Dehydroepiandrosterone suppresses interleukin 10 synthesis in women with systemic lupus erythematosus

D M Chang, S J Chu, H C Chen, S Y Kuo, J H Lai

Objective: To study the effects of dehydroepiandrosterone (prasterone, DHEA) 200 mg/day on cytokine profiles in adult women with active systemic lupus erythematosus (SLE).

Methods: In a double blind, randomised, placebo controlled study conducted as part of a larger multicentre study, 30 adult women with active SLE received oral DHEA 200 mg/day or placebo for 24 weeks. Baseline prednisone (<10 mg/day) and other concomitant SLE medications were to remain constant. The levels of cytokines including interleukin (IL) 1, IL2, interferon γ, IL4, and IL10 were determined by ELISA. The mean change from baseline to 24 weeks of therapy was analysed.

Results: The two groups (DHEA n = 15; placebo n = 15) were well balanced for baseline characteristics. Only IL1β and IL10 could be detected in the serum of lupus patients; however, there was no significant mean (SD) difference in serum IL1β before and after treatment (9.94 (8.92) v 9.20 (6.49) pg/ml). IL10 demonstrated a greater and significant reduction from baseline (9.21 (9.66) to 1.89 (1.47) pg/ml in the DHEA treatment group).

Conclusions: In a 24 week study of adult Chinese women with mild to moderate SLE, treatment with DHEA 200 mg once daily resulted in significant reduction of serum levels of IL10. This finding may suggest why DHEA could significantly reduce lupus flares.
200 mg/day (provided by Genelabs Biotechnology Co Ltd) or placebo for 24 weeks.

Physicians and patients were instructed to make all efforts to keep doses of prednisone and other SLE medications constant during the study. Prednisone dosage was permitted to increase up to 10 mg/day over baseline dosage for up to 2 weeks, but only if medically required. Changes in non-steroidal anti-inflammatory drugs were allowed, but only if medically required and approved by the treating physician.

The protocol was approved by the institutional review board. All patients gave written informed consent.

**Patient grouping**

A total of 32 patients was randomised into the study; 17 patients received DHEA 200 mg/day and 15 patients received placebo. Fifteen (88%) of the patients receiving DHEA and 15 (100%) of the patients in the placebo group completed the study.

**Hormone and cytokine determination**

Routine laboratory and hormone assays were conducted by Mithra Bioindustry Company Ltd, Taipei, Taiwan. Various serum cytokines including IL1β, IL2, IFNγ, IL4, and IL10 in SLE patients were measured using ELISA kits (R&D, Minneapolis, MN, USA) according to the manufacturer’s instructions. The lowest detection levels were: IL1β, 0.5 pg/ml; IL2, 1.6 pg/ml; IFNγ, 15.6 pg/ml; IL4, 0.25 pg/ml; and IL10, 0.781 pg/ml. Serum testosterone, oestradiol, and cytokine profiles were measured at baseline and last visit.

**Statistical analysis**

Wilcoxon matched paired signed ranks test was used, and level of significance was set at 0.05.

**RESULTS**

**Baseline characteristics demographics**

The patient population consisted of Chinese women. There were only two patients (one in each group) with a baseline SLEDAI score of <3.

The two treatment groups were well matched for age, baseline prednisone dose/use, menopausal status, cytotoxic use, and antimalarial use. The groups were also well matched with regard to values at baseline for scoring instruments (data not shown). The prednisone dose at study completion in DHEA and placebo group was 7.2 (2.8) v 6.3 (3.9) mg/day. There was no statistical difference (p = 0.4175) compared with the dose at study entry (table 1).

**Hormone determination**

Oestradiol decreased in both groups. The mean decrease was slightly larger for the DHEA group (48 v 24 pg/ml). As the study population comprised mainly premenopausal women, and measurements were not timed in relation to menses, changes in mean and median oestradiol levels were probably related to variability in these data and were not of clinical relevance. Mean testosterone levels increased in the DHEA group and decreased in the placebo group (470 ng/l compared with −70 ng/l, respectively) (fig 1). Most patients in both treatment groups had DHEA-S levels of 0–2 g/l at baseline. At the post-baseline visits, approximately 60% of patients in the DHEA treatment group had levels of >10 mg/l. The levels for the remaining 40% were distributed over each of the lower 2 g/l incremental ranges (data not shown). There was no evidence of elevated DHEA-S levels in the placebo group at baseline or on subsequent visits.

**Cytokine determination**

IL10 was significantly higher at the last visit in the placebo treated group compared with the DHEA treated group (placebo 9.06 (7.46) v DHEA 1.89 (1.47) pg/ml; p = 0.045) (fig 2). In addition, the reduction in IL10 from baseline to the last visit was significant within the DHEA treated group, with mean baseline concentration of 9.21 (9.66) and mean last visit concentration of 1.89 (1.47) pg/ml (p = 0.005) (fig 2).

![Figure 1](http://ard.bmj.com/Ann Rheum Dis: first published as 10.1136/ard.2003.016576 on 16 November 2004. Downloaded from http://ard.bmj.com/ on May 11, 2022 by guest. Protected by copyright.)

Table 1 Demographic summary by treatment group

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age [years]</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean/median (SD)</td>
<td>33.3/32.0 (10.2)</td>
<td>32.0/32.0 (9.6)</td>
<td>0.672</td>
</tr>
<tr>
<td>Range</td>
<td>18.0 to 62.0</td>
<td>18.0 to 59.0</td>
<td></td>
</tr>
<tr>
<td><strong>Prednisone dose (mg/day)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean/median (SD)</td>
<td>7.0/7.5 (3.1)</td>
<td>6.7/5.0 (3.1)</td>
<td>0.732</td>
</tr>
<tr>
<td>Range</td>
<td>0.0 to 10.0</td>
<td>0.0 to 10.0</td>
<td></td>
</tr>
<tr>
<td><strong>Pre-menopausal</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cytotoxic use at baseline</td>
<td>6 (40.0%)</td>
<td>6 (40.7%)</td>
<td>0.940</td>
</tr>
<tr>
<td>Prednisone use at baseline</td>
<td>14 (93.3%)</td>
<td>14 (93.3%)</td>
<td>1.000</td>
</tr>
<tr>
<td>Antimalarial use at baseline</td>
<td>9 (65.0%)</td>
<td>10 (66.6%)</td>
<td>0.602</td>
</tr>
</tbody>
</table>

*The p values for continuous variables were obtained with one way analysis of variance, and p values for categorical variables from a χ² test.*

Dehydroepiandrosterone suppresses IL10 synthesis in women with SLE

found a significant reduction of IL10 in patients’ blood after DHEA treatment for 24 weeks. IL6 was not originally included in this study, which in hindsight was possibly not the correct decision.

IL10 is a B cell stimulatory cytokine that also inhibits type 1 cytokine response. Several lines of evidence suggest that IL10 plays a critical role in the immunopathogenesis of SLE. Lupus patients have increased serum levels of IL10, which may correlate with disease activity. PBMCs from patients with SLE exhibit increased IL10 mRNA expression and increased spontaneous IL10 production. In addition, the peripheral blood of SLE patients contains a significantly increased number of IL10 secreting cells. Disease activity in SLE patients correlates with the ratio of IL10 to IFNγ secreting cells.

Lymphocytes exposed to DHEA were noted to produce increased quantities of IFNγ and IL2, and lesser amounts of other interleukins such as IL4. Suzuki et al suggested a causal link between low serum DHEA levels and diminished IL2 secretion by activated peripheral blood T lymphocytes. The addition of exogenous DHEA to T cells in vitro resulted in a significant restoration of IL2 secretion by such cells, suggesting that the defect in the production of this cytokines was not related to exhaustion but rather to a relative shortage of the androgen. These investigators suggested that the relative abundance of the enzyme DHEA sulphatase, which converts the sulphate ester to the biologically active form in various lymphoid tissues, could determine how much of this immunomodulatory effect occurs and which T cell phenotype would predominate at the level of the local immunological microenvironment. This investigation may suggest some mechanistic insights into how DHEA affects IL10 secretion.

There is evidence that PBMCs from SLE patients produce up to 30 times more IL10 than normal PBMCs in vitro, with most of this IL10 being derived from monocytes and B cells. However, the current study did not investigate the effect of DHEA or testosterone on IL10 secretion from B cells or monocytes, and to our knowledge, it has not been described in the literature. The reduction in IL10 levels was caused by increased catabolism or decreased production; which cell type is involved should be investigated further. Park et al showed that mean (SE) IL10 levels in SLE patients were significantly higher than those of controls (29.2 (6.8) vs 3.5 (0.6) pg/ml). Elevated IL10 levels correlated well with the SLEDAI in SLE patients. The changes in serum IL10 levels also correlated with the changes in the SLEDAI score during the patients’ disease course.

Our finding of significant IL10 suppression by DHEA 200 mg daily for 24 weeks in adult Chinese female patients with mild to moderate SLE may add new knowledge to the understanding of how DHEA offers meaningful benefit to SLE patients.

ACKNOWLEDGEMENTS

We deeply appreciate the advice and revision given by Dr P H Schur.

Authors’ affiliations

D M Chang, S J Chu, H C Chen, S Y Kuo, J H Lai, Rheumatology/Immunology/Allergy, Tri-Service General Hospital, National Defense Medical Center

This study was partially sponsored by National Science Council NSC90-2314-B-016-069.

REFERENCES


