Impairment of Regulatory Capacity of CD4+ CD25+ Regulatory T Cells Mediated by Dendritic Cell Polarization and Hyperthyroidism in Graves' Disease

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Regulatory T Cells Mediated by Dendritic Cell Polarization and Hyperthyroidism in Graves’ Disease

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Graves’ disease (GD) is one of the most common autoimmune diseases. The immune dysfunction in GD involves the generation of thyroid-stimulating hormone receptor (TSHR) autoantibodies that presumably arise consequent to interactions among dendritic cells (DCs), T cells, and regulatory T (Treg) cells. However, the immunological mechanisms of interactions between them that lead to the induction and regulation of this autoimmune disease are poorly defined. In this study, we investigated whether DCs are the main cause of the defective activity of Treg cells in GD patients. We found a significant decrease in the percentage of circulating CD4+CD25+FOXP3+ Treg cells in untreated GD patients (uGD), which was negatively correlated with the concentration of TSHR autoantibodies. uGD-derived DCs were polarized to increase the number of plasmacytoid DCs (pDCs) and conferred the ability to abrogate the suppressive function of Treg cells through inducing apoptosis of CD4+CD25+ Treg cells in an IFN-α-dependent manner, and elevated thyroid hormones further exacerbated the effect. The nucleotide UDP, which inhibits IFN-α secretion of pDCs through P2Y6 receptor signaling, restored the suppressive function of CD4+CD25+ Treg cells. Collectively, uGD-derived DCs through pDC polarization and elevated thyroid hormones act in concert to impair the regulatory capacity of Treg cells, facilitating the production of TSHR autoantibodies in the pathogenesis of GD. The Journal of Immunology, 2011, 186: 4734–4743.

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Abbreviations used in this article: 7-AAD, 7-amino-actinomycin D; BDCA, blood dendritic cell Ag; CD, control donor; DC, dendritic cell; eGD, euthyroid Graves’ disease patients; eHT, euthyroid Hashimoto’s thyroiditis patients; FCM, flow cytometry; GD, Graves’ disease; mDC, myeloid dendritic cell; pDC, plasmacytoid dendritic cell; T3, 3,3’,5-triiodo-l-thyronine; TdR, thymidine deoxyriboside; TH, thyroid hormone; Treg, regulatory T; TSHR, thyroid-stimulating hormone receptor; uGD, untreated GD patient. Copyright © 2011 by The American Association of Immunologists, Inc. 0022-1767/11/$16.00

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otal role in autoimmune diseases because they are capable of either triggering autoreactive T cells or activating Treg cells, depending on the maturation stimuli and/or DC subsets (18, 19). Circulating human DCs, which typically constitute 0.5–2% of PBMCs, are classified into two different subsets with distinct surface markers: CD11c+CD123b or CD11c+CD123+ myeloid DCs (mDCs) and CD11c+CD123b plasmacytoid DCs (pDCs) (20, 21). pDCs are found primarily in the peripheral blood and lymphoid organs. They possess the capacity to respond to self-nucleic acids or viruses via TLR7 and TLR9 by producing large amounts of IFN-α and other proinflammatory cytokines, which participate in autoimmunity and innate antiviral immunity (22–24). In contrast, mDCs mainly produce proinflammatory cytokines, such as IL-12 and TNF-α, in response to microbial stimulation (25). It has been suggested that DCs have the ability to control the suppressive function, expansion, and/or differentiation of Treg cells in mouse models of autoimmune diseases (26–28). Human DCs are able to partially abrogate the inhibition by Treg cells (29). More recent studies suggest that a feedback regulatory loop modulates the number of Treg cells and DCs in vivo. This regulatory circuit is essential for the steady-state balance between immunity and tolerance (30, 31). However, under the pathology conditions, particularly in the context of elevated thyroid hormones (THs), as the functional cross talk between immune and endocrine systems, the regulatory mechanism of DCs, Treg cells, and THs in the pathogenesis of GD remains uncertain.

We therefore mainly focused our study on the interaction between naturally occurring CD4+CD25+ Treg cells and DCs in the GD patients. We provide evidence that the pDC subset was polarized in untreated GD patients (uGD), leading to a reduction in the number and regulatory capacity of Treg cells through induction of apoptosis. THs further aggravated the apoptosis of Treg cells. Furthermore, the effect of uGD-derived DCs was reversed by the nucleotide UDP through P2Y6 receptor signaling, which restored the regulatory activity of Treg cells.

Materials and Methods

Subjects

The patients in this study were recruited from the Outpatient Department of Rujin Hospital, Shanghai Jiao Tong University School of Medicine, and the Outpatient Department of Affiliated Hospital of Jiaou University. Seventy-seven uGD, 13 euthyroid Hashimoto’s thyroiditis patients (eHT) were diagnosed through standard clinical and laboratory examinations. Control donors (CD) (n = 74) were selected based on normal physical examination and endocrine function tests. Demographic and clinical information of the study subjects is presented in Table 1. The serum levels of FT3, FT4, TSH, and TPOAb were measured by automated chemiluminescent immunoassays (Architect i2000SR; Abbott). The level of serum TSHR Abs was measured by a radioimmunoassay assay with a commercial kit (Dia Sorin). Informed consent was obtained from all participants before the samples for the study were collected. The study protocol was approved by the Ethics Committee of Shanghai Jiao Tong University School of Medicine.

Cell isolation and purification

Peripheral blood was collected in sodium-heparin vacutainer tubes, and PBMCs were isolated with a Ficoll density gradient (Sigma-Aldrich). DCs (>95% purity) were separated by negative and positive selection using the Blood Dendritic Cell Isolation Kit II (Miltenyi Biotec, Bergish Gladbach, Germany) according to the manufacturer’s instructions. The kit allows the concurrent isolation of pDCs and mDCs by magnetic labeling of CD303, CD1c, and CD141, respectively. The remaining cells were used to further isolate CD4+CD25- and CD4+CD25+ T cells by negative and positive selection using the human CD4+CD25+ Regulatory T Cell Isolation Kit (Miltenyi Biotec). In this study, to remove autoactivative CD4+CD25+ T cells from the CD4+CD25+ Treg cells, CD25- T cells were isolated from the CD4+ populations by using 50% of the manufacturer’s recommended concentration of anti-CD25 microbeads, because CD4+CD25+ Treg cells have previously been shown to express a high level of CD25 (32). The isolated CD4+CD25- T cells (>90% purity) and CD4+CD25+ T cells (>90% purity) were used in both the proliferation and suppression assays. In some experiments, isolated DCs were further sorted into mDCs (CD11c+CD123+) and pDCs (CD11c-CD123+) with >90% purity of both by FACSaria cytometer (BD Biosciences).

Flow cytometric analysis

PBMCs were freshly isolated by Ficoll density gradient centrifugation. The proportion of CD4+CD25+FOXP3 T cells in the CD4+ T cell population was determined with a commercially available kit according to the manufacturer’s instructions. In brief, after CD4 and CD25 surface staining, cells were washed and fixed using fixation/permeabilization solution. Cells were then stained intracellularly for FOXP3. Human blood DC subsets (mDC and pDC) were analyzed with a DC enumeration kit (Miltenyi Biotec) according to the manufacturer’s instructions. In brief, samples were stained with anti-blood DC Ag (BDCA) mixture (containing mAbs specific for the DC markers BDCA1, BDCA2, and BDCA3 along with CD14 and CD19 Abs) or control mixture containing appropriate isotype controls. The percentage of positively stained cells was analyzed using flow cytometry (FCM; BD Biosciences). In some experiments, the expression of cell-surface Ags was assessed with the following mAbS: PE-labeled anti-CD123 (BD Pharmingen); anti-CD25 (Miltenyi Biotec); anti-CD40 (R&D Systems); and allophycocyanin-labeled anti-CD11c (BD Pharmingen). The appropriate isotype Abs were used as controls.

Functional responses of lymphocytes and DCs

Freshly isolated CD4+CD25- and CD4+CD25+ T cells were cultured in 96-well V-bottom plates containing 200 μl RPMI 1640 medium supplemented with 10% FBS, 100 U/ml penicillin, and 100 μg/ml streptomycin. In the DC-free assay, CD4+CD25+ T cells (5 × 105 cells/well) and CD4+CD25- T cells (5 × 105 cells/well) were stimulated with anti-CD3 mAb (OKT3, 1 μg/ml; EBiocience) and anti-CD28 mAb (CD28.2, 1 μg/ml; EBiocience). In the DC-based assay, CD4+CD25+ T cells (5 × 105 cells/well) were incubated with or without CD4+CD25+ T cells (5 × 105 cells/well) in the presence of irradiated (30 Gy) autologous DCs (2 × 105 cells/well) and anti-CD3 mAb (1 μg/ml) for 3 d. [3H]Thymidine incorporation was measured during the last 12–16 h of the incubation. Triplicate wells were cultured for each group. In some experiments, the isolated DCs were pretreated with the nucleotide UDP (1 μM; Sigma-Aldrich) or suramin (0.1 μM; Sigma-Aldrich) for 24 h before addition to the culture. Apoptosis assay

Apoptosis detection for T cells in an FCM assay was adapted from Godoy-Ramirez et al. (33). First, freshly isolated DCs were prelabeled with 2.5 μM CFSE (Sigma-Aldrich) for 10 min, then freshly isolated CD4+CD25- T cells (1 × 105 cells/well) were cocultured with labeled autologous DCs (2 × 103 cells/well) in 96-well V-bottom plates containing 200 μl RPMI 1640 medium supplemented with 10% FBS, 100 U/ml penicillin, and 100 μg/ml streptomycin. In the DC-free assay, anti-CD3 mAb (1 μg/ml) and anti-CD28 mAb (1 μg/ml) were added to the culture. In the DC-based assay, anti-CD3 mAb (1 μg/ml) was added to the culture. In some experiments, recombinant human IFN-α (100 U/ml; PBL Biomedical), neutralizing anti-human IFN-α mAb (5 μg/ml; Chemicon International), anti-human IL-12 mAb (5 μg/ml; R&D Systems), anti-human TNF-α mAb (5 μg/ml; R&D Systems), or 3,3’,5-triido-L-thyronine (T3) (5, 15, and 30 nM; Sigma-Aldrich) were added to the culture. In some experiments, the isolated DCs were pretreated with the nucleotide UDP (1 μM; Sigma-Aldrich) or suramin (0.1 μM; Sigma-Aldrich) for 24 h before addition to the culture.

Measurement of cytokine level

Supernatants from cell culture and serum from GD patients were stored at −80°C until use. The levels of serum and supernatant IFN-α, TNF-α, and IL-12 were then measured using an ELISA kit according to the manufacturer’s instructions (R&D Systems).
Results are expressed as the means ± SD. Comparison between two groups was performed by Student t tests. Data from more than two groups were compared using one-way ANOVA with the Tukey–Kramer multiple comparison test. Correlation analysis was performed by Spearman’s rank correlation coefficient. The p values < 0.05 were considered to be statistically significant.

Results

Proportion of CD4+CD25+FOXP3+ Treg cells in the peripheral blood of uGD is reduced

To determine the number of Treg cells in GD patients, we measured the proportion of circulating CD4+CD25+ Treg cells in CD4+ T cells in the peripheral blood from 48 CD, 48 uGD, 10 eGD, and 10 eHT (Table I). As FOXP3 is thought to be the most unambiguous marker to identify Treg cell populations (34), a combination of the markers CD4+, CD25+, and FOXP3+ was used to identify Treg cells in this study. As shown in Fig. 1A and 1B, compared with that in CD (3.36 ± 0.96%), there was a lower proportion of CD4+CD25+FOXP3+ T cells over CD4+ T cells in the peripheral blood of uGD (1.57 ± 0.67%; p < 0.001), but not in eGD (2.98 ± 0.88%) or eHT (3.09 ± 1.02%). Approximately 70–80% of FOXP3+ T cells fell within the CD25hi T cell gate, whereas ~5–10% of FOXP3+ T cells fell within the CD25lo T cell gate from either patients or CD (Fig. 1C). Further analysis indicated that, compared with that in CD (2.69 ± 0.77%), there was a lower proportion of CD4+CD25hiFOXP3+ T cells over CD4+ T cells in uGD (1.26 ± 0.54%; p < 0.001), but not in eGD (2.38 ± 0.71%) or eHT (2.47 ± 0.81%). However, there was no significant difference in the proportion of CD4+CD25loFOXP3+ T cells over CD4+ T cells in uGD (0.26 ± 0.10%), eGD (0.31 ± 0.10%), or eHT (0.34 ± 0.12%) as compared with that in CD (0.32 ± 0.11%). There was no significant difference in the proportion of CD4+CD25loFOXP3+ T cells over CD4+ T cells in uGD (2.88 ± 0.76%), eGD (3.09 ± 0.81%), or eHT (3.61 ± 0.92%) as compared with that in CD (3.23 ± 0.85%). Taken together, results with markers of CD25hiFOXP3+ or CD25loFOXP3+ for the assessment of CD4+CD25+ Treg cells yielded a similar conclusion. Interestingly, the serum level of TSHR Abs in uGD (21.27 ± 11.74 U/l) was markedly increased as compared with that in CD (0.50 ± 0.62 U/l; p < 0.001). Statistical analysis showed that the proportion of CD4+CD25loFOXP3+ T cells was strongly negatively correlated with the TSHR Ab concentration in uGD (r = −0.735, p < 0.001; Fig. 1D), suggesting that CD4+CD25+ Treg cells may be associated with the production of TSHR Abs.

Table I. Clinical characteristics of the study subjects

<table>
<thead>
<tr>
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<th>CD</th>
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<td>n</td>
<td>74</td>
<td>77</td>
<td>13</td>
<td>15</td>
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<tr>
<td>Female, n (%)</td>
<td>60 (81.1)</td>
<td>65 (84.4)</td>
<td>11 (84.6)</td>
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<tr>
<td>Age (y)</td>
<td>40.7 ± 10.5</td>
<td>41.1 ± 12.7</td>
<td>35.8 ± 8.8</td>
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<td>FT3 (pmol/l)</td>
<td>3.74 ± 0.90</td>
<td>19.41 ± 5.72</td>
<td>4.75 ± 1.27</td>
<td>3.75 ± 0.84</td>
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<tr>
<td>FT4 (pmol/l)</td>
<td>13.34 ± 2.50</td>
<td>43.03 ± 12.03</td>
<td>15.80 ± 2.09</td>
<td>13.17 ± 2.20</td>
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<tr>
<td>s-TSH (mIU/l)</td>
<td>2.09 ± 1.02</td>
<td>0.013 ± 0.008</td>
<td>1.12 ± 0.72</td>
<td>3.72 ± 0.67</td>
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<td>TPOAb (IU/ml)</td>
<td>3.52 ± 2.03</td>
<td>90.55 ± 65.33</td>
<td>67.77 ± 37.69</td>
<td>726.29 ± 241.86</td>
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<tr>
<td>TRAb (U/l)</td>
<td>0.49 ± 0.33</td>
<td>26.06 ± 12.17</td>
<td>3.25 ± 1.17</td>
<td>1.19 ± 0.84</td>
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</table>

Values are expressed as means ± SD unless indicated otherwise.

FT3, free triiodothyronine; FT4, free thyroxin; s-TSH, sensitive TSH; TPOAb, Ab against thyroperoxidase; TRAb, TSH receptor Ab.

To determine the intrinsic function of CD4+CD25+ Treg cells in GD remaining normal, we then examined whether DCs control the function of CD4+CD25+ Treg cells. As shown in Fig. 2C, except for uGD-derived DCs, CD-, eGD-, or eHT-derived DCs initiated slight proliferation of autologous CD4+CD25+ T cells. uGD-, CD-, eGD-, or eHT-derived DCs initiated significant proliferation of autologous CD4+CD25+ T cells. However, compared with CD-, eGD-, or eHT-derived DCs, uGD-derived DCs had a stronger stimulatory effect on CD4+CD25+ T cells. When DCs were cocultured with autologous CD4+CD25+ and CD4+CD25- T cells, we found that these T cells had higher proliferation rates in response to uGD-derived DCs than that in CD-, eGD-, or eHT-derived DCs. Thus, it is likely that uGD-derived DCs have the ability to reverse the suppressive effect of CD4+CD25+ T cells, whereas CD-, eGD-, or eHT-derived DCs do not. Taken together, these results indicate that uGD-derived CD4+CD25+ Treg cells have normal immunosuppressive effect; however, uGD-derived DCs impair the effect of CD4+CD25+ Treg cells.

pDCs are increased in the uGD-derived DC population

To determine the reason for impaired activity of CD4+CD25+ Treg cells by uGD-derived DCs, the characteristics of uGD-derived DCs were investigated. First, using identical conditions for DC isolation, we compared the absolute numbers of isolated DCs from CD, uGD, eGD, or eHT. As shown in Fig. 3A, the absolute numbers of isolated DCs from the peripheral blood had no significant difference in CD (n = 20; 0.45 ± 0.17 × 10⁶/ml), uGD (n = 20; 0.61 ± 0.38 × 10⁶/ml), eGD (n = 8; 0.42 ± 0.09 × 10⁵/ml), or eHT (n = 8; 0.53 ± 0.24 × 10⁵/ml). We then analyzed the phenotypes of the DC population. As shown in Fig. 3B, the expression of CD80, CD86, and CD40 in uGD slightly increased as
in uGD could increase the production of IFN-α, 3.55; 8.02 pg/ml, 3.96%; 360.7 pg/ml, 3.96%; 8.39%) was significantly positively correlated with the ratio of pDC/DC (r = 0.825, p < 0.001; Fig. 3F) in uGD, whereas the ratio of pDC/DC had a significant negative correlation with the proportion of CD4+CD25+FOXP3+ T cells in uGD (r = −0.689, p < 0.001; Fig. 3J). These results suggest that there is a significant skewing to pDCs in uGD, which might contribute to impairing the activity of CD4+CD25+ Treg cells in these patients.

pDCs and THs are the main contributors in impairing CD4+CD25+ Treg cell-mediated immunosuppression

To explore the mechanism of increased pDCs in uGD-derived DCs in impairing the activity of CD4+CD25+ Treg cells, IFN-α and autologous DCs with or without related functional neutralizing Abs were added to the culture system of CD4+CD25+ T cells and CD4+CD25+ T cells from CD or uGD. As compared with controls, the addition of IFN-α did not increase T cell proliferation (Fig. 4A), suggesting that IFN-α does not directly impair the inhibitory activity of CD4+CD25+ Treg cells. By contrast, the addition of uGD-derived DCs to the culture system markedly impaired the

FIGURE 1. Proportion of CD4+CD25+FOXP3+ T cells in the peripheral blood of GD patients. A. Freshly isolated PBMCs from CD, uGD, eGD, and eHT were stained for intracellular FOXP3 after CD4 and CD25 surface staining. Representative FCM graphs of the proportions of CD4+CD25+ FOXP3+ T cells from a CD, an eGD, and an eHT are depicted. B. Cumulative data of the proportions of CD4+CD25+FOXP3+ T cells over 3 d with irradiated autologous DCs (2 × 10^5 cells/well) and/or CD4+CD25+ T cells (5 × 10^5 cells/well) were cocultured for 3 d with irradiated autologous DCs (2 × 10^5 cells/well) in 96-well V-bottom plates in the presence of anti-CD3 mAb (1 μg/ml) and anti-CD28 mAb (1 μg/ml). C. Isolated CD4+CD25+ T cells (5 × 10^5 cells/well) and/or CD4+CD25+ T cells (5 × 10^5 cells/well) were cultured in 96-well V-bottom plates for 3 d in the presence of anti-CD3 mAb (1 μg/ml) and anti-CD28 mAb (1 μg/ml). C. Isolated CD4+CD25+ T cells (5 × 10^5 cells/well) and/or CD4+CD25+ T cells (5 × 10^5 cells/well) were cocultured for 3 d with irradiated autologous DCs (2 × 10^5 cells/well) in 96-well V-bottom plates in the presence of anti-CD3 mAb (1 μg/ml). [3H]Tdr incorporation was measured during the last 12–16 h of the incubation. Results are expressed as means ± SD in cpm of triplicate wells. The data are representative of at least three independent experiments.

FIGURE 2. Impaired immunosuppressive function of CD4+CD25+ Treg cells in the presence of uGD-derived DCs. CD4+CD25+ T cells, CD4+CD25+ T cells, and DCs from PBMCs were isolated by MACS. A. Representative FCM graphs of the purities of isolated DCs and isolated CD4+CD25+ T cells that coexpress FOXP3 from PBMCs of a CD and a uGD are depicted, respectively. B. Isolated CD4+CD25+ T cells (5 × 10^5 cells/well) and/or CD4+CD25+ T cells (5 × 10^5 cells/well) were cultured in 96-well V-bottom plates for 3 d in the presence of anti-CD3 mAb (1 μg/ml) and anti-CD28 mAb (1 μg/ml). C. Isolated CD4+CD25+ T cells (5 × 10^5 cells/well) and/or CD4+CD25+ T cells (5 × 10^5 cells/well) were cocultured for 3 d with irradiated autologous DCs (2 × 10^5 cells/well) in 96-well V-bottom plates in the presence of anti-CD3 mAb (1 μg/ml). [3H]Tdr incorporation was measured during the last 12–16 h of the incubation. Results are expressed as means ± SD in cpm of triplicate wells. The data are representative of at least three independent experiments.
inhibitory activity of CD4+CD25+ Treg cells and strikingly promoted T cell proliferation (p < 0.001), but not that of CD-derived DCs. This suggests that the stimulatory effect may be confined to uGD-derived DCs. When uGD-derived DCs together with anti–IFN-α mAb, but not anti–TNF-α mAb or IL-12 mAb, were added to the culture system, proliferation was largely reduced as compared with uGD-derived DCs (p < 0.01), suggesting that uGD-derived DCs need their secreted IFN-α to work together. To further determine whether the effect of uGD-derived DCs is driven by pDC subset, not mDC subset, pDCs and mDCs were sorted for further analysis. The results showed the addition of uGD-derived pDCs to the culture system markedly impaired the inhibitory activity of CD4+CD25+ Treg cells and strikingly promoted T cell proliferation, as compared with that of uGD-derived mDCs, CD-derived mDCs, or pDCs (p < 0.01), strongly indicating that the pDC subset is a contributor in the effect of uGD-derived DCs on CD4+CD25+ Treg cells.

As elevated THs occurred in the uGD patients, the effect of THs on the interaction between DCs and Treg cells was also determined. As shown in Fig. 4B, T3 alone did not display a direct impact on the suppressive effect of CD-derived or uGD-derived CD4+CD25+ Treg cells as compared with controls. However, uGD-derived DCs and T3 together significantly increased the proliferation of T cells as compared with uGD-derived DCs alone (p < 0.05). T3 and CD-derived DCs together slightly increased the proliferation of T cells; however, the extent of proliferation was significantly lower than uGD-derived DCs alone or with T3 together (p < 0.001). Collectively, these results suggest that THs exert an indirect impact on the immunosuppressive effect of CD4+CD25+ Treg cells, dependent on uGD-derived DCs.

uGD-derived DCs and THs render CD4+CD25+ Treg cells more susceptible to apoptosis

To explore the mechanism of DCs on CD4+CD25+ T cells, DCs were cocultured with CD4+CD25+ T cells for 3 d, and the apoptosis of CD4+CD25+ T cells was analyzed. Fig. 5A showed apoptosis measurements for gated T cells and representative FCM graphs from a CD and an uGD. As shown in Fig. 5B, there was no marked difference in spontaneous apoptosis of CD4+CD25+ T cells either from CD or uGD. However, when CD4+CD25+ T cells were cocultured with DCs, uGD-derived DCs significantly promoted the apoptosis of CD4+CD25+ T cells as compared with
CD-derived DCs (n = 5; 16.52 ± 3.10% versus 5.72 ± 1.58%; p < 0.01). However, anti–IFN-α mAb treatment significantly inhibited the apoptosis of CD4+CD25+ Treg cells induced by uGD-derived DCs as compared with isotype control (n = 5; 10.36 ± 0.89% versus 15.26 ± 1.95%; p < 0.01). Of note, the addition of extraneous IFN-α not only slightly promoted DC-induced apoptosis of CD4+CD25+ T cells in uGD-derived DCs, but also produced a significantly elevated apoptosis in CD-derived DCs (n = 5; 8.48 ± 1.22% versus 5.72 ± 1.58%; p < 0.05). To further determine whether uGD-derived DC-induced apoptosis of CD4+CD25+ Treg cells is driven by pDC subset, not mDC subset, pDCs and mDCs were sorted for further analysis. The results showed uGD-derived pDCs strikingly promoted apoptosis of CD4+CD25+ T cells (19.28 ± 2.45%; p < 0.01) as compared with uGD-derived mDCs (9.74 ± 0.61%), CD-derived mDCs (5.56 ± 0.43%), or CD-derived pDCs (6.04 ± 1.01%). As elevated THs occurred in the uGD, the effect of THs on DC-induced apoptosis of Treg cells was also determined. As shown in Fig. 5C, T3 did not directly induce apoptosis of CD-derived or uGD-derived CD4+CD25+ Treg cells as compared with controls. However, T3 and uGD-derived DCs together significantly increased apoptosis of CD4+CD25+ Treg cells as compared with uGD-derived DCs alone (p < 0.01). Of note, T3 and CD-derived DCs together did not significantly alter apoptosis of CD4+CD25+ Treg cells as compared with CD-derived DCs alone. Taken together, these findings suggest that uGD-derived DCs induce the apoptosis of CD4+CD25+ Treg cells in an IFN-α–dependent mechanism, whereas elevated THs exacerbate the apoptotic effect.

Activity of CD4+CD25+ Treg cells is restored through regulating the P2Y6 receptor on uGD-derived DCs

The approach by which uGD-derived DCs are negatively regulated to restore the activity of CD4+CD25+ Treg cells is an interesting
subject. Recent studies have shown that extracellular nucleotides, such as UDP, can modulate the function and IFN-α production of human pDCs through the P2Y6 receptor, which is mainly expressed on pDCs, not T cells (35, 36). Thus, it is likely that the function of uGD-derived DCs is reversed by the P2Y6 ligand. To test this possibility, we treated uGD-derived DCs with the P2Y6 ligand UDP and assessed whether it affected CD4⁺CD25⁺ Treg cells by regulating DC function. As shown in Fig. 6A, uGD-derived DCs resisted the suppressive function of autologous CD4⁺CD25⁺ T cells. However, after treatment with UDP, T cell proliferation was markedly decreased (p < 0.001), accompanied by a decrease in supernatant IFN-α, indicating that the suppressive activity of CD4⁺CD25⁺ Treg cells was restored through UDP on pDCs. To further confirm that this effect was mediated by the P2Y6 receptor, suramin, an inhibitor of the P2Y6 receptor, was used to block P2Y6 receptor signaling. As expected, we found that T cell proliferation was restored significantly (p < 0.01) along with increased IFN-α secretion, but not TNF-α or IL-12, indicating that suramin may abrogate the effect of UDP on P2Y6 receptor signaling. In addition, it was observed that the effect of UDP or suramin on uGD-derived DC-induced apoptosis of CD4⁺CD25⁺ Treg cells had a similar corresponding trend as T cell proliferation (p < 0.01, Fig. 6B). Thus, these results collectively demonstrate that UDP, which downregulates the function of uGD-derived DCs through regulation of P2Y6 receptor signaling, restores the suppressive function of CD4⁺CD25⁺ Treg cells and inhibits DC-mediated apoptosis of CD4⁺CD25⁺ Treg cells.

**Discussion**

The mechanisms by which Treg cells lose suppressive activity in autoimmune diseases have attracted increasing attention. Treg cells are recognized as an important player in a variety of immunoregulatory processes, and defective activity of Treg cells typically contributes to the development of autoimmune diseases. However, the proportion of Treg cells in peripheral blood has been previously reported to be increased, decreased, or unchanged in several autoimmune disorders, such as autoimmune thyroid diseases (37), multiple sclerosis (12), and systemic lupus erythematosus (38). Our results showed that the proportion of CD4⁺CD25⁺ Treg cells was reduced in the peripheral blood of primary uGD, which is consistent with the conclusion from Nakano et al. (39), but in contrast to the reports from Pan et al. (40) and Wang et al. (41). One possible cause for this discrepancy is related to selected marker differences for the detection of Treg cells. For example, Pan et al. (40) selected CD4⁺CD25⁺hi-CD127lo as Treg cell markers, whereas Wang et al. (41) selected CD4⁺CD25⁺, different from the CD4⁺CD25⁺FOXP3⁺ markers for our study. In addition, our functional assays demonstrated that CD4⁺CD25⁺ Treg cells from uGD still exhibited suppressive function, suggesting that these Treg cells are not intrinsically defective in function. These findings are in agreement with some (32, 38, 42, 43) but not with others that examine functionally defective Treg cells themselves (37, 44, 45). In contrast, it is possible that besides the pathological differences in disease types, the disagreement among studies may be associated with differences in race, disease status, clinical course, treatment, and site of specimen collection as well as use of different Treg cell markers. These differences impact the assessment of Treg cells in number and function. For example, the purity of isolated CD4⁺CD25⁺ Treg cells is a critical factor for assessment of the function of Treg cells, though there is so far a lack of specific markers for Treg cells. CD25 is one of the characteristic markers of CD4⁺CD25⁺ Treg cells; it is an activation marker and also expresses on the surface of autoreactive CD4⁺ T cells at a low level in autoimmune diseases. As a result, the coisolated CD4⁺CD25⁺ Treg and CD4⁺CD25⁺ effector T cells could affect the assessment of the suppressive function of Treg cells.

A question raised from these findings is what attenuated the regulatory capacity of Treg cells in the pathogenesis of GD. Environmental, endocrine, and genetic factors play etiological roles in the development of GD (46). It has been well established that DCs in the periphery capture and process Ags, express lymphocyte costimulatory molecules, migrate to lymphoid organs, and secrete cytokines to initiate adaptive immune responses, including autoimmunity (47). Our data showed that uGD-derived DCs abrogate the regulatory function of CD4⁺CD25⁺ Treg cells through pDCs.
Consequently, the loss of CD4+CD25+ Treg cells enhances the activities of autoreactive CD4+ T and B cells, which contributes to the promotion of TSHR autoantibodies. Under steady-state conditions, it has been reported in recent studies that the immune system maintains immune homeostasis through a feedback regulatory loop between Treg cells and DCs in vivo, in which the number of DCs plays a critical role (30, 31). However, under pathological conditions, it is unclear whether DCs break the regulatory loop to initiate autoimmunity. In the current study, we demonstrated that the increased pDCs from uGD induced the apoptosis of Treg cells, suggesting their possible role in the breakdown of Treg-mediated regulatory loop. In conclusion, in the development of GD, DC migration and division in lymphoid organs may lead to pDC polarization after encountering the autoantigen TSHR. The polarization of pDCs and secretion of IFN-α impair Treg cell-mediated regulatory effect in lymphoid organs and consequently triggers the activation and interaction of autoreactive Th cells and B cells, resulting in the generation of large amounts of autoantibodies to TSHR and the development of GD (47).

Notably, evidence indicates functional cross talk between immune and endocrine systems in the modulation of innate and adaptive immunity, such as the immunosuppressive effects of thyroxine on T and B cells in C57BL/6 mice (50), suppression of peripheral blood NK cell activity by excess thyroid hormone (51), and modulation of differential homing of CD4+ T cells and CD8+ T cells to peripheral lymphoid organs (52), and control of maturation and function of DCs by triiodothyronine (53, 54). Because the polarization and effect of uGD-derived DCs are found in uGD patients with elevated THs, it is necessary to determine the effect of elevated THs on DCs and Treg cells. Our study revealed that T3 could not directly increase apoptosis of CD4+CD25+ Treg cells, which is different from uGD-derived DCs. However, it could largely promote the apoptosis of CD4+CD25+ Treg cells induced by uGD-derived DCs, suggesting that it is favorable for the generation of TSHR autoantibodies (Fig. 7). These findings are in agreement with previous published observations indicating that THs exert an effect on the immunological function of DCs (53, 54). Our results further provide experimental evidence that the interaction between the endocrine and immune systems occurs under GD pathological conditions.

It is interesting to note the relation between polarized DCs and elevated THs in the pathogenesis of GD. In general, in the pathogenesis of GD, production of TSHR stimulatory autoantibodies is a precondition that leads to the production of elevated THs. Thus, Graves’ hyperthyroidism is a consequence of GD development. Decreased numbers of Treg cells and immune dysfunction are beneficial to the generation of TSHR autoantibodies. As polarized uGD-derived DCs directly induce the apoptotic effect of Treg cells and THs promote the effect, DC polarization may be an initial factor compared with THs in the pathogenesis of GD. The hypothesis also partially explains why in patients with toxic nodular goiter, hyperthyroidism arises in the absence of thyroid autoimmunity, due to lack of polarized pDCs in these patients.

Recent studies suggest that the apoptosis-induced decrease in Treg cells is an important mechanism that leads to the progressive breakdown of self-tolerance and the development of some autoimmune diseases (39, 55). Our data demonstrated that uGD-derived pDCs and elevated THs conspire to induce apoptosis of CD4+CD25+ Treg cells, suggesting that the apoptotic mechanism may be one of the main causes for the decrease of CD4+CD25+ Treg cells in GD patients. Our results provide evidence that the apoptosis of Treg cells was associated with IFN-α from uGD-derived pDCs, but not Fas–FasL signaling pathway (data not shown); thus, the molecular mechanisms of pDC-induced apoptosis need to be further defined.

The capacity of pDCs to induce the loss of CD4+CD25+ Treg cell activity suggests that depletion or downregulation of pDCs could be favorable for controlling the development of autoimmune disease. An alternative strategy would be to manipulate TLR signaling in pDCs, for example, with hydroxychloroquine treatment, which may inhibit pDC function and production of IFN-α (56), much like treatment with anti-BDCA-2/4 mAb and corticosteroids (57, 58). A more recent report suggests that nucleotide UDP and UDP-glucose strongly suppress IFN-α production and function of human pDCs through P2Y6 receptor signaling (35), indicating that UDP administration may serve as a potential approach to inhibit IFN-α production and the function of pDCs in GD patients. It is possible that the application of UDP for regulating pDC function is more desirable compared with other methods because it is a common component of glycometabolism in the body. In the current study, we demonstrated that UDP inhibited pDC-induced apoptosis of CD4+CD25+ Treg cells, which may provide a target for modulating of the suppressive capacity of Treg cells in GD patients.

In summary, uGD-derived pDCs and elevated THs impair the activity of CD4+CD25+ Treg cells in GD patients. Manipulating pDCs by P2Y6 receptor agonists protects CD4+CD25+ Treg cells in GD patients. Accordingly, these findings have important impli-

![Figure 7](https://www.jimmunol.org/content/jim.4741.4)

**FIGURE 7.** A hypothetical diagram of the production of TSHR Abs in GD patients. Triggered by multiple pathological factors, DC polarization leads to an increase in the number of pDC and IFN-α secretion, which plays a central role in the induction of apoptosis of CD4+CD25+ Treg cells in GD patients. Consequently, the loss of CD4+CD25+ Treg cells enhances the activities of autoreactive CD4+ T and B cells, which contributes to the production of TSHR autoantibodies and hyperthyroidism. Elevated THs further aggravate the effect of DC-induced apoptosis of Treg cells and promote the production of TSHR autoantibodies.
cations in the understanding of immunopathogenesis of GD and in the therapy potential for GD patients.

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Disclosures

The authors have no financial conflicts of interest.

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