Serum concentrations of soluble P-selectin glycoprotein ligand-1 are increased in patients with systemic sclerosis: association with lower frequency of pulmonary fibrosis

K Yanaba, K Takehara, S Sato

Objective: To determine serum concentrations of soluble P-selectin glycoprotein ligand-1 (sPSGL-1) and its clinical associations in patients with systemic sclerosis.

Methods: Serum sPSGL-1 concentrations from 65 patients with systemic sclerosis were examined by enzyme linked immunosorbent assay. In a retrospective longitudinal study, 177 sera from 35 patients with systemic sclerosis were analysed (follow up 0.3 to 6.3 years)

Results: Serum sPSGL-1 was raised in patients with limited cutaneous systemic sclerosis (lSSc) (n = 34) and diffuse cutaneous systemic sclerosis (dSSc) (n = 31) compared with healthy controls (n = 22) and patients with systemic lupus erythematosus (n = 20) or dermatomyositis (n = 20). Patients with systemic sclerosis who had raised sPSGL-1 concentrations less often had pulmonary fibrosis and decreased vital capacity (%VC) than those with normal sPSGL-1 levels. sPSGL-1 concentrations were positively correlated with %VC in patients with systemic sclerosis. In the longitudinal study, patients with systemic sclerosis without pulmonary fibrosis had consistently increased sPSGL-1 concentrations in the early phase, while those with pulmonary fibrosis had decreased sPSGL-1 throughout the follow up period.

Conclusions: A raised serum sPSGL-1 is associated with a lower frequency and severity of pulmonary fibrosis in systemic sclerosis. sPSGL-1 could be a protective factor against the development of pulmonary fibrosis in this disease and as such would be a possible therapeutic target.

Serum samples were obtained from 65 Japanese patients with systemic sclerosis (57 female and eight male). All patients fulfilled the criteria for systemic sclerosis proposed by the American College of Rheumatology (ACR).34 According to the classification system proposed by LeRoy et al.,35 34 patients had limited cutaneous systemic sclerosis (lSSc) and 31 had diffuse cutaneous systemic sclerosis (dSSc). Anti-topoisomerase I (Topo I) antibodies were positive in 28 patients; anticentromere antibodies in 21; anti-RNA polymerase I antibodies in three; anti-U1 RNP antibodies in six; anti-centromere antibodies in two; anti-Th/To antibodies in three; and two were negative. The patients were aged 2 to 72 years (mean age 45). The mean disease duration was 5.4 years (range 0.2 to 30). The duration of the disease was calculated from the time of onset of the first clinical event.
(other than Raynaud’s phenomenon) that was a clear manifestation of systemic sclerosis.

At their first visit, nine patients had been treated with low dose steroids (prednisolone 5 to 20 mg/day) and eight with low dose D-penicillamine (100 to 500 mg/day). None of the patients had received immunosuppressive treatment.

Twenty patients with systemic lupus erythematosus (SLE) who fulfilled the ACR criteria and 20 with dermatomyositis who fulfilled the criteria of Bohan and Peter acted as disease controls; 22 healthy age and sex matched Japanese subjects acted as healthy controls.

In a retrospective longitudinal study, we analysed 177 serum samples from 35 of 65 patients with systemic sclerosis who could have been followed longitudinally. There was no bias in patient selection. The mean follow up period was 3.3 years (range 0.3 to 6.3), with 5.1 (2 to 9) time points. The mean disease duration was 5.4 years (range 0.2 to 22.8). Fifteen patients had dSSc and 20 had dSSc. Anti-topo I antibodies were positive in 23 patients; anticientromere antibodies in nine; anti-RNA polymerase I antibodies in two; and anti-U1-RNP antibodies in one. These patients were aged 2 to 72 years (mean 49).

Fresh venous blood samples were centrifuged shortly after clot formation. All samples were stored at −70°C before use.

Clinical assessment

Complete medical histories, physical examinations, and laboratory tests were conducted for all patients at their first visit, with evaluations especially for pulmonary function during follow up visits. Organ system involvement was defined as described—lung: bibasilar fibrosis on chest radiography and high resolution computed tomography (HRCT); oesophagus: hypomotility shown by barium radiography; joints: inflammatory polyarthalgia, tendon friction rubs, oracro-osteolysis; heart: pericarditis, congestive heart failure, or arrhythmias requiring treatment; kidney: malignant hypertension and rapidly progressive renal failure with no other explanation; and muscle: proximal muscle weakness and raised serum creatinine kinase. Pulmonary fibrosis was defined as bibasilar interstitial fibrosis on chest radiographs, and ground glass opacities, reticular opacities, or honeycombing on HRCT. Each chest radiograph and HRCT was evaluated and ground glass opacities, reticular opacities, or honeycombing on HRCT. Each chest radiograph and HRCT was evaluated by a radiologist blinded to the patient’s clinical status and serum findings, and independently by a second investigator.

Pulmonary function tests, including vital capacity (VC) and diffusion capacity for carbon monoxide (DLCO), were conducted to evaluate the severity of pulmonary fibrosis. When the DLCO and VC were <75% and <80%, respectively, of predicted normal values, they were considered to be abnormal. Patients with systemic sclerosis who were smokers or who had other respiratory disorders that could have affected %DLCO or %VC were excluded from the study. The erythrocyte sedimentation rate was considered raised if it was more than 20 mm/h. C reactive protein if it was above 0.5 mg/dl. IgG if it was above 1774 mg/dl, and IgM if it was above 355 mg/dl.

The protocol was approved by the Kanazawa University Graduate School of Medicinal Science and Kanazawa University Hospital, and informed consent was obtained from all patients.

Detection of serum sPSGL-1

Serum sPSGL-1 concentrations were measured using specific enzyme linked immunosorbent assay (ELISA) kits (Bender MedSystems, Vienna, Austria), according to the manufacturer’s protocol. This ELISA system can detect all circulating sPSGL-1 isoforms. Each sample was tested in duplicate. The detection limit of the assay was 1.5 U/ml.

Statistical analysis

The Mann–Whitney U test was used to compare sPSGL-1 concentrations, Fisher’s exact probability test to compare frequencies, and the Bonferroni test for multiple comparisons. Spearman’s rank correlation coefficient was employed to examine the relation between two continuous variables. A probability (p) value of less than 0.05 was considered statistically significant.

RESULTS

Serum sPSGL-1 in systemic sclerosis

Serum concentrations of sPSGL-1 in patients with systemic sclerosis and healthy controls are shown in fig 1. For comparison, patients with dermatomyositis or SLE were also included in the study. Serum sPSGL-1 at the first visit was raised in patients with systemic sclerosis (median 18.1 U/ml (range 6.8 to 45.2)) compared with healthy controls (14.2 (9.5 to 17.6); p<0.05), in patients with SLE (10.1 (6.7 to 16.5); p<0.001), and in patients with dermatomyositis (13.0 (5.2 to 29.2); p<0.05). Serum sPSGL-1 in patients with SLE was decreased compared with healthy controls (p<0.001). There was no significant difference in sPSGL-1 levels between patients with dermatomyositis and the healthy controls. In the systemic sclerosis subgroups, serum sPSGL-1 was 18.5 U/ml (6.8 to 45.2) in patients with lSSc and 17.6 (8.5 to 36.9) in patients with dSSc; these values were significantly higher than in normal controls (p<0.05 for both), patients with SLE (p<0.005 and p<0.0005, respectively), or patients with dermatomyositis (p<0.05 and p<0.05). There was no significant difference in serum sPSGL-1 between patients with lSSc and dSSc.

Clinical correlations of serum sPSGL-1

Values higher than the mean +2 SD (18.4 U/ml) of the control serum samples were considered to be raised. Raised sPSGL-1 concentrations were observed in 42% of patients with systemic sclerosis (27/65). As shown in table 1, the prevalence of pulmonary sclerosis and decreased %VC in patients with systemic sclerosis and raised sPSGL-1 values was significantly lower than in those with normal sPSGL-1 levels. Because of the observed clinical correlations with systemic sclerosis, we measured sPSGL-1 concentrations in a group of patients who could have been followed longitudinally. There was no bias in patient selection. The mean follow up period was 3.3 years (range 0.2 to 22.8). Fifteen patients had lSSc and 20 had dSSc. Anti-topo I antibodies were positive in 23 patients; anticientromere antibodies in nine; anti-RNA polymerase I antibodies in two; and anti-U1-RNP antibodies in one. These patients were aged 2 to 72 years (mean 49).

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Table 1: Clinical and laboratory data in patients with systemic sclerosis

<table>
<thead>
<tr>
<th>Clinical feature</th>
<th>Raised sPSGL-1 (n = 27)</th>
<th>Normal sPSGL-1 (n = 38)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at onset (years) (mean (SD))</td>
<td>40 (16)</td>
<td>49 (11)</td>
</tr>
<tr>
<td>Male female (n)</td>
<td>1.26</td>
<td>7.31</td>
</tr>
<tr>
<td>Duration (years) (mean (SD))</td>
<td>6.0 (6.3)</td>
<td>5.0 (1.2)</td>
</tr>
<tr>
<td>Clinical features</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracture of phalanges</td>
<td>56</td>
<td>45</td>
</tr>
<tr>
<td>Pitting scars</td>
<td>41</td>
<td>42</td>
</tr>
<tr>
<td>Short sublingual frenulum</td>
<td>56</td>
<td>55</td>
</tr>
<tr>
<td>Organ involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased %VC</td>
<td>15%</td>
<td>39%</td>
</tr>
<tr>
<td>Decreased %DLco</td>
<td>44%</td>
<td>66%</td>
</tr>
<tr>
<td>Oesophagus</td>
<td>70%</td>
<td>71%</td>
</tr>
<tr>
<td>Heart</td>
<td>7%</td>
<td>24%</td>
</tr>
<tr>
<td>Joint</td>
<td>12%</td>
<td>29%</td>
</tr>
<tr>
<td>Muscle</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Laboratory findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-topoisomerase I ab</td>
<td>52%</td>
<td>37%</td>
</tr>
<tr>
<td>Anticentromere ab</td>
<td>37%</td>
<td>26%</td>
</tr>
<tr>
<td>Increased IgG</td>
<td>19%</td>
<td>47%</td>
</tr>
<tr>
<td>Raised ESR</td>
<td>33%</td>
<td>32%</td>
</tr>
<tr>
<td>Raised C reactive protein</td>
<td>15%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Values are percentages except where stated otherwise. *p<0.05 vs patients with normal sPSGL-1.

Raised sPSGL-1 concentrations were positively correlated with %VC and %DLco in patients with systemic sclerosis (r = 0.45, p<0.005, and r = 0.41, p<0.01, respectively; fig 2). In addition, patients with a raised serum sPSGL-1 less often had a raised serum IgG than those with a normal sPSGL-1 (19% v 47%, p<0.05). Thus raised sPSGL-1 concentrations were associated with a lower frequency and severity of pulmonary sclerosis and an increased IgG.

Longitudinal study of sPSGL-1 concentrations

To assess changes in serum sPSGL-1 over time, 177 serum samples from 35 patients with systemic sclerosis were analysed retrospectively. The patients were divided into two groups: a group of 11 patients who had pulmonary sclerosis (fig 3A) and one of 24 patients who did not have pulmonary sclerosis (fig 3B).

In group A, two patients had already been treated with low dose steroids and one with low dose D-penicillamine at the time of their first visit. During the follow up period, low dose steroids (prednisolone, 5–20 mg/day) were started in five patients and low dose D-penicillamine (100–300 mg/day) in one. In addition, one patient received steroid pulse therapy, followed by 40 mg/day of oral prednisolone, for subacute deterioration of pulmonary sclerosis.

In group B, two patients had already been treated with low dose steroids and two with low dose D-penicillamine (100–500 mg/day) at the time of their first visit. During the follow up period, low dose steroids (prednisolone, 5–20 mg/day) were started in 10 patients and low dose D-penicillamine (100–500 mg/day) in three.

No patient with systemic sclerosis received immunosuppressive therapy. Among the 11 patients with pulmonary sclerosis (group A), two had raised serum sPSGL-1 at their first visit and their sPSGL-1 concentrations decreased to the normal range during the follow up period. In four of the patients in group A, sPSGL-1 concentrations increased only transiently during follow up. However, the maximum sPSGL-1 values were relatively low (<24 U/ml) and they returned to normal levels in the late phase of disease process. In the remaining five patients in group A, sPSGL-1 concentrations remained normal throughout the follow up period.

Among the 24 patients without pulmonary sclerosis (group B), 17 had raised serum sPSGL-1 concentrations at their first visit, and in eight of these the levels remained high throughout the follow up period. The maximum serum sPSGL-1 was comparatively high (>30 U/ml in five patients). Only four patients in this group had normal sPSGL-1 concentrations throughout the follow up period.

In general, serum sPSGL-1 concentrations tended to be raised in the early stages of the disease process, but, except in two patients, during the follow up period the values declined to below the initial levels. Thus the serum sPSGL-1 seemed to reflect disease activity. However, as steroids and D-penicillamine were started in 19 of the 35 patients after their first visit, the decrease in sPSGL-1 may have been an effect of these agents. Overall, patients with systemic sclerosis but without pulmonary sclerosis tended to have increased sPSGL-1 values in the early phase of the disease. In contrast, those with pulmonary sclerosis tended to have decreased sPSGL-1 levels throughout the follow up period.

DISCUSSION

This is the first report of raised serum sPSGL-1 concentrations in patients with systemic sclerosis. We assessed patients with systemic sclerosis, SLE, and dermatomyositis, but the sPSGL-1 levels were increased only in the patients with systemic sclerosis.
systemic sclerosis (fig 1). The sPSGL-1 concentrations were raised not only in dSSc, but also in ISSc. Furthermore, raised concentrations of sPSGL-1 were associated with a lower prevalence of pulmonary involvement and better pulmonary function (table 1, fig 2). In our longitudinal study, patients with systemic sclerosis but without pulmonary sclerosis tended to have increased sPSGL-1 levels in the early stages of the disease. In contrast, the patients with pulmonary sclerosis tended to have decreased sPSGL-1 levels throughout the follow up period (fig 3). Overall, these results suggest that a raised sPSGL-1 may be protective against the development of pulmonary sclerosis in systemic sclerosis.

It has been reported that the soluble forms of various adhesion molecules—including P-selectin, E-selectin, L-selectin, ICAM-1, and VCAM-1—are significantly raised in sera from patients with systemic sclerosis.19,20 Gruschwitz et al defined clinical disease activity as an increase in skin score, deterioration of pulmonary sclerosis on chest radiograph or PFT, or progression of oesophageal hypomotility shown by barium; and raised serum levels of sICAM-1, sVCAM-1, and sE-selectin correlate with the severity of skin sclerosis and pulmonary sclerosis in systemic sclerosis.21-23 Raised serum sL-selectin is linked to a clinically more severe subset of cases of systemic sclerosis.24 Furthermore, serum concentrations of sE-selectin, sVCAM-1, and sICAM-1 are raised in cases of systemic sclerosis with scleroderma renal crisis.25 Thus the soluble forms of cell adhesion molecules in patients with systemic sclerosis correlate with a more severe type of disease or with major organ involvement, and may reflect disease activity. In this study, sPSGL-1 was also increased in systemic sclerosis. However, the sPSGL-1 values did not correlate with the severity of skin sclerosis, though they did correlate with a lower prevalence of pulmonary sclerosis. These findings suggest that sPSGL-1 may play a specific role in the evolution of systemic sclerosis that is different from the soluble forms of other adhesion molecules such as E-selectin, P-selectin, L-selectin, ICAM-1, and VCAM-1. Moreover, our longitudinal study showed that the patients who did not have pulmonary sclerosis had consistently increased sPSGL-1 concentrations in the early phase of disease, whereas those with pulmonary sclerosis had decreased levels throughout the follow up period. These results suggest that measurement of sPSGL-1 in patients with systemic sclerosis may offer an important approach to the evaluation of pulmonary involvement.

Recently, recombinant sPSGL-1 was developed to evaluate the role of P-selectin. Recombinant sPSGL-1 is engineered by linking a truncated PSGL-1 to the Fc portion of human immunoglobulin. The protein lacks the transmembrane and cytoplasmic portion of PSGL-1, but contains the complete extracellular regions of PSGL-1 that are necessary for receptor–ligand binding.26 It is capable of binding P-, E-, and L-selectins and acts as an antagonist of PSGL-1. Recombinant sPSGL-1 is beneficial in animal models of deep vein thrombosis,30 myocardial ischaemia–reperfusion,31 renal ischaemia–reperfusion,32 hepatic ischaemia–reperfusion,33 initial hyperplasia after angioplasty;34 35 arterial thrombosis,36 37 and ocular allergy.38 These previous studies suggest that blocking leukocyte accumulation through inhibition of the binding of selectins to PSGL-1 provides a means of treating these diseases. In our longitudinal study, the finding that serum sPSGL-1 was raised at the early phase of the disease process in the patients without pulmonary sclerosis (fig 3) suggests that persistent elevation of sPSGL-1 may be related to inhibition of factors concerned with the development of pulmonary sclerosis. Thus the administration of sPSGL-1 might be a possible treatment in patients with systemic sclerosis who have pulmonary sclerosis in the early stages of the disease process.

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