Myeloid-Derived Suppressor Cells Prevent Type 1 Diabetes in Murine Models

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Effective immunotherapy for type 1 diabetes (T1D) relies on active induction of peripheral tolerance. Myeloid-derived suppressor cells (MDSCs) play a critical role in suppressing immune responses in various pathologic settings via multiple mechanisms, including expansion of regulatory T cells (Tregs). In this study, we investigated whether MDSCs could act as APCs to induce expansion of Ag-specific Tregs, suppress T cell proliferation, and prevent autoimmune T1D development. We found that MDSC-mediated expansion of Tregs and T cell suppression required MHC-dependent Ag presentation. A murine T1D model was established in INS-HA/RAG−/− mice in which animals received CD4-HA-TCR transgenic T cells via adoptive transfer. We found a significant reduction in the incidence of diabetes in recipients receiving MDSC plus HA, but not OVA peptide, leading to 75% diabetes-free mice among the treated animals. To test further whether MDSCs could prevent diabetes onset in NOD mice, non diabetic NOD/SCID mice were injected with inflammatory T cells from diabetic NOD mice. MDSCs significantly prevented diabetes onset, and 60% of MDSC-treated mice remained diabetes free. The pancreata of treated mice showed significantly lower levels of lymphocyte infiltration in islet and less insulitis compared with that of the control groups. The protective effects of MDSCs might be mediated by inducing anergy in autoreactive T cells and the development of CD4+CD25+Foxp3+ Tregs. This study demonstrates a remarkable capacity of transferred MDSCs to downregulate Ag-specific autoimmune responses and prevent diabetes onset, suggesting that MDSCs possess great potential as a novel cell-based tolerogenic therapy in the control of T1D and other autoimmune diseases. The Journal of Immunology, 2010, 185: 5828-5834.

Type 1 diabetes (T1D; diabetes mellitus) is an insulin-dependent disorder characterized by kidney failure, blindness, heart disease, and chronic ulcers (1). It is now clear that the chronic inflammatory response against specific autoantigens, mainly insulin, leads to the eventual destruction of insulin-producing endocrine β cells. Daily injection of insulin cannot match the naturally precise timing and dosing of insulin secretion of the pancreas in response to hyperglycemia. Even well-managed diabetic patients, therefore, can experience severe treatment side effects and worsening of their disease (2). More recently, a variety of strategies has been developed, aimed at re-establishing physiological insulin production in diabetic patients (3). Despite these advancements, devising a means capable of restoring self-tolerance or specifically down-modulating autoimmunity remains a critical step toward preventing and/or reversing T1D. In this respect, regulatory T cells (Tregs) have received particular attention (4).

Myeloid-derived suppressor cells (MDSCs) represent a population of myeloid origin with immunoregulatory activity. These cells can function to suppress Ag-specific and nonspecific T cell responses via diverse mechanisms (5–9). Accumulating evidence has implicated a potential broad application of MDSCs as a novel cell-based immunotherapy within the fields of transplantation and autoimmune diseases (10–12). To date, transfer of MDSCs has been shown to be capable of inducing immune tolerance in allogeneic bone marrow transplantation (13), prolonging the survival of allo-skin transplants via inhibitory receptor Ig-like transcript 2 mediated tolerance (14), participating in anti-CD28-mediated tolerance in allo-kidney transplantation (15), and amelioration of symptoms in the inflammatory bowel disease model (10). In this study, we have shown that adoptive transfer of CD115*Gr-1+ MDSCs plus hemagglutinin (HA) peptides efficiently prevents the onset of HA-specific TCR T cell-induced diabetes in INS-HA/RAG−/− recipient mice. Further, MDSCs prevented diabetes onset in NOD/SCID mice and maintained these mice diabetes-free for the long term.

Materials and Methods

Mice

CD4-HA-TCR transgenic mice (BALB/c, H-2d), a gift from Dr. Constantin A. Bona (Mount Sinai School of Medicine, New York, NY), express the 14.3d HA-specific TCR, which recognizes the influenza hemagglutinin (HA, 110-120) of A/PR/834 influenza virus in association with I-Eβ. INS-HA/RAG−/− mice (B10.D2, H-2d) express the HA protein in pancreatic β cells under the control of the rat insulin promoter. MHC class I KO, MHC class II KO, and actin-OVA transgenic mice were purchased from...
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The Jackson Laboratory (Bar Harbor, ME). All animal experiments were performed in accordance with the animal guidelines of the Mount Sinai School of Medicine.

**Peptide and Abs**

HA peptide (H9GFERFEIFKPE230) and OVA peptide (L13SQAVHAA-HAINEAGRG239) were purchased from Washington Biotechnology (Baltimore, MD). All fluorescence-conjugated monoclonal Abs were purchased from eBioscience (San Diego, CA).

**Isolation of MDSCs**

BALB/c mice bearing syngeneic colon cancer MCA26 and C57BL6 mice bearing syngeneic Lewis lung carcinoma were used as the source of MDSCs. The detailed Percoll protocol for MDSC isolation has been described previously (6). The fraction II Gr-1+CD11b+ MDSCs were sorted by flow cytometry, and cells with a purity of 98% were used in the INS-IA diabetic model.

**Treg expansion and suppression of CD4+CD25 T cell proliferation by MDSCs**

CFSE-labeled, purified CD4+CD25 Tregs and CD4+CD25+ T cells from naive CD4-HA-TCR transgenic mice (BALB/c background) or CD4-OVA-specific TCR transgenic (OT-II) mice (B6 background) were cocultured with MDSCs, at a 4:1 ratio, in the presence of HA or OVA peptides (0.5 μg/ml) and IL-2 (100 U/ml) for 4 d. Proliferation was assessed by flow cytometry (CFSE dilution) using fluorochrome-labeled Abs against CD4, CD25, and Foxp3 or isotype controls.

**Diabetes model**

CD4-HA-TCR transgenic T cells were enriched by T cell enrichment (CA). Female NOD/SCID females (B6 background) were cocultured with CD4.CD25+Foxp3+ Tregs and CD4.CD25- T cells from normal; >50% MDSCs, the proliferation of CD4.CD25- T cells was significantly suppressed (9.4 ± 2.6% and 18.4 ± 5.0%; p < 0.001, compared with control splenocytes with OVA peptide and irradiated naive splenocytes (53.5 ± 5.4%) (CT. Fig. 2B). In the presence of WT MDSCs and OVA peptide, Treg expansion was not significantly decreased (77.0 ± 10.0%; p < 0.001). Taken together, these data suggest that MDSC-mediated Treg expansion is Ag-specific and MHC class II dependent.

**Histopathological analysis**

Pancreatic tissue was fixed in 10% buffered formalin solution and embedded in paraffin. Prepared sections were stained by Mayer's H&E. For each organ, 10 sections were analyzed. Staining for intracellular insulin was performed using polyclonal rabbit anti-insulin (Santa Cruz Biotechnology, Santa Cruz, CA) in conjunction with HRP-goat-anti-rabbit conjugate (Southern Biotechnologies, Birmingham, AL). Additional tissue samples were frozen at ~80°C, and frozen sections were cut in stepwise fashion (8 μm per section). Staining for CD4 T cells in islets was performed using monoclonal anti-CD4 (eBioscience) in conjunction with HRP-goat-anti-mouse conjugate (Southern Biotechnologies).

**Cytokine detection by ELISA**

The concentrations of mouse IFN-γ, IL-10, and TGF-β in the culture supernatants were measured by ELISA (R&D Systems).
MDSC SUPPRESSES TID ONSET

FIGURE 1. MDSC-mediated Treg expansion requires MHC class II-restricted Ag presentation. MDSCs were isolated from tumor-bearing WT, actin-OVA transgenic, MHC class I KO, or MHC class II KO mice. Purified CD4+CD25- Tregs from naive OT-II transgenic mice were labeled with CFSE and cocultured with MDSCs at a 4:1 ratio for 4 d in the presence or absence of exogenously added OVA peptides. Peptide 53.5% (Fig. 2B), MHC class II-deficient MDSCs lost their suppressive activity, whereas MHC class I-deficient MDSCs remained suppressive (percentage proliferating CD4+CD25- OT-II T cells: 67.2 ± 16.0% versus 17.5 ± 5.5%).

Collectively, these data indicate that both MDSC-mediated suppression of T cell proliferation and Treg expansion are Ag-dependent and MHC class II-restricted processes.

MDSCs prevent the onset of autoimmune T cell-mediated diabetes

Evaluation of autoimmune responses against natural autoantigens has been impeded due to the polyclonal nature of autoimmune T cells and the lack of traceable markers for in vivo studies. Moreover, the results depicted in Figs. 1 and 2 indicate that both MDSC-mediated suppression of T cell proliferation and Treg expansion were both Ag-dependent and MHC class II restricted. Therefore, we chose a well-characterized TID model (18) in which a surrogate autoantigen and Ag-specific TCR transgenic T cells were used to induce diabetes. In this model, T cells isolated from the CD4-HA-TCR transgenic mice were adoptively transferred into INS-HA/RAG-/- mice. For the proof-of-principle study, we used MDSCs isolated from tumor-bearing mice and HA peptide as autoantigen to induce suppression of autoreactive T cells and expansion of autoreactive Tregs.

Consistent with previous reports (18), the onset of diabetes, as determined by high blood glucose levels (≥200 mg/dl), was readily detectable 7–10 d after T cell injection. This was true for all treated mice that received MDSCs plus OVA, control cells from Fr.3 cells plus HA, or PBS. However, the incidence of disease was drastically decreased in mice receiving MDSCs plus HA peptides, with 75% of all treated mice remaining diabetes free (Fig. 3; p < 0.005). These data strongly imply that transfer of MDSCs plus HA peptide can effectively suppress the HA-specific T cell-mediated immune response against pancreatic islet cells expressing HA and, thus, prevent the development of diabetes in INS-HA/RAG-/- recipient mice.

MDSCs inhibit lymphocyte infiltration and insulitis

Lymphocyte infiltration and the resultant inflammation is a hallmark feature of diabetes. To better understand the effect of MDSCs on the suppression of diabetes development, we examined the histological changes in the pancreata of treated mice. H&E staining
indicated those recipients of MDSCs plus HA peptide had intact islets, and the severity of insulitis in these mice was markedly reduced (Fig. 4, upper left panel). In sharp contrast, examination of nontreated (PBS) mice showed massive peri-islet infiltration of mononuclear cells (Fig. 4, upper right panel). These observations were further verified by assessing CD4 T lymphocyte infiltration. MDSC plus HA peptide recipients showed only minimal staining (Fig. 4, middle left panel), whereas the islets recovered from PBS-treated mice contained large numbers of CD4 T cells (Fig. 4, middle right panel). Furthermore, immunohistochemical staining for insulin revealed strong insulin expression in the intact islets of mice treated with MDSCs plus HA (Fig. 4, lower left panel). On the contrary, insulin production was almost absent from the pancreata of mice that received transferred T cells and destruction of insulin-producing islets, thus avoiding the harmful inflammatory response against islet cells and destruction of insulin-producing β cells.

**MDSCs mediate T cell tolerance**

We postulated that the profound suppression of T cell infiltration into the islets of treated mice likely resulted from potent induction of T cell tolerance by MDSCs. To test this idea, we reisolated autoreactive CD4-HA-TCR T cells from treated mice and examined their ability to proliferate in vitro. As shown in Fig. 5A, T cells recovered from mice receiving MDSCs + OVA, control cells from Fr.3 + HA, or PBS proliferated vigorously upon restimulation with HA peptide. In the group treated with MDSCs + HA, T cells isolated from clinically diabetic mice still proliferated to some extent, but those from diabetes-free mice exhibited barely detectable proliferative potential, similar to that of naive mice (without HA-CD4 T cell transfer). The inability of T cells to proliferate in response to specific Ag stimulation suggests that an anergic state was actively induced in the autoreactive T cells from the mice treated with MDSCs + HA.

We also assessed cytokine expression in the culture supernatants harvested from the above T cell proliferation assays. Strikingly, although there was no substantial difference in IFN-γ production between all HA-CD4 T cell transferred groups, large amounts of IL-10 and TGF-β were detected only in samples from diabetes-free mice treated with MDSCs + HA (Fig. 5B; p < 0.001). This indicates that regulatory, rather than inflammatory, cytokines were generated in vivo in the presence of MDSCs, and, hence, these factors may play a critical role in the induction of T cell tolerance by MDSCs.

**MDSCs induce Treg development**

Previous studies from our group and others have demonstrated that MDSCs exhibit an exceptional ability to activate and expand Tregs (6, 17), a cell type shown to be a key component in the regulation of T1D and other autoimmune responses. To assess the potential involvement of Tregs in the control of T1D by MDSCs, Treg development in secondary lymphoid organs (i.e., spleen) was evaluated. As shown in Fig. 6A, T cells recovered from diabetes-free mice receiving MDSCs and HA peptide contained a significantly higher percentage (35.5%) of Foxp3+CD4+CD25+ T cells compared with that of T cells recovered from diabetic mice (15.0%) receiving the same treatment or control treatments. We further confirmed these findings by examining Foxp3 gene expression by both RT-PCR (Fig. 6B, upper panel) and real-time RT-PCR (Fig. 6B, lower panel), which demonstrated that the highest level of Foxp3 gene expression was detected in nondiabetic mice that received MDSC and HA treatment (lane 1). These results suggest that transfer of HA peptide pulsed MDSCs induced a considerable proportion of autoreactive T cells to become Tregs.
We then aimed to test whether MDSC-induced Tregs possess suppressive activity. T cells purified from naive CD4-HA-TCR transgenic mice and CD25+ T cells isolated from diabetes-free mice receiving MDSC plus HA were cultured alone or in the presence of HA peptide at various ratios. The results indicate that the CD25+ T cells from nondiabetic mice mediated potent suppression of Ag-specific T cell proliferation in a dose-dependent manner (Fig. 6C).

**Effects of MDSCs on the development of diabetes in NOD/SCID mice**

To test whether MDSCs could affect the development of TID in another murine model, NOD/SCID mice were adoptively transferred with PBS, splenic CD4+ T cells isolated from NOD diabetic mice, or splenic CD4+ T cells from NOD diabetic mice along with MDSCs. NOD/SCID mice treated with PBS did not develop diabetes (nontreatment, Fig. 7A). In sharp contrast, NOD/SCID mice, which received autoreactive CD4+ T cells from diabetic NOD mice, did become diabetic around day 10, as evidenced by fasting blood glucose levels over 200 mg/dl (CD4, Fig. 7A). However, a single adoptive transfer of MDSCs effectively decreased the rate of diabetes development (CD4 + MDSC, Fig. 7A), and 60% of the animals remained diabetes-free as long as 100 d posttreatment. We also assessed the extent of leukocyte infiltration, a hallmark of insulinis, in the above mice at 15 d postinjection. We consistently found that adoptive transfer of CD4+ T cells, versus PBS control transfer, significantly increased the extent of leukocyte infiltration into the pancreata of NOD/SCID mice (nontreatment versus CD4, Fig. 7B). In contrast, inclusion of MDSCs remarkably decreased the extent of leukocyte infiltration (Fig. 7B). These findings regarding dysregulated glucose and insulinis suggest that MDSCs can suppress autoreactive T cells and thereby prevent TID in the NOD system. As shown in Supplemental Fig. 1, this protective effect was maintained even at lower MDSC doses.

**Discussion**

In recent years, MDSCs have garnered increased interest. Previous studies have shown that MDSCs may be involved in down-modulating alloimmune responses in a variety of allogeneic transplant models (11–15). In this study we provide firm evidence...
that in vitro MDSC-mediated suppression of CD4+CD25− T cell proliferation and Treg expansion were Ag-dependent, MHC class II-restricted processes, and that MDSCs were effective at perturbing the autoimmune response in the two diabetic animal models tested. Using a transgenic murine model of autoimmune diabetes, we demonstrated that injection of CD115Gr-1+ MDSCs and HA peptide, a surrogate autoantigen, could efficiently protect INS-HA/RAQ−− mice from HA-specific TCR T cell-mediated diabetes in an Ag-dependent fashion. In addition, we observed markedly reduced lymphocyte infiltration and islets in the islets of the MDSC-treated mice. We also confirmed the ability of MDSCs to prevent the natural autoimmune T cell response in NOD/SCID diabetic mice. These findings suggest that MDSCs may have great translational implications for treating T1D and other autoimmune diseases.

The protective effects afforded by MDSC treatment include hypoproliferation of autoreactive T cells and dramatically decreased infiltration of T lymphocytes into pancreatic islets in the diabetes-free treated mice. The latter likely results from an early onset or progression of TID in both models tested.

In conclusion, our findings clearly indicate that MDSCs may provide long-term protection against the onset of T1D. We and others have shown that monocytes may play a crucial role in preventing graft-versus-host disease in allo-organ transplantation. Using our Gr-1+CD11b+ MDSC population, we observed a significant treatment effect even at doses as low as 1 × 10^7/mouse and with only a diminutive monocyte population (4–6%; Supplemental Fig. 2). We continue to investigate the relative potency of monocytes versus granulocytic MDSCs. Quantifying the relative abilities of monocytes and granulocytic MDSCs to provoke immune suppression and give rise to Ag-specific immune tolerance is an area of continued investigation.

In conclusion, our findings clearly indicate that transfer of MDSCs conferred an exceptional capability to establish immune tolerance to self-Ag and protect against the onset of autoimmune T1D.

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Disclosures

The authors have no financial conflicts of interest.

References


