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Successful Treatment of Animal Models of Rheumatoid Arthritis with Small-Molecule Cyclin-Dependent Kinase Inhibitors

Chiyoko Sekine,* Takahiko Sugihara,*† Sachiko Miyake,‡ Hiroshi Hirai,§ Mitsuaki Yoshida,§ Nobuyuki Miyasaka,† and Hitoshi Kohsaka2*†

Intraarticular gene transfer of cyclin-dependent kinase (CDK) inhibitors to suppress synovial cell cycling has shown efficacy in treating animal models of rheumatoid arthritis. Endogenous CDK inhibitors also modulate immune function via a CDK-independent pathway. Accordingly, systemic administration of small molecules that inhibit CDK may or may not ameliorate arthritis. To address this issue, alvocidib (flavopiridol), known to be tolerated clinically for treating cancers, and a newly synthesized CDK4/6-selective inhibitor were tested for antiarthritic effects. In vitro, they inhibited proliferation of human and mouse synovial fibroblasts without inducing apoptosis. In vivo, treatment of collagen-induced arthritis mice with alvocidib suppressed synovial hyperplasia and joint destruction, whereas serum concentrations of anti-collagen type II (CII) Abs and proliferative responses to CII were maintained. Treatment was effective even when therapeutically administered. Treated mice developed arthritis after termination of treatment. Thus, immune responses to CII were unimpaired. The same treatment ameliorated arthritis induced by K/BxN serum transfer to lymphocyte-deficient mice. Similarly, the CDK4/6-selective inhibitor suppressed collagen-induced arthritis. Both small-molecule CDK inhibitors were effective in treating animal models of rheumatoid arthritis not by suppressing lymphocyte function. Thus, the two small-molecule CDK inhibitors ameliorated arthritis models in a distinctive way, compared with other immunosuppressive drugs. The Journal of Immunology, 2008, 180: 1954–1961.

Rheumatoid arthritis (RA) is a chronic inflammatory disease characterized by synovial hyperplasia with massive infiltration of inflammatory cells in the affected joints. This hyperplasia leads to degeneration of cartilage, erosion of bone, and ultimately functional loss of joints. Although the etiology of RA remains elusive, T cells recognizing unknown autoantigens have been proposed to initiate inflammation in synovial tissues. This mechanism is followed by local recruitment of leukocytes, which are further activated in the inflamed sites. Immune complexes, complement activation, and activation of lymphocytes, macrophages, neutrophils, mast cells, and synovial fibroblasts are part of the aberrant humoral and cellular network.

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Cytokines derived from these cells induce intense proliferation in synovial fibroblasts. Activated fibroblasts become another source of inflammatory cytokines and mediators including tissue-degrading proteinases and prostaglandins. In this manner, the hyperplastic synovial tissue, called a pannus, serves as a nidus for further spread of destructive inflammation, producing cartilage-degrading enzymes and invading the bone matrix of rheumatoid joints.

Therapeutic agents of a biologic nature, such as mAbs against TNF-α, soluble TNFR, anti-IL-6R Ab, and IL-1R antagonist, were recently brought into clinical use with the aim of interrupting inflammatory cytokine circuits in joints affected by RA. Although these agents often are more effective than conventional antirheumatic drugs, quite a few patients fail to obtain expected clinical benefit from these medications. Other new drugs such as abatacept, tacrolimus, and rituximab are given to suppress upstream targets such as T and B lymphocytes. These anti-inflammatory agents share similar limitations in clinical response. More seriously, these medications often render patients immunocompromised, making them susceptible to serious infections.

As mentioned earlier, a salient characteristic in rheumatoid pathology is overgrowth of synovial fibroblasts to form a hyperplastic pannus. This feature has led us to explore cell cycle regulation as a new therapeutic approach to treatment of RA. This antiproliferative treatment focuses on cyclin-dependent kinase (CDK) inhibitors (CDKI) as primary cell cycle regulators. These endogenous nucleoproteins inhibit CDKs that bind to cyclins to initiate catalytic activation (5). CDKs phosphorylate a retinoblastoma (RB) gene product, which results in release of E2F transcription factors for cell cycle progression (5). Based on structural and functional characteristics, CDKIs have been grouped into two distinct families, INK4 and Cip/Kip (3, 6). The INK4 proteins, consisting of p16INK4α, p15INK4b, p18INK4c, and p19INK4d, form binary complexes with CDK4 or CDK6, which otherwise would promote

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G_{1}/S phase transition in the cell cycle. In contrast, the Cip/Kip proteins, consisting of p21Cip1, p27Kip1, and p57Kip2, bind to all cyclin-CDK complexes.

We have reported that p16^{INK4a} and p21^{Cip1} were induced readily in vitro in cultured RA fibroblast-like synoviocytes (FLSs). Intra-articular gene transfer of p16^{INK4a} or p21^{Cip1} ameliorated disease in animal models of RA, including collagen-induced arthritis (CIA) in mice and adjuvant arthritis in rats (7–9). These studies have indicated that induction of p16^{INK4a} and p21^{Cip1} expression in synovial tissue should hold promise as a new therapeutic strategy for RA treatment. Notably, because cell cycle regulation therapy suppresses a phase of rheumatoid pathology distinct from that suppressed by anti-inflammatory drugs, combination with another antirheumatic drug might act synergistically.

To apply gene transfer to treatment of patients with RA, vectors and protocols need to be optimized to avoid unexpected tragic complications (10). An alternative to gene therapy as a way to inhibit CDK activity is the use of small-molecule (sm) compounds that inhibit CDK. Because uncontrolled CDK activity drives neoplastic cell cycling in some tumor cells, CDK activity represents an attractive target in development of anti-cancer therapeutics (11). In response to these smCDK inhibitors, some tumor cells stop proliferation and then also undergo apoptotic cell death (12–14).

Thus, many smCDK inhibitors have been developed as candidate oncostatic drugs with a prototype being alvocidib (formerly called flavopiridol) (11). This synthetic flavone, the first CDK1 to undergo clinical trials (11), inhibits the kinase activity of multiple CDKs such as CDK1, 2, 4, 6, and 7 (15). Structural-activity studies have shown that alvocidib interferes with binding of ATP to the adenine-binding pocket of CDK2 (16). However, although alvocidib generally proved safe in clinical trials, its efficacy was limited except for a subtype of malignant cells (11, 17). Other smCDK inhibitors, such as staurosporine, R-roscovitine, and BMS-387032, have also been studied in clinical trials, showing good tolerability (11).

The primary known role for CDKI is suppression of CDKs required for cell cycle progression. However, our group as well as other investigators have shown that p16^{INK4a} and p21^{Cip1} also have immunomodulatory effects (7, 18, 19). Notably, overexpression of p21^{Cip1} in RA FLs reduced production of inflammatory cytokines and tissue-degrading enzymes involved in rheumatoid pathology. This is at least partly a result of inhibition of JNK by p21^{Cip1} (18). Thus, immunomodulation by CDKI, which potentially contribute to antiarthritic effects of CDKI gene transfer, would not necessarily depend on inhibition of CDK activity, raising a question as to whether inhibition of CDK per se can control arthritis. Of special interest here is inhibition of CDK4/6, which are shared targets of p16^{INK4a} and p21^{Cip1}.

In the present study we evaluated how systemic administration of two smCDK inhibitors affects animal models of RA. One was alvocidib, while the other was a newly synthesized CDK4/6-selective inhibitor. Systemic administration of either compound inhibited arthritis without obvious immunosuppression or side effects. The results argue that alvocidib exerted its effects primarily by CDK4/6 inhibition.

Materials and Methods

Reagents

Alvocidib was provided by Aventis Pharmaceuticals. A stock solution of alvocidib prepared in DMSO was diluted to working concentrations before each experiment. In addition, a CDK4/6-selective inhibitor compound A (N-[5-[2-([cyclolhexyloxy]-6-methylpyrimidin-4-yl)-1-thiazol-2-yl]-5-[4-(methylpiperazin-1-yl)methyl]pyrazin-2-amine), which was characterized as compound 4 in the previous report (20), was synthesized at Merck-Banyu. It was dissolved in DMSO for in vitro analyses and in 5% glucose containing 10 mM citrate buffer (pH 4) for treatment of mice. Human and mouse IL-1β and TNF-α were purchased from WAKO.

Cells

FLSs were prepared from synovial tissues of patients with RA who underwent total joint replacement surgery or synovectomy at Tokyo Medical and Dental University Hospital (Tokyo, Japan) or National Shimoshizuhu Hospital (Chiba, Japan). RA was diagnosed according to the criteria of the American College of Rheumatology (21). Written consent forms concerning experimental use of resected tissues were completed by patients before surgery. All procedures in the present studies were approved by the ethics committees of RIKEN and Tokyo Medical and Dental University. Mouse fibroblast-like synoviocytes (MFLSs) were prepared from synovial tissues from knee joints of CIA mice as previously described (22). Although FLSs were used from 7 to 11 passages, MFLSs were used from 6 to 11 passages. Both were cultured in DMEM (Sigma-Aldrich) supplemented with 1-glutamine, penicillin, streptomycin, and 10% FBS (Sigma-Aldrich). Purity of the fibroblasts was assessed with flow cytometry (23). CD14 or HLA class II were not expressed by FLSs, suggesting that macrophages and dendritic cells were not present in FLSs.

Proliferation assays

From 2000 to 5000 cells/well were grown overnight in 96-well plates and stimulated with 10 ng/ml IL-1β and 10 ng/ml TNF-α. These cytokine concentrations were determined to be optimal in preliminary experiments. Alvocidib (1–100 nM), compound A (0.01–10 μM), and DMSO alone was placed in wells in the presence of 10% FBS. After 24–48 h, BrdU was added and culture was continued for 20 h. Then incorporation of BrdU was quantified by ELISA with a BrdU cell proliferation ELISA kit (Exalpha Biologicals).

Cell cycle analysis

Cells were stimulated for 24 h in the presence or absence of smCDK inhibitors, washed with PBS, and resuspended in 0.15% Triton X-100/PBS before staining with propidium iodide (50 μg/ml) and examination for DNA content with a FACScanlter flow cytometer (BD Biosciences).

Animal models of arthritis

CIA was induced in 7-wk-old male DBA/1 mice purchased from Japan Charles River Breeding Laboratories. Each mouse was immunized with 200 μg of bovine type II collagen (CII; Collagen Research Center) emulsified with CFA (Difco) by injection at the tail base. Immunization was repeated 21 days after primary immunization.

Serum-transfer arthritis was induced by transfer of serum from arthritic K/BxN mice, which spontaneously develop arthritis resembling RA. These mice were provided by Drs. C. Benoist and D. Mathis (Joslin Diabetes Center, Boston, MA) (24). Preliminary titration experiments showed that injection of 300 μl of serum into the peritoneal cavity transferred arthritis consistently in Rag2-null mutant (RAG2–/–) and C57BL/6 wild-type mice. All procedures met institutional regulations for animal experiments.

Assessment of arthritis

Arthritis in each limb of arthritic mice was assessed clinically by visual scoring from 0 to 4: 0, no swelling; 1, detectable swelling in one joint; 2, non-severe swelling in two or more joints; 3, severe swelling in two or more joints; and 4, severe swelling in two or more joints including digital swelling. Maximal score for an individual animal was 16. Joint swelling was quantified by measuring hindpaw thickness and the ankle width within a micrometer (Ozaki Manufacturing). Arthritis scores were analyzed statistically with unpaired Student’s t test.

In histological examination, hindpaws were obtained and fixed in 10% buffered formalin, decalcified in 10% EDTA, and embedded in paraffin. Sections (4 μm) were stained with H&E for histologic examination. Infiltration of inflammatory cells, transformation of synovial lining, cartilage destruction, and pannus formation were independently scored in a blind manner from 0 to 3 as previously described (25). Maximum histological score was 12. Histological scores were analyzed statistically with unpaired Student’s t test. Radiographs of formalin-fixed hindpaws were obtained with a cabinet soft x-ray apparatus (CMB-2; Softex).

Measurement of serum levels of anti-CII Abs

Serum samples were collected at indicated time points and examined for anti-CII Ab concentrations by ELISA. Briefly, wells of 96-well plates were
pressed severity of arthritis in a dose-dependent manner (Fig. 2). Five mg/kg of alvocidib for 10 consecutive days significantly suppressed arthritis in DBA/1 mice with CIA. Treatment was started on day 25 after the first immunization, when joint swelling became evident according to examination by our protocol. Repeat injection of 1 or 2.5 mg/kg alvocidib produced similar effects. Drug effects were dose-dependent; joints from most mice treated with 2.5 mg/kg of alvocidib appeared normal (Fig. 2, B). A similar effect was observed when alvocidib was given only twice weekly, starting at about the time of clinical disease outset (day 24). The effect persisted for as long as 5 wk (Fig. 2C).

Histologic analysis of synovial tissues from DMSO-treated control mice showed hyperplastic pannus tissues massively infiltrated by mononuclear cells, cartilage destruction, and bone erosion, which are all characteristic of the pathology of RA disease. These features were suppressed in synovial tissues from alvocidib-treated mice. Drug effects were dose-dependent; joints from most mice treated with 2.5 mg/kg of alvocidib appeared normal (Fig. 2, A). Proliferation was assessed by BrdU incorporation. FLSs or MFLSs were stimulated with TNF-α and IL-1β for 24 h, and cultured for 24 h with indicated concentrations of alvocidib in the presence of TNF-α and IL-1β. The growth inhibitory effect as alvocidib concentrations increase is shown as declining BrdU incorporation relative to incorporation into cells incubated without alvocidib. DMSO, which was used to solubilize alvocidib, had no effects on incorporation at concentrations used in these experiments. Mean percentage is derived from three wells with error bars representing SD. Data are representative of three independent experiments. Two different cell lines of FLSs and MFLSs were tested in each plate in serial dilution. Arbitrary units for anti-CII IgG1, IgG2a, and IgG2b Ab (Zymed Laboratories) was added. Reaction product formed with 3,3′,5,5′-tetramethylbenzidine was measured as OD at 490 nm. A standard mixture serum from arthritic mice was placed on each plate in serial dilution. Arbitrary units for anti-CII IgG1, IgG2a, and IgG2b Abs were determined with this standard curve.

Western blot analysis
Whole-cell lysates (15 μg of protein) were separated by SDS-PAGE on 7.5% polyacrylamide gel and transferred to polyvinylidene difluoride membranes. Anti-phospho RB (Ser807/Ser811) Ab (Cell Signaling Technology) at 1/1000 dilution and anti-RB mAb (clone G3-245; BD Pharmingen) at 1 μg/ml were used as primary Abs. Bound Abs were visualized with peroxidase-conjugated secondary Ab (Amer- sham Biosciences) at 1/5000 dilution and ECL system (ECL; Amer- sham Biosciences).

Immunohistochemistry
Paraffin-fixed tissue sections were deparaffinized and incubated with anti-phospho RB (Ser807/Ser811) Ab. They were then incubated with biotinylated anti-rabbit IgG Ab and with ABC reagent (VectorStain Elite ABC kit; Vector Laboratories). Color was developed with diaminobenzidine (Kirkegaard & Perry Laboratories), whereas the sections were counterstained with hematoxylin. Diaminobenzidine-positive cells and stained nuclei were counted by observers in a blind manner at three independent sites per slide to calculate percentage of nuclei with phosphorylated RB gene product. The data were analyzed statistically with unpaired Student’s t test.

Lymph node (LN) cell responses to CII
Single-cell suspensions derived from inguinal LNs (4 × 10^5 cells per well in a 96-well plate) were stimulated with denatured CII (0–100 μg/ml) in RPMI 1640 medium (Sigma-Aldrich) supplemented with L-glutamine, penicillin, streptomycin, 2-ME, and 10% FBS (Sigma-Aldrich). After 72 h, BrdU was added and culture was continued for 17 h to quantify incorporated BrdU.

Results
Alvocidib suppresses proliferation of synovial fibroblasts
FLSs from the inflamed joints of rheumatoid patients were isolated and cultured in the presence of alvocidib, a pan-CDKI. MFLSs from arthritic joints of CIA mice were isolated and treated in the same way. When alvocidib was present in culture medium, growth of FLS and MFLS was inhibited in a concentration-dependent manner (Fig. 1A). No cell death was visually apparent at concentrations below 300 nM in FLSs and 150 nM in MFLSs. We next analyzed the cell cycle in these fibroblasts after treatment with alvocidib. In either human or mouse cells, alvocidib increased cell populations at the G0/G1 phase of cell cycle without increasing the sub-G1 population (Fig. 1B). Although alvocidib has been reported to induce apoptotic death in some cell types (12–14), this result was not seen in synovial fibroblasts.

Alvocidib treatment suppresses arthritis in CIA mice
Next, mice with experimentally induced arthritis were treated with alvocidib. In the first series of experiments, the drug was given i.p. to DBA/1 mice with CIA. Treatment was started on day 25 after the first immunization, when joint swelling became evident according to examination by our protocol. Repeat injection of 1 or 2.5 mg/kg of alvocidib for 10 consecutive days significantly suppressed severity of arthritis in a dose-dependent manner (Fig. 2A). Therapeutic effect was seen even when the treatment was started 3 days later, showing that alvocidib suppressed ongoing disease (Fig. 2B). A similar effect was observed when alvocidib was given only twice weekly, starting at about the time of clinical disease onset (day 24). The effect persisted for as long as 5 wk (Fig. 2C).

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These results agreed well with specimen radiographic findings in the feet. DMSO-treated control mice displayed severe bone destruction, most characteristically as cystic changes and ankylosis of the articular bones. These changes were inhibited dose-dependently by alvocidib (Fig. 2, H–J).

Immune responses to CII are not impaired by alvocidib treatment

CIA is triggered by host immune responses to CII. Ab response is of central importance because B cell-deficient mice do not develop the disease, whereas transfer of mAbs against CII can induce full-blown arthritis (26). Immune responses require activation and proliferation of lymphocytes. Although peripheral lymphocyte counts were not affected by the dose of alvocidib used in the present study (data not shown), lymphocyte activation might be blocked by alvocidib. To assess immune suppression by alvocidib treatment, we determined serum concentrations of anti-CII Abs in the treated mice. When anti-CII-specific Abs of IgG1, IgG2a, and IgG2b subclasses were quantified separately with a specific ELISA, alvocidib-treated mice had serum IgG concentrations comparable to

![FIGURE 2. Alvarodib treatment suppresses arthritis in CIA mice. Mice with CIA were treated by i.p. injection of alvarodib at 1 mg/kg, or 2.5 mg/kg in saline containing 0.01% DMSO, or injection of only DMSO in saline, for 10 consecutive days (A and B) or twice weekly for 5 wk (C). Treatment was started 25 (A), 28 (B), or 24 (C) days after the initial immunization. Severity of arthritis was rated with an arthritis score. In other mice with CIA, twice-weekly treatment with 2.5 mg/kg of alvarodib was terminated after 10 days (C) (square). Mean score ± SD of seven mice per group. *, p < 0.05; **, p < 0.01; ***, p < 0.001. D–F, H&E staining of joints. Original magnification, ×100. G, Histological score of the arthritis. Results are the mean ± SD from 10 paws. ***, p < 0.001. H–J, Specimen radiographs. Paws were examined at completion of the treatment for 10 consecutive days with DMSO in saline (control) (D and H) or 1 mg/kg alvarodib (E and I) and 2.5 mg/kg (F and J). Representative staining and radiograph are shown.](http://www.jimmunol.org/content/1957/2/1057F2)

![FIGURE 3. CII-specific IgG responses are maintained during alvarodib treatment. Serum concentrations of anti-CII Abs with IgG1, IgG2a, and IgG2b subclasses were determined by specific ELISA. Sera were collected 24, 35, and 63 days after the primary CIA immunization in a series of experiments shown in Fig. 2C. Data are in arbitrary units for mean ± SD (n = 7 mice per group).](http://www.jimmunol.org/content/1957/2/1057F3)
those in control mice (Fig. 3). No difference was seen in relation to dose or time during the experiment. We then studied effect of terminating alvocidib treatment, following the clinical disease. In a group of CIA mice given 2.5 mg/kg of alvocidib twice weekly, treatment was terminated after 10 days. Arthritis became evident ~8 days later, and then progressed rapidly until the disease score approached that in untreated mice (Fig. 2C). The results showed that the underlying immune reaction against CII was not impaired during alvocidib treatment.

**Alvocidib shows efficacy in treating a lymphocyte-independent arthritis**

To substantiate that alvocidib can inhibit arthritis without suppressing lymphocyte function, we investigated its effect on a K/BxN serum-induced arthritis model induced in lymphocyte-deficient RAG2<sup>−/−</sup> mice. K/BxN mice spontaneously develop arthritis similar to RA in several aspects (24). Transfer of serum from these arthritic mice induces arthritis depending upon the genetic background of recipient mice (27). Pathology in the joints is characterized by acute edema in synovial tissues followed by proliferative and erosive arthritis that can be induced in lymphocyte-deficient mice (28). Making use of this model, we induced arthritis in RAG2<sup>−/−</sup> mice and began i.p. administration of 2.5 mg/kg of alvocidib on the day after serum transfer, continuing for 10 days. Treatment reduced edematous swelling of the joints in the early phase, and then abrogated proliferative arthritis (Fig. 4). Thus, suppression of immune responses is not required for the antiarthritic effect of alvocidib.

**A newly synthesized CDK4/6-selective inhibitor suppresses synovial fibroblasts growth and CIA**

Alvocidib was tolerated well in clinical trials except for a few occurrences of diarrhea when administered as a prolonged infusion; its toxicity profile was dose- and schedule-dependent (11). This agent has broad activity, inhibiting all CDKs and some other kinases (29). To study further whether cell cycle inhibition by CDK4/6 inhibition had an important role in ameliorating arthritis, a selective inhibitor, compound A, was synthesized (20). It is an aminothiazole CDKI that is structurally unrelated to alvocidib (Fig. 5A). It selectively inhibited CDK4 and CDK6, both of which have been shown to have indistinguishable activities in vitro (20). The IC<sub>50</sub> for CDK4 and CDK6 was 9.2 and 7.8 nM, respectively, which were at least 100-fold less than concentrations for other CDKs.

As alvocidib did, compound A inhibited growth of FLSs and MFLSs in a concentration-dependent manner (Fig. 5B) and induced cell cycle arrest at the G<sub>1</sub> phase (Fig. 5C). It suppressed RB expression of immune responses is not required for the antiarthritic effect of alvocidib.
phosphorylation at Ser807/Ser811, which are among residues specifically targeted by CDK4/6 in FLS and MFLS (Fig. 5D). Titration experiments showed that 0.25 μM compound A, which was below IC50 for other CDKs, started inhibiting the RB phosphorylation and also increasing cells at the G0/G1 phase; 83.0% in FLS and 72.0% in MFLS.

Compound A (200 mg/kg) was given orally twice daily for 7 days, beginning 24 days after the initial CII immunization. This treatment reduced arthritis score, ankle and paw swelling of the CIA mice (Fig. 6, A–C). The dose could be reduced to 30 mg/kg once daily i.p. injection without loss of therapeutic effects (Fig. 6D). This treatment was started after the onset of clinical arthritis. Five-day treatments repeated after a day hiatus suppressed ongoing arthritis. Histological analysis of the synovial tissues revealed that a CDK1/2/5 inhibitor, R-roscovitine, suppressed a passively induced arthritis model by promoting apoptosis of inflammatory cells (30). Alvocidib induces apoptotic cell death in various tumor cells (13, 14, 31, 32), likely by inhibition of other kinases than CDK (29). In this regards, TUNEL of the joint tissues treated with the two inhibitors did not show increase of apoptotic synovial cells (data not shown). This suggested that local induction of apoptosis in the joints was not responsible for the effect. Although we could not formally exclude effects of these agents on lymphocytes, the results argue that effects on nonlymphoid cells including synovial

Discussion

We have demonstrated that systemic administration of the two CDKIs exerted an antiarthritic effect without critical impairment of lymphocyte responses. Such an inhibitor proved effective in treating a lymphocyte-independent arthritis. Although alvocidib is known as a pan-CDKI, CDK4/6-selective inhibitor showed a comparable effect. This finding suggested that inhibition of CDK4/6 played an important role in the antiarthritic activity. It was reported that a CDK1/2/5 inhibitor, R-roscovitine, suppressed a passively induced arthritis model by promoting apoptosis of inflammatory cells (30). Alvocidib induces apoptotic cell death in various tumor cells (13, 14, 31, 32), likely by inhibition of other kinases than CDK (29). In this regards, TUNEL of the joint tissues treated with the two inhibitors did not show increase of apoptotic synovial cells (data not shown). This suggested that local induction of apoptosis in the joints was not responsible for the effect. Although we could not formally exclude effects of these agents on lymphocytes, the results argue that effects on nonlymphoid cells including synovial

We found no abnormality by physical or behavioral observation in association with administration of compound A. At completion of the therapeutic experiment, inguinal LNs cells were isolated and stimulated with CII. No difference in proliferative response was observed between the compound A-treated and the nontreated mice (Fig. 6G). The preservation of T cell response was also observed in the alvocidib-treated mice (data not shown). Thus, inhibition of the lymphocytes did not play an important role in the therapeutic effects of the smCDK inhibitors.

FIGURE 6. Treatment with compound A suppresses CIA in mice. A–C. Mice with CIA were treated with compound A orally (200 mg/kg) every 12 h for 7 days. Treatment was started when arthritis became evident, 24 days after the initial immunization. D. Other mice with CIA were treated i.p. with compound A (30 mg/kg for 5 days, repeated after a 1-day hiatus). Data are representative of two independent experiments. Control mice were treated with buffer alone. Severity of arthritis was assessed by an arthritis score (A and D), paw thickness (B), and ankle width (C). Data are the mean ± SD (n = 8 per group). *, p < 0.05; **, p < 0.01; ***, p < 0.001. E and F. H&E staining of joints at original magnification [times]100. Paws were examined at completion of the treatment with buffer alone (E) or compound A (F). Representative staining is shown. G. Histological abnormality of the mice treated as in D was scored. Results are mean ± SD from 12 paws. ***, p < 0.001. H and I. Immunohistological staining of joints. Original magnification at [times]200. The paw samples in E and F were stained with phospho-RB Ab. Representative staining is shown. J. Phospho-RB positive cells were semiquantified as percentage of positive nuclei in total nuclei. Data are mean ± SD from 5 paws. *, p < 0.05. K. LN cells from the mice treated as in D were isolated at completion of the treatment. Their proliferative responses to different concentrations of CII were assessed by BrdU incorporation. Data were displayed as BrdU incorporation relative to that in cells cultured without CII. Data are mean ± SD from three mice.
fibroblasts and innate immune cells should account for the therapeutic activity. A reported immunomodulatory action of endogenous CDKI does not depend upon CDK inhibition. This immune modulation could be at least partly responsible for therapeutic effects seen in CDKI gene therapy (18, 19). However, the present study demonstrated that inhibition of CDK activity alone is sufficient to ameliorate arthritis. A major concern with systemic delivery of smCDK inhibitors is possible inhibition of normal cell turnover, which is essential for maintenance of organ homeostasis. Reassuringly, alvocidib, the prototype CDKI, was tolerated relatively well in clinical trials involving cancer (33). Diarrhea, the most frequent side effect in these trials, was not observed in any mice during our experiments. We suspect that proliferating cells involved in the arthritis were more sensitive than tumor cells because 2.5 mg/kg or less of alvocidib sufficed to treat arthritis, whereas at least 5 mg/kg was required to treat tumors (34, 35). Although alvocidib was injected i.v. for tumor treatment, oral administration of compound A was effective in treating arthritis. Although toxic effects might not be tolerated by patients without malignancies, route and dosage could be reconsidered in RA patients being treated in clinical trials. RA might respond to much lower doses than do tumors as is true in treatment with methotrexate.

Compound A is a more selective inhibitor acting primarily upon CDK4 and CDK6. Like alvocidib, it induced cell cycle arrest of syovial fibrasts at the G1 phase. The cell cycle arrest was accompanied by inhibition of RB phosphorylation. In selectivity testing of compound A against other serine/threonine or tyrosine kinases beyond those of the CDK family, only 6 of 45 kinases were inhibited >75% by compound A at 1 μM. No kinase among these six showed a IC50 comparable to those of CDK4 and CDK6. Partly because of structural relevance, alvocidib and compound A do not share the same kinases as off-target kinases. Accordingly, inhibition of cell cycling by CDK4/6 inhibition seemed important in suppressing arthritis. It has been proposed that MAPKs are potential therapeutic targets in RA (36). When their inhibitors showed efficacy, they suppressed Ab responses (37, 38). This was in contrast to the treatment with the CDKIs. We assume that CDKIs might represent a new class of antirheumatic drugs. Based on the results of clinical trials of alvocidib as well as those of the present experiments, patients with RA easily should tolerate an antitumor dose of alvocidib because alvocidib seems to exert cytotoxic adverse effects primarily via inhibition of other kinases at antineoplastic doses (29). Alvocidib exhibited higher protein binding in human serum than in FBS, which led to development of an effective administration schedule (17). The optimal dose should be carefully determined for actual use in treating arthritic patients. In contrast, compound A needs to be modified to improve its pharmacokinetics. It was cleared quite rapidly in vivo, necessitating us using a relatively high dose as its present form. The antiarthritic effect of these drugs did not require obvious suppression of the lymphocyte responses. Most of presently available antirheumatic treatments aim to inhibit harmful immune reactions. Combined use of conventional medication and smCDK inhibitors may well have a synergistic antiarthritic effect. As was revealed by our recent report and others (30, 39, 40), CDKI may have broader activity than anticipated. We found recently that both alvocidib and compound A suppressed matrix metalloproteinase-3 production by synovial fibrasts and osteoclastogenesis of macrophages (data not shown). These effects may contribute to protection from joint damage.

The results of the present studies should encourage further development, clinical testing, and use of the smCDK inhibitors to treat human RA.

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Disclosures

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References


