Synthesis of the active metabolite of vitamin D, 1,25(OH)2D3, by synovial fluid macrophages in arthritic diseases

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SUMMARY Synthesis of 1,25-dihydroxyvitamin D3 (1,25(OH)2D3) has been shown in cells from knee joint synovial fluid of 20 patients with inflammatory rheumatoid disease, reactive or psoriatic arthritis, or gout, all of which had high synovial fluid cell counts, and by cells from a patient with aseptic necrosis of a femoral condyle after short term (<24 hours) or long term (seven days) primary culture. Cells from 18 patients with inflammatory arthritis, five of which had low synovial fluid cell counts and cells from six patients with osteoarthritis were unable to synthesise this metabolite from 25-hydroxyvitamin D3 (25(OH)D3). Macrophages are believed to be the cells responsible for synthesising 1,25(OH)2D3 because these were significantly more numerous in samples that formed 1,25(OH)2D3; they were also the predominant cell type present in the aseptic necrosis sample and the only cell type present in preparations maintained for one week in monolayer culture.

Vitamin D is metabolised by sequential hydroxylation steps, first to 25-hydroxyvitamin D3 (25(OH)D3) in the liver and then to either 24,25-dihydroxyvitamin D3 (24,25(OH)2D3) or the active hormonal form, 1,25-dihydroxyvitamin D3 (1,25(OH)2D3), in the kidney. The last metabolite then exerts calcium homeostatic actions in the intestine, bone, and renal tubule after binding to specific intracellular receptors.

Peripheral blood lymphocytes and synovial tissue derived fibroblasts from patients with rheumatoid arthritis have also been shown to possess specific receptors for 1,25(OH)2D3, and the role of the metabolite in these cells is not known. Furthermore, little is known of the actions of vitamin D and its metabolites in arthritis, though they are clearly involved in normal bone and calcium metabolism, and deficiencies are associated with the development of rickets or osteomalacia.

Fairney et al have recently shown that knee joint synovial fluid from patients with arthritic disorders contains 25(OH)D3, 24,25(OH)2D3, and the vitamin D binding protein at about half serum concentrations. Similarly, 1,25(OH)2D3 is also present in synovial fluid at 50–100% serum concentrations (Mawer, unpublished observations). These metabolites and their binding protein are probably present because synovial fluid is formed as a plasma dialysate supplemented with mucins such as hyaluronic acid and lubricating glycoproteins.

Studies of the extrarenal metabolism of 25(OH)D3 have now shown that 1,25(OH)2D3 is synthesised in vitro by normal human macrophages activated with interferon gamma or bacterial lipopolysaccharides; by macrophages activated by peritonitis from the peritoneal cavity of patients with renal failure receiving continuous ambulatory peritoneal dialysis; and by alveolar macrophages from patients with granulomatous conditions such as sarcoidosis. In sarcoidosis this synthesis appears to depend on the substrate concentration and is not homeostatically controlled, in contrast with the normal well regulated synthesis of 1,25(OH)2D3 in the renal tubule. Possibly, activated macrophages in one or more of the many forms of arthritis can also synthesise 1,25(OH)2D3 within the affected joints.

This study was undertaken to establish whether cells, including macrophages, present in synovial fluid from patients with various forms of arthritis or gout are able to synthesise 1,25(OH)2D3.
Patients and methods

Samples of synovial fluid were obtained from 45 patients (details in Table 1) with knee joint effusions attending the rheumatology outpatient clinics of various local hospitals. Patients were assigned to well recognised diagnostic groups on the basis of clinical criteria supplemented by appropriate immunological, radiological, and crystallographic investigations. Six patients with symmetrical polyarthritis or oligoarthropathies could not be assigned to a specific diagnostic group and were classified together as inflammatory arthritis not otherwise specified.

Table 1 Details of patients studied

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid arthritis</td>
<td>Three taking drugs*</td>
</tr>
<tr>
<td>Reactive arthritis</td>
<td>7</td>
</tr>
<tr>
<td>Psoriatic arthritis</td>
<td>5 Three taking drugs†</td>
</tr>
<tr>
<td>Unspecified inflammatory arthritis</td>
<td>6</td>
</tr>
<tr>
<td>Lymphocytic arthritis</td>
<td>1</td>
</tr>
<tr>
<td>Gout</td>
<td>5</td>
</tr>
<tr>
<td>Aseptic necrosis of a femoral condyle</td>
<td>1</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>6</td>
</tr>
</tbody>
</table>

*One each taking gold, penicillamine, and methotrexate.
†Taking methotrexate.

Table 2 Total and differential synovial fluid cell counts and 1,25-hydroxyvitamin D₃ synthesis. Values are given as mean (SEM)

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Cell/μl (x 10⁶)</th>
<th>1,25(OH)₂D₃ synthesis (fg/l/10⁶ macrophages)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Polymorphs</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>14</td>
<td>3-7-87</td>
</tr>
<tr>
<td>Reactive arthritis</td>
<td>7</td>
<td>12-03</td>
</tr>
<tr>
<td>Psoriatic arthritis</td>
<td>5</td>
<td>2-84</td>
</tr>
<tr>
<td>Reactive arthritis</td>
<td>6</td>
<td>1-26</td>
</tr>
<tr>
<td>High cell count</td>
<td>13</td>
<td>12-73</td>
</tr>
<tr>
<td>Low cell count</td>
<td>5</td>
<td>2-00</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>6</td>
<td>0-31</td>
</tr>
</tbody>
</table>

*p<0.05, **p<0.01 compared with low cell count non-formers; ***p<0.001 compared with high cell count non-formers.
†Results from patients were divided into 1,25(OH)₂D₃ formers and non-formers. The formers were subdivided into types of arthritis or gout and the non-formers into low and high cell count samples.
Synthesis of 1,25(OH)₂D₃ in arthritic diseases

liquid scintillation counting. Standard 25(OH)D₃, 24,25(OH)₂D₃, and 1,25(OH)₂D₃ (donated by Dr M R Uuskovic, Hoffmann-LaRoche Inc, New Jersey, USA) were also chromatographed, and the retention times of these markers were determined by ultraviolet absorption at 265 nm. Further analyses of selected chloroform extracts were carried out on the normal phase (Zorbax-Sil) and on reverse phase (Zorbax-ODS, 4-6 mm×25 cm) HPLC systems, developed with mobile phases of 2-5% methanol in dichloromethane (2 ml/min) and 15% water in methanol (2 ml/min) respectively, to confirm the identity of the metabolic product. For these analyses [³H]-1,25(OH)₂D₃ was used as a marker.

Cytocentrifuge preparations were made with 40 000 cells per slide for each sample. Cells were identified and differential cell numbers determined on the basis of their morphology in Giemsa stained preparations and their reaction for non-specific esterase with α-naphthyl propionate as substrate.⁹

Results

Synovial fluid samples were divided into two groups according to whether or not the cells were able to form 1,25(OH)₂D₃. Cells from 21 patients synthesised [³H]-1,25(OH)₂D₃ after overnight culture followed by a six hour incubation with [³H]-25(OH)D₃. The cells with this ability were found in eight out of 14 samples from patients with rheumatoid arthritis, all seven of those with reactive arthritis, two out of five with gout, and three out of 12 with other types of arthritis (two with non-specific inflammation and one with psoriatic arthritis)
and in the patient with aseptic necrosis of a femoral condyle (Table 2). Figure 1A shows typical chromatograms from HPLC analyses from the first three groups; peaks of radioactivity corresponding to the precursor [3H]-25(OH)D3 and a product cochromatographing with 1,25(OH)2D3 are clearly shown, but there was no radioactive peak corresponding to 24,25(OH)2D3. Synthesis of [3H]-1,25(OH)2D3 was similarly shown in cells from the patient with aseptic necrosis (Fig. 1B); by all morphological and histochemical criteria more than 95% of these cells were macrophages (Fig. 2). To confirm that macrophages were responsible for 1,25(OH)2D3 synthesis cells were placed in culture for one week before incubation with [3H]-25(OH)D3 for six hours. Figure 3A shows [3H]-1,25(OH)2D3 synthesis by macrophages from a psoriatic arthritis sample maintained for one week in culture. The identity of the metabolite formed by these cells was confirmed by cochromatography with authentic [3H]-1,25(OH)2D3 on two further HPLC systems (Figs 3B and C).

The non-formers included all six of the patients with osteoarthritis, three patients with gout, six with rheumatoid arthritis, four with psoriatic arthritis, four with unspecified arthritis, and a patient with lymphocytic arthritis.

In general terms, therefore, it appears that cells from the synovial fluid of patients with non-inflammatory arthropathies did not form 1,25(OH)2D3, whereas those fluids in which 1,25(OH)2D3 synthesis occurred were from patients with inflammatory arthropathies. This is clearly not a complete explanation of the results, however, as synovial fluid cells from 18 of the 38 patients with inflammatory arthropathies did not synthesise 1,25(OH)2D3, whereas those from the patient with non-inflammatory aseptic necrosis did. We have examined all the available data on these patients to establish if there are any obvious variables that might distinguish formers from non-formers.

Non-formers differed from formers in one of two ways. Either they had high total cell counts like the formers but with a low proportion of macrophages (high cell count non-formers) or they had total cell counts below 2.5×10^9 cells/l (low cell count non-formers). The first group contained six patients with rheumatoid arthritis (including three taking drugs), four with psoriatic arthritis (including three taking methotrexate), one with unspecified inflammatory arthritis, and two with gout. The second group consisted of three patients with unspecified inflammatory arthritis, one patient with lymphocytic arthritis, and one with gout. Interestingly, one exception to this generalisation was the sample from the patient with aseptic necrosis, which was a non-inflammatory arthropathy characterised by a low total cell count. This sample contained a high proportion of macrophages but few lymphocytes and no polymorphs and was able to form large amounts of 1,25(OH)2D3 (Table 2). It would seem, therefore, that a major difference between formers and non-formers is the absolute number of macrophages in the joint; however, samples from two patients with low total cell counts had macrophage counts of 0.84 and 1.38×10^9/l but failed to synthesise 1,25(OH)2D3.

Synthesis of 1,25(OH)2D3 was shown by cells from high cell count samples that had been maintained in cell culture for one week to select for adherent macrophages. Cells from six out of nine of these samples synthesised 1,25(OH)2D3 during a six hour incubation period (50–2970 fg/h/incubation). Of the six samples that formed 1,25(OH)2D3 after seven days in cell culture, three did not initially form 1,25(OH)2D3; of these, one was from a patient taking methotrexate and two had low macrophage numbers. In the three samples in which 1,25(OH)2D3 synthesis could not be shown the numbers of adherent cells were low after seven days in culture.
Discussion

These results show for the first time that synovial fluid cells are capable of synthesising the active vitamin D metabolite, 1,25(OH)₂D₃, when maintained in either short term (<24 hours) or long term (seven days) primary culture. In contrast, no synthesis of 24,25(OH)₂D₃ could be shown, though other workers have previously reported synthesis of this metabolite in normal human macrophages in vitro. In one such study macrophages exposed to interferon gamma initially formed 1,25(OH)₂D₃, but after prolonged exposure they began to synthesise 24,25(OH)₂D₃. Synthesis of 24,25(OH)₂D₃ has also been observed in articular cartilage and by chondrocytes cultured in vitro.

Although synovial fluid contains a heterogeneous population of cells, with particularly high numbers of polymorphs in high cell count inflammatory arthritides, it appears to be the macrophages that synthesise 1,25(OH)₂D₃. Macrophages were significantly more numerous in samples that formed 1,25(OH)₂D₃ and were also the predominant cell type present in the aseptic necrosis sample and the only cell type present in preparations maintained for one week in cell culture. Macrophages from most forms of high cell count inflammatory arthritis and gout appeared to synthesise 1,25(OH)₂D₃. In our study 13 cell samples did not metabolise 1,25(OH)₂D₃ but six of these patients were receiving either the antimetabolite methotrexate (one with rheumatoid arthritis, three with psoriasis), gold, or penicillamine (both rheumatoid arthritis), which may have influenced cellular functions in macrophages, including the activity of the 25(OH)D-1-hydroxylase enzyme.

To form 1,25(OH)₂D₃ the macrophages must presumably be in an activated state (as in sarcoidosis and peritonitis), but it is uncertain whether this occurs before or after they enter the synovial fluid. In gout the cells are activated by uric acid crystals within the joint, whereas in reactive arthritis, which develops secondary to systemic inflammatory conditions, the monocytes are probably activated before they enter the joint. The need for cells to be activated may explain why two of the patients with low cell count non-specific inflammatory arthritis did not form 1,25(OH)₂D₃ despite having high numbers of macrophages. In the aseptic necrosis sample the cells were probably activated by particles of necrotic bone and thus actively synthesised 1,25(OH)₂D₃.

An adequate substrate concentration is another requirement for the synthesis of 1,25(OH)₂D₃, which is likely as 25(OH)D₃ is present in synovial fluid at about half serum concentrations.1 and these

Fig. 3 Metabolism of [³H]-25(OH)D₃ in a six hour in vitro incubation by adherent synovial fluid macrophages from a patient with psoriatic arthritis after maintenance in cell culture for seven days. Bars represent the amount of tritiated material in eluent fractions obtained by analysis of aliquots of the cell extract on three different high performance liquid chromatography (HPLC) systems: (A) Zorbax-Sil column developed with n-hexane: propan-2-ol: methanol (110:6:4); (B) Zorbax-Sil column developed with 2.5% methanol in dichloromethane; (C) Zorbax-ODS column (reverse phase) developed with 15% water in methanol. Standard 25(OH)D₃, 24,25(OH)₂D₃, and 1,25(OH)₂D₃, detected by ultraviolet absorbance at 265 nm (---) or [³H]-1,25(OH)₂D₃, (---) were used as markers.
concentrations are about 50 times greater than those presented to the cells in the incubation system used in our study.

The significance of the ability of macrophages from patients with high cell count inflammatory arthritis to synthesise 1,25(OH)₂D₃ is not clear. Evidence that the reaction may occur in vivo is provided by results showing that patients with rheumatoid arthritis respond to a single dose of 25(OH)D₃ (10 000 IU) by increasing serum 1,25(OH)₂D₃ concentrations significantly compared with controls, but this rise is short lived. There is no evidence that rheumatoid patients as a group have higher than normal circulating concentrations of 1,25(OH)₂D₃ as a result of extrarenal synthesis. This may result from feedback regulation of renal 1,25(OH)₂D₃ synthesis by that formed outside the kidney. Synthesis of 1,25(OH)₂D₃ mediated by macrophages may result in raised concentrations only when the 25(OH)D₃ levels are abnormally high or the mass of tissue involved is large, as in some cases of sarcoidosis and malignant disease.

Measured concentrations of 1,25(OH)₂D₃ in synovial fluid are lower than in serum (Mawer, unpublished observations), probably owing to the smaller concentration of vitamin D binding protein. The importance of 1,25(OH)₂D₃ production by macrophages from arthritic patients may be greater when cells are contained within the synovium and are thus adjacent to the sites of tissue damage and bone erosion within the joint.

The presence of specific receptors for 1,25(OH)₂D₃ in normal human monocytes and activated lymphocytes and in peripheral blood lymphocytes and synovial tissue derived fibroblasts from patients with rheumatoid arthritis suggests a physiological role for the metabolite in joint disease. Furthermore, many of the reported effects of 1,25(OH)₂D₃ may be relevant to arthritis. For example this metabolite appears to inhibit proliferation of both B and T activated lymphocytes and reduces interleukin 2 production by activated T lymphocytes in vitro. 1,25(OH)₂D₃ has also been shown to promote differentiation of monocytes into macrophages and the fusion of macrophages to multinucleated giant cells with bone resorbing activity. This is in addition to the known ability of 1,25(OH)₂D₃ to inhibit collagen synthesis by osteoblasts and to promote bone resorption. This last effect may be achieved by an indirect action of 1,25(OH)₂D₃ on osteoblasts to stimulate bone resorption by osteoclasts, which unlike osteoblasts do not appear to have receptors for 1,25(OH)₂D₃. Thus within the synovial fluid and synovium 1,25(OH)₂D₃ may have complex paracrine and immunoregulatory functions which could influence the development of the juxta-articular osteoporosis that occurs in arthritis. If this is the case then the use of drugs that inhibit the extrarenal 25(OH)D₁- hydroxylase may play an important part in reducing the extent of tissue damage and bone erosion that occurs in arthritis.

Support for this study was provided by project grants from the Medical Research Council to Dr E B Mawer and Professor S Tomlison, and by the Arthritis Research Council and North West Regional Research Grants Committee to Dr A J Freemont. We are also grateful to the many clinicians who collected samples, to D Bayley and P Lockey for technical assistance, and to Dr M Davies for helpful discussions.

References


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doi: 10.1136/ard.48.9.723

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