therefore have lower levels of VDR expression. The resulting insensitivity to 1,25(OH)2D3 during early infection is advantageous in enabling maintenance of inflammatory T cell populations for maximal clearing of pathogenic antigen [40].
By contrast, at later stages of immune response to infection, more activated T cells express higher levels of VDR and are therefore more sensitive to 1,25(OH)2D3, with the principal response being minimization of T cell activity and chronic inflammation [40]. Data from the current study suggest that in chronically activated T cells from inflammatory sites such as the rheumatoid joint, there is re-instatement of 1,25(OH)2D3-insensitivity. However, in contrast to early stage T cell responses, decreased responsiveness to 1,25(OH)2D3 in activated SF T cells does not appear to be due to lower VDR-binding capacity for 1,25(OH)2D3: VDR expression was increased in SF T cells ex vivo consistent with the activated CD69+ phenotype of these cells, and levels of VDR and co-regulator proteins were similar for blood and SF T cells following in vitro stimulation. Likewise differential expression of VDR and its co-regulators did not account for the lesser effect of 1,25(OH)2D3 on anti-inflammatory responses by memory vs naive T cells.

Several single nucleotide polymorphisms (SNPs) in the VDR gene have been associated with RA risk and severity [41], although the functional consequence of these VDR genetic variations yet to be defined. VDR polymorphisms were not explored in this study. Whilst it is possible that differences could influence patient sensitivity to 1,25(OH)2D3 systemically, it is unlikely that they would contribute to the differential 1,25(OH)2D3 sensitivity of blood versus SF T cells as the same VDR would be expressed in different tissues. In addition to SNPs, however, a number of 5′ variant VDR transcripts have been described that are driven by alternative promoters and display tissue specific patterns [42]. It is therefore possible that an inflammation-induced switch in VDR isoform could influence the sensitivity of SF T cells relative to blood despite equivalent levels of VDR expression, and this will be a key target for future studies of 1,25(OH)2D3 sensitivity in RA.

An additional feature of memory T cells versus naive is their commitment to phenotype as defined by cytokine expression. T cells that express multiple inflammatory cytokines including those doubly expressing IL-17 and IFNγ (Th17.1 cells) are regarded the most pathogenic in inflammatory disease [43]. Correspondingly, Th17.1 cells were present at increased frequency in SF T cells ex vivo compared to blood. Previous studies into 1,25(OH)2D3 effects upon T cell cytokine expression have used mixed cultures of cytokine-expressing and non-expressing cells, making it impossible to determine effects of 1,25(OH)2D3 upon phenotype-committed T cells which, as our data on phenotype maintenance following stimulation suggest, are more enriched in SF compared to blood. By using novel cytokine cell capture methods to sort live Th17, Th17.1,
5. Conclusion

Data in the current study endorse the potential use of vitamin D and/or 1,25(OH)₂D₃ in controlling the de novo generation of Th17 and Th17.1 cells that are associated with inflammatory disease. However, the limited effect of 1,25(OH)₂D₃ on phenotype-committed T cells from the site of inflammation suggests that vitamin D supplementation is unlikely to be successful as treatment for established active RA patients. Consistent with this hypothesis, not all early vitamin D supplementation trials in RA have reported positive effects of the treatment [48–50]. The fact that peripheral blood T cells from patients were responsive to the anti-inflammatory effects of 1,25(OH)₂D₃, and equally as responsive as those from healthy donors, nevertheless supports a use for vitamin D in the management of RA, either as a prophylactic or to reduce the risk of future disease flares in patients in remission. Owing to its powerful anti-inflammatory effects in vitro, vitamin D supplementation has been proposed as a cost-efficient, ‘natural’ and low-risk treatment strategy in multiple inflammatory diseases. However, since memory T cells with committed inflammatory phenotypes dominate the inflamed tissues in multiple inflammatory conditions, this study raises questions about widespread application of vitamin D therapy in the management of inflammatory diseases, especially cases of established, active disease. Further studies are required to identify the cause of the insensitivity to 1,25(OH)₂D₃ at the molecular level. Strategies to overcome this and restore 1,25(OH)₂D₃ sensitivity in inflammatory phenotype-committed memory T cells at the inflamed site may provide a novel approach to the treatment of RA and other inflammatory diseases.

Acknowledgements

The authors would like to thank Kath Howlett and Holly Adams for help in processing patient samples. LJ, DS, KR, MH designed the research. AF, and KR, consulted and consented patients and obtained clinical samples. LJ, PH, NM performed experiments. LJ analysed data and performed statistical analyses. LJ, KR and MH wrote the manuscript. Research was funded by the European Union (FP7-HEALTH-F2-2012-305549 to KR), National Institutes of Health (R01 AR063910 to MH), Arthritis Research UK (The Arthritis Research UK Rheumatoid Arthritis Pathogenesis Centre of Excellence is funded by Arthritis Research UK grant number 20298), and Royal Society Wellson Merit Award (WM130118 to MH). PH and NM were funded by Wellcome Trust and Dr Hadwen Trust (DSAA RDF019454) summer studentships respectively. This report is independent research supported by the National Institute for Health Research/Wellcome Trust Clinical Research Facility at University Hospitals Birmingham NHS Foundation Trust. The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health.

Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.jaut.2017.10.001.

References


Fig. 7. T cell responses to 1,25(OH)₂D₃ correlate directly with capacity for phenotype change. Bidirectional plot of fold change in frequency of the population (Th17 blood (Bld), Th17 synovial fluid (SF), Th17.1 Bld, Th17.1 SF, Th1 Bld, Th1 SF) after seven day culture under control conditions versus the ratio of the population frequency in the presence versus the absence of 1,25(OH)₂D₃. Correlation significance was tested by Pearson’s analysis and the linear regression line with 95% confidence interval (hashed line) is shown.


