Processes of Sterile Inflammation

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Sterile inflammation occurs in acute conditions, such as ischemia reperfusion injury and crystal-induced arthritis, as well as with chronic diseases, such as particle-induced lung diseases and atherosclerosis. The triggers of sterile inflammation are still being identified, and the pathways that transduce sterile inflammatory signals are not completely clear. Most of the innate immune pathways that sense infection have been implicated in sterile inflammation, although distinct signaling pathways of sterile inflammation exist. Whether immune pathology ensues after sterile inflammation depends on the balance of induced inflammatory and resolution pathways. Further identification of the molecular mechanisms of sterile inflammation will lead to novel therapeutics to treat a range of diseases. The Journal of Immunology, 2013, 191: 2857–2863.

Over the last two decades, our understanding of innate immunity has increased greatly. Although much of what has been learned has come from examining how pathogens induce inflammation, it has become evident that nonmicrobial activators trigger inflammation. In certain conditions, such as trauma, nonmicrobial and microbial activators both contribute to inflammation. In this Brief Review, we discuss the conditions that result from sterile inflammation, the triggers of these conditions, signaling pathways of sterile inflammation, the implications of sterile inflammation, and potential avenues for future investigation.

Conditions that result from sterile inflammation

The acute conditions that result from sterile inflammation include ischemia reperfusion injury (IRI), trauma, crystal-induced inflammation, and toxin exposure. IRI is a condition in which the blood supply to an organ is abruptly halted and then reinstated (1). Injury to the tissues results from the initial hypoxia, as well as from the restoration of blood flow and reoxygenation, which exacerbates inflammation. Acute myocardial infarctions, cerebral infarctions, acute kidney injury, and solid organ transplantation are all conditions in which IRI occurs. Some of these disorders (e.g., myocardial and cerebral infarctions, and acute kidney injury) may share common disease pathologies, such as atherosclerosis, in which acute atherosclerotic plaque rupture or thromboembolism leads to cessation of blood flow. In the case of organ transplantation, the harvest and procurement of the organ lead to ischemic tissue injury, which are followed by additional inflammation after implantation into the recipient when blood supply to the organ is restored.

Crystal deposition within joints leads to gouty arthritis and elicits the classic clinical signs of inflammation, including redness, pain, heat, swelling, and loss of function. Toxins, such as acetaminophen or cobra venom, induce hepatic and muscle injury, respectively. Trauma, including crush injury, triggers an abrupt inflammatory response, and endogenous and microbial triggers (from bacterial exposure) may contribute to inflammation in this context. How sterile inflammation is triggered is discussed in the next section.

Chronic conditions that trigger sterile inflammation include particle-induced lung diseases, such as asbestosis and silicosis; cardiovascular diseases, such as atherosclerosis; some causes of chronic heart failure; and certain cases of tumors (2, 3). Studies in germ-free mice provide evidence that microbes are not essential for the development of experimental atherosclerosis (4). With atherosclerosis, the chronic deposition of cholesterol within the arterial wall induces an injury response characterized by the recruitment of immune cells, including macrophages, dendritic cells (DCs), T cells, and B cells, leading to the development of atherosclerotic plaque, which is the hallmark of the disease.

Triggers of sterile inflammation

Cellular necrosis that results from either acute or chronic inflammation leads to the release of immune triggers that are typically “hidden” in quiescent states. This contrasts with apoptosis that is the result of an orchestrated cell death program and is typically immunologically silent. Indeed, necrotic cells induce neutrophil infiltration when injected into the perito-
neum of mice (5), indicating that the rupture of plasma membranes releases intracellular contents that activate inflammation.

Conceptually, a putative trigger of sterile inflammation would meet the following criteria. First, the levels of the trigger should correlate with immune activation in an experimental model of sterile inflammation or in relevant clinical samples. Second, the trigger should elicit a proinflammatory response in cultured cells, such as macrophages or DCs. Third, the trigger should provoke an inflammatory response after injection into disease-free hosts. Evidence that the trigger is not contaminated by microbial motifs (e.g., LPS) should also be demonstrated. These last two criteria require modification with two-step activators (e.g., those that stimulate the inflammasome [see next section] after priming with another trigger, such as TNF-α) (6). Lastly, the inflammatory response should be abrogated with blockade of the receptor or inhibition of the signaling pathway of the trigger. This last criterion depends upon whether the receptor and the downstream signaling pathways of the trigger are known.

The triggers of sterile inflammation can be broadly divided into those that are intracellular and those that originate from the extracellular matrix (Fig. 1A, Table I). Intracellular triggers include nuclear proteins (e.g., high-mobility group box 1 [HMGB1]), mitochondrial DNA and peptides, uric acid, and cellular chaperones (e.g., heat shock proteins). Studies provided evidence that HMGB1 meets several of the above criteria for a trigger of sterile inflammation. Specifically, HMGB1 is elevated in murine renal IRI models (7, 8). Furthermore, HMGB1 translocation from the nucleus to the cytoplasm is abrogated with treatment with ethyl pyruvate, and this treatment significantly reduces inflammation in the renal IRI model (7). Importantly, administration of recombinant HMGB1 to disease-free mice elicits a systemic inflammatory response (7). Another study also found that HMGB1 levels are increased after renal IRI and that administration of an anti-HMGB1 Ab reduces inflammation, whereas administration of recombinant HMGB1 exacerbates inflammation during renal IRI (8).

Additionally, this latter study demonstrated that TLR4−/− mice are protected from renal IRI and are insensitive to the effects of HMGB1 manipulation. Recent studies also implicated HMGB1 in hepatic IRI (9). Specifically, TLR4 expression in hepatocytes is important for HMGB1 release to promote inflammation within the liver (10).
Mitochondrial components, including mitochondrial peptides or DNA, trigger sterile inflammation. Mitochondria are organelles that may have originated from bacteria that existed in a symbiotic relationship with the host cell. Hence, the release of mitochondrial components during necrosis may lead to activation of inflammatory pathways that are typically stimulated by microbes. One study found that mitochondrial DNA was released into the plasma of patients that had sustained traumatic injury (11). Mitochondrial components stimulate inflammatory responses in neutrophils, and transfer of mitochondrial components to rodents induces a systemic inflammatory response. Furthermore, the activity of mitochondrial components is reduced by either inhibition of formyl peptide receptor 1 or TLR9, indicating that the mitochondrial components that trigger inflammation are either formylated peptides or DNA. Other mitochondrial components (e.g., ATP) may also enhance inflammatory responses. Evidence exists that ATP signals via a purinergic receptor PX27, in combination with TLR activation, to induce inflammation via the inflammasome (see next section) (12). This indicates that ATP enhances inflammation by priming the inflammatory response, rather than being both necessary and sufficient for inflammation induced by injection of necrotic cells (20).

Uric acid is produced by all cells and is a product of purine metabolism. Upon cell necrosis, the increased uric acid concentration allows for formation of monosodium urate (MSU) crystals when exposed to extracellular sodium. Although not formally proven experimentally, this may explain why physiological circulating uric acid levels are not associated with inflammation. MSU activates DCs in vitro by upregulating costimulatory molecules and producing proinflammatory cytokines, such as IL-1β and TNF-α (19). Direct injection of MSU into the peritoneum of mice induces neutrophil recruitment in vivo, an inflammatory response that is abrogated in IL-1R−/− and MyD88−/− mice (5). IL-1R expression on cells not derived from bone marrow is required for inflammation in this model. Using transgenic mice, which overexpress uricase, it was demonstrated that uric acid is required for inflammation induced by injection of necrotic cells (20).

Cells that are damaged but have not yet undergone necrosis send signals that are sensed by the immune system. For example, DNA damage from tumorigenesis leads to the up-regulation of NKG2D ligands, which are sensed by NKG2D receptors on NK cells and initiate antitumor immunity (22, 23). Although this pathway is not necessarily the result of tissue necrosis, it is a mechanism by which cellular damage alerts the immune system.

In summary, several triggers of sterile inflammation exist. However, it is likely that many more are yet to be identified. Most studies focused on the examination of one trigger when it

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**Table I. Inflammatory triggers, signaling, and associated diseases**

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Sensor + Signaling Pathway</th>
<th>Associated Diseases</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuclear proteins</td>
<td>TLR2/4</td>
<td>Acute kidney injury</td>
<td>(7–10, 71)</td>
</tr>
<tr>
<td>HMGB1</td>
<td>RAGE</td>
<td>Acute hepatic injury</td>
<td></td>
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<tr>
<td></td>
<td>CD24</td>
<td>Acute allograft rejection</td>
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<tr>
<td>Mitochondrial components</td>
<td></td>
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<tr>
<td>Formylated peptides</td>
<td>Formyl peptide receptor 1</td>
<td>Crush injury/trauama</td>
<td>(10–12, 72)</td>
</tr>
<tr>
<td>DNA</td>
<td>TLR9</td>
<td>Acute kidney injury (ATP + NLRP3)</td>
<td></td>
</tr>
<tr>
<td>ATP</td>
<td>ATP in combination with NLRP3</td>
<td>Gout</td>
<td>(19, 20, 22, 73)</td>
</tr>
<tr>
<td>Monosodium uric acid crystals</td>
<td>IL-1R + MyD88</td>
<td>Acute lung injury induced by bleomycin</td>
<td>(17, 18, 74)</td>
</tr>
<tr>
<td>Components of extracellular matrix</td>
<td>NLRP3</td>
<td>Acute lung injury induced by bleomycin</td>
<td></td>
</tr>
<tr>
<td>Hyaluronan</td>
<td>TLR2/4</td>
<td>Atherosclerosis</td>
<td>(43)</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>CD44</td>
<td></td>
<td>(48)</td>
</tr>
<tr>
<td>Particles</td>
<td>NLRP3</td>
<td>Lung fibrosis</td>
<td></td>
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<tr>
<td>Silica</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asbestos</td>
<td>IL-1R</td>
<td>Acute allograft rejection</td>
<td>(53)</td>
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is likely that several may contribute and synergize to induce inflammation. Unbiased approaches (e.g., proteomics or genomics) may be required to identify novel inflammatory triggers in sterile inflammation. Such approaches have been used to identify triggers of inflammation in experimental models of organ transplantation (24).

**Signaling pathways of sterile inflammation**

The evolution of the immune system was likely shaped by the pressure to defend against pathogens. Although some sterile inflammatory conditions have been evident for many centuries (e.g., trauma and gout), some entities have arisen due to modernization of our society (e.g., organ transplantation and atherosclerosis). Evidence indicates that pathways that have evolved to respond to infection are also used to respond to nonmicrobial triggers, although some distinct pathways exist.

TLRs are one of the principle innate immune receptors that have been implicated as mediators of certain sterile inflammatory conditions. These innate immune receptors respond to a broad range of microbial motifs and are expressed within the cell or on the cell surface on both hematopoietic and non-hematopoietic cells (reviewed in Ref. 25). TLR2 and TLR4 have been implicated in IRI, specifically in coronary ligation models and models of acute kidney injury (26–29). In both models, TLR2 and TLR4 were shown to signal via the signal adaptor MyD88 to contribute to inflammation. In the kidney IRI model, TLR4 on epithelial cells contributes to inflammation (26). Furthermore, inhibition of TLR2 can reduce renal IRI in mice (30). Within the heart, cardiomyocytes and vascular cells express TLRs, and these cells were shown to transduce inflammatory responses, at least in vitro (31, 32). TLRs are involved in acute sterile inflammatory conditions, as well as chronic sterile vascular diseases, because TLR2, TLR4, and MyD88 enhance the development of atherosclerosis in mice (33–35). In hepatic IRI models, TLR4 is critical for inflammation, yet this effect is independent of MyD88 and dependent on IRF-3 (36). As stated above, HMGB1 has been implicated in hepatic injury via TLR4 signaling on hepatocytes (37, 38). Although hepatic IRI models are likely sterile, it is possible that microbial motifs from commensal bacteria, such as LPS, enter the hepatic circulation with the induction of ischemia. Acetaminophen-induced hepatic injury requires TLR9, a TLR that is expressed within endosomes, by signaling in sinusoidal endothelial cells. Finally, TLR3, another TLR expressed within endosomes that typically responds to double-stranded viral RNA, is required for macrophage inflammation after stimulation by necrotic neutrophils, indicating that TLR3 may respond to endogenous RNA (39). However, the in vivo implications of this finding have been tested in experimental models of septic peritonitis, which are not sterile inflammatory models (39).

The inflammasome is a multiprotein intracellular complex that, upon activation of its receptors, the NOD-like receptors (NLRs), leads to recruitment of apoptosis-associated speck-like protein containing a caspase recruitment domain (ASC). This leads to activation of caspase-1 and production of mature IL-1β. Patients who die of acute myocardial infarction display ASC expression, implying that the inflammasome may have contributed to the pathology (40). Furthermore, ASC−/− mice exhibit increased heart function after cardiac IRI via coronary ligation compared with wild-type (WT) mice (40). Although infarct sizes were similar between the groups, the degree of fibrosis was smaller in the ASC−/− mice compared with the WT mice, indicating that the inflammasome is important for efficient inflammation resolution (40). This study also found evidence that inflammasome signaling within bone marrow cells and nonhematopoietic, cardiac-resident cells (e.g., cardiomyocytes) contributes to sterile inflammation after cardiac IRI. In a complementary study, ASC formation occurred in mice subjected to permanent ligation of the coronary artery with subsequent acute myocardial infarction (41). Caspase 1 is activated in cardiomyocytes that are exposed to ischemia or to the combined effects of LPS activation and ATP stimulation in vitro (41). Furthermore, in vivo inhibition of the P2X7 receptor, a purinergic receptor that responds to extracellular ATP by increasing K+ influx, reduces infarct size in the acute myocardial infarction model in mice (41). Hence, these two studies indicate that the inflammasome is essential for sterile inflammation in acute models of cardiac ischemia.

NOD-, LRR-, and pyrin domain-containing 3 (NLRP3), is one of the best-studied NLRs in sterile inflammation. In a chronic murine model of cardiac inflammation induced by overexpression of calcineurin within the myocardium, increased IL-1β and NLRP3 activation was noted (42). Importantly, genetic ablation of NLRP3 decreases inflammation and improves cardiac function in this model (42). NLRP3 was also implicated in atherosclerosis. Specifically, cholesterol crystals activate NLRP3 in vitro; when LDLr−/− (atherosclerotic prone) mice are reconstituted with NLRP3−/− bone marrow, they exhibit reduced atherosclerosis compared with mice reconstituted with WT bone marrow (43). NLRP3 has been implicated in other sterile inflammatory disorders, including mechanical stretch–induced lung inflammation. In this latter instance, a study found that ventilator-induced lung injury in mice leads to increased reactive oxidative stress release from mitochondria that, in combination with TLR4 signaling, activates NLRP3 to produce IL-1β and lung inflammation (44), in agreement with other recent reports in both humans and mice (45, 46). Another study found that mitochondria released from necrotic cells activate NLRP3 in macrophages in vitro, and NLRP3 is required for maximal inflammation after renal IRI (12). Lastly, NLRP3 also contributes to inflammation in acute hepatic inflammation induced after acetaminophen (47) exposure, and there is evidence that NLRP3 is important for particle-induced inflammation (48). In summary, NLRP3 has been implicated in several sterile inflammatory conditions. Whether other inflammasomes, such as absent in melanoma 2, which responds to DNA, contributes to sterile inflammation has not been determined.

Not all sterile inflammatory responses engage receptors that are also known to respond to pathogens. The receptor for advanced glycation end products (RAGE) is such a receptor. This receptor is a type 1 transmembrane protein that is expressed at low levels in vascular endothelial cells, cardiomyocytes, and immune cells (e.g., neutrophils, DCs, and lymphocytes). It responds to a variety of ligands (e.g., advanced glycated end products, DNA, RNA, HMGB1, S100 proteins, and β-fibril sheets). RAGE was implicated in cardiac IRI (49) and in the development of atherosclerosis (50).

The release of bioactive cytokines from necrotic cells occurs with sterile inflammation and enhances the inflammatory response. In particular, IL-1α is released from necrotic cells and
sensed by the IL-1R to induce the production of neutrophil-attracting chemokines (e.g., CXCL1) in mesothelial cells (51). In a murine model in which inflammation was induced by injection of MSU crystals into the peritoneum, IL-1 inhibition via an inhibitory Ab or injection of MSU in IL-1R−/− mice reduces neutrophil recruitment into the peritoneum (52). The same group of investigators subsequently found that injection of necrotic T cell lymphoma cells into peritoneum of mice induces neutrophil recruitment via an IL-1α-dependent (but IL-1β-independent) mechanism (5). IL-1α also enhances adaptive immunity after sterile inflammation, as shown in an experimental model in which a human coronary artery is implanted into an immunodeficient mouse that is reconstituted with allogeneic human PBMCs (53). In this model, IL-1α is present in endothelial cells lining the human artery, and inhibiting IL-1α reduces subsequent T cell graft infiltration (53). This study also indicates that sterile inflammatory pathways may enhance subsequent adaptive immunity. A recent study provided evidence that intracellular pro–IL-1α is not active after release from necrotic cells unless converted to an active form (54). This study also found that IL-1α release is controlled by intracellular IL-1R2, which prevents cleavage of IL-1α. Furthermore, cells found to induce inflammation after necrosis (e.g., vascular smooth muscle cells) either do not express IL-1R2 or have evidence of caspase 1 activation, which abrogates the effects of IL-1R2 (54).

Resolution of sterile inflammation

Regardless of whether inflammation is sterile or microbial in origin, immunopathology will ensue without effective repair and resolution (reviewed extensively in Ref. 55). One of the first cellular mediators of sterile inflammation are neutrophils, which home to sites of sterile inflammation within hours of injury and form clusters, as shown recently by dynamic two-photon imaging in murine models of cardiac IRI and burn injury (56, 57). Neutrophils are short-lived cells that propagate the initial inflammatory response. Effective resolution of inflammation requires that these cells be efficiently cleared after they undergo apoptosis or necrosis. Furthermore, it is important that recruitment of more neutrophils is inhibited to the inflammatory site for efficient inflammation resolution. In this regard, apoptotic neutrophils secrete mediators (e.g., annexin A1) that can impair further neutrophil recruitment. Furthermore, neutrophils upregulate signals (e.g., sphingosine 1-phosphate) that enhance uptake by macrophages, a process termed efferocytosis (58). The release of extracellular adenosine that occurs in IRI also dampens inflammation, possibly by stabilizing hypoxia-inducible factor, which promotes a switch to glycolytic metabolism (59). Macrophages typically follow neutrophils into sites of inflammation and initially potentiate the inflammatory response. However, macrophages are dynamic cells, and they can change their phenotype to one that enhances resolution. Indeed, a transcriptional analysis comparing macrophages isolated at either an inflammatory or resolution phase of murine peritonitis found that resolution-phase macrophages express genes, such as TIM-4 and TGF-β, which are involved in tissue repair and clearance of inflammatory cells (60). Macrophages also secrete VEGF, which enhances tissue angiogenesis and restoration of oxygen to the hypoxic tissue, and immunosuppressive cytokines (e.g., IL-10), which may allow for recruitment of regulatory T cells that further assist in inflammation resolution. Finally, macrophages secrete proresolving mediators, such as lipoxins, and resolvins that enhance inflammation resolution (reviewed in Ref. 61).

Although macrophages have been implicated in inflammation resolution, a recent study provided evidence that eosinophils, which secreted IL-4, rather than macrophages are required to resolve acute muscle inflammation induced by cobra toxin (62). IL-4 produced by eosinophils is sensed by fibro/adipogenic progenitors (FAPs), a specific stem cell implicated in muscle cell regeneration that enhances the ability of FAPs to clear necrotic cells and induce muscle cell proliferation and regeneration (62). Whether this pathway of inflammation resolution is relevant to other forms of sterile inflammation has not been determined.

There are reports that endogenous innate immune triggers can stimulate specific receptors, which are not known to respond to pathogens, to dampen sterile inflammation. For example, CD24 is a glycosyl-phosphoinositol–anchored protein that provides costimulation to T cells, but it also signals in conjunction with a lectin (Siglec-10) to dampen sterile inflammation (63). Specifically, CD24–Siglec-10 signaling suppresses sterile inflammation after acute hepatic injury induced by acetaminophen, possibly by inhibiting signals mediated by HMGB1 or heat shock proteins (63). Future research is required to determine how broadly applicable this pathway is to other forms of sterile inflammation.

Activation of adaptive immunity by sterile inflammation: the case of organ transplantation

Before the molecular and cellular pathways of innate immunity were heavily investigated, it was postulated that innate immune activation enhances the induction of adaptive immune responses (64). Subsequent work using model Ags indicated that this is the case (65), and it was expanded to infectious models (reviewed in Ref. 66). Although activation of innate immunity during sterile inflammation alerts the host to the presence of a noxious stimulus, which can lead to a repair response, it has been argued whether this enhances the induction of adaptive immunity compared with inflammation induced by a pathogen. The example of organ transplantation indicates that sterile inflammation may enhance adaptive immunity. In this context, one study provided evidence that the reinitiation of IRI led to acute allograft rejection in cardiac allografts that were accepted by the host for >50 d (67). In another study, human coronary arteries were implanted into immune-deficient murine hosts that were reconstituted with allogeneic human PBMCs (68). Increasing hypoxic injury to the artery graft prior to implantation led to increased T cell recruitment to the graft (68). Because both of these studies used sterile inflammation models of transplantation, they indicate that the presence or degree of IRI enhances antidonor, adaptive T cell responses and provide evidence that sterile inflammation enhances adaptive immunity. Clearly, there is clinical evidence that increasing donor ischemic time and, thus, IRI enhances acute and chronic rejection (69). Furthermore, a clinical study revealed that IRI leads to innate immune cell migration into kidney allografts that precedes the recruitment of T cells (70). Thus, in the case of organ transplantation, there is evidence that sterile inflammation enhances adaptive immunity. It has not been determined whether this occurs in other...
forms of sterile inflammation, and the molecular links between sterile inflammation and induction of adaptive immunity have not been identified.

**Conclusions**

Sterile inflammation occurs in several broad medical conditions. Therefore, dissecting out the mechanisms by which sterile inflammation induces pathology will have a large biomedical impact. It is likely that there are many unidentified triggers of sterile inflammation, and exploratory approaches (e.g., proteomics, genomics, or metabolomics) will be required to identify these triggers. Identifying relevant sterile inflammatory triggers may allow for the development of localized therapeutics that will dampen inflammation at the injury site without disabling systemic innate immune pathways that afford protection against infection (Fig. 1B). This is particularly relevant in organ transplantation or in the setting of IRI due to acute myocardial infarction or stroke in which the host is either immune suppressed (i.e., organ transplant recipient) or likely to have compromised immune function (i.e., older people, who are at increased risk for vascular disease and exhibit immune senescence). In these susceptible populations, systemically inhibiting innate immune pathways that are used to respond to sterile and microbial-induced inflammation could lead to detrimental infectious complications. In conclusion, further investigation into the initiation and resolution of sterile inflammation will lead to novel therapeutics that could impact a wide array of human diseases.

**Disclosures**

The authors have no financial conflicts of interest.

**References**


