Keratinocyte Growth Factor Improves Allogeneic Bone Marrow Engraftment through a CD4⁺Foxp3⁺ Regulatory T Cell-Dependent Mechanism

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Keratinocyte Growth Factor Improves Allogeneic Bone Marrow Engraftment through a CD4+Foxp3+ Regulatory T Cell-Dependent Mechanism

Keratinocyte growth factor (KGF), also known as FGF-7, is a 28 kDa member of the fibroblast growth factor family (1). KGF is produced by cells of mesenchymal origin and intraepithelial γδ T cells. Binding of KGF to its receptor FGFR2-IIIb, which is primarily expressed by epithelial cells, stimulates cell proliferation, differentiation, and survival (2, 3). Several studies have shown that administration of KGF to mice before or shortly after allogeneic bone marrow (BM) transplantation (allo-BMT) ameliorates graft-vs-host disease (GVHD) (4–7) and enhances peripheral T cell reconstitution (6–9). These beneficial effects have mainly been attributed to the protection of KGF receptor-positive epithelial cells against damage caused by radiation, cytotoxic therapy, and/or GVHD. However, studies in unconditioned mice have shown that KGF also reduces GVHD and facilitates engraftment of allogeneic bone marrow cells by immunological effects (6, 10). KGF administration reduces the in vivo allo-response and alters plasma cytokine levels during acute GVHD. These alterations reflect the development of a mixed Th1/Th2 cytokine ratio in which Th2 cytokines, such as IL-4 and IL-13, predominate (6, 7, 10). In addition, lymphocytes isolated from KGF-pretreated allo-immunized mice exhibit reduced responsiveness in a secondary in vitro MLR (6). Recently, we demonstrated that administration of KGF to normal mice induces an increase in CD4+Foxp3+ regulatory T cell (Treg) numbers in blood, spleen, and lymph nodes (11). This increase follows two sequential kinetic patterns. The first wave of increase in CD4+Foxp3+ Treg occurring within 4 days after KGF application is due to selective peripheral expansion of Treg. During a subsequent wave from day 10 onwards, KGF treatment also enhances thymic output. The latter effect results in a selective increase of recent thymic emigrants, including CD4+Foxp3+ Treg. Accumulating evidence indicates a pivotal functional role for CD4+CD25+Foxp3+ Treg in transplantation tolerance (12). In various experimental models, it has been shown that adoptive transfer of large numbers of CD4+CD25+ Treg at the time of allo-BMT ameliorates GVHD (13–16) and reduces bone marrow graft rejection (15, 17). As Treg have a major role in the suppression of T cell-mediated immune responses, we hypothesized that KGF-induced expansion of CD4+Foxp3+ Treg may contribute to the immunomodulatory effects of KGF after BMT. In this study, we present experimental data indicating that selective peripheral expansion of Treg is a major immunomodulatory mechanism by which KGF improves engraftment of allogeneic bone marrow.

Materials and Methods

Mice
129Sv mice were purchased from Charles River Laboratories, B6.129S7Rag-1<sup>tm1Hkmj-/-</sup> (B6-CD45.2 RAG-1<sup>1/-</sup>) mice and B6.SJL-Piper-Pepc<sup>BoyJ</sup> (B6-CD45.1) mice, originally purchased from The Jackson Laboratory, were bred and housed under specific pathogen-free conditions in the Erasmus MC Animal Center (Rotterdam, The Netherlands). Mice were used at 8–12 wk of age. Heterozygous female B6.Cg-Foxp3<sup>sf/J</sup> mice (The Jackson Laboratory) were bred with male B6-CD45.1 mice to produce Foxp3<sup>gTg</sup>-B6-CD45.1.2 (Scurfy) mice. The presence of the scurfy mutation was confirmed by PCR as detailed in The Jackson Laboratory’s

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website. Male Scuffy mice were used at 17 days after birth. Food and water were available ad libitum. Housing, care, and animal experiments were performed in accordance with Dutch legal regulations, which include approval by an ethical committee.

**KGF treatment**

Palifermin, ΔN23-KGF (KGF) was provided by Amgen. KGF was dissolved in autoclaved demineralized water and further diluted in PBS/1% FCS before injection. T cell provider mice were injected s.c. with 5 mg/kg/day KGF once daily for 3 consecutive days and sacrificed 4 days after the final KGF administration.

**Bone marrow transplantation**

Bone marrow obtained from crushed femurs and tibias of donor mice was depleted of T cells by incubation with rat anti-mouse CD4 (YTS191, YTA312) and rat anti-mouse CD8 (YTS169) mAbs (18) followed by incubation with goat anti-rat Ig microbeads (Miltenyi Biotec) and magnetic separation using the autoMACS according to the manufacturer’s instructions (Miltenyi Biotec). The efficacy of T cell depletion was monitored by flow cytometry and always found to be more than 2 log. Splenic T cells were obtained by negative selection using a mixture of non-T cell mAbs according to the manufacturer’s instructions (Stem-Sep; Stem Cell Technologies). Purity of the T cell fraction was always found to exceed 90% as confirmed by flow cytometry. CD4<sup>+</sup> responders were obtained by negative selection using a mixture of non-T cell mAbs according to the manufacturer’s instructions (Miltenyi Biotec). The purity of the T cell fraction was always found to exceed 90% as confirmed by flow cytometry. Eight- to twelve-week-old RAG-1<sup>−/−</sup> mice were sublethally irradiated (3 Gy) (137Cs γ-source, Gammacell, Atomic Energy of Canada). Mice were supplied with graded numbers of CD45.1<sup>+</sup> congenic wild-type (WT) or Scuffy T cells and subsequently received 12.5 × 10<sup>6</sup> T cell depleted 129Sv bone marrow cells (minor Ag-mismatched) by tail vein infusion.

**Flow cytometric analysis**

At serial time points, blood was collected from the retro-orbital plexus. For flow cytometric analysis, 30–50 μl blood was incubated for 30 min at 4°C with Abs. Absolute numbers of peripheral blood leukocytes were determined by single platform flow cytometry as described previously (18). mAbs used for flow cytometric analysis were anti-CD3, anti-CD4, anti-CD19, and anti-CD45.1 (BD Pharmingen). The expression of Foxp3 was determined by intracellular staining with anti-Foxp3 (clone FJK-16s) using the fixation and permeabilization reagent from the manufacturer (eBioscience). Intracellular IL-4 and IFN-γ staining was performed on single cell suspensions prepared from spleen. Two million spleen cells were stimulated with medium supplemented with either 25 ng/ml PMA (Sigma-Aldrich) and 1 μg/ml ionomycin (Sigma-Aldrich) or with medium only for 5 h at 37°C and 5% CO<sub>2</sub>. Brefeldin A (Sigma-Aldrich) was added at a final concentration of 10 μg/ml for the final 4 h of incubation. Next, cells were stained with anti-CD3 and anti-CD4 mAbs and after fixation and permeabilization (BD Pharmingen), cells were stained with anti-IL-4 and anti-IFN-γ (BD Pharmingen). All analyses were performed in duplicate. All cells were analyzed on a flow cytometer (FACSCalibur, BD Biosciences, Immunocytometry Systems) using CellQuest software (BD Biosciences).

**Isolation of Treg and in vitro Treg activity assay**

CD4<sup>+</sup>CD25<sup>hi</sup> Treg were isolated from spleens using a Treg isolation kit (Miltenyi Biotec). The purity of the isolated cells always exceeded 95% as confirmed by flow cytometry. CD4<sup>+</sup>CD25<sup>hi</sup> Treg were evaluated for their ability to suppress T cell proliferation by coculture of graded numbers of CD4<sup>+</sup>CD25<sup>hi</sup> Treg with 5 × 10<sup>5</sup> CD4<sup>+</sup>CD25<sup>−</sup> responder T cells in round-bottom 96-well plates. Cells were stimulated with 0.5 μg/ml anti-CD3 mAb and RAG-1<sup>−/−</sup> spleen cells (2 × 10<sup>5</sup>) as APC at 37°C and 5% CO<sub>2</sub> for 3 days. Cell cultures were pulsed with 1 μCi [<sup>3</sup>H]thymidine (Amersham Biosciences) per well for the last 16 h of culture and harvested on glass fiber filters (Packard Instruments). Incorporated [<sup>3</sup>H]thymidine was measured using a liquid scintillation counter (Packard Instruments). All cultures were performed in quadruplicate.

**Statistical analysis**

Mann-Whitney U test was used to compare numbers of peripheral blood cell subsets in mice supplied with T cells from PBS- or KGF-treated congenic mice. Fisher’s exact test was used to compare the incidence of graft rejections between mice supplied with T cells from PBS- or KGF-treated congenic mice. A t test was used to compare the suppressive capacity of Treg isolated from PBS- and KGF-treated mice in vitro. p values < 0.05 were considered significant.

**Results**

**KGF treatment of T cell provider mice facilitates allografting of allogeneic bone marrow cells.** Three Gy-irradiated RAG-1<sup>−/−</sup> mice supplied with 10<sup>6</sup> congenic CD45.1<sup>+</sup> T cells from PBS-treated or KGF-treated mice received a T cell depleted minor Ag-mismatched BMT. Numbers of lymphocyte subsets were studied by single-platform flow cytometry of peripheral blood samples taken at several time points. Values represent percentage of Foxp3<sup>+</sup> Treg within CD45.1<sup>+</sup> T cells or KGF- (□) treated mice. C, Bone marrow-derived CD45.1<sup>+</sup>CD19<sup>−</sup>cells/μl blood (B) for individual mice supplied with T cells from PBS- (■) or KGF- (□) treated mice. C, Bone marrow-derived CD45.1<sup>+</sup>CD19<sup>−</sup>cells/μl blood, and bone marrow-derived CD45.1<sup>+</sup>CD3<sup>+</sup> T cells/μl blood (D) are shown for recipients of BMT alone (●). BMT plus T cells from PBS-treated provider mice (□), and BMT plus T cells from KGF-treated provider mice (□). Horizontal bars represent mean values for that time point. *p < 0.01; **p < 0.05; n.s. = not significant.

To evaluate the role of peripheral expansion of CD4<sup>+</sup>Foxp3<sup>+</sup> Treg in KGF-mediated facilitation of allo-engraftment, we applied KGF in an established MHC-matched minor-Ag mismatched BMT model (18). This model allows the evaluation of immunomodulatory effects of KGF in the absence of potentially confounding cytokinetic and thymopoietic effects of KGF. Congenic mice that served as T cell providers, rather than BMT-recipient mice were treated with KGF. Next, T cell-deficient B6-CD45.2 RAG-1<sup>−/−</sup>...
mice were irradiated 3Gy and supplied with $10^5$ T cells from congenic B6-CD45.1 mice that were pretreated with KGF or PBS (controls). Subsequently, T cell-supplied RAG-1$^{-/-}$ mice received an allogeneic MHC-matched minor Ag-mismatched T cell-depleted bone marrow graft from 129Sv mice. Engraftment as well as the fate of the administered CD45.1$^+$ T cells and the frequency of CD45.1$^+$CD4$^{+}$Foxp3$^+$ Treg were monitored at weekly intervals.

We previously showed that administration of KGF to B6-CD45.1 mice produces a 2-fold increase in frequency of Foxp3$^+$ Treg within splenic CD4$^+$ T cells at 4 days after cessation of KGF administration (Fig. 1A, starting population) (11). After adoptive transfer of T cells from KGF-treated mice (●), the frequency of Foxp3$^+$ Treg within CD45.1$^+$CD4$^{+}$ T cells remained significantly higher for 4 wk, but eventually returned to levels observed in transplanted RAG-1$^{-/-}$ mice that were supplied with T cells from PBS-treated CD45.1$^+$ mice (■) (Fig. 1A). Whereas T cells from CD45.1$^+$ PBS-treated mice vigorously expanded in RAG-1$^{-/-}$ allo-BMT recipients, there was only a moderate expansion of T cells from CD45.1$^+$ KGF-treated mice (Fig. 1B).

Bone marrow engraftment was monitored by quantifying CD45.2$^+$ T- and B-cells at weekly intervals in blood samples. RAG-1$^{-/-}$ mice receiving allogeneic BMT-only, all showed engraftment (Fig. 1, C and D, ◊). Adoptive transfer of $10^5$ T cells from PBS-treated congenic mice before allo-BMT of RAG-1$^{-/-}$ mice significantly reduced engraftment (Fig. 1, C and D, ■) and resulted in rejection (defined as a sustained peripheral blood CD45.2$^+$CD3$^+$ T cell number below 50 cells/µl) in 6 of 16 mice. The administration of $10^5$ T cells from KGF-treated congenic mice before allo-BMT of RAG-1$^{-/-}$ mice improved engraftment and significantly ($p = 0.04$) reduced the incidence of rejection (1 of 16 mice) compared with transplanted RAG-1$^{-/-}$ mice supplied with T cells from PBS-treated mice (Fig. 1, C and D, □). Thus, KGF pretreatment of the T cell provider mice promotes engraftment, which correlates with a sustained increased percentage of CD4$^+$Foxp3$^+$ T cells in the blood and a reduced expansion of CD3$^+$ T cells.

To assess whether a 2-fold increase in Treg frequency in itself is sufficient to induce an increase in bone marrow engraftment in our model, we doubled the frequency of Treg in the supplied T cell donor mice by adding 5000 purified CD4$^+$CD25$^{high}$ Treg (Fig. 3). In contrast to the results obtained after supply of T cells from KGF-treated mice (Fig. 1B), KGF facilitated alloengraftment by expanding Treg.

FIGURE 3. Suppressive activity of CD4$^+$Foxp3$^+$ Treg from PBS- and KGF-treated mice. CD4$^+$CD25$^{high}$ Treg were added to cultures of responder T cells from PBS-treated congenic mice before allo-BMT of RAG-1$^{-/-}$ mice, to which 5000 CD19$^{+}$ cells (○) or T cells plus Treg (●) or T cells plus CD25$^{+}$ T cells (□) were added. Horizontal bars represent mean values for the responder T cell population.
Treg in vivo, but also enhanced the in vitro Treg immunosuppressive activity.

KGF-expanded Treg are pivotal for improving engraftment

To assess a causal relationship between selective expansion of Treg and improved engraftment, we used Scurfy mice as T cell provider mice. Due to a natural mutation in the Foxp3 gene, Scurfy mice lack CD4\(^{+}\) Foxp3\(^{+}\) Treg and die within 3–4 wk after birth from lymphoproliferative autoimmune syndromes mediated by uninhibited, autoreactive T cells (19, 20). Previously, it was shown that the spontaneous autoimmune response observed in Scurfy mice results in selective T cell expansion and significant changes in TCR repertoire (21). Because this might influence the alloreactivity of Scurfy cells compared with wildtype cells, we first assessed the number of Scurfy cells that were required to inhibit engraftment. Irradiated RAG-1\(^{-/-}\) mice were supplied with either no T cells or \(10^4\), \(10^5\), or \(10^6\) Scurfy T cells and received a T cell-depleted minor Ag-mismatched BMT. T and B cell recovery was studied by single-platform flow cytometry of peripheral blood samples. Values represent bone marrow-derived CD45.1\(^{+}\) CD19\(^{+}\) cells/μl blood (A), and bone marrow-derived CD45.1\(^{-}\)CD3\(^{+}\) T cells/μl blood (B) of individual mice at day 28 after transplantation. Horizontal bars represent mean values for that time point.

KGF-expanded Treg abrogate the ability of KGF to facilitate allogeneic bone marrow engraftment.

Three Gy-irradiated RAG-1\(^{-/-}\) mice supplied with \(10^6\) T cells from PBS- or KGF-treated Scurfy mice received 12.5 \(\times\) \(10^6\) T cell-depleted minor Ag-mismatched BM cells. T and B cell numbers were studied by single-platform flow cytometry of peripheral blood samples taken at weekly intervals. Values are shown for bone marrow-derived CD45.1\(^{-}\)CD19\(^{+}\) cells/μl blood (A), bone marrow-derived CD45.1\(^{-}\)CD3\(^{+}\) T cells/μl blood (B), and congenic CD45.1/2\(^{+}\) Scurfy T cells/μl blood (C) for individual BMT recipients supplied with T cells from PBS-treated Scurfy mice (○) or T cells from KGF-treated Scurfy mice (○). Horizontal bars represent mean values for that time point. *, \(p<0.01\); **, \(p<0.05\).

![FIGURE 4](image)

**FIGURE 4.** Scurfy T cells suppress MHC-matched, minor-Ag mismatched bone marrow engraftment. Three Gy-irradiated RAG-1\(^{-/-}\) mice were supplied with either no T cells or \(10^4\), \(10^5\), or \(10^6\) Scurfy T cells and received a T cell-depleted minor Ag-mismatched BMT. T and B cell recovery was studied by single-platform flow cytometry of peripheral blood samples. Values represent bone marrow-derived CD45.1\(^{+}\) CD19\(^{+}\) cells/μl blood (A), and bone marrow-derived CD45.1\(^{-}\)CD3\(^{+}\) T cells/μl blood (B) of individual mice at day 28 after transplantation. Horizontal bars represent mean values for that time point.

![FIGURE 5](image)

**FIGURE 5.** The absence of CD4\(^{+}\) Foxp3\(^{+}\) Treg abrogates the ability of KGF to facilitate allogeneic bone marrow engraftment.

Three Gy-irradiated RAG-1\(^{-/-}\) mice supplied with \(10^6\) T cells from PBS- or KGF-treated Scurfy mice received 12.5 \(\times\) \(10^6\) T cell-depleted minor Ag-mismatched BM cells. T and B cell numbers were studied by single-platform flow cytometry of peripheral blood samples taken at weekly intervals. Values are shown for bone marrow-derived CD45.1\(^{-}\)CD19\(^{+}\) cells/μl blood (A), bone marrow-derived CD45.1\(^{-}\)CD3\(^{+}\) T cells/μl blood (B), and congenic CD45.1/2\(^{+}\) Scurfy T cells/μl blood (C) for individual BMT recipients supplied with T cells from PBS-treated Scurfy mice (○) or T cells from KGF-treated Scurfy mice (○). Horizontal bars represent mean values for that time point. *, \(p<0.01\); **, \(p<0.05\).
KGF FACILITATES ALLOENGRAFTMENT BY EXPANDING Treg

In addition, we assessed the expansion kinetics of T cells from PBS- and KGF-treated Scurfy mice in BMT recipients (Fig. 5C). No difference in congenic T cell numbers between BMT recipients supplied with T cells from PBS- and KGF-treated Scurfy mice were noted. At later time points (day 21 and 28 after BMT), BMT recipients of T cells from KGF-treated Scurfy mice even showed a trend toward increased numbers of congenic T cells. The fact that the engraftment promoting effect is not seen with T cells derived from KGF-pretreated Scurfy mice suggests a mechanism dependent on CD4+Foxp3+ Treg.

The bone marrow engraftment facilitating effects of KGF are not due to a shift in the Th1/Th2 balance toward Th2

Apart from its effects on peripheral Treg, KGF has also been shown to increase serum levels of Th2 cytokines like IL-4 and IL-13 (6, 7, 23). The KGF-driven redirection of the cytokine profile from Th1 to a mixed Th1/Th2 pattern may also protect against graft rejection. To evaluate the contribution of a shift in Th1/Th2 pattern, we measured the effect of KGF-treatment of Scurfy mice on the Th1/Th2 cell ratio. Similar to WT mice, KGF significantly increased the percentage of IL-4 producing CD4+ T cells in Scurfy mice (Fig. 6A). Furthermore, a similar reduction in the ratio of IFN-γ and IL-4 producing CD4+ T cells was observed in both KGF pretreated WT (Fig. 6B) and Scurfy (Fig. 6C) mice. Therefore, the cytokine shift in itself can unlikely account for the engraftment-facilitating effects of KGF.

Discussion

Administration of KGF shortly before or after BMT has been shown to reduce bone marrow graft rejection in mice by cytoprotective and immunoregulatory effects (6, 10). The mechanisms underlying the immunoregulatory effects of KGF are still largely unknown. We recently showed that KGF selectively expands CD4+Foxp3+ Treg in blood, spleen and lymph nodes of normal mice (11). However, whether the expansion of these Treg cells can indeed be accounted responsible for the facilitation of engraftment has remained unresolved. Using KGF-treated Scurfy mice as T cell providers, we show that in the absence of Treg the ability of KGF to improve engraftment is lost. The latter observation would be consistent with the notion that KGF improves allogeneic bone marrow engraftment through a CD4+Foxp3+ Treg-dependent mechanism.

Several studies reported that adoptive transfer of large numbers of donor- or host-type CD4+CD25+ Treg at the time of allogeneic BMT prevents bone marrow graft rejection in mice (15, 17). Our notion that selective in vivo expansion of endogenous Treg is involved in the KGF-induced prevention of bone marrow graft rejection is in line with these studies. Both selective peripheral expansion of endogenous Treg and adoptive transfer of Treg shifts the balance between effector T cells and Treg toward Treg, resulting in suppression of the effector T cell-mediated immune response. In addition to the induction of an increase in the frequency of Treg, KGF also enhances the suppressive activity of Treg. Although a 2-fold increase in Treg frequency in itself is sufficient to promote engraftment in our MHC-matched, minor Ag-mismatched BMT model, it is likely that the increased suppressive activity of Treg from KGF-treated mice contributes to the engraftment facilitating effects of KGF.

Preliminary data suggest that the ability of KGF to improve engraftment of MHC-matched, minor Ag-mismatched bone marrow is lost in a MHC-mismatched BMT model. KGF treatment of T cell provider mice had no effect on the bone marrow engraftment in RAG-1–/– mice supplied with 10^7 T cells that were transplanted with a bone marrow graft from MHC incompatible

effectively inhibit engraftment. Mice receiving 10^6 Tscurnf y cells gradually developed autoimmune symptoms from 28 days onwards, prohibiting the monitoring of engraftment beyond day 28.

Next, we evaluated whether pretreatment of Scurfy T cell provider mice with KGF would affect engraftment. As expected, CD4+Foxp3+ Treg in blood, spleen and lymph nodes of normal mice (11). However, whether the expansion of these Treg cells can indeed be accounted responsible for the facilitation of engraftment has remained unresolved. Using KGF-treated Scurfy mice as T cell providers, we show that in the absence of Treg the ability of KGF to improve engraftment is lost. The latter observation would be consistent with the notion that KGF improves allogeneic bone marrow engraftment through a CD4+Foxp3+ Treg-dependent mechanism.

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BALB/c mice. The frequency of allo-MHC reactive T cells is much higher than the frequency of T cells specific for minor Ags. Hence, the Treg to effector T cell ratio in the MHC mismatched model is much lower than in the minor Ag model, making it more difficult to suppress. The KGF-induced increase in Treg frequency and suppressive activity is likely insufficient to control the overwhelming allo-MHC reactive T cell response in the MHC-mismatched setting. Moreover, NK cells might have contributed to the rejection of MHC-mismatched bone marrow.

In addition to expanding CD4+Foxp3+ Treg (11), the use of KGF may also elevate the serum levels of the Th2 cytokines IL-4 and IL-13 and reduce the levels of the Th1 cytokines IFN-γ and TNF-α, resulting in a redirection of the Th1/Th2 cytokine profile toward Th2 cytokines (6, 7, 10). The data reported in this study appear in agreement with these observations. They demonstrate that KGF reduces the frequency of Th1 cells and increases that of Th2 cells in both normal and Scuffy mice. In GVHD studies it has also been postulated that the immunoregulatory protective effect of KGF was caused by a redirection of the cytokine profile (7, 10). In addition, acute GVHD could be prevented in mice receiving CD4+ T cells enriched for Th2-type populations (22). Alternatively, we used Scuffy mice that lack Treg, thereby excluding effects mediated by Treg. Bone marrow engraftment was not improved in mice supplied with T cells from KGF-treated Scuffy mice, although KGF effectively increased the frequency of IL-4-producing CD4+ Th2 cells in Scuffy mice, similarly to WT mice. These results suggest that it is highly unlikely that the increased frequency of Th2 cells observed both in WT and Scuffy mice contributed to the engraftment-facilitating effects of KGF.

In summary, we demonstrate that peripheral expansion and increased suppressive activity of CD4+Foxp3+ Treg is a major immunomodulatory mechanism by which KGF improves allogenic bone marrow engraftment. The altered ratio of Treg to alloreactive T cells, rather than a higher frequency of Th2 cells, effectively suppressed T cell-mediated graft rejection. The findings reported here might imply a broader therapeutic potential of KGF than as an anti-mucositis agent only, for which it is currently approved by the FDA (23, 24). KGF could be envisaged to be used in clinical hematopoietic stem cell transplantation to improve immunological tolerance and to improve engraftment. Especially patients at high risk for graft rejection, including recipients of (small) umbilical cord blood grafts; recipients of haploidentical or multiple mismatched stem cell grafts; and patients receiving non-myeloablative conditioning might benefit from KGF treatment. Although umbilical cord blood transplantation has several advantages over the use of stem cells from unrelated adult donors (25, 26), it is still associated with an increased risk of graft rejection and insufficient hematopoietic recovery. Expansion of Treg shortly before and after stem cell transplantation might, therefore, have clinical merits and repair and improve engraftment-facilitating effects of KGF.

Disclosures

The authors have no financial conflict of interest.

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