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Skin Homing (Cutaneous Lymphocyte-Associated Antigen-Positive) CD8+ T Cells Respond to Superantigen and Contribute to Eosinophilia and IgE Production in Atopic Dermatitis

Mübeccel Akdis, Hans-Uwe Simon, Lorenz Weigl, Oliver Kreyden, Kurt Blaser, and Cezmi A. Akdis

In allergic inflammations of the skin, activation of CD4+ T cells was demonstrated to play an important role; however, a minor role for CD8+ T cells is implied. In the present study, we compared cutaneous lymphocyte-associated Ag (CLA)-expressing CD4+ and CD8+ subsets, which were isolated from peripheral blood and lesional skin biopsies in atopic dermatitis (AD) patients. We demonstrated that CD8+ CLA+ T cells proliferate in response to superantigen and are as potent as CD4+ CLA+ T cells in IgE induction and support of eosinophil survival. In atopic skin inflammation, the existence of high numbers of CD4+ and CD8+ T cells was demonstrated by immunohistochromistry and by culturing T cells from skin biopsies. In peripheral blood, both CD4+ and CD8+ subsets of CLA+CD45RO+ T cells were in an activated state in AD. The in vivo-activated CLA+ T cells of both subsets spontaneously released an IL-5- and IL-13-dominated Th2 type cytokine pattern. This was confirmed by intracytoplasmic cytokine staining immediately after isolation of the cells from peripheral blood. In consequence, both CD4+ and CD8+, CLA+ memory/effector T cells induced IgE production by B cells mainly by IL-13, and enhanced eosinophil survival in vitro by delaying eosinophil apoptosis, mainly by IL-5. These results indicate that in addition to the CD4+ subset, the CD8+ CLA+ memory/effector T cells are capable of responding to superantigenic stimulation and play an important role in the pathogenesis of AD. The Journal of Immunology, 1999, 163: 466–475.
Materials and Methods

Study population

Nineteen patients, 11 female and 8 male, with chronic AD (mean age, 31 yr) who fulfilled the criteria of Hanifin and Rajka (30) and who required hospitalization were selected for the study. All were polyallergic and had positive cutaneous tests to at least three allergoeluidants. None of these patients had asthma. Patients showed specific IgE Abs at radioulogeosorbent test class ≥2 and total IgE of >400 U/mL (mean, 3219 ± 1862 IU/mL). None of the patients had systemic immunosuppressive treatment at least 1 mo before peripheral venous blood was taken. Skin biopsies were therefore five of the AD patients after receiving their informed consent. Total IgE of patients who underwent skin biopsy was 9132 ± 3265 IU/mL. Peripheral eosinophilia was 9.75 ± 2.39%. They were all severely ill patients who required hospitalization. Five healthy individuals (mean age, 28 yr) with no history of atopy were included in the study as normal control group. Their mean IgE levels were 72 ± 18 IU/mL. The study was approved by the ethical committee of Davos, Switzerland.

Abs and reagents

The CLA-specific rat mAb HECA-452 was kindly provided by Dr. E. Butcher, Stanford University, Palo Alto, CA (18–20). All fluorescent- or biotin-labeled mAbs for cell purification or FACS analyses were purchased from Coulter (Hialeah, FL), Immunotech (Marseilles, France), or Phar-Mingen (San Diego, CA). Anti-CD4, anti-CD8, anti-CD14, anti-CD19, anti-mouse Ig, and streptavidin-conjugated magnetic microbeads for Magnet Activated Cell Sorting (MACS) cell separation were from Miltenyi Biotech (Marburg, Germany). Anti-CD2 (4B2 and 6G4) and anti-CD28 (15E8) mAbs were from the Red Cross Blood Transfusion Service, Amsterdam, The Netherlands. Anti-CD3 was produced by clone CRL 8001 obtained from American Type Culture Collection (Manassas, VA). Anti-CD4 mAb was obtained from Novocastra Laboratories (Newcastle, U.K.). Anti-CD8 and control mAbs were purchased from Dako (Zug, Switzerland). Neutralizing anti-IL-4 mAbs (8F12 and 3H4) and anti-IFN-γ mAbs 45-15 were provided by Novartis (Basel, Switzerland). Anti-IL-13 mAbs (JE8-5A2 and JE510-2P9) and mutant IL-4 antagonist (Y121D) with an IL-4-like IL-13 antagonist activity were provided by UWX-Research Institute (Palo Alto, CA). Neutralizing anti-IL-5 and anti-GM-CSF were purchased from R&D Systems (Abingdon, U.K.) and PharMingen.

Culture of T cells from skin biopsies

Biopsies from AD skin lesions that were not treated by any topical treatment were incised at 8 mm diameters with 1% Xylocaine as local anesthesia. The biopsy specimens were minced with two scalpels; no proteolytic enzymes were used. Skin fractions from biopsy specimens were cultured in 25 U/mL IL-2 containing RPMI 1640 supplemented with 1 mM sodium pyruvate, 1% MEM nonessential amino acids and vitamins, 2 mM L-glutamine, 100 U/mL penicillin, 100 μg/mL streptomycin, 50 μg/mL 2-ME (all from Life Technologies, Basel, Switzerland), and 10% heat-inactivated FCS (SerA-Lab, Sussex, U.K.). Three times and resuspended in DMEM (Life Technologies, Basel, Switzerland), 2% heat-inactivated FCS (SerA-Lab, Sussex, U.K.), 100 U/mL penicillin, and 100 μg/mL streptomycin (both from Life Technologies). CLA+ and CLA− cells were isolated with the MACS magnet-activated cell separation system (Miltenyi Biotech) as described in detail (21, 23, 26). In brief, anti-CD3- and anti-CD19-depleted cells were incubated with MACS microbead-conjugated anti-CD45RA and anti-CD16 mAbs and anti-CD4 or anti-CD8. The negatively selected CD4+CD45RO+ and CD8+CD45RO+ T cells were sequentially incubated with anti-CLA-CD45RA goat-antirat IgG, biotin-conjugated mAb HECA-452, streptavidin-conjugated microbeads. The magnetic (CD4+CLA+CD45RO+ or CD8+CLA+CD45RO+) and nonmagnetic (CD4+CLA+CD45RO− or CD8+CLA+CD45RO−) T cell fractions were recovered by sequential elution from the MACS column. This procedure yielded 5 × 103–1.5 × 106 CLA+ T cells, 9 × 104–2.4 × 105 CLA− T cells, 3 × 105–9 × 104 RPE-labeled anti-IL-4, anti-IL-5, anti-IL-13, or anti-IFN-γ mAbs and R-PE-labeled anti-CD14, anti-CD19, and anti-CD34 mAbs from PBMC. The CD4+ T cell population was further collected by MACS bead elution and CD14+ and CD19+ cells were negatively selected by MACS purification. Although CLA+CD45RO+ T cells were positively selected by MACS purification, it was clearly demonstrated in the previous studies that ligation of CLA with HECA-452 mAb induces neither proliferation nor cytokine production (23, 26).

Flow cytometric analysis

After purification, 5 × 104 cells were sequentially stained with FITC-conjugated anti-CLA mAb HECA-452, together with anti-CD4-EC or anti-CD8-PEC and either anti-IFN-γ mAbs and R-PE-labeled anti-IL-4, anti-IL-5, anti-IL-13, or anti-IFN-γ mAbs and R-PE-labeled goat IgM and streptavidin- or CD45RO-PE. Stained cells were fixed in 2% paraformaldehyde. The controls were FITC-conjugated rat IgM and FITC- or ECD-conjugated mouse IgG1. The purity of the CLA+, CD4+, and CD8+ populations ranged from 93 to ≥99%.

Indocyanine-staining experiments in CLA+ and CLA− T cells was performed by fixing and permeabilizing the cells immediately after purification from PBMC with a paraformaldehyde and saponin solution (ORTHO PermeaFix, Ortho Diagnostic Systems, Raritan, NJ) (26, 32). After washing with PBS containing 5% FCS, 1.5% BSA (Sigma, St. Louis, MO), and 0.0055% EDTA (Fluka, Chemie), cells were stained with 0.5 μg/mL CD45RO PE and streptavidin- or CD45RO-PE labeled rat IgG1 and rat IgG2a control Ab (all from PharMingen) for 30 min at 4°C. The flow cytometric analysis was performed by an Epics Profile II (Coulter).

T cell cultures

Freshly isolated CLA+ and CLA− T cells were resuspended in the above supplemented RPMI 1640 medium. Spontaneous cytokine secretion was determined in supernatants of 107 freshly isolated, unstimulated cells, cultured in 200 μL medium for 24 h. Cultures were performed in 96-well flat-bottom plates (Costar, Cambridge, U.K.). Time points for harvesting the supernatants were chosen according to previous kinetic studies (26). The spontaneous proliferation of the cell subsets was analyzed by a [3H]Tdr incorporation of 105 cells in 200 μL medium in 96-well flat-bottom plates that were pulsed with 1 μCi/well [3H]Tdr (ICN) for 24 h immediately after purification. The CLA+ or CLA−T cells isolated from peripheral blood or skin of the patients were stimulated with different doses of SEB in 200 μL medium in 96-well flat-bottom plates that were pulsed with 1 μCi/well [3H]Tdr (ICN). The plates were harvested on glass fiber plates, and radioactivity was measured in a β-plate reader (Phar-macia-Wallac, Turku, Finland). Cytokine production by SEB stimulation was determined in parallel cultures from supernatants taken after 3 days.

Induction of IgE and IgG4 production

B cells were purified by MACS microbead-conjugated anti-CD19 after depletion of monocytes with microbead-conjugated anti-CD14 (26). Either CD4+ or CD8+ subsets of CLA+ or CLA− T cells (105/200 μL/well, 96-well plate) were cocultured with the same number of purified B cells at 37°C in a 5% CO₂ atmosphere. IgE and IgG4 were determined in supernatants taken after 12 days. Production of Ig production was attempted by...
addition of neutralizing mAbs to IL-4 or IL-13, each at 10 µg/ml. The neutralization capacity of the anticytokine mAbs was previously established (26, 33). Mutant IL-4 and IL-13 antagonist Y124D is used at 100 ng/ml (34). Mouse IgE1 (10 µg/ml) (Immunotech) was used as a control. All experiments were performed in triplicate.

Quantification of cytokines and Ig isotypes
Solid phase sandwich ELISAs for IFN-γ, IL-3, IL-4, IL-5, IL-13, and GM-CSF are described (26, 31, 35, 36). Briefly, microtiter plates (Maxisorb, Nunc, Roskilde, Denmark) were coated with mAb 43-11 to human IFN-γ and developed with biotinylated mAb 45-15. The sensitivity of the IFN-γ ELISA was <10 pg/ml (mAbs and IFN-γ standard were gifts from Dr. S. S. Alkan, Novartis, Basel, Switzerland).

IL-4 was measured by using mAb 3H4 for coating and biotinylated mAb 1F12 for detection (mAbs and IL-4 standard were provided by Dr. C. H. Heusser, Novartis). The sensitivity of IL-4 ELISA was <30 pg/ml. IL-5 was determined by using mAb TRFK5 for coating and biotinylated mAb JES15-A10 for detection (mAbs and IL-5 standard were from Pharmingen). The detection limit of the IL-5 ELISA was 50 pg/ml. IFN-γ, IL-4, and IL-5 ELISAs were developed by peroxidase-labeled Extravidin (Sigma), and o-phenylenediamine HCl in citrate buffer, pH 5.5, was used as substrate. Optical density was measured at 490 nm in an ELISA reader (Molecular Devices, Menlo Park, CA) after stopping the reaction with 0.5 N H₂SO₄.

For the detection of IL-13, the mAb JES10-29F (kindly provided by DNAx Research Institute) was used for coating. Recombinant IL-13 from PeproTech (Rocky Hill, NJ) was used as a standard. Rabbit anti-IL-13 (PeproTech) and alkaline phosphatase-labeled goat anti-rabbit Ab (Zymed Labs, San Francisco, CA) were used for detection. The detection limit was 300 pg/ml IL-13. GM-CSF and IL-3 were detected by commercial ELISA kits (R&D), with a sensitivity of <5 pg/ml. In IL-3, IL-13, and GM-CSF ELISAs, the chromogenic substrate was 4-nitrophenyl phosphate-disodium hexahydrate (E. Merck, Darmstadt, Germany) in diethanolamine buffer, pH 9.8. Optical density was measured at 405 nm. The IL-2 activity was measured by [³H]Tdr uptake of the IL-2-dependent cytotoxic T lymphocyte line cells as described (37, 38).

IgE and IgG4 in supernatants were measured in duplicates by sandwich ELISA as described (31, 35, 36). The assays reached a sensitivity of 0.2 ng/ml human IgE standard (Behringwerke, Marburg, Germany) and 0.6 ng/ml IgG4 World Health Organization 67-97 standard reference.

Determination of eosinophil death and apoptosis
Eosinophils were purified by negative MACS separation as previously described (39). Briefly, PBMC were separated from peripheral blood of patients with moderate eosinophilia (5–8%) by Ficoll-Hypaque centrifugation. The remaining cell population, mainly granulocytes and erythrocytes, was depleted by passing the through a MACS column. The resulting cell population contained 99% eosinophils as controlled by staining cell smears with Diff-Quick (Baxter, Düdingen, Switzerland) and light microscopy.

Eosinophils (10⁶ cells/well) were cultured in 96-well tissue culture plates in RPMI 1640, either with spontaneously secreted 25% supernatants of CLA⁺ or CLA⁻ T cell or with recombinant cytokines at different concentrations for indicated time points. Cell death of eosinophils was assessed by uptake of 1 µM ethidium bromide and flow cytometric analysis as described (30).

Oligonucleosomal DNA fragmentation, a characteristic feature of cells undergoing apoptosis, was assessed as previously described (41). Briefly, MACS-purified eosinophils were cultured in the presence or absence of CLA⁺ or CLA⁻ T cell supernatants for the indicated conditions and indicated times. After culture, the cells were resuspended in 0.3 ml hypotonic fluorochrome solution (50 µg/ml propidium iodide, 0.1% sodium citrate, 0.1% Triton X-100) and incubated for 6 h at 4°C in the dark. The relative amounts of apoptotic eosinophils were determined by flow cytometric discrimination of DNA fragmentation in hypodiploid and diploid cells.

Membrane phosphatidylserine redistribution from the inner to the outer membrane leaflet takes place in apoptotic cells. Annexin V is a phosphatidylserine-binding protein and is used to detect apoptotic cells (42). Briefly, 2 × 10⁶ eosinophils were washed twice with cold PBS and resuspended in 1 ml binding buffer (HEPES, 0.25 mM CaCl₂). FITC-conjugated annexin V (PharMingen) and propidium iodide (500 ng/ml) were added to the cells. After gentle vortexing and incubating for 15 min in the dark, the cells were immediately analyzed for annexin V binding and propidium iodide uptake by flow cytometry.

Statistical interpretation
Data are expressed as means ± SEM. Statistical analysis for paired comparisons was conducted by Student’s t test and for percentages by the z test.

Results
Comparison of CLA-expressing CD4⁺ and CD8⁺ T cells in the lesional skin of AD patients
The CD4⁺ and CD8⁺ T cell subsets in lesional skin of AD patients were identified in punch biopsies by immunohistochemistry. The CD4 and CD8 T cells in the eczema lesions in AD are shown in Fig. 1. The majority of the cells in the inflammatory cellular infiltrate in dermis represented CD4⁺ and CD8⁺ T cells. Two CD4⁺ T cells and one CD8⁺ T cell are stained in the basal cell layer of epidermis. Results shown are representative of five skin biopsies from five AD patients. Cumulative results of enumeration of cells are shown in Table I.

Table I. Distribution of CD4⁺ and CD8⁺ T cells in PBMC and skin biopsies of AD patients

<table>
<thead>
<tr>
<th></th>
<th>Control (PBMC)</th>
<th>Atopic Dermatitis (PBMC)</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>% CD4</td>
<td>49.20 ± 7.25</td>
<td>43.14 ± 3.43</td>
<td>502 ± 78</td>
</tr>
<tr>
<td>% CD8</td>
<td>33.05 ± 6.42</td>
<td>24.82 ± 4.29</td>
<td>297 ± 56</td>
</tr>
<tr>
<td>CD4/CD8</td>
<td>1.49 ± 0.31</td>
<td>1.74 ± 0.24</td>
<td>1.62 ± 0.20</td>
</tr>
</tbody>
</table>

a PBMC from five AD patients and five healthy controls were stained immediately after purification. CD3⁺ cells were gated, and the percentages of CD4⁺ or CD8⁺ T cells was measured by FACS. The skin-infiltrating CD4⁺ and CD8⁺ T cells were determined by immunohistochemistry per square millimeter of skin section in five AD patients. Results are shown as mean ± SE.
assures that the experiments are done with real skin T cells but not the T cells inside the vessels of the skin biopsies.

Peripheral blood CLA\(^+\) T cells from AD patients represent an vivo-activated memory T cell subset

The CLA\(^+\) memory/effector T cells demonstrated typical features of in vivo activation in AD. CLA\(^-\)CD45RO\(^+\) T cells highly expressed CD25 and HLA-DR in contrast to the CLA\(^-\) T cell population of AD patients and both CLA\(^+\) and CLA\(^-\) subsets of healthy individuals (21, 26). Additional evidence for in vivo activation appeared from the fact that both CD4\(^+\) and CD8\(^+\) CLA\(^+\) T cells showed spontaneous proliferation in vitro without further activation. This was demonstrated by \[^{3}H\]Tdr incorporation in cells that were pulsed immediately after purification from PBMC with \[^{3}H\]Tdr for 24 h. As shown in Fig. 2, freshly isolated CD4\(^+\) and CD8\(^+\) CLA\(^+\) T cells spontaneously proliferated, whereas the CLA\(^-\) T cell subsets from AD patients and control subjects remained resting \((p < 0.001)\). CD4\(^+\) CLA\(^+\) T cells of AD patients showed higher spontaneous proliferation than CD4\(^+\) CLA\(^+\) T cells of the control group \((p < 0.05)\).

CD8\(^+\) T cells respond to superantigenic stimulation to the same extent as CD4\(^+\) T cells and secrete a Th2 cytokine profile in AD

One explanation for the existence and in vivo activation of CD8\(^+\) T cells in skin lesions in amounts similar to those of CD4\(^+\) T cells could be that their responsiveness to superantigenic stimuli released by Staphylococcus aureus colonizing the skin was analyzed by stimulating the CD8\(^+\) and CD4\(^+\) subsets of CLA\(^+\) T cells from peripheral blood and skin biopsies of AD patients with SEB, by using irradiated autologous PBMC as APC. As shown in Fig. 3A, both CD4\(^+\) T cells and CD8\(^+\) T cells of AD patients responded to SEB in a dose-dependent manner. The cytokines released from CD4\(^+\) and CD8\(^+\) T cells isolated from skin showed a similar pattern by SEB stimulation (Fig. 3B). Both CD4\(^+\) or CD8\(^+\) T cells released high amounts of IL-5 and IL-13 and relatively lower amounts of IL-4 and very little IFN-\(\gamma\).

CD4\(^+\) CLA\(^+\) and CD8\(^+\) CLA\(^+\) memory/effector T cells in AD display an IL-5- and IL-13-dominated Th2 cytokine profile

To analyze in vivo-activated cytokine patterns of CLA\(^+\) and CLA\(^-\)CD45RO\(^+\) T cells among CD4\(^+\) and CD8\(^+\) subsets, we visualized their IL-4, IL-5, IL-13, and IFN-\(\gamma\) cytokine content in the cytoplasm immediately after isolation from PBMC. In Fig. 4, the intracellular IL-4, IL-5, IL-13, and IFN-\(\gamma\) content of CLA\(^+\) and CLA\(^-\) T cells from an AD patient and a healthy nonatopic control are shown. In AD patients, the number of IL-5- and IL-13-positive cells was significantly higher in CD8\(^+\) CLA\(^+\) cells \((IL-5, 71 \pm 9\%; IL-13, 55 \pm 7\%)\) compared with CD4\(^+\) CLA\(^+\) cells \((IL-5, 52 \pm 11\%; IL-13, 35 \pm 7\%)\) \((p < 0.01)\). Neither CD4\(^+\) nor CD8\(^+\) CLA\(^+\) T cells contained significant amounts of intracytoplasmic IL-4 and IFN-\(\gamma\). In healthy individuals, only 2–17% of the CD4\(^+\) or CD8\(^+\) CLA\(^+\) T cells contained intracellular IL-5 and IL-13 but no IL-4 and IFN-\(\gamma\).

**Table II.** CLA expression in CD4\(^+\) and CD8\(^+\) T cells in PBMC and skin biopsies of AD patients

<table>
<thead>
<tr>
<th></th>
<th>Control (PBMC)</th>
<th>Atopic Dermatitis (PBMC)</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>% CD4(^+)CLA(^+)</td>
<td>9.75 ± 0.75%</td>
<td>13.06 ± 1.69%</td>
<td>31.26 ± 8.86%**</td>
</tr>
<tr>
<td>% CD4(^+)CLA(^-)</td>
<td>39.45 ± 7.75%</td>
<td>30.08 ± 2.63%</td>
<td>12.97 ± 3.07%</td>
</tr>
<tr>
<td>% CD8(^+)CLA(^+)</td>
<td>4.54 ± 1.95%</td>
<td>5.62 ± 1.38%</td>
<td>18.94 ± 6.53%**</td>
</tr>
<tr>
<td>% CD8(^+)CLA(^-)</td>
<td>27.60 ± 5.60%</td>
<td>18.29 ± 5.18%</td>
<td>5.24 ± 2.25%</td>
</tr>
<tr>
<td>CLA(^+)CD4/CD8</td>
<td>1.78 ± 0.71%</td>
<td>1.97 ± 0.33%</td>
<td>0.85 ± 0.73%**</td>
</tr>
</tbody>
</table>

* PBMC from five AD patients and five healthy controls were stained immediately after purification, and skin T cells were stained after 7–10 days of culture with IL-2 and anti-CD2, anti-CD3, anti-CD28 mAb mixture. The percentages of CD4\(^+\) or CD8\(^+\) T cell subsets with and without CLA were measured by FACS. Results are shown as mean ± SE. ** Significant difference between control group and AD PBMC \((p < 0.001)\). ** Significant difference between AD PBMC and skin \((p < 0.003)\).
The spontaneously secreted cytokine profile was determined in freshly isolated peripheral CLA⁺CD45RO⁺ T cells with no further in vitro stimulation. As shown in Fig. 5, the CLA⁺CD45RO⁺ T cells spontaneously released large amounts of IL-5. The amount of IL-5 released from CD4⁺ cells was 4.22 ± 0.59 ng/ml, and the amount from CD8⁺ cells was 8.43 ± 0.71 ng/ml. The amount of IL-13 released from CD4⁺ cells was 0.74 ± 0.19 ng/ml, and that from CD8⁺ cells was 2.73 ± 0.34 ng/ml. Only low amounts of IL-4 (CD4⁺, 0.18 ± 0.02; CD8⁺, 0.32 ± 0.03 ng/ml) and IFN-γ (CD4⁺, 0.09 ± 0.02; CD8⁺, 0.19 ± 0.03 ng/ml) was secreted in both CLA⁺ subsets. Significantly high amounts of Th2 cytokines were released by CLA⁺ T cells from AD patients in comparison with healthy subjects (p < 0.01). Similar to intracellular cytokine staining, the amounts of IL-4, IL-5, and IL-13 secreted by CD8⁺ CLA⁺ T cells were significantly higher than those from the CD4⁺ CLA⁺ subset (p < 0.01). Although the spontaneous cytokine release by the CLA⁺ T cell subsets reached higher levels in cells from AD patients than from the controls, it was in both groups significantly higher among the CLA⁺ populations than among the CLA⁻ T cells (p < 0.001). On the other hand, there was no significant difference for IFN-γ between patients and controls. Neither the CLA⁺ nor the CLA⁻ cell subsets secreted detectable amounts of IL-2, IL-3, and GM-CSF.

Both CD4⁺ and CD8⁺ subsets of CLA⁺ T cells induce IgE production primarily by IL-13

We then determined the capacity of both T cell subsets to induce and regulate IgE synthesis in vitro. In the first set of experiments, the two memory T cell populations and autologous B cells, purified from PBMC of AD patients, were cocultured without further stimulation. Fig. 6 demonstrates that either CD4⁺ or CD8⁺ subsets of CLA⁺ T cells were capable of inducing IgE in B cells. In contrast the enhancement of IgE by CLA⁻ T cells was much less pronounced. IL-4 and IL-13 possess similar isotype-regulatory properties on IgE production (43–45). To analyze whether IL-4 or IL-13 is responsible for IgE production in AD, either CD4⁺ or CD8⁺ subsets of CLA⁺ memory/effector T cells were cultured with autologous B cells in the presence of neutralizing anti-IL-4, anti-IL-13, or mutant IL-4 antagonist Y124D. Neutralization of IL-4 in cultures had a small effect (11.1–18.4%) on suppression of the IgE production, whereas IL-13 neutralization and Y124D mutant IL-4, which also inhibits IL-13 (34), decreased IgE levels by 84.2–91.7%. These results point out the pivotal role of IL-13 but not IL-4 in induction of IgE in AD, and CD4⁺ and CD8⁺ T cells were similarly potent in IgE induction by B cells.
IL-5, and IL-13 secreted by CD4+ memory/effector T cells induced IgE by IL-13. Purified B cells were cocultured with autologous purified CD4+ or CD8+ subsets of CLA+ or CLA− T cells. The cells did not receive additional stimulation. IgE and IgG4 were measured from supernatants harvested after 12 days. IL-4 and IL-13 were neutralized by mAbs to these cytokines and by mutant IL-4 antagonist Y124D added from the start of culture. A mouse IgG1 was used as a control mAb. Results represent mean of triplicate cultures ± SD from three different experiments (*, p < 0.001).

In vivo-activated CLA+CD45RO+ T cells of both CD4+ or CD8+ subsets prevent eosinophil apoptosis

The spontaneously secreted cytokine pattern of CLA-bearing CD4+ and CD8+ memory/effector T cells suggested the investigation of the role of CLA+ T cells on eosinophil survival and apoptosis of AD patients. Therefore, the number of viable eosinophils, measured by ethidium bromide exclusion, was quantified from the supernatants harvested after 24 h. The results are shown as mean ± SD. Significantly higher amounts of IL-4, IL-5, IL-13, and IFN-γ were measured from the supernatants harvested after 24 h. The differences between CLA+ and CLA− T cells of AD patients than by control subjects (p < 0.01). The amounts of IL-4, IL-5, and IL-13 secreted by CD8+ CLA+ T cells were significantly higher than those from the CD4+ CLA− subset in AD patients (***, p < 0.01).

In both groups, the spontaneous cytokine release was significantly higher among the CLA+ populations than among the CLA− T cells (*, p < 0.001).

FIGURE 5. Peripheral blood CD4+ and CD8+ subsets of CLA+CD45RO+ T cells spontaneously release a Th2 pattern of cytokines in AD. Purified CD4+ and CD8+ subsets of CLA+ and CLA− T cells of nine AD patients and five controls were cultured without stimulation. IL-4, IL-5, IL-13, and IFN-γ were measured from the supernatants harvested after 24 h. The results are shown as mean ± SD. Significantly higher amounts of IL-4, IL-5, and IL-13 were released by either CD4+ or CD8+, CLA+ T cells of AD patients than by control subjects (p < 0.01). The amounts of IL-4, IL-5, and IL-13 secreted by CD8+ CLA+ T cells were significantly higher than those from the CD4+ CLA− subset in AD patients (**, p < 0.01). In both groups, the spontaneous cytokine release was significantly higher among the CLA+ populations than among the CLA− T cells (*, p < 0.001).
**Discussion**

Activation of peripheral blood T cells and preferential secretion of Th2 cytokines are associated with atopic syndromes such as asthma and AD (2–6). In previous studies investigating the mechanisms of allergy, CD4^+ T cells were inscribed as pivotal cells and the main producers of Th2 type proinflammatory cytokines and inducers of allergic inflammation (2–6). In contrast, there was limited evidence for involvement of CD8^+ T cells in human allergic responses (46, 47). Culturing of T cells from AD skin lesions allowed the comparison of CD4^+ and CD8^+ T cell subsets in the present study. Previously, it was demonstrated that in blisters of AD skin almost the entire T cell population was of the CD4^+ phenotype (18, 20). Accordingly, CD4^+ and CD8^+ T cell subsets express immunological features and functional properties of in vivo-activated memory/effector cells, whereas CD8^+ T cells represent resting memory T cells in AD. Most of the previous studies to demonstrate intracytoplasmic cytokines have been conducted by a full T cell stimulation with a phorbol ester and ionomycin combination (32, 47). To demonstrate in vivo-generated intracytoplasmic IL-5 and IL-13, the cells were not further stimulated but only fixed and stained immediately after purification, because CD4^+ T cells were in vivo activated in AD patients. CD8^+ T cells appeared to be higher producers of IL-5 and IL-13 and more potent in inhibition of apoptotic eosinophil death. Both subsets induced IgE to the same extent. In certain diseases including Schistosoma mansoni infection, leishmaniasis, lepromatous leprosy, and AIDS, a CD8^+ T cell subset has been identified with a cytokine profile usually attributed to CD4^+ Th2 type cells (13–15, 48). In allergic diseases, CD8^+ T cells seem to exhibit diverse effects. In a study comparing IgE induction by IL-4 and IL-13, IL-13 was shown to be the major IgE-inducing cytokine secreted from CD8^+ T cell clones (33). However, in mouse and rat systems of allergic sensitization, IgE production and allergic inflammation was dependent on CD4^+ T cells, whereas CD8^+ T cells were shown to be negative regulatory T cells (49, 50). Apparently, these animal models of allergic sensitization and CD4^+ T cell accumulation in aeroallergen-induced cutaneous late phase responses do not adequately represent the immune responses in AD (49–53).

A number of pathogenetic mechanisms leading to T cell activation in AD including aeroallergens, food allergens, and superantigens have been emphasized. The role of aeroallergens in T cell activation in AD has been extensively studied (2–6, 51, 52). Aeroallergens can induce both immediate type and delayed type responses in the skin (51, 52). The frequency of aeroallergen-specific T cells was investigated in AD lesions, and they were found to be <1% in nonchallenged AD lesions (54). Besides, such allergen-specific T cells can be detected in the skin of atopic patients after allergen administration, without signs of AD lesions (53). The contribution of food allergens in the exacerbation of AD by T cell activation has also been studied. Food allergen-specific T cells have been cloned from lesional skin of patients with clinically relevant hypersensitivity responses to foods; however, this type of allergy plays a role in a minority of adult AD (55, 56). It is obvious that allergen-specific T cell responses in food and aeroallergen allergy are confined to CD4^+ T cells; this does not explain the activation and recruitment of CD8^+ T cells in AD skin lesions.

From a number of studies, it could be concluded that bacterial superantigens contribute to the pathogenesis and exacerbation of AD. Staphylococcal superantigens were isolated from AD skin (28, 29). The superantigen patch test elicits skin inflammation in AD patients (57) and in the human SCID mouse model (58). In addition, superantigens up-regulate the CLA molecule (27). The present study shows that CD8^+ T cells cultured from skin or CLA^+ CD8^+ T cells freshly isolated from peripheral blood efficiently proliferate by superantigenic stimulation. Furthermore, purified CD4^+ or CD8^+ T cells cultured from skin biopsies secrete a Th2-like cytokine profile with high IL-5 and IL-13 by SEB stimulation. Bacterial superantigens can interact with certain Vb elements of the TCR, leading to activation, expansion, anergy, or deletion of T cells. This is evident from mouse studies that superantigen response of T cells is not restricted to CD4^+ or CD8^+ subsets (59, 60) and even CD4^+ CD8^+ T cells can respond to superantigenic stimuli (61).

The functional Ig isotype-regulatory capacity of peripheral CD4^+ and CD8^+ memory/effector T cells from AD patients was investigated by coculturing isolated T cell subpopulations with purified B cells or T cell-depleted PBMC. The IgE production by B cells mainly depended on secreted IL-13. Previous reports and our
present findings indicate that IL-4 inhibition is not sufficient to suppress IgE in atopic diseases. An IgE-inducing activity, which could be attributed to IL-13, has been found in PBMC cultures of atopic but not of normal individuals (62, 63). Accordingly, IL-13 produced by the skin-selective homing T cells in high amounts may have an important role in the pathogenesis of chronic AD. In contrast to IL-4, there is no feedback or priming mechanism exerted by IL-13 on T cells, because human T cells do not display specific receptors for IL-13 (34). Therefore, IL-4 may be decisive at the initial phase of allergic responses and in the priming and development of Th2 cells (64, 65), whereas IL-13 becomes more prominent in IgE induction in atopy.

Increased numbers of blood and tissue eosinophils are regularly observed in subjects suffering from AD and/or bronchial asthma (7, 8). Inhibition of apoptosis by survival factors, such as IL-3, IL-5, and GM-CSF, was demonstrated to substantially contribute to the prolonged survival of eosinophils (1, 11, 12, 40). In the present study, the functional eosinophil antiapoptotic properties were demonstrated in two ways by DNA fragmentation and phosphatidylserine translocation. Although IL-5 appeared to be the major cytokine, it may not be the only cytokine released by CLA$^+$ T cells that is responsible for the prolonged eosinophil survival. The isolated CLA$^+$ T cells did not release any detectable IL-3 and GM-CSF; therefore, other cytokines released from CLA$^+$ T cells may also contribute to eosinophil life span. Similar to the present study, IL-5 was repeatedly reported as an eosinophil-specific differentiation and survival factor (11, 66). In vivo, as observed in nasal polyps, IL-5 was determined as the major cytokine inhibiting eosinophil apoptosis (9). Moreover, transgenic mice overexpressing the IL-5 gene associate eosinophilia with IL-5 (67). In this context, it is now more reasonable that both CD4$^+$ and CD8$^+$ T cell populations expressing the appropriate TCR Vβ can be activated by superantigen in the presence of HLA class II-expressing cells. This suggests an explanation for the existence and activation of CD8$^+$ T cells in the eczema lesions contributing to IgE production and eosinophil survival similar to CD4$^+$ T cells and development, chronicity, and exacerbation of AD.

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