Methotrexate Has No Antifibrotic Effect in Bleomycin-induced Experimental Scleroderma

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To the Editor:

Scleroderma is a chronic inflammatory disease that is characterized by widespread microvascular damage and excessive deposition of collagen in the skin and internal organs, although its pathogenesis is not fully understood. Opinions regarding the current treatment of scleroderma are based on recently developed European League Against Rheumatism/EULAR Scleroderma Trials and Research Group recommendations. However, no disease-modifying drugs are currently available that can modify the course of the disease. In systemic sclerosis, methotrexate (MTX) has been studied in controlled trials, with controversial outcomes\(^1\),\(^2\). We evaluated the possible effectiveness of MTX in a bleomycin (BLM)-induced experimental scleroderma model\(^3\),\(^4\).

Our study included 3 groups of mice (n = 10 Balb/c mice in each group). Control group mice were only administered 100 µl of phosphate-buffered saline (PBS), while mice in the other 2 groups were subcutaneously administered BLM (100 µg/day, dissolved in 100 µl PBS) for 4 weeks. In addition to BLM, the mice in the third group were administered MTX intraperitoneally (1 mg/kg/week).

At the end of the fourth week, all mice were sacrificed and blood and tissue samples were harvested. Interleukin 2 (IL-2), IL-4, and transforming growth factor β1 serum levels, tissue hydroxyproline contents, dermal thicknesses, and the number of α-smooth muscle actin-positive (α-SMA+) cells were determined. The Kruskal-Wallis 1-way analysis of variance and Mann-Whitney U tests were used.

Histological evaluation revealed that subcutaneous BLM administration markedly increased dermal thickness (p < 0.001), subcutaneous eosinophilic infiltration (p < 0.05), and expression of α-SMA (p < 0.001), and the hydroxyproline content of the skin showed an increase of up to about 3-fold following BLM administration compared with the PBS-treated mice (p < 0.001). MTX treatment did not change the tissue hydroxyproline content, dermal thickness (Figure 1), inflammatory cell infiltration, or number of α-SMA+ cells (Table 1).

Controversial results of MTX treatment have been reported in patients with scleroderma\(^1\),\(^2\). MTX is reported to be more effective than placebo according to predefined response criteria, although it does not significantly improve total skin score, extension indexes, grip strengths, oral opening, visual analog scale of patient’s general well-being, and organ involvement\(^1\). Moreover, a subsequent study\(^2\) demonstrated the ineffectiveness of MTX. Our study also supports the ineffectiveness of MTX.

A number of antiinflammatory effects exerted by MTX seem to be related to endogenous adenosine increase\(^5\). However, stimulation of the adenosine A\(_2A\) receptor dramatically increases collagen production from dermal fibroblasts, and suppresses the expression and activity of matrix metalloproteinases\(^6\). Moreover, blockade of the adenosine A\(_2A\) receptor is reported to prevent BLM-induced dermal fibrosis\(^6\). In addition, MTX is reported to increase synthesis of glycosaminoglycans in scleroderma and normal fibroblast cultures\(^7\). Therefore, it could not be expected that MTX may exert antifibrotic effects.

Increased levels of Th2-type cytokines, which stimulate the synthesis of collagen by fibroblasts\(^8\), have been reported in scleroderma\(^9\). However, MTX modulates the immune status toward Th2 dominance\(^10\). The possible effect of MTX on Th2 cytokines may have led to its lack of antifibrotic effect in our study.

The results of our study demonstrate that MTX had no antifibrotic effect in the experimentally induced dermal fibrosis/sclerosis model.

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Table 1. Serum cytokines, tissue hydroxyproline levels, and histopathological findings in Balb/c mice groups.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Control</th>
<th>Bleomycin</th>
<th>Bleomycin + Methotrexate</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL-2, pg/ml</td>
<td>7.53 ± 0.45</td>
<td>8.44 ± 2.82</td>
<td>8.66 ± 2.99</td>
</tr>
<tr>
<td>IL-4, pg/ml</td>
<td>7.04 ± 0.13</td>
<td>8.43 ± 2.90</td>
<td>8.13 ± 2.66</td>
</tr>
<tr>
<td>TGF-B1, pg/ml</td>
<td>1098.4 ± 486.2</td>
<td>1363.6 ± 487.2</td>
<td>1257.8 ± 421.4</td>
</tr>
<tr>
<td>Tissue hydroxyproline, mg/g dry tissue</td>
<td>0.52 ± 0.19</td>
<td>1.71 ± 0.58*</td>
<td>1.51 ± 0.65*</td>
</tr>
<tr>
<td>Dermal thickness, μm</td>
<td>192.8 ± 53.5</td>
<td>435.5 ± 77.8*</td>
<td>466.6 ± 192.2*</td>
</tr>
<tr>
<td>Dermal tissue, eosinophil/HPF</td>
<td>9.9 ± 9.4</td>
<td>9.80 ± 5.1</td>
<td>13.6 ± 7.2</td>
</tr>
<tr>
<td>Subcutaneous tissue, eosinophil/HPF</td>
<td>9.0 ± 9.3</td>
<td>19.4 ± 15.5**</td>
<td>19.3 ± 8.9**</td>
</tr>
<tr>
<td>α-SMA, cells/HPF</td>
<td>1.02 ± 0.4</td>
<td>2.4 ± 1.1*</td>
<td>2.9 ± 0.9*</td>
</tr>
</tbody>
</table>

α-SMA: α-smooth muscle actin; HPF: high-power field (×400); IL: interleukin; TGF: transforming growth factor. ** p < 0.05, * p < 0.001 compared to the control group.