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*J Immunol* 2013; 191:2144-2154; Prepublished online 5 August 2013; doi: 10.4049/jimmunol.1300384

http://www.jimmunol.org/content/191/5/2144

Supplementary Material

http://www.jimmunol.org/content/suppl/2013/08/06/jimmunol.1300384.DC1

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Paradoxical Effect of Cortistatin Treatment and Its Deficiency on Experimental Autoimmune Encephalomyelitis

Luciana Souza-Moreira,* Maria Morell,* Virginia Delgado-Maroto,† Marta Pedreño,* Laura Martinez-Escudero,*† Marta Caro,* Francisco O’Valle,‡ Raul Luque,§ Milagros Gallo,¶ Luis de Lecea,¶ Justo P. Castaño,§ and Elena Gonzalez-Rey*†‖

Cortistatin is a cyclic-neuropeptide produced by brain cortex and immune cells that shows potent anti-inflammatory activity. In this article, we investigated the effect of cortistatin in two models of experimental autoimmune encephalomyelitis (EAE) that mirror chronic and relapsing-remitting multiple sclerosis. A short-term systemic treatment with cortistatin reduced clinical severity and incidence of EAE, the appearance of inflammatory infiltrates in spinal cord, and the subsequent demyelination and axonal damage. This effect was associated with a reduction of the two deleterious components of the disease, namely, the autoimmune and inflammatory response. Cortistatin decreased the presence/activation of encephalitogenic Th1 and Th17 cells in periphery and nervous system, and downregulated various inflammatory mediators, whereas it increased the number of regulatory T cells with suppressive effects on the encephalitogenic response. Moreover, cortistatin regulated glial activity and favored an active program of neuroprotection/regeneration. We further used cortistatin-deficient mice to investigate the role of endogenous cortistatin in the control of immune responses. Surprisingly, cortistatin-deficient mice were partially resistant to EAE and other inflammatory disorders, despite showing competent inflammatory/autoimmune responses. This unexpected phenotype was associated with elevated circulating glucocorticoids and an anxiety-like behavior. Our findings provide a powerful rationale for the assessment of the efficacy of cortistatin as a novel multimodal therapeutic approach to treat multiple sclerosis and identify cortistatin as a key endogenous component of neuroimmune system. The Journal of Immunology, 2013, 191: 2144–2154.

Multiple sclerosis (MS) is a disabling inflammatory, autoimmune demyelinating disease of the CNS. Although the mechanisms of disease pathogenesis remain unclear, MS is considered as archetypal CD4 Th1/Th17 cell–mediated autoimmune disease in which Th1 and Th17 cells reactive to components of the myelin sheath, infiltrate CNS parenchyma, release proinflammatory cytokines and chemokines, and promote inflammatory cell infiltration and activation (1–3). Inflammatory mediators such as cytokines (i.e., IFN-γ, IL-17, and TNF-α) and free radicals, produced by infiltrating cells and resident microglia, play a critical role in demyelination, contributing to oligodendrocyte loss and axonal degeneration. Moreover, a deregulation in the mechanisms involved in maintenance of immune tolerance, especially those affecting regulatory T cells (Tregs), seems to critically contribute to establishment and progression of the autoimmune response (4). Although available therapies based on immunosuppressive agents inhibit the inflammatory component of MS and either reduce the relapse rate or delay disease onset, they do not suppress progressive clinical disability. This illustrates the need for novel multistep therapeutic approaches to prevent the inflammatory and autoimmune components of the disease and to promote mechanisms of regeneration and restoration of immune tolerance.

Cortistatin is a recently discovered neuropeptide that shows a remarkable sequential resemblance with somatostatin (5). Although it shares many functions with somatostatin, especially concerning the regulation of hormone secretion and neuronal activities (6), cortistatin exerts unique functions in the CNS and immune system. Thus, cortistatin, but not somatostatin, decreases locomotor activity, shows potent sleep-promoting activities, and deactivates inflammatory and Th1-driven responses in experimental sepsis, arthritis, and colitis (5, 7–10). Besides its release by cortical and hippocampal interneurons, cortistatin is produced by macrophages and T cells in response to inflammatory and immune stimulation (11), supporting a physiological role of cortistatin in the immune system. In this study, we investigated the potential therapeutic effect of cortistatin in two murine MS models and the role played by endogenous cortistatin in the control of inflammatory and autoimmune responses by using mice deficient for cortistatin.

Materials and Methods

Peptides and animals

Female SJL/J and C57BL/6 mice 8 wk old were obtained from Charles River. Mice lacking the gene for cortistatin (cortistatin-deficient [CST−/−])
and for somatostatin were generated in a C57BL/6 background (12), bred in-house, and matched by sex and weight with wild-type (wt) C57BL/6 mice. All experiments with animals were performed in accordance with the European ethical guidelines and approved by the Animal Care Unit Committee from the Institute of Parasitology and Biomedicine Lopez-Neyra-Consejo Superior Investigaciones Cientificas (protocol SAP2007-60101; SAP2010-16923). Proteloid protein (PLP, 99–121; HCLGKLWHPDFK) and myelin oligodendrocyte glycoprotein (MOG35–55; MEVGWYRSPFSRVHLY-RNGK) peptides were purchased from GeneScript and mouse cortistatin-29 from American Peptides.

**Induction and treatment of experimental autoimmune encephalomyelitis**

To induce chronic experimental autoimmune encephalomyelitis (EAE), we immunized C57BL/6 mice s.c. with 200 μg MOG35–55 emulsified in CFA containing 400 μg Mycobacterium tuberculosis H37 RA (Difco). Mice also received i.p. injections of 200 ng pertussis toxin (Sigma) on days 0 and 2. Treatment consisted of the i.p. injection of cortistatin (1 nmol/d) or PBS (controls) for 5 consecutive days after disease onset in animals with a clinical score of 0.5–1 (onset) or of 2 (acute phase). In some animals, we applied a preemptive regimen of treatment consisting of 9 i.p. injections of cortistatin (1 nmol/d) starting 4 d before immunization. To study the role of endogenous cortistatin, we challenged CST−/− mice for EAE as described for wt C57BL/6 mice. For the relapsing-remitting EAE model, SJL/J mice were immunized with 150 μg PLP21–35, emulsified in CFA containing 400 μg M. tuberculosis H37 RA and treated i.p. with 5 d with cortistatin (1 nmol/d) or PBS (controls) starting after the first disease peak. Mice were scored daily for signs of EAE according to the following clinical scoring system: 0, no clinical signs; 0.5, partial loss of tail tonicity; 1, complete loss of tail tonicity; 2, flaccid tail and abnormal gait; 3, hind–leg paralysis; 4, hind–leg paralysis with hind–body paresis; 5, hind- and fore–leg paralysis; and 6, death.

**Tissue collection and cell isolation**

At various time points after immunization, spleen, draining lymph nodes (DLNs: cervical, inguinal, and axillary), brain, and spinal cord were removed. Single-cell suspensions were obtained from spleen or pooled DLNs and used for flow cytometry analysis, determination of autoreactive responses, and adoptive transfer of EAE as described later. Brain and spinal cord segments of the cervical and lumbar regions were prepared separately and used for RNA isolation, protein extraction, and histopathological analysis as described later. Proteins were extracted from cervical and lumbar segments of spinal cord and brain by homogenization (50 mg tissue/ml) in lysis buffer (50 mM Tris-HCl, pH 7.4, 0.5 mM DTT, and 10 μg/ml protease inhibitors PMSF, pepstatin, and leupeptin). Samples were centrifuged (20,000 × g, 15 min, 4°C) and the supernatants were assayed for cytokine contents (15 min, 4°C), and the supernatants were assayed for cytokine contents with polyclonal anti-Myelin Basic Protein Ab (Master Diagnostics) and for somatostatin were generated in a C57BL/6 background (12), bred in-house, and matched by sex and weight with wild-type (wt) C57BL/6 mice. All experiments with animals were performed in accordance with the European ethical guidelines and approved by the Animal Care Unit Committee from the Institute of Parasitology and Biomedicine Lopez-Neyra-Consejo Superior Investigaciones Cientificas (protocol SAP2007-60101; SAP2010-16923). Proteloid protein (PLP, 99–121; HCLGKLWHPDFK) and myelin oligodendrocyte glycoprotein (MOG35–55; MEVGWYRSPFSRVHLY-RNGK) peptides were purchased from GeneScript and mouse cortistatin-29 from American Peptides.

**Histopathological analysis of EAE**

For light microscopy, cervical and lumbar spinal cord segments were fixed with buffered 10% formalin for 48 h and processed for paraffin inclusion and sectioning. Transversal sections (4–m thickness) were stained with Luxol fast blue, cresyl violet, and hematoxylin following the Klüver-Barrera technique (13) and were analyzed for the presence of areas of demyelination and cell infiltration using a light microscope (Olympus). For immunofluorescence staining, cervical and lumbar spinal cord segments were fixed in 4% paraformaldehyde pH 7.4 for 4–8 h at 4°C, treated with 30% sucrose for 24 h, and embedded in OCT in liquid nitrogen. Transversal cryosections (10-μm thickness) were blocked with 10% FBS in PBS-T (PBS + 0.2% Triton X-100) for 30 min at 22°C, in PBS, and incubated for 2 h at 37°C with serial dilutions of sera obtained by culture were injected i.p. (12 cells/mouse) into naive C57BL/6 mice suffering from EAE at the disease onset. When indicated, CD4+CD25− and CD4+CD25+ cells were isolated (purity >98%) before transference by using immunomagnetic beads (Miltenyi Biotech) following the manufacturer’s recommendations and then injected i.p. (15 × 106 CD25− or 1.5 × 106 CD25+ cells/mouse) into mice with EAE at the disease onset.

To determine the capacity to transfer immune tolerance, we retrovirally transduced T cells harvested from EAE mice with the lentiviral vector pLKO.1-Tat/CD4-2D10 with YFP and injected into syngeneic mice. The list of mice used in this study is available on request. In this study, we used wild-type C57BL/6 and C57BL/6 mice with a targeted mutation in cortistatin-29 (C57BL/6.Crt29−/−). All experiments were performed in accordance with the European ethical guidelines and approved by the Animal Care Unit Committee of the Instituto de Parasitología y Biomedicina Lopez-Neyra-Consejo Superior de Investigaciones Científicas.

**Determination of autoreactive response**

Spleen and DLN cells recovered from untreated and cortistatin-treated C57BL/6 mice at the peak of clinical EAE (18–20 d postimmunization) were stimulated in complete medium (RPMI 1640 containing 10% FBS, 50 μM 2-ME, 2 mM L-glutamine, 100 U/ml penicillin, and 100 μg/ml streptomycin) with 15 μg/ml MOG35–55. Cell proliferation was evaluated by adding 2.5 μCi/ml tritiated thymidine during the last 8 h of culture (72 h) and determining cpm incorporation in a Microbeta counter 1450. For immunohistochemistry, spinal cord sections were obtained as described later. Brain and spinal cord segments were fixed in 4% paraformaldehyde pH 7.4 for 4–8 h at 4°C, and processed for paraffin inclusion and sectioning. Histopathological analysis and the evolution of the disease was assessed as described earlier.

**Determination of autoantibodies**

We used ELISA to determine the specific anti-MOG Ab responses. Maxisorb plates (Millipore) were coated overnight at 4°C with MOG35–55 (10 μg/ml) in 0.1 M biphosphate buffer (pH 9.6), blocked with PBS/10% FBS, and incubated for 2 h at 37°C with serial dilutions of sera obtained by cardiac puncture at the disease peak. Biotinylated anti-IgG1 or anti-IgG2a Abs (2.5 μg/ml; Serotec) were added for 1 h at 37°C. After washing, plates were incubated with streptavidin-HRP, developed with ABTS, and absorbance was determined in a spectrophotometer.

**Neuron and glial cell isolation and culture**

Primary mixed neuron-glia, microglia, astrocytes, and oligodendrocytes were obtained from brains of newborns (postnatal days 1–3) of naive C57BL/6 and C57BL/6.Crt29−/− mice following the protocol described for rats (14), adapted for mice. Purity of the different glial populations was determined before culture by immunofluorescence: microglia cultures were >95% Iba1+, astrocyte cultures were >99% GFAP+; and cultures of oligodendrocyte precursor cells were >85% Olig-2+. Our neuron-glia cocultures consisted of 27.28% Olig-2+ and 99% GFAP+, cultures of oligodendrocyte precursors were >85% Olig-2+. Our neuron-glia cocultures consisted of 27.28% Olig-2+ and 99% GFAP+. Oligodendrocytes were isolated from brains of newborns (postnatal days 1–3) of naive C57BL/6 and C57BL/6.Crt29−/− mice following the protocol described for rats (14), adapted for mice. Purity of the different glial populations was determined before culture by immunofluorescence: microglia cultures were >95% Iba1+, astrocyte cultures were >99% GFAP+, and cultures of oligodendrocyte precursor cells were >85% Olig-2+. Our neuron-glia cocultures consisted of 27.28 ± 1.8% neurons, 43.9 ± 2.4% astrocytes, and 8.9 ± 1.6% microglia (mean ± SEM). The cell cultures were used 10–14 d after the plating.

Microglia and astrocytes were cultured in DMEM/2% FBS or activated with LPS (0.1 μg/ml) or LPS (0.1 μg/ml) plus IFN-γ (500 U/ml) in the absence or presence of 100 nM cortistatin. After 24–48 h, cytokine-
tents were determined by ELISA in supernatants, and NO production was determined by measuring oxidized nitrite amounts in culture supernatants by using the Griess reagent (8). Oligodendrocyte precursors were incubated in free-serum DMEM/Nutrient Mixture F-12 (Life Technologies) supplemented with Apo-transferrin (25 μg/ml), bovin (10 nM), sodium selenite (30 nM), putrescine (1 μg/ml), insulin (5 μg/ml), hydrocortisone (20 nM), progesterone (20 nM), penicillin (100 U/ml), streptomycin (100 μg/ml), basic fibroblast growth factor (5 ng/ml), platelet-derived growth factor (5 ng/ml), and BSA (0.1%). Mature oligodendrocytes were generated by incubation of precursors with T3 hormone (30 nM) for 3–5 d. Oligodendrocyte cell death was caused by oxidative stress by incubation with 200 μM H₂O₂ in the absence or presence of 100 nM cortistatin, and cell survival was assayed by the reduction of MTT after 24 h of culture.

Neuron-glial cocultures (5 × 10⁵ cells/ml) were incubated in DMEM/10% FBS and stimulated with LPS (0.1 μg/ml) in the absence or presence of 100 nM cortistatin, and expression of neurotrophic factors was determined by real-time PCR as described later in RNA samples isolated after 6 h of culture.

Primary sensory neurons were isolated from lumbar dorsal root ganglia (DRGs) of 4-wk-old C57BL/6 mice as described previously (15). Isolated neurons were cultured in F12-defined medium (Invitrogen) supplemented with 10% FBS and stimulated with LPS (1 μg/ml) in the absence or presence of cortistatin (100 nM). After 24 h, NO and cytokine levels were determined in supernatants isolated after 6 h of culture.

**RNA isolation and RT-PCR assay**

We assayed gene expression of cytokine, neurotrophic factors and cortistatin by semiquantitative RT-PCR. Total RNA was isolated using Tripure (Roche) from brain and spinal cord segments. After DNase I treatment, RNA (1 μg/sample) was reverse transcribed using Revert Aid First Strand cDNA kit (Fermentas) and random hexamer primers. Semi-quantitative PCR was performed using Taq polymerase (Biotools) and the specific primers and conditions depicted in Supplemental Table I. Amplified PCR products were resolved in a 2% agarose gel and densitometric analysis was performed and normalized by β-actin y/o hypoxanthine guanine phosphoribosyl transferase (HPRT) expression. We also assessed activity-dependent neuroprotective protein (ADNP) and brain-derived neurotrophic factor (BDNF) gene expression by real-time quantitative RT-PCR (60˚C as annealing temperature) by using iQ SYBR Green Supermix (Bio-Rad) according to the manufacturer’s instructions, using β-actin for normalization and estimating fold change expression with Delta-Delta Ct method.

**Induction of inflammatory models**

Polyarthritis arthritis was induced in C57BL/6 wt and CST −/− mice by s.c. immunization with 200 μg chicken type II collagen (CII; Sigma) emulsified in CFA containing 200 μg M. tuberculosis H37 RA, and s.c. boosting with 100 μg CII in CFA. Mice were injected i.p. with 50 μg LPS 26 d later to synchronize arthritis and were monitored for signs of arthritis by evaluating paw swelling (measuring thickness in both hind paws with a caliper) and clinical score (0, no swelling; 1, slight swelling and erythema; 2, pronounced edema; 3, joint rigidity) in each limb.

Sepsis was induced by cecal ligation and puncture (CLP). Cecum of anesthetized C57BL/6 wt and CST −/− mice was ligated 5.0 mm from the cecal tip, punctured once with a 22-gauge needle, and the stool then extruded (1 mm). Animals were monitored for survival. Serum was obtained by cardiac puncture, and peritoneal exudates and livers were collected 18 h after surgery.

To induce experimental colitis, we repetitively injected C57BL/6 wt and CST −/− mice intrarectally with 2,4,6-trinitrobenzene sulfonic acid (TNBS, 3 mg, in 50% ethanol; Sigma) once every 7 d for a period of 3 wk. Animals were monitored for the appearance of diarrhea, body weight loss, and survival.

Local persistent inflammation was induced by intraplantar injection of carrageenan (200 μg/20 μl; Sigma) in left hind paw of C57BL/6 and CST −/− mice, detected paw swelling was measured using calipers. For cytokine determination in inflamed paws, protein extracts were isolated by homogenization of skins (50 mg tissue/ml) in tissue lysis buffer (in 50 mM Tris-HCl, pH 7.4, with 0.5 mM DTT, and 10 μg/ml protease inhibitors) digested 2 h after carrageenan injection. Samples were centrifuged at 20,000 × g for 15 min at 4˚C, and the supernatants were assayed for cytokine contents by sandwich ELISAs as described earlier. Neutrophil infiltration was determined by measuring myeloperoxidase (MPO) activity in the paw after 4 h (8).

Anesthetized C57BL/6 and CST −/− mice were injected intra-articularly with 10 μg CFA (10 μl in left knee) and saline (10 μl in right knee) to induce monoarticular inflammation. Knee diameter was measured with calipers at different times and used as an index of joint swelling. MPO activity and TNF-α levels were determined in the knee synovial fluid extracted 24 h after CFA injection. Knees obtained at day 10 were fixed, decalcified, embedded in paraffin, and processed for histopathological analysis (15).

**Glucocorticoid receptor blocking**

To investigate the involvement of glucocorticoids in the phenotype observed in CST −/− mice, we blocked glucocorticoid receptors with RU-486 (Sigma) in wt and CST −/− mice subjected to the various inflammatory models. RU-486 dissolved in ethanol was diluted in PEG400 at a ratio 1:1 before administration. We used ethanol/PEG400 (1:1) as vehicle control. In the EAE model, CST −/− and wt mice were injected s.c. with vehicle or RU-486 (1 mg, 3 times/wk, for 3 wk) starting the day of immunization. In the sepsis model, RU-486 (0.6 mg) or vehicle was injected s.c. immediately after CLP and 24 h later.

**Behavioral tests**

To measure anxiety-like behavior, we used individually housed male and female CST −/− and wt littermates. We handled the animals on alternate days 1 wk before testing and carried out the tests during the light phase of the light/dark cycle as described previously (16). In brief, mice were placed in the center of the plus maze platform and videotaped for a period of 5 min; we then determined the number of entries into and the time spent on the open arms. Moreover, mice were placed in the center of the open-field apparatus (Plexiglas box 40 × 40 × 35 cm divided in outer and inner squares) and allowed to explore the whole field for 3 min. We monitored the behavior by determining time spent in the inner and outer squares, ambulation (number of squares crossed), defecation, rearings, and time spent grooming.

**Infection with Leishmania major**

C57BL/6 wt and CST −/− mice were injected s.c. in the left hind footpads with 10⁵ L. major purified metacyclic promastigotes isolated from stationary cultures by negative selection with peanut agglutinin (17). Disease progression was monitored by measuring the inflammation edema with a plethysmometer (ITTC Life Sciences) and the area of the cutaneous lesion of the infected footpad using a caliper, in comparison with the values obtained in the uninfected contralateral footpad. Paradise burden was determined 6 wk postinfection by the presence of amastigotes in homogenates of footpad using a limiting dilution assay (18).

**Statistical analysis**

All data are expressed as the mean ± SEM. Statistical analysis was carried out with two-way ANOVA followed by Bonferroni multicomparison test or Student post hoc test. We assumed significance at p < 0.05.

**Results**

**Treatment with cortistatin reduces EAE severity**

We investigated the effect of the systemic administration of cortistatin in two models of EAE that mirror different clinical characteristics of MS (19). Chronic progressive EAE induced by MOG55-55 in C57BL/6 mice is a model that mimics 20% of clinical MS. Without treatment, these mice developed moderate (27%) to severe (63%) clinical signs, and they never recovered from the disease (Fig. 1A–C). Pre-emptive and delayed treatment with cortistatin after the onset or during the effector phase of the disease greatly reduced incidence and severity (Fig. 1A–D, Table I). Remarkable are the facts that most of the cortistatin-treated EAE mice displayed mild symptoms and a significant number of them completely recovered and were entirely asymptomatic 20–30 d after disease onset (Fig. 1C, 1D; Table I). Interestingly, a short treatment with cortistatin was enough to generate a long-lasting protective effect (Fig. 1). In the majority of MS patients, clinical disease follows a relapsing-remitting course. In a model of relapsing-remitting EAE induced by PLP139-151 in SJL/J mice, a short systemic treatment with cortistatin after the onset of clinical symptoms substantially reduced clinical severity (Fig. 1E, Table I).
FIGURE 1. Treatment with cortistatin reduces EAE severity. Chronic progressive EAE was induced in C57BL/6 mice (16–18/group) by immunization with MOG<sub>35-55</sub> (A–D) and relapsing-remitting EAE in SJL/J mice (8/group) with PLP<sub>139-151</sub> (E). Mice were treated i.p. with PBS (control) or cortistatin (1 nmol/d, black bars) starting 4 d before immunization (A), at disease onset (B, C, clinical score 1), or at the acute phase of the disease in a therapeutic regimen (C, clinical score 2). Data represent the mean clinical score (±SEM) (A–C, E) or maximum peak of disease per animal (D, mean: horizontal line). **p < 0.01, ***p < 0.005 versus control. Similar results were obtained in three (A–C) or two (E) independent experiments.

Cortistatin modulates the inflammatory and autoimmune components of EAE

We next investigated the mechanisms underlying the amelioration of chronic EAE after cortistatin treatment. The pathology of MS and EAE features focal areas of inflammatory infiltration and demyelination with oligodendrocyte depletion (1, 19). Histopathologic examination of spinal cords confirmed that the beneficial actions of cortistatin were due to a decrease in inflammatory infiltrates and in the subsequent demyelination and axonal loss (Fig. 2A). Evaluation of CNS infiltrates in EAE mice revealed that the inflammatory cells (CD45<sup>+</sup>) close to the perivascular area were mostly CD4<sup>+</sup> cells and Iba-1<sup>+</sup> macrophages (Fig. 2B). Cortistatin significantly decreased the number of all these infiltrating cell populations and probably of activated Iba1<sup>+</sup> microglia (Fig. 2B).

The reduction of inflammatory infiltration in CNS of cortistatin-treated EAE mice correlated with the decrease in the expression of inflammation-related genes including IL-12, TNF-α, IL-6, IL-17, and IFN-γ, and the chemokines Rantes, MCP-1, and IP-10 (Fig. 3A, Supplemental Fig. 1A). Interestingly, despite the lower cell infiltration, cortistatin did not reduce levels of anti-inflammatory cytokines such as IL-4, TGF-β, or IL-10 in the CNS (Fig. 3A, Supplemental Fig. 1A).

In both EAE and MS, autoreactive Th1 and Th17 cells, producing IFN-γ and IL-17, respectively, infiltrate the CNS and promote the disease, whereas treatments that induce a skewing toward an IL-4–dominated Th2 response generally suppress EAE (20). Cortistatin could ameliorate EAE by reducing encephalitogenic T cell responses and/or their migration to the CNS. Therefore, we determined the proliferation and cytokine profile of peripheral T cells from cortistatin-treated EAE mice. Lymphocytes derived from DLNs of EAE mice showed marked MOG-dependent proliferation and production of IFN-γ, IL-2, and IL-17, whereas T cells from cortistatin-treated mice proliferated much less and did not produce Th1 and Th17 cytokines in the MOG-specific recall response (Fig. 3B). The effect was Ag specific because T cell activation with anti-CD3/anti-CD28 Abs resulted in similar proliferation and cytokine secretion in both groups (Fig. 3B). Moreover, cortistatin treatment did not reduce the number of effector T cells secreting IFN-γ and IL-17 in DLNs and spleen, although it elevated the percentage of IL-4–expressing CD4<sup>+</sup> cells (Fig. 3C). These results indicate that cortistatin injection during the effector phase of EAE partially inhibits autoreactive Th1 and Th17 cell activation and clonal expansion in the periphery. This effect seems to be exerted directly on lymphoid cells because cortistatin deactivated MOG-specific recall responses in vitro (Supplemental Fig. 1B). Notably, cortistatin treatment of EAE mice also reduced the capacity of activated lymphoid cells to produce GM-CSF (Fig. 3D), a cytokine mandatory for EAE induction (21).

Table I. Effect of cortistatin in chronic progressive EAE and remitting and relapsing EAE

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Mortality</th>
<th>CDI&lt;sup&gt;a&lt;/sup&gt;</th>
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<tr>
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<td></td>
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<td>Cortistatin</td>
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<td>3/18 (17%)</td>
<td>2/18 (11%)</td>
<td>0/18 (0%)</td>
<td>34.0 ± 6.1**</td>
</tr>
<tr>
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<td>Cortistatin</td>
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<td>3/8 (37%)</td>
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<td>0/8 (0%)</td>
<td>0/8 (0%)</td>
<td>20.5 ± 6.6*</td>
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Chronic progressive EAE (CP-EAE) was induced in C57BL/6 mice by immunization with MOG<sub>35-55</sub> and relapsing and remitting EAE (RR-EAE) was induced in SJL/J mice by immunization with PLP<sub>139-151</sub>. Immunized mice were treated i.p. for 5 d with PBS (control) or with cortistatin (1 nmol/day) starting at the onset of clinical signs (clinical score, 1). n = 3 independent experiments for CP-EAE; n = 1 experiment for RR-EAE.

*Disease incidence is graded as severe (clinical score, >4), moderate (clinical score, 2–4), mild (clinical score, <2), or none (no clinical signs) at day 36 for CP-EAE and at day 50 for RR-EAE.

*Clinical disease index (CDI), the mean of the sum of the daily disease scores.

*p < 0.005, **p < 0.0001 versus control.
High levels of circulating Abs directed against myelin Ags invariably accompany the development of MS and EAE, and are major factors in determining susceptibility to the disease (3). Cortistatin regulated serum levels of MOG-specific IgG, particularly reducing the ratio between IgG2a and IgG1, generally reflective of Th1 and Th2 activities, respectively (Fig. 3E).

Cortistatin induces the emergence of functional Tregs in EAE

We next evaluated the capacity of cortistatin to generate Tregs during EAE, because Tregs confer significant protection again EAE by promoting Th2 protective responses and deactivating autoreactive T cells and their homing to CNS (22, 23). We found that cortistatin injection increased the percentage of IL-10–secreting CD4 cells and CD4⁺CD25⁺Foxp3⁺ Treg in DLNs and spleens of mice suffering from EAE (Fig. 3F). This increase in Tregs could be functionally related with the suppression of encephalogenic responses and the induction of immune tolerance, because injection of T cells from spleen/DLNs of cortistatin-treated, but not of untreated EAE mice, into diseased mice alleviated their clinical signs (Fig. 3G). Experiments of cell depletion before transference suggested that the capacity to generate tolerance resides in the CD4⁺CD25⁺ Treg population (Fig. 3G, right panel). Moreover, injection of CD4⁺CD25⁺ T cells isolated from cortistatin-treated EAE mice into diseased mice significantly protected from EAE development, being more efficient cell by cell than CD4⁺CD25⁺ T cells isolated from untreated EAE mice (Supplemental Fig. 1C).

Cortistatin regulates CNS resident glial cells and promotes neuroprotective responses

We next investigated whether, besides its immunoregulatory activity, cortistatin exerts an active protective effect in the CNS directly acting on resident cells. We observed that cortistatin treatment significantly increased the expression of neuroprotective
**Adapt and provide any necessary clarifications based on the image.**

**Cortistatin alleviates EAE severity by modulating both inflammatory and autoimmune components of the disease.** Mice with MOG₃₅–₅₅–induced chronic EAE were treated with PBS (control) or cortistatin for 5 d at the disease onset. (A) Expression of inflammatory cytokines and chemokines determined by RT-PCR in spinal cords at the disease peak (6/group, n = 2). (B) Cortistatin decreases peripheral encephalitogenic Th1/Th17 responses. Proliferation and cytokine production by DLN cells isolated at EAE peak and stimulated with medium, the encephalitogenic Ag (MOG₃₅–₅₅), or a polyclonal stimulus (anti-CD3/CD28 Abs). We obtained similar results with spleen cells (6/group, n = 2). (C) Cortistatin affects Th1, Th17, and Th2 numbers in lymphoid organs. Spleen cells isolated at EAE peak were assayed for intracellular cytokine expression by flow cytometry in the CD4 population. We used naive mice as basal controls. We obtained similar results with DLNs (6–8/group, n = 3). (D) Cortistatin reduces GM-CSF production upon restimulation (6/group, n = 2). (E) MOG-specific IgG1 and IgG2a levels in sera collected at the disease peak (14/group, n = 3). (F) Cortistatin induces the emergence of Tregs in EAE. Percentage of CD4⁺IL-10⁺ and CD4⁺CD25⁺Foxp3⁺ Tregs in DLN cells isolated at EAE peak (18–20/group, n = 3). (G) Treatment (arrow) of EAE mice with T cells or CD25-depleted CD4 cells isolated from spleen/DLNs of EAE mice that were previously treated with PBS (control) or cortistatin (7–9/group, n = 2). We used untreated EAE mice as reference. *p < 0.05, **p < 0.005, ***p < 0.0001 versus control.

**Paradoxical effect of cortistatin deficiency in EAE and other inflammatory disorders**

Once the protective action of cortistatin in EAE was established, we asked about the role played by endogenous cortistatin in the regulation of inflammatory and autoimmune responses in EAE. We found that the expression of cortistatin expression in the CNS of mice inversely correlated to the clinical severity of EAE (Fig. 5). As expected, macrophages, microglia, and lymphocytes deficient in cortistatin responded with exacerbated responses to inflammatory and T cell stimulation (Fig. 6A; Supplemental Fig. 2A), supporting an autocrine/paracrine effect of cortistatin. Surprisingly, the induction of EAE in CST⁻/⁻ mice showed a paradoxical response. CST⁻/⁻ mice challenged for the induction of EAE showed delayed disease onset (11.7 ± 0.8 d for wt versus 15.3 ± 1.1 d for CST⁻/⁻, p < 0.05) and reduced clinical disease index (CDI) (CDI: 79.2 ± 10.3 for wt versus 39.9 ± 6.4 for CST⁻/⁻, p < 0.005) compared with wt mice (Fig. 6B). Moreover, CST⁻/⁻ mice showed less demyelination and spinal cell infiltration than wt mice, which correlated with decreased CNS expression of inflammatory mediators, especially chemokines, and elevated neurotrophic factors and Th2 cytokines in these animals (Supplemental Fig. 2B–D). However, mice that lacked somatostatin, a peptide structurally related with cortistatin, experienced development of exacerbated EAE signs (Supplemental Fig. 2E).

We next investigated whether the unexpected effect of cortistatin deficiency in the development of EAE was due to a defect in the autoreactive response. CST⁻/⁻ mice generated similar levels of autoantibodies than wt mice, and immune cells from CST⁻/⁻ mice with EAE strongly responded to MOG restimulation, even with higher Th1 and Th17 autoreactive responses (Fig. 6C; Supplemental Fig. 2F, 2G). The encephalitogenic capacity of T cells of CST⁻/⁻ mice was confirmed in experiments of adoptive transfer of EAE to naive mice. Transfer of spleen/DLN cells from CST⁻/⁻ mice restimulated ex vivo with MOG caused an EAE more severe and with an earlier onset in the recipient mice than
contents in culture supernatants were determined 24 h later.

isolated from adult mouse DRGs were cultured in medium or stimulated with LPS in the absence or presence of cortistatin (100 nM) and cytokine, and NO

that induced by transfer of cells from wt mice (Fig. 6D). Interestingly, recipient CST−/− mice were mostly resistant to adoptive transfer of EAE with encephalitogenic cells, suggesting that the effector phase of the disease is affected (Fig. 6D).

We further studied whether this paradoxical effect observed in CST−/− mice was exclusive of EAE or it could be extended to other inflammatory conditions, in which cortistatin-based therapies were proved effective (8–10). CST−/− mice showed delayed disease onsets and initial lower severity in collagen-induced polyarthritis and experienced less severe chronic colitis than wt mice (Fig. 6E, Supplemental Fig. 3A). Similarly, lack of cortistatin significantly protected mice from sepsis (Fig. 6F). Despite septic CST−/− mice showing lower systemic inflammation and histopathologic signs than wt mice, macrophages isolated from both mice at the disease peak produced similar levels of IL-6, TNF-α, and IP-10 ex vivo (Fig. 6F, Supplemental Fig. 3B, 3C). Surprisingly and contrary to that observed in systemic inflammatory conditions, CST−/− mice were more susceptible to suffering local inflammation caused by intraplantar carrageenan injection (Supplemental Fig. 3D) and by monoarticular knee arthritis (Fig. 6G). These results indicate that cortistatin deficiency differentially affects systemic and local inflammatory responses. Although the intrinsic deficiency of cortistatin in immune cells predisposes to stronger self-reactive and inflammatory responses, a compensatory, probably systemic, mechanism impairs the development of EAE and other inflammatory disorders in these animals.

CST−/− mice show increased glucocorticoids, states of anxiety, and infection susceptibility

Characterizing the endocrine system of CST−/− mice, we found recently that lack of cortistatin significantly affects the functionality of the hypothalamic-pituitary-adrenal (HPA) axis (12). The systemic levels of the glucocorticoid corticosterone in CST−/− mice in basal conditions are markedly elevated (Fig. 7A). High glucocorticoid levels, as a consequence of an altered HPA axis, are frequently related to altered states of anxiety and immunosuppression (27). We evaluated the behavior of CST−/− mice in basal conditions and observed that CST−/− mice entered less and spent less time in the open arms of the elevated plus-maze, and explored longer in peripheral areas of the open field than did wt mice (Fig. 7B). Both behaviors are indicative of states of anxiety. Moreover, we found that the systemic immunosuppressive state observed in CST−/− mice increased susceptibility to infection. In a model of cutaneous leishmaniasis, CST−/− mice had higher edema and parasite burden in the infected paw than wt mice and showed cutaneous lesions (Fig. 7C).

We finally investigated the effect of blocking the glucocorticoid system in the response of CST−/− mice to EAE and sepsis. Sys-
temic injections of the glucocorticoid receptor antagonist RU-486 partially reversed the phenotype observed in CST 2/2 mice in both conditions (Fig. 7D). However, pre-emptive cortistatin injection did not reverse this resistance, probably because cortistatin treatment is itself protective (Supplemental Fig. 3E).

Discussion
The initial stages of MS and EAE involve multiple steps that can be divided into two main phases: early events associated with initiation and establishment of autoimmunity to myelin sheath components, and later events associated with the evolving destructive inflammatory responses. Progression of the autoimmune response involves the development of reactive Th1 and Th17 cells with encephalitogenic potential, their entry into the CNS, and further recruitment of inflammatory cells through multiple mediators (1, 3). In this study, we report that the neuropeptide cortistatin provides a highly effective therapy for chronic and relapsing-remitting EAE. The therapeutic effect of cortistatin is associated with a striking reduction of the two deleterious components of the disease, namely, the autoimmune and inflammatory responses. As a consequence, cortistatin reduced the appearance of inflammatory infiltrates in the CNS and the subsequent demyelination and axonal damage typical of EAE.

Our data indicate that treatment with cortistatin decreased the presence of encephalitogenic Th1 and Th17 cells in both the periphery and CNS. This effect is mostly exerted by regulating the encephalitogenic sensitization in the peripheral immune compartment. Importantly, this treatment did not result in a general immunosuppression. Cortistatin did not affect the number of Th1 and Th17 cells in lymphoid organs or the response to a polyclonal stimulation, but it specifically impaired the activation of MOG-specific Th1 and Th17 responses; at the same time, it favored
Th2 responses, which is reflected by a class switch in autoantibodies. The potent suppressive effect of cortistatin on the activation of encephalitogenic Th17 cells might be an important component in its protective effect on EAE, because of the critical role that Th17 cells play in the disease effector phase in EAE and MS (28, 29). Of relevance is also the fact that cortistatin downregulated the production of GM-CSF by activated T cells, because it serves a nonredundant function in the initiation of autoimmune inflammation in EAE regardless of T cell polarization (21).

The increase in the repertory of CD4+CD25+Foxp3+ Tregs in lymphoid organs could partially explain the specificity of Ag of the long-lasting protective response generated by cortistatin treatment, and that cortistatin injection inhibits events in the inflammatory phase of EAE after the activation/differentiation of Ag-specific effector Th1/Th17 cells. In agreement with our results, a recent study described the generation of CD4+CD25+ Tregs by cortistatin in a model of allogeneic skin transplantation (30). However, to our knowledge, our work is the first to demonstrate the involvement of functional Tregs in the therapeutic action of cortistatin in autoimmunity. Further investigation will determine whether this increase in Tregs is a consequence of an effect of cortistatin on the expansion of already existing Tregs or on de novo generation of peripheral Tregs. Other neuropeptides, such as vasoactive intestinal peptide, urocortin, and adrenomedullin, with protective effects in autoimmunity (31), increased the repertory of Tregs by promoting their generation from the non-Treg compartment through direct actions on T cells and indirectly on tolerogenic dendritic cells (31). It remains also unknown whether the population of IL-10–secreting CD4 T cells increased by cortistatin corresponds to a subtype of Tr1-like cells (32) and whether it plays any role in its protective effect in EAE.

Regarding the inflammatory response in EAE, it is evident that the regulation of a wide spectrum of inflammatory mediators by cortistatin could suppose an advantage over other therapies directed against a single mediator. The reduction in the inflammatory infiltration of CNS observed in the cortistatin-treated EAE mice seems to be associated with the decrease in the levels of chemokines in CNS parenchyma. This is especially relevant for chemokines such as IP-10 (chemotactic for Th1 cells), Rantes (for T cells), and MCP-1 (for macrophages and T cells) that contribute to MS neuropathology (1, 3). Interestingly, cortistatin did not decrease MDC-1, which is chemotactic for Th2 cells. As a consequence, cortistatin increased the rate of Th2 versus Th1/Th17 cytokines in the CNS of EAE mice, which is protective for the disease. Whether the effect on chemokines is exerted at the local level or as a consequence of the peripheral action of cortistatin (i.e., on Th17 or GM-CSF) is unknown. The fact that cortistatin failed to inhibit Rantes secretion by activated glial cells in vitro argues against a local effect of cortistatin in the chemokine repertoire. However, we found that cortistatin might exert its anti-inflammatory action locally by downregulating the production of cytokines and NO by astrocytes and microglia. This effect on resident inflammatory cells, together with the inhibitory action of cortistatin on infiltrating macrophages (9), probably contributes to the protection against oligodendrocyte/neuronal loss and axonal damage in this inflammatory milieu.

However, attention has recently focused on regenerative mechanisms as targets for therapy in MS, especially in the secondary progressive phase of the disease. Notably, the delayed treatment with cortistatin induced a whole recovery in a significant number of animals, suggesting a role of cortistatin in repair, neuroregeneration, or both. In this article, we found that cortistatin protected oligodendrocytes from cell death in an oxidative milieu as occurs in EAE. Moreover, cortistatin increased the local levels of BDNF and ADNP, which induce axonal outgrowth, remyelination, and rescue of degenerating neurons (24, 25). For ADNP, this effect is exerted on both peripheral lymphoid cells and resident CNS cells. However, the increase in BDNF could mainly depend on a central action of cortistatin on neuron-glia cells.
Which is the role of endogenous cortistatin in this scenario? Evidence suggests that cortistatin is an endogenous immunomodulator: immune cells produce cortistatin in response to inflammatory/immune stimulation (11); cortistatin produced by macrophages and lymphocytes plays an autocrine/paracrine regulatory role in the immune response, as lack of cortistatin predisposes to stronger response to immunostimulation (Fig. 6A); an inverse correlation exists between EAE severity and the levels of cortistatin in the CNS (Fig. 5); and a deficiency of cortistatin in the retina of diabetic patients with retinopathy correlated with increased retinal neurodegeneration and glial activation (33). These findings suggest that endogenous cortistatin might normally provide protection against autoimmune and neurodegenerative pathologies. Indeed, we found exacerbated local inflammatory responses in CST−/− mice. However, lack of cortistatin surprisingly conferred certain resistance to EAE and other systemic inflammatory pathologies, with delayed onset and mild clinical profile. Despite this, the levels of autoantibodies and Ag-rechallenge experiments indicated that MOG-treated CST−/− mice exhibited robust Th1/Th17 cell responses. Moreover, adoptive transfer of the disease with lymphocytes from immunized CST−/− mice to naive recipients supports their encephalitogenic potential. This suggests a compensatory mechanism in CST−/− mice other than an intrinsic defect in immune cells. Although unpredictable, the case of cortistatin is not unique. Mice that lacked the immunomodulatory neuropeptide vasoactive intestinal peptide were almost completely resistant to EAE (34), although they generate Th1 with stronger encephalitogenic capacity than wt mice.

We present evidence that supports the partial involvement of an altered glucocorticoid system in the paradoxical phenotype observed in CST−/− mice challenged through induction of EAE and other pathologies. Glucocorticoids are well-known immunosuppressive factors with widespread actions in different components of the immune system. The elevated levels of corticosterone found in CST−/− mice could partially explain their resistance to systemic immune responses. These abnormal glucocorticoid levels might be consequence of an altered HPA axis (i.e., elevated adrenocorticotropic hormone [ACTH] levels) (12), which is reflected by an exacerbated anxiety-like behavior in these animals. Numerous studies correlate stress to states of immunosuppression and alteration in the HPA axis (27). Indeed, CST−/− mice were more susceptible to infection by the intracellular parasite L major, which depends on fully functional Th1-driven inflammatory responses to be eliminated. How cortistatin regulates this neuroimmune axis is still unknown. However, evidence indicates that cortistatin could act at multiple levels as an endogenous brake for the HPA axis. Thus, systemic injection of cortistatin decreased the levels of ACTH and cortisol in patients with Cushing disease (35), and it inhibited ACTH production in murine and monkey pituitary cultures (12), supporting a direct pituitary effect. However, the fact that cortistatin inhibited the secretion of corticotropin-releasing hormone (CRH) by tissue cultures of hypothalamus and hippocampus (36), two brain areas where CRH functions are associated with the control of endocrine HPA-mediated responses and with the pathogenesis of anxiety/depressive disorders, respectively, supports its action at these brain levels. Moreover, because cortistatin is produced by hippocampal interneurons (7), a possible interplay between CRH and cortistatin is expected. Besides glucocorticoids, we cannot rule out the involvement in the establishment of the phenotype observed in CST−/− mice of other factors related to stress and anxiety, namely, adrenergic and cholinergic systems (27, 37–40), especially considering that cortistatin is a negative regulator of acetylcholine in the brain (5, 7).

Moreover, the anti-inflammatory ghrelin and the proinflammatory prolactin are elevated and decreased, respectively, in CST−/− mice (12). Besides a direct effect on the immune response (41), an elevated ghrelin level could affect the activity of HPA axis in CST−/− mice because ghrelin stimulates the production of hypothalamic CRH and pituitary ACTH (42, 43).

In summary, we are proposing a novel treatment strategy for MS that is targeted to the inhibition of the different neuropathological components of the disease, whereas restoring long-lasting immune tolerance and mounting an active program of neuroprotection. This multimodal action would suppose a therapeutic advantage versus current treatments. Its ability, on delayed administration, to ameliorate the ongoing disease also fulfills an essential prerequisite for a therapeutic agent for MS. This work also demonstrates that cortistatin from the immune source plays a critical role in the tuning of the immune responses in health and disease, and that cortistatin is a key player in the bidirectional communication that exists between the neuroendocrine and immune systems, which together define the final immune response of our body.

Acknowledgments

We thank Dr. C. Guaza (Institute Cajal, Consejo Superior Investigaciones Científicas, Madrid, Spain) for guidance in the isolation of glial cells and Dr. M. Delgado (Institute of Parasitology and Biomedicine, Consejo Superior Investigaciones Científicas, Granada, Spain) for assistance in the induction of the experimental animal models.

Disclosures

The authors have no financial conflicts of interest.

References


