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Evidence for an Association between Thyroid-Stimulating Hormone and Insulin-Like Growth Factor 1 Receptors: A Tale of Two Antigens Implicated in Graves’ Disease

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Thyroid-stimulating hormone receptor (TSHR) plays a central role in regulating thyroid function and is targeted by IgGs in Graves’ disease (GD-IgG). Whether TSHR is involved in the pathogenesis of thyroid-associated ophthalmopathy (TAO), the orbital manifestation of GD, remains uncertain. TSHR signaling overlaps with that of insulin-like growth factor 1 receptor (IGF-1R). GD-IgG can activate fibroblasts derived from donors with GD to synthesize T cell chemokina and hyaluronan, actions mediated through IGF-1R. In this study, we compare levels of IGF-1R and TSHR on the surfaces of TAO and control orbital fibroblasts and thyrocytes and explore the physical and functional relationship between the two receptors. TSHR levels are 11-fold higher on thyrocytes than on TAO or control fibroblasts. In contrast, IGF-1R levels are 3-fold higher on TAO vs control fibroblasts. In pull-down studies using fibroblasts, thyrocytes, and thyroid tissue, Abs directed specifically against either IGF-1R or TSHR bring both proteins out of solution. Moreover, IGF-1R and TSHR colocalize to the perinuclear and cytoplasmic compartments in fibroblasts and thyrocytes by confocal microscopy. Examination of orbital tissue from patients with TAO reveals similar colocalization to cell membranes. Treatment of primary thyrocytes with recombinant human TSH results in rapid ERK phosphorylation which can be blocked by an IGF-1R-blocking mAb. Our findings suggest that IGF-1R might mediate some similar colocalization to cell membranes. Treatment of primary thyrocytes with recombinant human TSH results in rapid ERK phosphorylation which can be blocked by an IGF-1R-blocking mAb. Our findings suggest that IGF-1R might mediate some similar colocalization to cell membranes.

Insulin-like growth factor 1 receptor (IGF-1R) represents a ubiquitously expressed heterotetrameric protein involved in the regulation of proliferation and metabolic function of many cell types (1, 2). It is a tyrosine kinase receptor comprising two subunits. IGF-1Rα contains a ligand-binding domain while IGF-1Rβ is involved in signaling and contains tyrosine phosphorylation sites. IGF-1R signaling leads to a diverse set of cellular responses, including those involved in the modulation of apoptosis through the PI3K/AKT/FRAP/mTOR/p70S6k pathway (3). Its pathway plays diverse roles in thymic development and immune function through IGF-1R display and activation in B and T cells (4–6). In contrast to IGF-1R, the thyrotopin receptor (thyroid-stimulating hormone receptor (TSHR)) is a consequence of its interactions with G proteins and the activation of adenylate cyclase (9). TSHR possesses an expansive ligand-binding ectodomain linked by disulfide bonds to the membrane-anchoring domain. Like other members of the G protein-coupled receptor family, TSHR can dimerize. Although the functional consequence of associating with other receptors is not yet understood, complex formation might modulate TSH action and receptor activation.

Graves’ disease (GD) is an autoimmune disease where pathogenic Abs (GD-IgG) activate TSHR, leading to overproduction of thyroid hormone and accelerated metabolism of many tissues (10). Another component of GD is an orbital process, termed thyroid-associated ophthalmopathy (TAO), where connective tissue and fat expand, in part from accumulating hyaluronan, and become infiltrated with T and B cells and extensively remodeled (11). It has been suggested that TSHR might have some pathogenic role in the development of TAO (12). Indeed, a positive correlation has been found between anti-TSHR Abs and the activity of TAO (13). TSHR mRNA has been detected, usually by PCR, in orbital tissues from patients with TAO (7) as well as in orbital fibroblasts derived from these patients, albeit at low levels (14). But no convincing link has been identified thus far establishing a role for TSHR or the Abs against it in the pathogenesis of TAO. In contrast, GD-IgG can induce orbital fibroblasts from patients with TAO to produce hyaluronan (15) cells in which it instigates T cell chemotactic

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3 Abbreviations used in this paper: IGF-1R, insulin-like growth factor 1 receptor; TSHR, thyroid-stimulating hormone; GD, Graves’ disease; TAO, thyroid-associated ophthalmopathy; rTSH, recombinant human TSH; siRNA, short interfering RNA; MFI, mean fluorescence intensity; ABC, Ab-binding capacity.

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expression, including up-regulating the synthesis of IL-16 and RANTES (16). These effects are absent in fibroblasts from normal controls and are mediated through IGF-1R (17). Thus, the trafficking of lymphocytes to the orbit and the disordered accumulation of hyaluronan in TAO might be explained, at least in part, by interactions between GD-IgG and IGF-1R.

Potential functional relationships between the TSHR and IGF-1R pathways were first suggested from studies reported nearly 20 years ago. Using the clonal rat thyroid follicular cell line FRTL-5, Ingbar and colleagues (18–21) demonstrated that IGF-1 could enhance TSH actions in vitro. No evidence to our knowledge has been advanced previously suggesting a physical association between TSHR and IGF-1R. Such a link could potentially help explain the permissive effects of IGF-1 on TSH-dependent thyroid function and growth. In this study, we compare for the first time cell surface TSHR and IGF-1R protein levels on orbital fibroblasts from control donors and patients with TAO with those on primary human thyroid epithelial cells (thyrocytes). TSHR levels are similar on control and TAO-derived orbital fibroblasts but are dramatically lower than those found on thyrocytes. TSHR levels increase substantially when fibroblasts are differentiated in vitro into fat cells. In contrast, IGF-1R levels are considerably higher a priori on the TAO orbital fibroblasts than on those from control donors. These differences are mirrored by immunostaining of orbital tissue in situ. Immunoprecipitation of either IGF-1Rβ or TSHR from human orbital fibroblasts, thyrocytes, or thyroid tissue results in an insoluble complex containing both receptors. They colocalize as revealed by confocal microscopy in orbital fibroblasts and thyrocytes. The rapid activation of ERK in primary human thyrocytes by recombinant human TSH (rhTSH) could be attenuated with IGF-1R-blocking mAbs, suggesting that TSHR and IGF-1R might form a functional complex. These unexpected results could explain the molecular basis for GD-IgG triggering multiple manifestations of GD.

Materials and Methods

Anti-human IGF-1R (SC-712), IGF-1R (sc-713), phosphorylated ERK (sc16982), and those Abs directed against human TSHR (MCA1281 and sc-13936) were purchased from Santa Cruz Biotechnology or Serotec. Secondary Abs were from Vector Laboratories. rhTSH was obtained from Sigma-Aldrich and rIGF-1 was purchased from R&D Systems. The mAb 1H7 was supplied by BD Pharmingen. Specific short interfering RNA (siRNA) for IGF-1R was purchased from Qiagen.

Cell culture

Human orbital fibroblasts were harvested and propagated as described previously (22). They were obtained from patients undergoing orbital surgery for severe TAO or for some medical condition not involving orbital inflammation. Explants were allowed to attach to plastic culture dishes and were covered with Eagle’s MEM or DMEM supplemented with 10% FBS, glutamine, and antibiotics. They were maintained in a 5% CO2 humidified environment at 37°C. Explants were removed after fibroblasts encircled them and were passaged by gentle treatment with trypsin/EDTA. They were used between the 2nd and 12th passage and were stored in liquid N2. They were determined not to express factor VIII, cytokeratin, or smooth muscle-specific actin (23). Human primary thyrocytes were obtained from surgical waste as previously described (24). They were covered with RPMI 1640 medium, passaged with trypsin treatment, and used between the second and sixth passage. These activities were approved by the Institutional Review Board of the Harbor-University of California at Los Angeles Medical Center. Donors were euthyroid at the time of participation in these
studies. Control donors had no history of autoimmune disease and no biochemical or physical evidence of thyroid disease.

**Immunoprecipitation and Western blot analysis**

Confluent monolayers were washed in PBS and lysed in a buffer containing 50 mM HEPES (pH 7.5), 150 mM NaCl, 1.5 mM MgCl2, 1 mM EDTA, 10% glycerol, 0.5% Triton X-100, 100 mM NaF, 1 mM sodium vanadate, and 10 mM sodium pyrophosphate. Proteins were solubilized and centrifuged at 13,000 × g for 15 min at 4°C. The supernatant was collected, an aliquot taken for protein determination by the Bio-Rad method, and 400 μg of protein was subjected to immunoprecipitation with anti-human IGF-1Rα, IGF-1Rβ, or anti-human TSHR polyclonal Abs (1 μg) at 4°C with gentle rotation for 16 h. Protein A-conjugated CL-4B Sepharose beads (Sigma-Aldrich) were added to the complex and the mixture was mixed for another 2 h. Beads were washed three times in a buffer containing 10 mM HEPES (pH 7.5), 50 mM NaCl, 10% glycerol, 0.1% Triton X-100, 1 mM sodium vanadate, and 1 mM PMSF. These were then suspended in 2% sample buffer and boiled for 5 min before separation by 7% SDS-PAGE. Separated proteins were transferred to polyvinylidene difluoride Immobilon membranes (Millipore) and probed with primary Ab against IGF-1Rα (1/1000), IGF-1Rβ (1/1000), or TSHR (1/800). Membranes were washed and incubated with HRP-conjugated anti-rabbit secondary Ab. Blots were developed using the Super Signal Extended Duration Substrate System (Pierce). Studies involving the phosphorylation of ERK 1/2 involved treating thyrocytes with the test agents as indicated (see the legend to Fig. 6). To knock down IGF-1R expression, siRNA was incubated with the cultures for 96 h following the instructions of the supplier.

**Confocal microscopy**

Immunofluorescence staining and confocal microscopy were performed essentially as described previously (25). Briefly, cells adherent to glass cover slips were fixed in 2% paraformaldehyde in PBS for 30 min and permeated with 0.2% Triton X-100 for 30 min. Following rinses in PBS, they were incubated with anti-IGF-IRα, anti-IGF-1Rβ, or anti-TSHR Abs alone or in combination at a dilution of 1/100 in PBS containing 5% goat serum for 2 h followed by incubation with FITC- or Texas Red-conjugated secondary Ab (Vector Laboratories) for 45 min. Cover slips were rinsed and mounted on glass slides with Vectashield mounting medium. Images were acquired and analyzed using a Nikon Eclipse 800 microscope interfaced with a Nikon PCM 2000 two-laser confocal system.

**Flow cytometry**

Techniques used in these studies have been published previously (26). Briefly, 1 × 10^6 cells were placed in 12 × 75-mm polypropylene tubes and fluorochrome-conjugated mAbs were added (1 μg/10^6 cells). These were then incubated in the dark for 20 min at room temperature. Cells were washed twice with staining buffer, resuspended in Cytofix (BD Biosciences), and kept in the dark at 4°C until cytometric analysis (within 24 h). Analysis was performed on a FACSCalibur flow cytometer (BD Biosciences). Mean fluorescent intensity (MFI) was calculated as a ratio of mean fluorescence of positive sample/isotype fluorescence. To quantify binding sites represented by fluorescence signals, 50 μl of Quantum Simply Cellular Microbeads (Sigma-Aldrich) were incubated with 10 μl of anti-IGF-IR, 10 μl of anti-TSHR, or isotype Ab for 30 min at room temperature. The bead standards consisted of four populations of microbeads coated with goat anti-mouse Ab. Each binds a different number of mouse IgG mAb molecules (4,603, 14,354, 54,401, and 203,303 molecule-binding capacity). After Ab addition, beads were washed three times with staining buffer. Flow cytometric analysis was performed using the same settings as for cell analysis. A histogram of red fluorescence (FL2) was produced for the beads and the mean fluorescence channel number for each peak was taken. A best-fit curve was drawn to relate linear channel number to logarithmic binding capacity (molecules) from which values for the IGF-IR samples and isotype controls could be read. The F1 values were corrected for autofluorescence and nonspecific binding (QuickCal; QSC calibration software). To calibrate the fluorescence scale of the flow cytometer, we determined the Ab-binding capacity (ABC) which represents the number of Ab molecules bound on each cell or microbead.

**Quantification of fibroblast number**

Fibroblasts were cultured as described above. Cell counts were determined according to the manufacturer’s protocol (CyQuant; Invitrogen). Briefly, cells were cultured in 96-well plates and incubated for 24 h to 7 days. At the desired time, plates were frozen at −70°C until analysis. Culture solution did not contain Phenol Red since the dye can interfere with CyQuant GR dye fluorescence. Plates were thawed at room temperature and 200 μl of CyQuant GR dye/cell lysis buffer was added to each well and incubated for 5 min with gentle mixing. Samples were protected from light and emissions were determined using a Wallac Victor 1420 fluorometer (PerkinElmer) at 480-nm excitation and 520-nm emission wavelengths. They were assayed in quadruplicate and compared with a standard curve.

**Statistics**

Data are expressed as the mean ± SEM. Statistical significance was determined using Student’s t test.

**Results**

IGF-1R is overexpressed by orbital fibroblasts from patients with TAO compared with control donors while TSHR levels are low in fibroblasts from both sets of donors

Three strains of orbital fibroblasts, each from a different donor were examined for IGF-1R and TSHR cell surface display by flow cytometry, as shown in Fig. 1. As the individual cytometric profiles demonstrate, IGF-1R levels are substantially higher in each GD cell strain, as is indicated by the shift away from that of the isotype control. In contrast, TSHR levels in both GD and control fibroblasts are vanishingly low and their profiles are very similar to those generated by the isotype control Abs. IGF-1R levels were then examined in a total of nine different TAO strains compared with five control fibroblast strains (Fig. 2, top). The MFI were dramatically higher in those strains from TAO donors and the data from the two sources did not overlap (TAO, 3-fold, p < 0.003 vs control). Relative receptor densities, as reflected in the MFI were substantially and significantly
different as were results from the ABC analysis (Fig. 2, middle; $p < 0.01$). In contrast, TSHR protein levels appear similar in TAO and control fibroblasts, although the disease-derived strains exhibit higher receptor densities than do four of five of the normal controls. TSHR levels in all 10 fibroblast strains examined were dramatically lower than those found in primary thyrocytes (11-fold difference, $p < 1 \times 10^{-6}$) (Fig. 2, bottom). In paired studies, orbital fibroblasts from patients with TAO display high levels of IGF-1R but fail to express detectable surface TSHR (Fig. 3A). In contrast, thyrocytes, in this case from a patient with GD, express high levels of both receptors.

Differentiation of orbital fibroblasts from patients with TAO into adipocytes leads to increased surface TSHR levels as well as to accumulation of Oil Red O droplets (Fig. 3B and insets). Although levels may fail in some studies to approximate those found on thyrocytes, they increase $\sim 8$-fold above those in undifferentiated fibroblasts. In contrast, control orbital fibroblasts incubated under identical conditions failed to differentiate or display elevated TSHR levels. As in other models of adipocyte differentiation, IGF-1R levels fail to change (data not shown).

**Relatively high IGF-1R levels on TAO fibroblasts result in proliferation when treated with IGF-1**

As the data in Fig. 4 demonstrate, TAO orbital fibroblasts appear to proliferate more rapidly, even under control culture conditions, than do their counterparts from individuals without GD. Treatment of disease-derived fibroblasts with IGF-1 (10 or 50 nM) for 7 days resulted in concentration-dependent cell proliferation compared with that seen in control fibroblast cultures. In contrast, treatment of orbital fibroblasts from either donor source with rhTSH (2 mU/
ml) under identical conditions failed to alter fibroblast proliferation. This absence of an effect differs from the findings in cultured rat preadipocytes (27) where an extremely high concentration of TSH (30 μU/ml) caused substantial proliferation.

Immunolocalization of IGF-1R, IGF-1R, and TSHR in orbital fibroblasts, primary thyrocytes, and intact orbital tissue by confocal microscopy

TSHR was detected using a FITC-conjugated secondary Ab against a rabbit polyclonal anti-TSHR Ab (green) (Fig. 5). Detection of IGF-1Rβ was accomplished with a Texas Red-conjugated secondary Ab against a mouse monoclonal anti-IGF-1Rβ Ab (red). As shown in Fig. 5, A–F, IGF-1Rβ was localized to the periphery of both orbital fibroblasts and thyrocytes as well as to the perinuclear area, a distribution that was identical to the staining pattern of TSHR. The yellow or orange staining seen in the merged images (Fig. C and F) results from colocalization of IGF-1Rβ and TSHR. Thyrocytes exhibit particularly heavy membrane TSHR staining that dominates the IGF-1Rβ signal, as is evident in the merged image where green color is retained in the cell periphery. Perinuclear localization of both receptors was confirmed by the characteristic yellow color evident over the nuclear area when the images are merged. To verify the specificity of the respective signals, a second pair of Abs was tested. In this case, the primary anti-TSHR Ab used was monoclonal and that directed against IGF-1Rβ was polyclonal. As the images in Fig. 5, G and H, attest, staining with this second Ab pair was very similar to that seen with the first set of Abs with regard to localization of the receptors. The merged image found in Fig. 5J again demonstrates the colocalization of the two receptors.

IGF-1Rα was detected using a Texas Red-conjugated secondary Ab against the mouse monoclonal anti-IGF-1Rα Ab (red). As shown in Fig. 5J, intense TSHR staining could again be localized to the perinuclear areas of orbital fibroblasts. Weak to moderate immunostaining was also noted in the central region of the cells. In contrast, IGF-1Rα was cytosolic and predominantly localized in the perinuclear and central regions of the cell but was absent from
IGF-1R is expressed by many different cell types, including cultured human fibroblasts (28) and thyrocytes (29). As the Western blot in Fig. 6A demonstrates, both IGF-1R and TSHR can be detected in these two cell types as well as in thyroid tissue. We next determined whether each receptor could be detected in the immunoprecipitate resulting from treating cell and tissue lysates with Abs against IGF-1R and TSHR. When the homogenates were subjected to precipitation with Abs directed against IGF-1Rβ, TSHR as well as IGF-1Rβ were both detectable by Western blot (Fig. 6A). Similarly, when the samples were immunoprecipitated with anti-TSHR Ab, both receptors proved abundant in the precipitated complex. In contrast, IGF-1Rβ or TSHR could not be detected in the immunoprecipitate resulting from an irrelevant Ab, such as anti-IL-6R (designated control in Fig. 6). When orbital fibroblast lysates were immunoprecipitated with anti-TSHR Ab, both receptors proved abundant in the precipitated complex. In contrast, IGF-1Rβ and TSHR form a relatively tight complex. This complex was disrupted when cells were treated with specific siRNA to IGF-1Rα, as is evidenced by double immunostaining of these proteins. The yellow staining seen in the merged panel (Fig. 5L) resulted from colocalization of the green TSHR and red IGF-1Rα.

**IGF-1R staining in orbital fat from patients with TAO**

We have also examined IGF-1R staining in orbital tissue in situ to determine whether the colocalization occurring in cultured cells was relevant to the intact human orbit. Tissue from patients with TAO exhibited specific staining for IGF-1R (Fig. 5A). These results strongly suggest that IGF-1Rβ and TSHR form a relatively tight complex. This complex was disrupted when cells were treated with specific siRNA to down-regulate IGF-1R expression (Fig. 6C). In contrast, IGF-1Rα fails to coprecipitate with TSHR, suggesting that the colocalization of the two demonstrated by confocal microscopy (Fig. 5) results in a weaker association. In contrast, IGF-1Rα and IGF-1Rβ coprecipitate, as expected.

**Immunoprecipitation of IGF-1Rα, IGF-1Rβ, and TSHR in orbital fibroblasts, primary thyrocytes, and thyroid tissue**

**Activation by TSH of ERK in thyrocytes involves the IGF-1R**

We next tested whether the association of TSHR and IGF-1R had functional consequences. Thyrocytes were treated with rhTSH (1 mU/ml) for 15 min. Monolayers were harvested and subjected to Western blot analysis for phosphorylated ERK. As the immunoblot in Fig. 6D indicates, TSH rapidly activates ERK. When the IGF-1R-blocking mAb 1H7 (30) (5 μg/ml) was added to the medium in addition to rhTSH, it could completely block the activation of ERK.
El-Shewy et al. (44) suggested that IGF-1 might activate ERK 1/2 through G protein trans-activating sphingosine 1 phosphate receptors. In contrast, IGF-1 might also enhance some but not all TSHR signaling, a strong possibility based on several earlier reports. For instance, Tramontano et al. (18) found that both IGF-1 and TSH could enhance FRTL-5 cell proliferation and DNA synthesis in a concentration-dependent manner and that these actions were synergistic. In contrast, TSH-dependent cAMP generation appears not to be influenced by IGF-1 in FRTL-5 cells (18–21). More recently, Clement et al. (45) demonstrated that the conditional overexpression of both IGF-1 and IGF-1R in the thyroid of double-transgenic mice results in increased thyroid gland weight and area of the follicular lumen in vivo. In addition, these animals exhibited decreased serum TSH and a slightly elevated thyroxine level, suggesting enhanced sensitivity to TSH (45). Thus, it would appear that IGF-1 and its receptor may enhance the impact of TSH on thyroid function and growth in vivo. Our finding that treatment of thyrocytes with TSH results in ERK 1/2 phosphorylation that can be attenuated with an IGF-1Rα-blocking Ab suggests that previously recognized signaling downstream from TSHR, including the activation of p66Shc (46), Jak/STAT (47), and suppressor of cytokine signaling 1 (48) might involve IGF-1R transactivation. Cass and Meinhold (49) reported that the ligated TSHR could activate the p70S6K pathway in thyrocytes. This pathway can be activated in FRTL-5 cells by TSH and TSH-stimulating Abs from patients with GD (50). The authors suggested an interaction between TSHR and PI3K as the basis for this signaling pattern. Saumier et al. (51) found that TSH could activate p42 ERK in primary human thyrocytes and that the effects were attenuated with TSH-stimulating Abs and were mediated through a pertussis toxin-insensitive pathway. Vandeput et al. (52) reported treatment with rhTSH and bovine TSH resulted in modest activation of ERK in human thyrocytes but not in those from canines. The authors ruled out involvement of Gq in this effect and could not attenuate the activation of ERK with TSH-neutralizing Abs, although that strategy blocked cAMP generation. They concluded that both rhTSH and bovine TSH were contaminated with an uncharacterized substance that initiated this pattern of signaling. Our findings not only confirm this TSH effect on ERK phosphorylation (Fig. 6D), but suggest that TSHR and IGF-1Rβ form an insoluble complex and that tyrosine phosphorylation sites on IGF-1Rβ might mediate some aspects of TSHR signaling. Thus, our findings suggest that a physical and functional association between TSHR and IGF-1R could mediate aspects of signaling traditionally attributed to each receptor alone.

Precedent for intracellular localization of both tyrosine kinase and G protein-coupled membrane receptors abounds. IGF-1Rβ can internalize following its ligation (53) and can localize to the cell nucleus (54). Moreover, epidermal growth factor receptor translocates to the nucleus and functions as a transcription factor (55). Little information currently exists regarding TSHR distribution in cell monolayers, such as those used in these studies. Baratti-Elbaz et al. (56) described recently the intracellular trafficking of TSHR and its recycling to the cell surface in cells overexpressing the protein. Epithelial cell polarity can be lost when tissue orientation becomes disrupted (57–59), thus offering a potential explanation for different distribution of TSHR in cell monolayers. TSHR density is usually greatest in the basolateral membrane in the thyrocytes comprising intact follicles as well as in transfected L cells (56, 60, 61). Other G protein-coupled receptors, including those for luteinizing hormone-releasing hormone, apelin, angiotensin, and bradykinin, have been shown to localize to the cell nucleus (62, 63). The high perinuclear concentrations of TSHR demonstrated in the current studies could represent similar compartmentalization. Thus, earlier findings coupled with those we now report strongly suggest additional biological roles for surface receptors
occurring inside the cell, functioning either as individual proteins or as complexes. Vanishingly little detail has been uncovered thus far concerning the precise nature of the immune responses in GD that underlie site-specific immune infiltration of thyroid and orbit. We recognize the importance to disease pathogenesis of Abs generated against TSHR (10) but have reported very recently that IgGs from these patients can also activate IGF-1R, an interaction that induces expression of T cell chemokactorrants (16, 17, 64) and hyaluronan (15). Thus, IGF-1R may represent a second self-Ag, in addition to TSHR, relevant to the pathogenesis of GD. The physical association between them, as is implied by our current findings, may play some as yet underdetermined role in Ab generation. One possibility concerns potentially exaggerated exposure of autoreactive T cells and B cells to increased numbers and diversity of Ags resulting from epitope spread. This process can enhance the amplitude of immune reactivity and promote Ag-specific tissue targeting by immunocompetent cells (65–67). Antigenic presentation and recognition of IGF-1R and TSHR through innate and cognate responses could broaden and intensify those responses. Thus, immunity associated with GD may prove analogous to that occurring in allied autoimmune disorders as type 1 diabetes mellitus and systemic lupus erythematosus, where a stepwise generation of new autoantigens results in multiple disease manifestations (68–70). Identifying neo-Ags relevant to GD and determining whether epitope spreading plays a role in their generation should put our current findings into a more complete context.

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Disclosures

The authors have no financial interest of reference.

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