Dimethyl Fumarate, an Immune Modulator and Inducer of the Antioxidant Response, Suppresses HIV Replication and Macrophage-Mediated Neurotoxicity: A Novel Candidate for HIV Neuroprotection

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Dimethyl Fumarate, an Immune Modulator and Inducer of the Antioxidant Response, Suppresses HIV Replication and Macrophage-Mediated Neurotoxicity: A Novel Candidate for HIV Neuroprotection

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Despite antiretroviral therapy (ART), HIV infection promotes cognitive dysfunction and neurodegeneration through persistent inflammation and neurotoxin release from infected and/or activated macrophages/microglia. Furthermore, inflammation and immune activation within both the CNS and periphery correlate with disease progression and morbidity in ART-treated individuals. Accordingly, drugs targeting these pathological processes in the CNS and systemic compartments are needed for effective, adjunctive therapy. Using our in vitro model of HIV-mediated neurotoxicity, in which HIV-infected monocyte-derived macrophages release excitatory neurotoxins, we show that HIV infection dysregulates the macrophage antioxidant response and reduces levels of heme oxygenase-1 (HO-1). Furthermore, restoration of HO-1 expression in HIV-infected monocyte-derived macrophages reduces neurotoxin release without altering HIV replication. Given these novel observations, we have identified dimethyl fumarate (DMF), used to treat psoriasis and showing promising results in clinical trials for multiple sclerosis, as a potential neuroprotectant and HIV disease-modifying agent. DMF, an immune modulator and inducer of the antioxidant response, suppresses HIV replication and neurotoxin release. Two distinct mechanisms are proposed: inhibition of NF-κB nuclear translocation and signaling, which could contribute to the suppression of HIV replication, and induction of HO-1, which is associated with decreased neurotoxin release. Finally, we found that DMF attenuates CCL2-induced monocyte chemotaxis, suggesting that DMF could decrease recruitment of activated monocytes to the CNS in response to inflammatory mediators. We propose that dysregulation of the antioxidant response during HIV infection drives macrophage-mediated neurotoxicity and that DMF could serve as an adjunctive neuroprotectant and HIV disease modifier in ART-treated individuals. The Journal of Immunology, 2011, 187: 000–000.

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dividuals effectively controlled for systemic viral load is incompletely explained, although recent evidence suggests that prolonged inflammation in both the CNS and periphery may be responsible (9–11).

Chronic systemic inflammation is tightly linked to morbidity and mortality in ART-treated patients, which suggests that adjunctive anti-inflammatory drugs or immune modulators may improve clinical outcomes. Despite undetectable plasma viral loads, measures of systemic inflammation correlate to cerebral spinal fluid (CSF) immune activation, CNS inflammation, and HAND (9–11). It has been proposed that elevated peripheral inflammation mediates neurocognitive decline by increasing the transendothelial migration of infected and/or activated monocytes into the brain (10, 12). An increased number of microglia and macrophages in the CNS correlates with the severity of premortem HAND, demonstrating the importance of these cell types in mediating neurologic impairment (4, 13, 14). Some of the most striking evidence linking peripheral inflammation to HAND derives from the strong association between early and persistent damage caused to GALT by inflammation and neurotoxin release from infected and/or activated monocytes, microglia, and astrocytes. Although the severity of HAND has been significantly reduced through the widespread use of ART, the prevalence and associated morbidity remain high (~50%) (7, 8). The persistence of HAND in individuals effectively controlled for systemic viral load is incompletely explained, although recent evidence suggests that prolonged inflammation in both the CNS and periphery may be responsible (9–11).

Chronic systemic inflammation is tightly linked to morbidity and mortality in ART-treated patients, which suggests that adjunctive anti-inflammatory drugs or immune modulators may improve clinical outcomes. Despite undetectable plasma viral loads, measures of systemic inflammation correlate to cerebral spinal fluid (CSF) immune activation, CNS inflammation, and HAND (9–11). It has been proposed that elevated peripheral inflammation mediates neurocognitive decline by increasing the transendothelial migration of infected and/or activated monocytes into the brain (10, 12). An increased number of microglia and macrophages in the CNS correlates with the severity of premortem HAND, demonstrating the importance of these cell types in mediating neurologic impairment (4, 13, 14). Some of the most striking evidence linking peripheral inflammation to HAND derives from the strong association between early and persistent damage caused to GALT by HIV infection (or SIV infection in macaques), increased microbial translocation, systemic immune/modecyte activation, and HAND progression (9, 10, 15, 16). Therefore, reducing inflammation in the periphery as well as within the CNS is expected to improve neurocognitive impairment in HIV-infected patients.
Fumaric acid esters, including dimethyl fumarate (DMF) and its primary in vivo metabolite monomethyl fumarate (MMF), are a class of compounds that have anti-inflammatory and immunomodulating effects in vitro and in vivo. Fumaderm, a formulation of DMF and other fumaric acid esters, has been used in Europe since 1995 as an effective treatment for psoriasis; its mechanism of action is attributed to modulation of T cell activation and infiltration into plaques (17). DMF is currently under investigation for use in multiple sclerosis and a recently completed phase III study demonstrated a significant benefit in suppressing relapses, disease progression, and brain lesion inflammation (18). Using the rodent model of multiple sclerosis, experimental allergic encephalomyelitis (EAE), it was shown that DMF reduces the recruitment of monocytes into areas of active demyelination in the brain (19). In vitro model systems, DMF has been shown to inhibit proinflammatory cytokine production and NF-κB signaling via inhibition of nuclear translocation (19–22). Furthermore, DMF induces the expression of NF E2-related factor 2 (Nrf2)-driven antioxidant response genes, including heme oxygenase-1 (HO-1) and NAD(P)H quinone oxidoreductase 1 (NQO1) (23, 24). Notably, induction of HO-1 expression in human monocytes by heme has been associated with suppression of HIV-1 replication (25).

Because HIV replication can be strongly driven by NF-κB activation and nuclear translocation, we hypothesized that DMF treatment of HIV-infected monocyte-derived macrophages (HIV/MDM) would result in attenuation of HIV replication, immune activation, and neurotoxicity production. Our in vitro system models macrophage-mediated neurotoxicity during HIV infection by using human MDM and rat cerebrocortical neuronal cultures. In this system, HIV infection of MDM results in the release of low m.w. excitotoxins that injure neurons through excessive activation of NADPH oxidase, which results in the production of reactive oxygen species, and matrix metalloproteinases, which result in ECM degradation (26). Neuronal death (by apoptosis) is only observed after HIV infection of MDM. Furthermore, supernatants from DMF- and MMF-treated HIV/MDM cultures are markedly less neurotoxic to primary neurons than those from nontreated HIV/MDM cultures. Suppression of neurotoxin production is mediated by induction of HO-1 in HIV/MDM and this suppression of neurotoxin production can occur even without suppression of HIV replication. Finally, DMF and MMF also reduce CCL2-induced chemotaxis in human monocytes. This study demonstrates that DMF inhibits key steps in HAND pathogenesis through distinct effects on HIV replication and macrophage-mediated neurotoxin production and DMF should be considered as an adjunctive therapeutic for ameliorating the neurologic complications of HIV infection.

**Materials and Methods**

**Reagents**

Stock solutions of DMF and MMF (Sigma-Aldrich, St. Louis, MO) were prepared in DMSO and stored at −20°C until use. Tin (IV) mesoporphyrin IX dichloride (SnMP) and cobalt (III) protoporphyrin IX chloride (CoPP; Frontier Scientific, Logan, UT) were prepared in 1 N NaOH and stored at −20°C until use. Stock solutions of Ara-C (Sigma-Aldrich), PHA (Sigma-Aldrich), TNF-α (R&D Systems, Minneapolis, MN), and CCL2 (Peprotech, Rocky Hill, NJ) were prepared in filter-sterilized distilled water and stored at −20°C. Stock solutions of efavirenz (EFZ; National Institutes of Health [NIH] AIDS Research and Reference Reagent Program, Germantown, MD) were prepared in DMSO and frozen at −80°C until use.

**Isolation and culture of human monocyte-derived macrophages**

All human studies were reviewed and approved by the Institutional Review Board at the University of Pennsylvania. Human monocytes were prepared from PBMCs of healthy donors and isolated by Ficol density gradient centrifugation as previously described (26, 29). Monocytes were plated at 1 × 10^6 cells/well to Cell-Bind six-well plates (Corning, Lowell, MA) and cultured in DMEM supplemented with 10% FBS, 10% horse serum, and 1% nonessential amino acids with 50 U/ml penicillin/streptomycin at 37°C, 6% CO₂. Cells were cultured for 7 to 8 d and visually inspected for MDM differentiation before use in HIV-infection experiments. MDM were cultured for 7–10 d before use in noninfectious experiments.

**HIV infection of MDM**

Prior to infection, MDM were treated with EFZ (5 or 20 nM), MMF, and/or DMF (1–100 μM), as indicated, for 1 h. All wells were normalized for the vehicles appropriate for drug treatments (DMSO and/or NaOH). Differentiated MDM were exposed to 50 ng (p24 ELISA, equivalent to 1.82 ± 0.22 kcpm/μl by reverse transcriptase [RT] activity assay) of HIV-1 Jago (R5 strain) or 8.6 (R5X4 strain) for 24 h. HIV-Jago is a macrophage-tropic CrSF isolate from a patient with confirmed HIV-associated dementia (29). Virus stocks were prepared by the University of Pennsylvania Center for AIDS Research Virology Core. Supernatants from HIV-infected or noninfected (mock) MDM were collected every 2–4 d and stored at −80°C. Supernatants were monitored for HIV replication by quantifying viral RT activity, as analyzed by the amount of radiolabeled deoxythymidine incorporation.

**Subcellular fractions and Western blot analysis**

For whole-cell lysis collection, cells were rinsed twice with ice-cold PBS, lysed in 75 mM Tris-HCl (pH 6.8), 15% glycerol, 3.75 mM EDTA, and 3% SDS, and supplemented with Complete Protease Inhibitor Cocktail (Roche Applied Science, Indianapolis, IN) and PhosSTOP phosphatase inhibitor mixture (Roche Applied Science).

To assess for nuclear translocation of NF-κB proteins, differentiated MDM were treated with DMF for 24 h, exposed to TNF-α (1 ng/ml) for 10 min, and fractionated. To prepare nuclear extracts, cells were rinsed twice in ice-cold PBS and lysed on ice for 10 min in 10 mM HEPES (pH 7.9), 10 mM KCl, 10 mM EDTA, 1 mM DTT, proteinase and phosphatase inhibitors and incubated at 4°C for 30 min. Nuclear pellets were resuspended in 20 mM HEPES (pH 7.9), 400 mM NaCl, 1 mM EDTA, 10% glycerol, 1 mM DTT, protease and phosphatase inhibitors and incubated at 30°C for 20 min. The nuclear pellet was resuspended in 20 mM HEPES (pH 7.9), 400 mM NaCl, 1 mM EDTA, 10% glycerol, 1 mM DTT, proteinase and phosphatase inhibitors and incubated at 30°C for 20 min.

**Densitometry analysis**

Films were scanned and a fixed cursor area centered over each band was assessed for pixel density using ImageJ (NIH, Bethesda, MD).

**DMF reduces HIV replication and neurotoxicity**

Rat cerebrocortical neuronal cultures were prepared from embryos of Sprague–Dawley rats at day 17 of gestation, as previously described (26). All procedures were within the Animal Research: Reporting In Vivo Experiments guidelines for animal research and in accordance with procedures reviewed and approved by the University of Pennsylvania Institutional Animal Care and Use Committee. Cells were plated in tissue-culture dishes pre-coated with poly-t-lysine (Peptides International, Louisville, KY) and maintained in neurobasal media plus B27 supplement (Invitrogen, Carlsbad, CA) at 37°C and 5% CO₂. Forty-eight hours after plating, cells were treated with 10 μM Ara-C. After 7 d in vitro, approximately one-half volume of fresh media was added to the cells to counteract effects of evaporation. All cultures were incubated between 14 and 16 d in vitro.

Cell-based microtubule-associated protein 2 (2MAP2) ELISAs were performed on primary rat cerebrocortical cells plated at a density of 6 × 10⁵ cells/well in 96-well plates. Following a 24-h exposure to HIV/MDM supernatant, cultures were fixed and fluorescently labeled as described (30, 31) using the following reagents: mouse anti-MAP2 (Covance, Princeton, NJ), goat anti-mouse β-lactamase TEM-1 conjugate (Invitrogen), and FluoroRatio stain (Invitrogen). Fluorescence intensity and density was measured using a fluorometric plate reader with the 480/520-nm filter set. Macrophage supernatant was applied at a 1:10–1:50 dilution; the dilution that gave values within the linear range of the assay is presented.
**Immunofluorescence**
Primary rat cerebrocortical cells were plated at a density of $2 \times 10^5$ cells per 35-mm dish with glass coverslips. Following exposure to HIV/MDM supernatant for 24 h, cultures were fixed and fluorescently labeled as described (26) using the following reagents: mouse anti-MAF2 (Sigma-Aldrich), species-specific Cy3-conjugated secondary Ab (Jackson ImmunoResearch Laboratories), and Hoechst 33342 (Invitrogen).

**Lactate dehydrogenase assay**
Soluble lactate dehydrogenase (LDH) in HIV/MDM culture supernatant was measured using the Cytotoxicity Detection KitPLUS (Roche Applied Science) according to the manufacturer’s instructions.

**EMSA**
Following 24 h of pretreatment with DMF, human MDM were exposed to 1 ng/ml TNF-α for 10 min and nuclear protein extracts were isolated as described. A total of 8 μg nuclear protein was assessed for NF-κB–DNA binding with an EMSA kit (Panomics, Santa Clara, CA), used according to the manufacturer’s directions. The labeled oligonucleotide for NF-κB p50 binding, 5′-AGTTGAGGGGACTTTCCAAGGC-3′, was used.

**Cytokine detection in culture supernatants**
The concentration of TNF-α in culture supernatants was detected using an ELISA kit (Invitrogen) and used according to the manufacturer’s instructions. Uninfected MDM were treated with 0.067% DMSO (vehicle) or DMF for 24 h prior to exposure to 10 μg/ml PHA for 6 h. Supernatants were collected and frozen at −80°C until assayed.

**Chemotaxis assay**
Monocyte chemotaxis was assayed using the Chemicon QCM 96-well (5-μM pore size) Migration kit (Millipore, Temecula, CA) according to the manufacturer’s directions. Freshly isolated human monocytes were plated at a density of $2 \times 10^5$ cells/well in serum- and growth factor-free culture media to the upper chamber in the presence of DMF, MMF, or vehicle (0.02% DMSO). CCL2 (300 ng/ml) was added to the lower chamber and media to the upper chamber in the presence of DMF, MMF, or vehicle. Cells that migrated through the insert, including those adhered to the bottom of the insert, were collected and frozen at −80°C until assayed.

**Flow cytometry**
Human PBMCs were cultured in RPMI 1640 supplemented with 10% FBS and 50 μg/ml penicillin/streptomycin at 37°C and 5% CO2. Following 6 h of treatment with the indicated concentrations of DMF or DMSO vehicle, cells were washed with ice-cold FACS buffer (PBS, 1% BSA, and 0.1% NaN3) and stained with CD11b-PE (clone ICRF44; eBioscience, San Diego, CA), CD14-PE/Cy7 (M5E2; BioLegend, San Diego, CA), and CCR2-PerCP/Cy5.5 (TG5; BioLegend) Abs. Mouse IgG2a-PerCP/Cy5.5 (MOPC-173; BioLegend) was used as the isotype control for CCR2 staining. Ab-stained cell suspensions were pretreated with DAPI to identify dead cells. Flow cytometry was performed on an LSR II (BD Biosciences, Franklin Lakes, NJ). Doublets were excluded using forward side scatter-height versus forward side scatter-width and side scatter-height versus side scatter-width parameters. Data were analyzed using FlowJo (Tree Star, Ashland, OR). Monocytes were identified as CD11b+CD14+ cells.

**Statistics**
All quantifications are expressed as mean ± SE of mean. Statistical comparisons were made by Student’s t test, one-way ANOVA plus Newman–Keuls post hoc test, or post hoc test for linear trend, as indicated. All graphs were generated and statistical analyses were performed using GraphPad Prism software (GraphPad, San Diego, CA) and values of $p < 0.05$ were considered significant.

**Results**
DMF and MMF inhibit HIV replication in human MDM
DMF and its in vivo primary metabolite MMF inhibit NF-κB signaling, suppress the production of inflammatory mediators, and induce an antioxidant response in a variety of cell types (19–22, 24, 35, 36). NF-κB signaling has been established as a major pathway of HIV transcriptional regulation and recent studies have implicated the antioxidant response enzyme HO-1 as a negative regulator of HIV replication in monocytes (25, 37). Therefore, we hypothesized that DMF could modulate HIV replication in human macrophages through one or both of these mechanisms. Human MDM infected with HIV-1 were treated with DMF or MMF and then examined for virus replication. As shown in Fig. 1, exposure of MDM to DMF (Fig. 1A) or MMF (Fig. 1B) attenuated HIV replication in a dose-dependent manner, as determined by culture supernatant RT levels. Suppression of replication in MDM was seen with the R5 CSF HIV strain Jago (Fig. 1) and the prototypic R5/X4 strain 89.6 (Supplemental Fig. 1). As shown in Supplemental Table I, HIV replication was inhibited by an average of ~30% at MMF concentrations achieved in vivo after single-dose administration (4.4 μM in CSF and 6.5 μM in plasma) (23, 38).

**FIGURE 1.** DMF and MMF attenuate HIV replication in human MDM. Human MDM infected with 50 ng HIV (p24 ELISA, equivalent to 1.82 ± 0.22 kcpm/μl by RT activity assay) were treated with DMF (A) or MMF (B) over the course of infection at the indicated concentrations (1–30 μM) or with 20 nM of the non-nucleoside RT inhibitor EFZ. Culture supernatants were collected every 2 to 3 d, as indicated, and HIV replication was quantified by RT activity. DMF (C) and MMF (D) cause no cytotoxicity in HIV/MDM as assessed by LDH assay of supernatants harvested at day 14 postinfection. Maximum (Max) LDH release represents the soluble LDH release following cell lysis. RT curves are representative of three to four independent experiments, with each replicate performed on cell preparations from different donors. LDH assays represent data averaged from three to five individual donors. All statistical comparisons were made by one-way ANOVA plus Newman–Keuls post hoc testing. ***p < 0.001 versus EFZ.
No drug toxicity was detected at concentrations up to 100 μM in HIV-infected MDM (HIV/MDM) (Fig. 1C, 1D) and noninfected MDM (data not shown). DMF demonstrated additive effects in attenuating HIV replication when used in combination with EFZ, a nonnucleoside RT inhibitor (Supplemental Fig. 2A). There was no observed cellular toxicity when DMF was used in combination with EFZ (Supplemental Fig. 2B).

**DMF and MMF reduce HIV/MDM-mediated neurotoxicity**

We and others (26, 29, 39) have shown that HIV-infected MDM release potent neurotoxins that injure neurons through overactivation of NMDAR and that this excitotoxicity is mediated by glutamate and other low m.w. NMDAR agonists. Although the mechanisms underlying neurotoxicity production in HIV/MDM are not fully understood, suppression of HIV replication in MDM generally suppresses such neurotoxicity, as demonstrated by treatment with EFZ (Fig. 2). Similarly, in addition to suppressing HIV replication (Fig. 1), DMF (Fig. 2A) and MMF (Fig. 2B) also reduce HIV/MDM neurotoxin production in a dose-dependent manner, as assessed by neuronal survival in our in vitro HIV neurotoxicity model. Representative images of HIV/MDM-mediated neurotoxicity and the protective effects of DMF and MMF are shown (Fig. 2C), in which surviving neurons are labeled for MAP2.

FIGURE 2. DMF and MMF reduce HIV/MDM-mediated neurotoxicity. Rat cerebrocortical cultures were exposed to supernatant from HIV-infected macrophages that were treated with DMF (A) or MMF (B) at the indicated concentrations (1–30 μM) during the course of infection. Neuronal survival was assessed by MAP2 ELISA and expressed as a percentage of untreated (UT) cultures (n = 6). C, Representative images of rat cerebrocortical cultures immunofluorescently stained for MAP2 (red) and Hoechst 33324 (blue) following 24 h treatment with the indicated HIV/MDM supernatant. Scale bar, 50 μm. All statistical comparisons were made by one-way ANOVA plus Newman–Keuls post hoc testing. ***p < 0.001 versus vehicle.

DMF and MMF inhibit NF-κB nuclear translocation and TNF-α production in human MDM. DMF (A) and MMF (B) inhibit the nuclear translocation of the NF-κB proteins RelB, p65, and p50 in human MDM in a dose-dependent manner. Cells were treated with DMF or MMF for 24 h, exposed to TNF-α (10 min), separated into cytoplasmic and nuclear fractions, and analyzed by Western blotting. Results of densitometry analysis are presented numerically under each panel as the ratio of NF-κB protein to poly(ADP-ribose) polymerase, a nuclear marker, and loading control. Blots are representative of four to six independent experiments, with each replicate performed on cell preparations from different donors. C, DMF inhibits nuclear NF-κB p50 binding to DNA in TNF-α–stimulated MDM, as assessed by EMSA. Results of densitometry analysis were normalized to vehicle. D, DMF inhibits the production of TNF-α in MDM stimulated with PHA (10 μg/ml). Values are expressed as percent TNF-α production relative to vehicle-treated cells (227 ± 11.9 pg/ml TNF-α in vehicle). Data are expressed as mean ± SEM and averaged from four different donors. E, TNF-α production in HIV/MDM is inhibited by DMF treatment. HIV/MDM were treated with DMF (1–30 μM) or 20 nM EFZ over the course of infection and culture supernatants from days 14 to 15 postinfection were assayed for TNF-α by ELISA. Values represent the mean ± SEM of data averaged from four different donors. All statistical comparisons were made by one-way ANOVA plus Newman–Keuls post hoc testing. *p < 0.05, **p < 0.01, ***p < 0.001 versus vehicle.

FIGURE 3. DMF inhibits NF-κB nuclear translocation, DNA binding, and TNF-α production in human MDM. DMF (A) and MMF (B) inhibit the nuclear translocation of the NF-κB proteins RelB, p65, and p50 in human MDM in a dose-dependent manner. Cells were treated with DMF or MMF for 24 h, exposed to TNF-α (10 min), separated into cytoplasmic and nuclear fractions, and analyzed by Western blotting. Results of densitometry analysis are presented numerically under each panel as the ratio of NF-κB protein to poly(ADP-ribose) polymerase, a nuclear marker, and loading control. Blots are representative of four to six independent experiments, with each replicate performed on cell preparations from different donors. C, DMF inhibits nuclear NF-κB p50 binding to DNA in TNF-α–stimulated MDM, as assessed by EMSA. Results of densitometry analysis were normalized to vehicle. D, DMF inhibits the production of TNF-α in MDM stimulated with PHA (10 μg/ml). Values are expressed as percent TNF-α production relative to vehicle-treated cells (227 ± 11.9 pg/ml TNF-α in vehicle). Data are expressed as mean ± SEM and averaged from four different donors. E, TNF-α production in HIV/MDM is inhibited by DMF treatment. HIV/MDM were treated with DMF (1–30 μM) or 20 nM EFZ over the course of infection and culture supernatants from days 14 to 15 postinfection were assayed for TNF-α by ELISA. Values represent the mean ± SEM of data averaged from four different donors. All statistical comparisons were made by one-way ANOVA plus Newman–Keuls post hoc testing. *p < 0.05, **p < 0.01, ***p < 0.001 versus vehicle.
the suppression of macrophage-mediated neurotoxicity (Supplemental Fig. 2C), demonstrating that DMF may successfully reduce HIV replication and macrophage-mediated neurotoxicity that is not fully suppressed by ART. This neuroprotection is due to drug effects on the macrophages, as DMF and MMF do not prevent HIV/MDM-mediated neurotoxicity when applied directly to the neurons prior to addition of HIV/MDM supernatants (data not shown).

DMF inhibits NF-κB nuclear entry, DNA binding, and TNF-α production in human MDM

NF-κB and TNF-α are part of a positive-feedback loop that regulates the transcriptional activity of the HIV long terminal repeat (LTR). In unstimulated cells, NF-κB is unable to bind DNA due to its association with IκB proteins, which sequester NF-κB in the cytoplasmic compartment (40–42). Following exposure to an activating stimulus such as TNF-α, NF-κB is rapidly freed from the inhibitory complex and translocates into the nucleus to induce transcriptional activation of viral and host genes. NF-κB proteins are major modulators of the HIV LTR and are among the most potent activators of proinflammatory and inflammatory genes. Five members of the mammalian NF-κB/Rel family have been described, including c-Rel, NF-κB1 (p50/p105), NF-κB2 (p52/p100), RelA (p65), and RelB. Functional NF-κB complexes are composed of heterodimer complexes containing p65, c-Rel, or RelB bound to p50 or p52 (40, 43, 44). Exposure to activating stimuli, such as TNF-α, induces the nuclear accumulation of NF-κB proteins, DNA binding by NF-κB p50, and transcription from the HIV LTR (45).

To determine if DMF and MMF inhibit the nuclear translocation of NF-κB proteins in MDM, DMF- and MMF-treated MDM were stimulated with TNF-α and subjected to subcellular fractionations before detection of NF-κB subunits by Western blotting. DMF and MMF each inhibited TNF-α–induced nuclear accumulation of RelB, p65, and p50 in a dose-dependent manner (Fig. 3A, 3B). We also demonstrate that DMF inhibited the formation of the NF-κB p50–DNA complex, as assessed by EMSA (Fig. 3C). Because NF-κB signaling also induces expression of inflammatory mediators, we assessed the effects of DMF treatment on TNF-α release from MDM. In agreement with previous reports of DMF decreasing the release of inflammatory mediators from multiple cell types, including TNF-α, IL-1β, and IL-6 (24, 46), we found that DMF suppresses release of TNF-α from PHA-activated MDM (Fig. 3D). Furthermore, DMF also markedly suppressed HIV-induced TNF-α release from MDM (Fig. 3E). Thus, DMF and its primary metabolite, MMF, inhibit NF-κB translocation and signaling events that contribute to the positive-feedback loop that modulates HIV transcription in infected and activated MDM.

DMF restores the antioxidant response suppressed by HIV infection in MDM

The antioxidant response is one of the cellular adaptive stress responses that can modulate virus replication and host cell survival, as shown in hepatitis B and dengue 2 infection models (47, 48). The antioxidant response maintains redox balance and counteracts oxidative damage through induction of proteins that are involved in detoxification of reactive oxygen species (ROS). These proteins are produced by genes with a common promoter element, the antioxidant response element (ARE), and ARE transcription is mediated by Nrf2. Under conditions of low oxidative stress, Nrf2 is kept transcriptionally inactive by Kelch-like ECH-associated protein 1 (Keap1), which sequesters Nrf2 in the cytoplasmic compartment (49). Following exposure to ROS or electrophiles, Keap1...

**FIGURE 4.** DMF restores the imbalance in the antioxidant response caused by HIV infection. HIV infection of human MDM reduces HO-1 and GPX1 expression, as assessed by Western blotting (A) and quantified by densitometry analysis (B). Values indicate mean ± SEM of six different donors. Statistical comparisons were made by two-tailed paired t test. C, DMF activates the Nrf2-dependent antioxidant response in HIV/MDM and restores HO-1 and GPX1 levels to that found in uninfected mock cells, as quantified by densitometry analysis (D). MMF activates the Nrf2-dependent antioxidant response in HIV/MDM and restores HO-1 and GPX1 levels to that found in uninfected mock cells (E), as quantified by densitometry analysis (F). Blots are representative of three independent experiments, with each replicate performed on cell preparations from different donors. Densitometry data are expressed as mean ± SEM and averaged from three different donors. *p < 0.05, **p < 0.01, ***p < 0.001 versus mock.
is degraded by the proteasome and Nrf2 translocates to the nucleus to drive expression of numerous genes, including HO-1, NQO1, glutathione peroxidase 1 (GPX1), and genes responsible for glutathione synthesis (glutamate cysteine ligase modifier, glutamate cysteine ligase catalytic subunit, and glutathione synthetase). HIV infection is associated with increased ROS production and depressed levels of glutathione, the major intracellular antioxidant (50). We observed a marked reduction in the level of HO-1 expression in HIV/MDM across multiple human donors, with a more modest but nonetheless consistent reduction in GPX1 levels (Fig. 4A, 4B). The effects of DMF on Nrf2 and NQO1 levels were more variable among HIV/MDM cultures from different donors, but trended toward increased expression relative to uninfected mock/MDM (Fig. 4A, 4B).

Upon exposure of HIV/MDM to DMF, expression of Nrf2, HO-1, GPX1, and NQO1 increased with increasing doses of DMF (Fig. 4C), suggesting a restoration of antioxidant responses in HIV-infected MDM. Both HIV infection and DMF increase total levels of Nrf2, suggesting that although HIV infection stabilizes or induces total cellular Nrf2 levels, this is not sufficient for the coordinated transcriptional activation of ARE-regulated genes, such as HO-1 and GPX1. DMF and MMF treatment activates transcription of these ARE-regulated genes in HIV-infected macrophages, possibly by disrupting inhibitory Nrf2–Keap1 interactions (23). DMF restores levels of HO-1 and GPX1 to those observed in uninfected MDM, whereas NQO1, which is not suppressed during HIV infection, is induced to levels exceeding those in uninfected MDM (Fig. 4D). We have also confirmed that MMF can induce the antioxidant response in HIV/MDM (Fig. 4E, 4F) and that both DMF and MMF induce the antioxidant response in uninfected MDM (data not shown). DMF induction of antioxidant responses in MDM occurs independently of HIV infection, which is consistent with previous findings describing induction of the antioxidant response by DMF in multiple cell types, including glia and neurons (23, 24).

**DMF inhibition of HIV replication and NF-κB signaling is not mediated by HO-1**

HIV infection of human MDM results in alterations to the antioxidant response with a striking reduction in HO-1 levels (Fig. 4A, 4B). Induction of HO-1 by hemin has been reported to decrease HIV replication in human monocytes, suggesting that DMF’s induction of HO-1 may underlie its antiviral effects (25). We used a pharmacologic inhibitor of HO-1 enzymatic activity, SnMP, to determine the potential role for HO-1 in DMF-mediated suppression of HIV replication and NF-κB translocation. As shown in Fig. 5A, SnMP had no effect on DMF-mediated HIV suppression, which suggests that DMF does not suppress HIV replication through enhanced HO-1 expression and activity. We found no effect of SnMP on DMF-mediated suppression of HIV replication regardless of donor, level of infection, DMF dose, or timing of SnMP addition (data not shown). We also confirmed that SnMP does not inhibit DMF’s suppression of TNF-α–induced nuclear accumulation of NF-κB (Fig. 5B). In addition, we show that an inducer of HO-1 expression, CoPP, had no effect on TNF-α–induced nuclear accumulation of NF-κB (Fig. 5B). These results suggest that DMF’s induction of HO-1 does not directly suppress HIV replication or NF-κB signaling.

**Induction of HO-1 reduces neurotoxin production from HIV/MDM**

We sought to determine whether the suppression of HIV/MDM neurotoxin production by DMF (Fig. 2) was associated with DMF’s suppression of HIV replication and/or induction of HO-1 expression. Inhibiting HIV replication in HIV/MDM can suppress neurotoxin release in vitro, as demonstrated by EFZ treatment (Fig. 2), and similar effects of ART drugs in vivo are thought to account for their ability to limit the severity of HAND in ART-experienced cohorts. Although previous studies found that increased HO-1 activity is associated with decreased HIV replication in MDM (25, 37), we found that neither inhibition of HO-1 activity by SnMP treatment of MDM (Fig. 6A) nor induction of HO-1 expression by CoPP (Fig. 6D) altered HIV replication. Remarkably, however, SnMP treatment significantly increased the neurotoxicity of MDM supernatant (Fig. 6B), even when HIV replication was low or absent (Fig. 6C). The increase in MDM-mediated neurotoxicity was a consequence of inhibiting HO-1 activity in the macrophage because SnMP was not toxic when added directly onto neurons (data not shown). Although CoPP does not attenuate HIV replication or inhibit NF-κB signaling, supernatant from CoPP-treated HIV/MDM is significantly less neurotoxic than untreated controls with a similar level of HIV replication (Fig. 6E). These studies demonstrate that HO-1 is a critical modulator of neurotoxin production in HIV/MDM and that HO-1 levels can modulate HIV/MDM neurotoxicity without affecting HIV replication.

**DMF and MMF inhibit CCL2-induced chemotaxis in human monocytes**

The recruitment of activated and infected monocytes to the CNS in response to CCL2 is a key step in the pathogenesis of HAND (51, 52). In a previous DMF study using the mouse EAE model, DMF reduced macrophage infiltration into the spinal cord in areas of
active demyelination (19). We hypothesized that DMF could inhibit chemotaxis of human monocytes in response to chemotactic cytokines, such as CCL2. We found that DMF and MMF inhibited chemotaxis in freshly isolated human monocytes in response to CCL2 in a dose-dependent manner (Fig. 7A, 7B). Furthermore, we found that DMF reduced the expression of the CCL2 receptor CCR2 in freshly isolated human CD11b+CD14+ monocytes within 6 h of treatment (Fig. 7C, 7D), without causing death (Fig. 7E). These results indicate that DMF and MMF can decrease monocyte chemotaxis in response to CCL2 and that this effect is associated with downregulation of CCR2 expression.

Discussion

Monocytes and macrophages are major reservoirs for HIV in both the periphery and CNS and they facilitate the spread of virus to target cells, allow for viral persistence, and serve as major contributors to inflammation-mediated pathology. Despite current ART, latently infected monocytes and CD4+ T lymphocytes persist, resulting in inflammation in the periphery and in the CNS in up to 50% of patients on ART (7, 8). Although ART will remain the mainstay of HIV therapy, effective adjunctive therapies that suppress inflammation, improve morbidity, and improve long-term cognitive outcomes are greatly needed. The immunomodulator DMF, which is effective for the treatment of psoriasis and shows promising results for multiple sclerosis treatment in recent clinical trials, is an attractive candidate as a safe adjunctive neuroprotectant against HIV. We have demonstrated that physiologically relevant doses of DMF and its primary metabolite MMF (23, 38) affect key steps in the pathogenesis of HAND in our in vitro model system by inhibiting HIV replication, neurotoxin production, NF-κB signaling, and TNF-α production in human MDM and by reducing monocyte chemotaxis in response to CCL2. These results suggest that DMF could serve as an effective neuroprotectant in HAND and have beneficial effects on systemic HIV disease progression as well.

We have shown that DMF and MMF attenuate macrophage-mediated neurotoxicity following HIV infection by simultaneously attenuating viral replication and inducing HO-1 expression. Furthermore, induction of HO-1 can significantly decrease macrophage-mediated neurotoxicity even without decreasing
HIV replication. Consequently, DMF may be an especially relevant therapeutic in patients who have relatively good virologic control but still suffer from neurologic complications of HIV. We have shown that HIV infection of MDM results in a dysregulation of the antioxidant response with an especially prominent reduction in HO-1 levels associated with superantigen neurotoxicity and that DMF treatment restores HO-1 levels and reduces neurotoxicity production in macrophages. In activated microglia, an oxidative burst is required for the release of excitotoxic glutamate (53), demonstrating that alterations to cellular oxidative state can mediate the production and/or release of MDM neurotoxins. DMF’s ability to decrease HIV replication and neurotoxin production by distinct mechanisms makes it an especially attractive therapeutic candidate for HAND. Furthermore, macrophage- and microglia-mediated neurotoxicity contribute to many other neurologic disorders including multiple sclerosis, Alzheimer’s disease, amyotrophic lateral sclerosis, Huntington’s disease, and stroke/reperfusion injury, for which therapeutics for restoring oxidative balance resultant from the disease state have been investigated (54).

Numerous proinflammatory factors contribute to HIV disease pathogenesis in both the peripheral and CNS compartments. TNF-α, IL-6, IL-1β, IFN-γ, and other proinflammatory cytokines are elevated in the blood and CSF of HIV-infected patients (55–58). Among these, TNF-α is the most potent mediator of inflammation and is induced early after HIV monocytic infection and its expression continues to increase over the course of infection (59–61). It is well established that TNF-α exposure upregulates HIV replication by initiating a signaling cascade that activates the nuclear translocation of NF-κB (62–65). We have shown that DMF and MMF attenuate TNF-α-mediated NF-κB signaling in human macrophages and reduce nuclear NF-κB levels, which are expected to decrease transcription from the HIV LTR. However, the NF-κB and TNF-α signaling loop may not entirely mediate DMF’s antiviral activity. Attenuation of HIV replication occurs at low concentrations, as does induction of the ARE, whereas inhibition of NF-κB signaling may be more relevant at concentrations of ≥15 μM. Future studies are necessary to assess the role of the antioxidant response, including NQO1 and the cellular redox state, in mediating HIV infection and replication. DMF may alter the expression of the HIV coreceptors CXCR4 and CCR5, similarly to the observed downregulation of cell-surface CCR2. It has been reported that antioxidants decrease the stability of mRNA transcripts for CXCR4 and CCR5 in human monocytes, suggesting that DMF treatment may directly reduce HIV entry into human monocytes (66).

However, DMF’s ability to inhibit NF-κB and TNF-α signaling following both PHA stimulation and HIV infection has clear implications for the physiologic reduction of neuroinflammation and cytokine-induced neuronal injury. Elevated TNF-α levels increase monocyte entry into the brain, promote HIV replication, and drive inflammatory cascades, thereby enhancing the production of neurotoxins in the CNS from MDM, microglia, and astrocytes (67). Therefore, dampening TNF-α-driven processes might also afford neuroprotection against HIV. Indeed, TNF-α is linked to glutamine synthetase and glutamate import in macrophages (68) and DMF’s inhibition of TNF-α–driven processes may further decrease the release of excitatory neurotoxins, such as glutamate, in HIV/MDM. In human macrophages, we have shown that DMF is a potent suppressor of NF-κB nuclear translocation, subsequent binding to DNA and expression of NF-κB–dependent genes. Therefore, DMF is a particularly good therapeutic candidate for pathological states characterized by macrophage-driven inflammation and NF-κB signaling.

Although not directly dependent upon HO-1, DMF’s antioxidant properties are likely mediating the inhibition of NF-κB activity.
We hypothesize that such effects are due to DMF’s modulation of the macrophage intracellular redox state as activation of the antioxidant response has been shown to block NF-κB activity and HIV transcription (69–71). Furthermore, classical (α and β), novel (δ), and atypical (ζ) protein kinase C (PKC) isoforms can modulate the nuclear translocation and transcriptional activity of NF-κB and PKC is activated by oxidative stress and inhibited by antioxidants (72–76). In addition to potential effects on PKC, DMF may also affect the phosphorylation of IκB kinases and subsequent phosphorylation and degradation of IκB proteins (21, 36). Finally, DMF may affect NF-κB–dependent transcription by modulating the preferred composition of NF-κB homo- and heterodimers that form after nuclear translocation has occurred. The intracellular oxidative state can affect levels of NF-κB p50 homodimers, which do not possess transactivation domains and are thought to act as transcriptional repressors of NF-κB heterodimeric-responsive genes (77–79). We are currently examining the role of DMF and MMF in modulating the activation state of the macrophage, which would affect the cell’s relative sensitivity to proinflammatory signals and thereby contribute to decreased NF-κB signaling.

Although other antioxidants have been considered as potential therapeutics for HAND through direct effects on macrophages or neurons, DMF is unique in its ability to inhibit CCL2-induced monocyte chemotaxis. Monocyte transmigration across the blood–brain barrier is dependent upon production of chemokines, such as CCL2, in the CNS and the activation of monocytes in the periphery. Levels of CCL2 in the CSF correlate with CSF viral load and with the clinical severity of HAND (51, 52, 80–83) and CCL2 is produced by brain macrophages, astrocytes, and endothelial cells in response to inflammatory mediators and HIV proteins (84–86). Not only does DMF decrease TNF-α production and NF-κB signaling in MD-M02, both of which have been implicated in CCL2 production, but DMF and MMF also inhibit CCL2-driven monocyte chemotaxis, possibly by modulation of CCR2 expression. DMF and MMF may modulate the cell-surface expression of CCR2 by inducing the antioxidant response and consequently altering the redox state of the cell. It has been demonstrated that direct antioxidants are capable of reducing the transcript stability of CCR2, which has been linked to decreased cell-surface expression and CCL2-induced chemotaxis in human monocytes (66). These findings in our in vitro model system predict suppression of transendothelial migration of monocytes into the CNS during HIV infection. Furthermore, it has been reported that DMF modulates adhesion molecule expression in human endothelial cells by inhibiting TNF-α–induced expression of ICAM-1, VCAM-1, and E-selectin (35). Expression of each of these adhesion molecules has been linked to monocyte entry into the CNS after HIV infection and downregulation by DMF is expected to further inhibit monocyte entry into the CNS. Given these findings, DMF should be considered as a potential therapeutic for other neuroinflammatory diseases associated with CCL2-induced recruitment of leukocytes to the CNS.

With this study, we identify DMF as a candidate adjunctive therapy and potential neuroprotectant against HIV. We believe this is the first demonstration that HIV infection dysregulates components of the antioxidant response in human macrophages and that restoration of HO-1 levels, specifically, can reduce macrophage-mediated neurotoxicity. To our knowledge, DMF is the first proposed neuroprotectant that reduces CCL2-mediated monocyte chemotaxis as a component of its mechanism of action. Furthermore, we have shown that DMF attenuates HIV replication associated with decreased TNF-α and NF-κB signaling. Given these findings, we propose that DMF should be considered a relevant therapeutic candidate for neurologic disorders and other complications of HIV-infection mediated by monocyte and macrophage inflammation.

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Disclosures

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