Spreading spondyloarthritis: are ILCs cytokine shuttles from base camp gut?

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A series of discoveries has transformed concepts of spondyloarthritis and pro-inflammatory cytokine interleukin-23 (IL-23) has taken centre stage. The IL-23 frenzy kicked off with the identification of single nucleotide polymorphisms in the IL-23 receptor (IL-23R) gene that are associated with ankylosing spondylitis (AS)1 and also with related disorders such as psoriasis, psoriatic arthritis and Crohn’s disease. The most striking and direct evidence comes from an in vivo IL-23 overexpression study in mice that phenocopies the human disease and its Janus-faced characteristics: joint inflammation and structural damage presenting as new bone formation.2 Patient studies reported increased serum levels of IL-23 in AS3–5 and the presence of IL-23-positive cells was shown in facet joints of patients with AS.6 Direct clinical evidence comes from a prospective, open-label clinical trial with ustekinumab, an antibody binding to the shared p40 subunit of IL-23 and IL-127 and successful clinical trials targeting IL-17, one of the downstream cytokines associated with IL-23 signalling.8 Key to the hypothesis and evidence proposed in the mouse model is the presence of an IL-23 receptor-positive T-cell population in the enthesis of mice. As enthesis is one of the main characteristics of AS and was proposed as the primary lesion,9 it is hard to ignore the potential key role of such cells. However, until now, these IL-23 receptor-positive cells have not yet been demonstrated in human samples.

Ciccia et al10 report on the presence of a population of IL-23R-positive innate lymphoid cells (ILCs) in the gut, peripheral blood, synovial fluid and bone marrow of patients with AS. Numbers of such cells are increased as compared with different controls and their surface characteristics show similarities with the mouse cells identified earlier. However, these ILCs are a rare cell type whose significance in human disease is as yet uncertain. In two previous studies Ciccia et al11,12 showed increased IL-23 expression in the gut of patients with AS as compared with healthy controls. In AS synovium and peripheral blood cells, however, no differences in expression of IL-23 were found.13,14 They characterised these cells as Lyn–IL-23R−NKP44+Tbet+RORC+ cells and the induced production of cytokines IL-17 and IL-22 led them to conclude that these are ILC3 cells. Unlike conventional ILC3 and IL-23R+ entheseal T cells, these cells seemingly do not express RORc but do express the transcription factor Tbet which can, according to the authors, possibly be explained by a specific stage of differentiation of these cells. This finding makes them somewhat atypical, even for ILC3s. The reasons for these differences between ‘conventional’ characteristics of ILCs and the spondyloarthritis’ associated cells are unclear and whether these changes precede onset of inflammation or are rather a secondary to already established inflammation remains to be determined. Further clarification of the exact nature of these cells clearly needs to be carried out. Hence, fine details in small subpopulations of cells may still represent a static, rather than dynamic, view on cell populations that are actively part of host defence or disease.

The expansion of these ILC3 cells in patients with AS with acute and chronic gut inflammation was significantly correlated with the disease activity as assessed by the Bath Ankylosing Spondylitis Disease Activity Index. In patients with AS without gut inflammation the upregulation of ILC3s was not detected. The authors reported an expansion of NKP44+ILC3s in gut samples of patients with AS and in the peripheral blood, synovial fluid and the bone marrow of patients with AS. ILC3s are defined by their capacity to produce the interleukins IL-17 and IL-22,15 portrayed as critical cytokines in the pathogenesis of AS. In the study, gut ILC3 cells were demonstrated to produce IL-17 and IL-22 and a small percentage of cells expressed both cytokines. In the peripheral blood, the majority of ILC3s produced IL-22 and only a small subset of ILC3s produced IL-17 or the combination of IL-22 and IL-17. Among synovial fluid and bone marrow, mononuclear ILC3s produced exclusively IL-22. The reasons for these differential patterns according to localisation are unclear and could reflect tissue-imprinted cytokine patterns. These data suggest that ILCs could be an important supplier of IL-17 and IL-22 in AS, which is also one of the implicit conclusions of this study by Ciccia et al.16 Insights into the role of IL-17 in spondyloarthritis are dynamically evolving with a shift from a focus on adaptive immune cells towards more innate immune populations. Indeed, IL-17 producing CD4+ cells, also known as Th17 cells, were shown to be elevated in HLA-B27/human β2m transgenic rats17 and in the lymph nodes of an AS mouse model.18 Moreover, there are studies demonstrating an increased amount of IL-17-producing CD4+ cells in the blood of patients with AS as compared with controls19–21 although this observation is not consistent.22–24 IL-17-producing cells were also found in the subchondral bone marrow cells of affected facet joints of patients with AS.6 Interestingly, the majority of these IL-17-positive cells were rather innate immune cells (CD15+ neutrophils and MPO+ cells of the myeloid lineage) than CD4+ T cells.6 Obviously, the most convincing proof of principle that IL-17 plays a key role in spondyloarthritis is found in the clinical trials evaluating the effect of secukinumab, a monoclonal anti-IL-17A antibody that rapidly reduced clinical and biological signs of active AS.8

IL-22 has also earned its place in the spotlight as it has been associated with enthesis/arthritis development in mice and with upregulation of genes potentially involved in the new bone formation process (such as Wnts and bone morphogenetic proteins).2 However, the role for IL-22 in AS and related disorders seems to be tissue dependent—as demonstrated in a study by Benham et al25 using the SKG mouse model. In this mouse model curdian injection in SKG mice leads to IL-23-dependent axial and peripheral arthritis and ileitis. When IL-22 was neutralised by an IL-22 antibody, the mice developed a reduced severity of enthesitis but an exacerbation of ileitis.23 This finding highlights that the effects of interleukins in the pathogenesis of AS are not always straightforward but can vary from tissue to tissue and be influenced by tissue-dependent environmental factors. It is important to note that the current

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attention towards IL-23, IL-17 and IL-22 to some extent neglects the critical role of tumour necrosis factor (TNF) in this type of diseases. A TNF overexpression model mimics many features of the disease and TNF inhibition is currently the mainstream approach with high and sustained efficacy in SpA. Bringing together the different proinflammatory cytokines in one paradigm is therefore an interesting challenge.

Detailed histological analysis of the gut biopsies驱者 the authors to propose the hypothesis that IL-23 receptor-positive ILC3s differentiate in the gut and then migrate to extraintestinal sites where they produce IL-17 and IL-22. This hypothesis was formulated in part on the abundant expression of αβ7 integrin on ILC3s, a β7 integrin with marked gut tropism, even though earlier work demonstrated its presence on synovial T cells in SpA synovium. Although this hypothesis touches on synovial T cells in SpA, it should be noted that earlier work demonstrated its presence on synovial T cells in SpA synovium. Therefore, the hypothesis that IL-23 receptor-positive ILC3s differentiate in the gut and then migrate to extraintestinal sites where they produce IL-17 and IL-22 is not necessarily contradictory with the earlier work.

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18 Jansen DT, Hameetman M, van Bergen J, et al. IL-17-producing CD4+ T cells are increased in early, active axial spondyloarthritis including patients without imaging abnormalities. Rheumatology (Oxford) 2015;54:728–35.


