Interleukin 6 (IL-6) Deficiency Delays Lupus Nephritis in MRL-\textit{Fas}^{lp}r\textit{m} Mice: The IL-6 Pathway as a New Therapeutic Target in Treatment of Autoimmune Kidney Disease in Systemic Lupus Erythematosus

HANNES CASH, MANFRED RELLE, JULIA MENKE, CHRISTOPH BROCHHAUSEN, SIMON A. JONES, NICHOLAS TOPLEY, PETER R. GALLE, and ANDREAS SCHWARTING


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ABSTRACT. Objective. To investigate the pathophysiological effect of interleukin 6 (IL-6) on lupus nephritis in MRL-\textit{Fas}^{lp}r\textit{m} mice.

Methods. We generated IL-6-deficient MRL-\textit{Fas}^{lp}r\textit{m} mice using a backcross/intercross breeding scheme. Renal pathology was evaluated using immunohistochemistry detection for macrophages, lymphocytes, vascular cell adhesion molecule-1 (VCAM-1), and TUNEL (terminal deoxynucleotide transferase-mediated dUTP nick end-labeling) for apoptotic cells, and renal IgG and C3 deposition by immunofluorescence staining. Expression of inflammatory markers in the spleen was analyzed by quantitative real-time reverse transcription-polymerase chain reaction. Serum cytokine concentrations were detected by FACS analysis.

Results. IL-6 deficiency was highly effective in prolonging survival and ameliorating the clinical, immunological, and histological indicators of murine systemic lupus erythematosus. During the study period of 6 months, MRL-\textit{Fas}^{lp}r\textit{m} IL-6\textsuperscript{−/−} mice showed delayed onset of proteinuria and hematuria compared to IL-6-intact control mice. Survival rate was 100% in IL-6-deficient MRL-\textit{Fas}^{lp}r\textit{m} mice and 25% in the control group at 6 months of age. The absence of IL-6 resulted in significant reduction of infiltrating macrophages in the kidney (p < 0.05), a decrease in renal IgG and C3 deposition, and a reduction of CD4\textsuperscript{+} and CD8\textsuperscript{+} lymphocytes. The parenchymal adhesion molecule VCAM-1 was found to be downregulated in kidneys of MRL-\textit{Fas}^{lp}r\textit{m} IL-6\textsuperscript{−/−} compared to IL-6-intact mice. We found elevated serum levels of IL-10 and interferon-\textgamma in IL-6-deficient mice, while splenic mRNA showed an overall downregulation of immunoregulatory genes.

Conclusion. IL-6 is a strong promoter of lupus nephritis and may be a promising new therapeutic target in the treatment of human lupus nephritis. (First Release Dec 1 2009; J Rheumatol 2010;37:60–70; doi:10.3899/jrheum.090194)

Key Indexing Terms:
INTERLEUKIN 6
LUPUS NEPHRITIS
KNOCKOUT MODEL
MRL-\textit{Fas}^{lp}r\textit{m}

The hallmark of systemic lupus erythematosus (SLE) includes inflammation in multiple organs and pathogenic autoantibodies. Renal disease is one of the most common and serious organ manifestations of SLE. Lupus nephritis is mediated by the infiltration of macrophages and lymphocytes and the deposition of autoantibodies in capillary walls. Advancing tubulointerstitial pathology and an increase in infiltrating leukocytes are unfavorable prognostic indicators\textsuperscript{1}. Renal injury in MRL-\textit{Fas}^{lp}r\textit{m} (formerly designated MRL-\textit{lpr}) is determined by the MRL background genes. The MRL-1/1 strain develops latent, mild autoimmune renal injury. The interaction of the MRL gene

From the Department of Internal Medicine, Division of Rheumatology and Clinical Immunology, Johannes Gutenberg-University, Mainz; Department of Urology, Charité – Universitätsmedizin Berlin, Berlin; Sana Center of Rheumatology Rheinland-Pfalz, Bad Kreuznach; Institute of Pathology, Johannes Gutenberg-University, Mainz, Germany; and Department of Infection, Immunity and Biochemistry, School of Medicine, Cardiff University, Cardiff, Wales; United Kingdom.

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H. Cash, MD, Department of Internal Medicine, Division of Rheumatology and Clinical Immunology, Johannes Gutenberg-University, Department of Urology, Charité – Universitätsmedizin Berlin; M. Relle, PhD; J. Menke, MD, Department of Internal Medicine, Division of Rheumatology and Clinical Immunology, Johannes Gutenberg-University; C. Brochhausen, MD, Institute of Pathology, Johannes Gutenberg-University; S. Jones, PhD; N. Topley, MD, Department of Infection, Immunity and Biochemistry, School of Medicine, Cardiff University; P. R. Galle, MD, Department of Internal Medicine, Division of Rheumatology and Clinical Immunology, Johannes Gutenberg-University; A. Schwarting MD, Department of Internal Medicine, Division of Rheumatology and Clinical Immunology, Johannes Gutenberg-University and Sana Center of Rheumatology Rheinland-Pfalz. H. Cash and M. Relle contributed equally to this report.

Address correspondence to Dr. A. Schwarting, Division of Rheumatology and Clinical Immunology, University Hospital of Mainz, Langenbeckstr. 1, D-55131 Mainz, Germany. E-mail: aschwert@mail.uni-mainz.de Accepted for publication August 7, 2009.

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background with single-gene mutation in Fas (MRL-Faslpr) converts this mild renal injury into a rapid and fulminant tissue-destructive process. Renal pathology in MRL-Faslpr mice is complex; it involves interstitial, glomerular, tubular, and perivascular lesions and is mediated by antibody-dependent and cellular mechanisms. Therefore, renal disease in MRL-Faslpr mice is a result of immune complexes and cytokine/growth factor-related events. Kidney inflammation, which is evident at 3 months of age, is rapidly progressive, and by 5–8 months of age, it is fatal.

Interleukin 6 (IL-6) is an immunomodulatory pleiotropic cytokine with a wide range of biological activities. Andus, et al described IL-6 as the main activator of acute-phase inflammatory cells in the kidney, mainly macrophages and lial cells, and mesangial cells. In lupus nephritis, infiltrating proinflammatory cells are capable of releasing IL-6, such as macrophages, B and T cells, monocytes, fibroblasts, keratinocytes, endothelial cells, and mesangial cells. In lupus nephritis, infiltrating inflammatory cells in the kidney, mainly macrophages and monocytes, are the main source of IL-6. In an area of inflammation IL-6 stimulates leukocyte recruitment and monocyte/macrophage migration via the release of chemokines by endothelial cells. High IL-6 concentrations are found in sera of SLE patients as well as in lupus mouse models. In addition to the high IL-6 serum levels, significant overexpression of IL-6 is found in SLE and other membra

**MATERIALS AND METHODS**

**Animals.** MRL-Faslpr mice and IL-6 knockout BALB/C mice were purchased from the Jackson Laboratory (Bar Harbor, ME, USA). The mice were kept in a germ-free environment in the animal facility of the University of Mainz. We generated IL-6-deficient MRL-Faslpr mice (IL-6−/−; MRL-Faslpr) using a backcross-intercross scheme as described. The progeny were screened by polymerase chain reaction (PCR) amplification of tail genomic DNA using primers for the IL-6 wild-type gene (sense, 5′-TTT GCC TTT TTT TGT GCT G-3′; antisense, 5′-TTC TCA TTT CCA CGA CGT TTT CCC-3′) and IL-6 deficiency (neomycin resistance insertion; sense, 5′-ATT GAA CAA GAT TTG TGG TAC CAC-3′; antisense, 5′-CGT CCA GAT CAT CCT GAT C-3′). Gel analysis identified the IL-6 and neoR gene fragments at 480 bp and 180 bp, respectively. We analyzed female B5 IL-6−/− MRL-Faslpr mice, using female IL-6 wild type littermate controls.

**Proteinuria/hematuria, serum urea, and creatinine.** The mice were tested for proteinuria and hematuria using albumin test strips (Albusbit; Miles, Naperville, IL, USA) at weekly intervals starting at Week 11 (Proteinauria: 0; none; 0.5; 15 mg/dl; 1, 30 mg/dl; 1.5, 100 mg/dl; 2, >2000 mg/dl. Hematuria: 0; none; 0.5, 5–10/µl; 1, 25/µl; 2, 80/µl; 3, >200/µl). Serum urea was measured using the commercial UREA/BUN kinetic UV-Test (cat. no. 1982486001V8; Roche, Mannheim, Germany). Serum creatinine was determined by the Institute of Clinical Chemistry, University Hospital of Mainz.

**Histopathology.** Kidneys were either frozen in OCT (Tissue Tek; Sakura, Zoeterwoude, Netherlands) for frozen sections or fixed in 10% neutral buffered formalin. Paraffin sections (4 µm) were stained with hematoxylin.

We evaluated kidney pathology as described. Glomerular pathology was assessed by scoring each glomerulus on a semiquantitative scale on glomerular cross-sections (gcs): 0 = normal (35–40 cells/gcs); 1 = mild; glomeruli with few lesions showing slight proliferative changes, mild hypercellularity (41–50 cells/gcs); 2 = moderate; glomeruli with moderate hypercellularity (51–60 cells/gcs), including segmental and/or diffuse proliferative changes, hyalinosis; and 3 = severe; glomeruli with segmental or global sclerosis and/or severe hypercellularity (>60 cells/gcs), nerosis, and crescent formation. We scored 20 glomerular cross-sections per kidney.

**Interstitial/tubular pathology was assessed semiquantitatively on a scale of 0–3 in 10 randomly selected high power fields. We determined the largest and average number of infiltrates and damaged tubules and adjusted the grading system accordingly: 0 = normal; 1 = mild; 2 = moderate; 3 = severe. Perivascular cell accumulation was determined semiquantitatively by scoring the number of cell layers surrounding the majority of vessel walls (0 = none; 1 = fewer than 5 cell layers; 2 = 5–10 cell layers; 3 = more than 10 cell layers). All scoring was performed on blinded slides.

**Immunostaining.** The phenotype of the renal infiltrating cells was analyzed by immunohistochemistry of frozen sections, as described; macrophages by staining with F4/80 (MCPA497; Serotec, Martinsried, Germany), T cells by anti-CD4, anti-CD8, and B cells by anti-CD20 goat anti-mouse antibodies (SC-7735; Santa Cruz Biotechnology, Santa Cruz, CA, USA). Vascular cell adhesion molecule-1 (VCAM-1) was detected by anti-VCAM/CD106 rat anti-mouse antibody (MCA1229; Serotec). The controls contained normal rat IgG, idiotypic controls, or rabbit serum as a substitute for the primary antibody. The immunostaining was analyzed by dividing the kidney into 4 compartments (perivascular, interstitial, glomerular, periglomerular) and counting the number of F4/80, CD4-positive, CD8-positive, CD20-positive, and VCAM-1-positive cells in 10 randomly selected high power fields of each compartment.

**Immunofluorescent evaluation of IgG and C3 deposits in kidney.** For light microscopy of IgG deposits, renal tissue samples were fixed in 4% formaldehyde and embedded in paraffin. Sections (4 µm) were deparaffinized, rehydrated, and incubated overnight with rabbit anti-mouse IgG polyclonal antibody (end concentration 10 µg/ml; AbD Serotec, Duesseldorf, Germany). Slides were stained with FITC-conjugated goat anti-rabbit IgG secondary antibody (end concentration 10 µg/ml; AbD Serotec).
For light microscopy C3 deposits, kidneys were embedded in OCT compound and snap-frozen in liquid nitrogen. Sections (4 µm) were incubated overnight with rat anti-mouse C3 monoclonal antibody (end concentration 1 µg/ml; ABR, Golden, CA, USA) and stained with the FITC-conjugated goat anti-rat IgG secondary antibody (end concentration 15 µg/ml; Jackson Immuno Research, West Grove, PA, USA). Slides were counterstained with DAPI and were analyzed with a fluorescence microscope (Leica DMR, with a 3CCD color video camera). The extent of IgG and C3 precipitation was assessed by titrating the antibodies on serial tissue sections using dilution steps. Semiquantitative analysis was performed on at least 50 glomeruli using a 0–3 scoring system.

Identification of apoptotic cells in kidney. Apoptotic cells in kidney sections were identified by TUNEL method (terminal deoxynucleotidyl transferase-mediated dUTP nick end-labeling) and immunoperoxidase staining (In Situ Cell Death Detection Kit; Boehringer Mannheim, Indianapolis, IN, USA).

Cytokine and chemokine expression in spleen. Splenic RNA was isolated from two IL-6-deficient mice (test group) and two control mice (control group) using the RNeasy minikit (Qiagen); 5 µg RNA was reverse transcribed using the RT2 First Strand Kit (SABiosciences, Frederick, MD, USA) according to the manufacturer’s instructions. The real-time PCR microarray for autoimmunity and inflammation (84 relevant genes) was performed using RT2 Profiler™ PCR Array (SABiosciences; PAMM-073) and the Stratagene MX3000P real-time cycler. Cytokine and chemokine expression was normalized to 5 internal controls (housekeeping genes GUSB, HPRT1, HSP90AB1, GAPD, and ACTB) to determine changes in expression between test and control group by the ∆∆Ct analysis method. All data with a 3-fold increase or decrease of gene expression in comparison to the control group were considered to be significant.

Cytokine detection. Cytokine levels were measured from serum using fluorescence-activated cell sorting (FACS). To detect mouse T helper (Th1/Th2) cytokines we used the Cytokine FlowCytomix kit (MBS720F; Bender Medsystems, Vienna, Austria) according to the manufacturer’s standards.

Determination of IgG subgroups. IgG subgroups were measured in the sera of mice by ELISA as described24 (5300-044 + 5300-1; Southern Biotech, Birmingham, AB, USA).

Statistics. The data were analyzed using the Mann-Whitney Wilcoxon test. P values < 0.05 were considered significant.

RESULTS
IL-6-deficient MRL-\textit{Faslpr} mice showed a milder course of lupus nephritis and considerable reduction in mortality. IL-6 deficiency delayed clinical manifestation of lupus nephritis. MRL-\textit{Faslpr} IL-6 \textit{--/--} mice (n = 4) showed a marked reduction of proteinuria and hematuria, with a rise only in the final 2–3 weeks of the study. The control group (n = 12) showed higher levels of proteinuria and hematuria at the beginning of the measurement, indicating an earlier decline in kidney function (Figure 1A, Table 1). In order to clinically specify renal damage, serum urea and creatinine levels were measured at the endpoint of the study. Urea levels of the female MRL-\textit{Faslpr} IL-6 \textit{--/--} mice were drastically reduced to 40 mg/dl. The control group showed median levels of 272 mg/dl (Figure 1B). In sera of IL-6-deficient MRL-\textit{Faslpr} mice, creatinine levels were below the detection limit of 0.2 mg/dl. In contrast, the control group had median creatinine levels of 0.42 mg/dl (Figure 1B). The reduction of serum levels of urea and creatinine, together with the longterm proteinuria/hematuria data, suggests that the absence of IL-6 in the MRL-\textit{Faslpr} lupus mouse model diminishes lupus activity, leading to a delayed onset of lupus nephritis.

Lifespans of test animals. The mortality rate of female MRL-\textit{Faslpr} mice is known to be 50% after 6 months24. The IL-6-deficient MRL-\textit{Faslpr} mice survived the observation period of 6 months, whereas only 25% of the control group survived to the end of the study (Figure 1C). About 41% died because of renal failure and 33% had to be sacrificed because of high proteinuria and rapid decline of general condition.

Reduction of kidney pathology and diminished infiltrating cells in kidneys. Renal pathology was reduced in MRL-\textit{Faslpr} IL-6 \textit{--/--} mice (n = 4) compared to the control group (n = 7). We found reduction of infiltrative cells and reduced kidney pathology (Figure 2). Upon specific immunohistochemical staining we detected a reduction in interstitial infiltration. Macrophages and CD4+ T cells were considerably reduced (p < 0.05; Figures 3 and 4). CD8+ T cells also showed a lower cell count (p = 0.07; Figure 3). CD4+ and CD8+ T cells were diminished in the periglomerular compartment (but p > 0.05). Detection of B cells with CD20 staining showed no difference between the 2 groups (Appendix figure 1). Apoptotic cell count was reduced in all 4 compartments (interstitial, perivascular, glomerular, and periglomerular; all p < 0.05; Appendix figure 2). VCAM-1 displayed perivascular and interstitial reduction (p < 0.05; Figure 5A, 5B). As macrophages displayed substantial reduction in all 4 compartments (p < 0.05), it seems that the improved kidney function was largely due to the diminished macrophage count.

Reduction of immune deposits in kidneys of IL-6 \textit{--/--} mice. Frozen and paraffin-embedded kidney sections were stained for IgG and C3 deposition. Glomerular immune complex deposits were detected by immunofluorescence staining in both groups. However, semiquantitative analysis showed a decrease of deposition of IgG and C3 in IL-6-knockout mice (Figure 5C; statistical data not shown).

Absence of IL-6 led to upregulation of IL-10. We measured cytokine concentrations of IL-1α, IL-2, IL-4, IL-10, IL-17, IFN-γ, TNF-α, and granulocyte-macrophage colony-stimulating factor in the sera of MRL-\textit{Faslpr} IL-6 \textit{--/--} mice and the control group. Serum levels of the antiinflammatory cytokine IL-10 were considerably elevated. MRL-\textit{Faslpr} IL-6 \textit{--/--} mice developed median IL-10 levels of 423 pg/ml compared to 186 pg/ml in control sera (p < 0.05; Figure 6A). IL-6-deficient MRL-\textit{Faslpr} mice also had elevated median levels of IFN-γ compared to the control group (518 pg/ml compared to 187 pg/ml, respectively; p < 0.05; Figure 6A).

IFN-γ is known to be a key cytokine in the development of lupus nephritis. There were no significant changes in the levels of other serum cytokines, IgG subtypes, or anti-dsDNA antibodies (Table 2).
Figure 1. IL-6 deficiency in MRL-Fas<sup>−/−</sup> mice delays lupus nephritis, shown by improved kidney function. A. IL-6 deficient MRL-Fas<sup>−/−</sup> mice (n = 4) show delayed onset and milder course of proteinuria/hematuria. Proteinuria scale: 0, none; 0.5, 15 mg/dl; 1, 30 mg/dl; 1.5, 100 mg/dl; 2, 300 mg/dl; 2.5, >2000 mg/dl. Hematuria: 0, none; 0.5, 5–10/µl; 1, 25/µl; 2, 80/µl; 3, 200/µl. The irregular diagram for the control group (n = 12) is due to early deaths of mice caused by severe glomerulonephritis. Proteinuria/hematuria measured semiquantitatively in weekly intervals. B. Serum urea levels were drastically reduced in MRL-Fas<sup>−/−</sup> IL-6 −/− mice, but did not return to baseline levels (18 mg/dl) of Fas-intact MRL mice. Serum creatinine was below the measurement range of 0.2 mg/dl, whereas the control group shows elevated levels. C. IL-6-knockout in MRL-Fas<sup>−/−</sup> mice improved survival. All IL-6-deficient mice (n = 4) survived the study period of 6 months compared to 25% in the control group (n = 12). MRL-Fas<sup>−/−</sup> mice are known to have an average mortality rate of 50% after 6 months.
Expression of markers for autoimmunity and inflammation in splenocytes. Detectable PCR products were obtained for 71/84 genes (defined as requiring < 35 cycles for both groups). Of these 71 genes, 5 were not altered, 23 were upregulated, and 43 were downregulated (Figure 6B). The \( \Delta \Delta C_t \) values of the 5 housekeeping genes (\( \text{GUSB}, \text{HPRT1}, \text{HSP90AB1}, \text{GAPD}, \text{and ACTB} \)) were similar between IL-6 \( ^{-/-} \) mice and the control group. While IL-6 was not detectable in IL-6-deficient mice, the expression of IFN-\( \gamma \) was elevated (1.7-fold); as well, 5 genes were expressed at significantly higher levels (> 3-fold upregulation) in IL-6 \( ^{-/-} \) mice compared with controls, including the proinflammatory cytokines IL2 (3.1-fold) and TNF\( \alpha \) (5.0-fold) and the interferon-stimulated exonuclease ISG20 (8.2-fold), and the chemokines CCL2 (MCP-1, 10.6-fold) and CXCL5 (ENA-78, 3.9-fold). More than 3-fold downregulation was found for CCL22 (–4.5-fold), CXCL2 (–14.9-fold), FOXP3 (–3.2-fold), IL17f (–6.6-fold), IL6ra (–4.2-fold), IL7r (–5.7-fold), STAT4 (–4.3), and TRAF6 (–3.3-fold) (Figure 6D), suggesting a broad immunomodulatory effect of IL-6 signaling. Of the T cell line-specific transcription factors, only Tbx21 (T-bet, TH1) was upregulated (2.4-fold) in IL-6-knockout mice (Figure 6C). All other factors tested were downregulated [ROR\( \gamma \)t (–1.9-fold), TH17], Gata-3 (–1.7-fold), Foxp3 (–3.2-fold), Treg), as well as the factors C/EBPbeta (–2.45-fold) and NFATc2 (–1.6-fold] or were not altered (nuclear factor-\( \kappa \)B, –1.1-fold).

Extrarenal lupus manifestation. Thirty percent of the control group developed skin lesions, whereas the IL-6-deficient mice did not. The weights of kidney and spleen showed no differences between the groups (Table 3).

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**Table 1.** Concentration of protein/erythrocyte in urine and the consecutive proteinuria/hematuria grading used in Figure 1.

<table>
<thead>
<tr>
<th>Grade of Proteinuria</th>
<th>Protein, mg/dl</th>
<th>None</th>
<th>0.5</th>
<th>1</th>
<th>1.5</th>
<th>2</th>
<th>2.5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>15</td>
<td>30</td>
<td>100</td>
<td>300</td>
<td>&gt;2000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade of Hematuria</th>
<th>Erythrocytes per µl</th>
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<tbody>
<tr>
<td></td>
<td>None</td>
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</tbody>
</table>

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Figure 2. IL-6-deficient MRL-Faslpr mice showed reduced kidney pathology. A. Representative photograph of reduced cell infiltration into the kidney illustrates reduction of glomerulosclerosis and crescent formation in IL-6 deficient MRL-Faslpr mice (n = 4) and controls (n = 7) at the age of 6 months (H&E staining, light microscopy, original magnification ×200). B. Histological analysis of glomerular, interstitial/tubular, and perivascular pathology. Glomerular pathology: 0 = normal, 1 = mild, 2 = moderate, 3 = severe. Interstitial/tubular pathology: 0 = normal, 1 = mild, 2 = moderate, 3 = severe. Perivascular pathology: 0 = none, 1 = less than 5 cell layers, 2 = 5–10 cell layers, 3 = more than 10 cell layers.

Figure 3. MRL-Faslpr IL-6 \( ^{-/-} \) mice showed reduction of infiltrating CD4 and CD8 cells in the kidney. A. Representative photographs of CD4+ cells (dark brown cells) from kidney of IL-6-deficient mice and controls (CD4+ and CD8+ staining, light microscopy, original magnification ×200). B. Histological analysis of interstitial and periglomerular reduction of infiltrating CD4+ and CD8+ cells in the kidney (p < 0.05, Mann-Whitney test).
DISCUSSION

MRL-Faslpr mice develop autoantibodies, immune complex renal injury, and disease features that closely resemble those in human SLE. The pathogenesis of this disease is characterized by the interplay of humoral, T helper (Th2)-mediated, and cellular (Th1) autoimmune responses. Yet the complex pathophysiological details of SLE remain uncertain.

IL-6 is believed to be an essential modulator of various inflammatory diseases, with a broad range of bioactivities on its target cells. Elevated concentrations of this cytokine have been found in patients with different inflammatory and autoimmune diseases. Studies showed that IL-6 correlates with disease activity and might even function as a biomarker for SLE activity. In a study by Liang, et al, NZB/NZW mice treated with anti-IL-6 monoclonal antibody showed beneficial effects on autoimmunity in murine SLE.

We tested the hypothesis that IL-6 plays an important role in the development of murine lupus nephritis. We generated IL-6-deficient MRL-Faslpr mice and monitored them for a period of 6 months. IL-6 deficiency in MRL-Faslpr mice diminishes lupus activity, leading to delayed onset of lupus nephritis. Further, it resulted in a reduction of infiltrating cells and immune complex deposition. The reduction of infiltrating cells can be explained by 2 mechanisms. First, the absence of IL-6, which is a strong activator of T cells, B cells, and macrophages, also stimulates differentiation of immature T cells to cytotoxic T cells and seems to inhibit the development of regulatory T cells. Romano, et al were able to show that in an area of inflammation IL-6 excites leukocyte recruitment and monocyte migration via the release of chemokines by endothelial cells. Thus, the reduction of these IL-6-dependent mechanisms can explain the considerable reduction of infiltrated renal macrophages, which showed the greatest reduction of infiltrating cells in all 4 renal compartments as well as the decrease of CD4+ and CD8+ T cells. IL-6-deficient mice showed decreased glomerular deposition of IgG and C3, which could also account for the prolonged survival. This finding emphasizes the improved immune status of IL-6–/– mice in comparison to controls.

The absence of IL-6 led to upregulation of IL-10 in sera of MRL-Faslpr IL-6–/– mice, a cytokine known to have antiinflammatory effects. Thus the second mechanism: high serum levels of IL-10 might also account for our results. Data from a study with rats that overexpressed IL-10 correlate with our findings that renal interstitial infiltration and renal expression of monocytes/macrophages, CD8+, and...
CD4+ T cells were reduced. Further studies showed that IL-10 is capable of inhibiting mesangial proliferative glomerulonephritis through inhibition of macrophage-induced glomerular injury. MRL-Fas<sup>dp</sup> mice with IL-10 deficiency developed exacerbated disease with heavy glomerulonephritis. Despite these antiinflammatory effects of IL-10, it is presumed to be an important modulator of disease activity in human and murine SLE; several

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**Figure 6.** Elevation of IL-10 and IFN-γ in MRL-Fas<sup>dp</sup> IL-6 –/– mice. Real-time PCR analysis of splenic mRNA of IL-6 –/– mice shows reduction of genes involved in inflammation and autoimmunity. A. Absence of IL-6 in MRL-Fas<sup>dp</sup> mice led to high serum levels of IL-10 (*p < 0.05, Mann-Whitney test). IL-10 is capable of inhibiting mesangial proliferative glomerulonephritis through inhibition of macrophage-induced glomerular injury. The control group had lower IL-10 levels. IL-6-deficient MRL-Fas<sup>dp</sup> mice showed upregulation of IFN-γ (*p < 0.05, Mann-Whitney test). Despite high IFN-γ levels, MRL-Fas<sup>dp</sup> IL-6 –/– mice had improvement of kidney function and reduction of renal pathology. B. Expression of splenic genes involved in immune regulation in IL-6-knockout and control mice. Compared to controls, 43 genes were downregulated, 23 upregulated, and 5 were unchanged (71 genes tested). C. Splenic expression of T cell subset-specific transcription factors: whereas most were downregulated, upregulation of the Th1-specific factor Tbx21 (T-bet) might indicate a reactive stimulation of the Th1 pathway. D. Splenic gene expression of IL-6-knockout and control mice: genes that show more than 3-fold altered expression in comparison to controls.

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investigations found a correlation of IL-10 to disease activity. Whereas some authors were not able to detect a correlation of IL-10 with SLE activity, a study by Llorente, et al with 7 lupus patients showed elevated serum levels of IL-10. On the other hand, a study by Ripley, et al with 171 lupus patients showed no correlation of IL-10 with SLE disease activity. Attempting to explain these discrepant results, Yin, et al proposed that IL-10 is needed in the early stages of the disease in order to prevent inflammation, but in later phases overproduction of IL-10 might lead to extensive autoantibody production and thus promote disease activity. In contradiction of this thesis, Tyrrell-Price, et al showed that peripheral blood mononuclear cells (PBMC) from lupus patients that were stimulated with IL-10 reacted differently depending on the patient’s disease activity. PBMC from patients with inactive SLE had an increase of anti-single-strand DNA and anti-double-strand DNA antibody production, whereas PBMC from patients with active disease reacted to IL-10 stimulation with reduction of body production, whereas PBMC from patients with active disease reacted to IL-10 stimulation with reduction of body production.

Table 2. IL-6-knockout in MRL-Faslpr mice had no effect on serum IgG subtype or dsDNA antibody levels. Serum IgG levels measured by ELISA.

<table>
<thead>
<tr>
<th>Antibodies</th>
<th>IgG1, mg/ml</th>
<th>IgG2a, mg/ml</th>
<th>IgG2b, mg/ml</th>
<th>IgG3, mg/ml</th>
<th>dsDNA, IU/ml</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL-6 –/–</td>
<td>1.8 ± 0.2</td>
<td>1.8 ± 0.6</td>
<td>1.2 ± 0.3</td>
<td>0.5 ± 0.2</td>
<td>12.9 ± 8.7</td>
</tr>
<tr>
<td>Controls</td>
<td>1.4 ± 0.5</td>
<td>2.1 ± 0.5</td>
<td>0.8 ± 0.3</td>
<td>0.7 ± 0.3</td>
<td>11.2 ± 4.4</td>
</tr>
</tbody>
</table>

Table 3. Weights of body, spleen, and kidney in IL-6-deficient and control mice did not differ significantly and there were no differences in grade of lymphadenopathy.

<table>
<thead>
<tr>
<th>Body Weight, g</th>
<th>Spleen Weight, g</th>
<th>Kidney Weight, g</th>
<th>Lymph Node abd/ing</th>
<th>Lymph Node med/ax/ing/ cerv</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL-6 –/–</td>
<td>30 ± 4.3</td>
<td>0.5 ± 0.4</td>
<td>0.26 ± 0.05</td>
<td>1 ± 2</td>
</tr>
<tr>
<td>Controls</td>
<td>37 ± 5.6</td>
<td>0.3 ± 0.3</td>
<td>0.25 ± 0.03</td>
<td>0.8 ± 1.5</td>
</tr>
</tbody>
</table>

All data p > 0.05, Mann-Whitney test. abd: abdominal; ing: inguinal; med: mediastinal; ax: axillary; cerv: cervical.
models and treatment of Crohn’s disease with anti-IL-6 antibodies resulted in downregulation of VCAM-1.  

IL-6 promotes cellular responses through a receptor complex consisting of at least one subunit of the signal-transducing glycoprotein gp130. IL-6 activates gp130 through a membrane-bound cognate IL-6 receptor (IL-6R) that is mainly expressed on hepatocytes and leukocytes. So how can the many biological activities assigned to IL-6 be explained? A soluble IL-6 receptor (sIL-6R) provides IL-6 with an alternative mechanism of gp130 activation. The IL-6/sIL-6R complex binds directly to cellular gp130, and thus enables IL-6 to stimulate cells that would otherwise remain unresponsive to IL-6 itself. This alternative IL-6 signaling is termed “IL-6 transsignaling.” IL-6 transsignaling is known to play a role in a number of inflammatory events. Suzuki, et al showed that serum sIL-6R levels correlated with serum IL-6 levels in MRL-lpr mice. Thus IL-6 transsignaling also contributes to the development of lupus nephritis. For example, mononuclear cell recruitment and VCAM-1 expression are known to be modulated by IL-6 transsignaling.

IL-6 deficiency was able to reduce kidney pathology and was capable of diminishing lupus activity in MRL-Faslpr mice. More research will be needed to understand the complex immune regulation of cytokines by IL-6 and IL-6 transsignaling in systemic lupus erythematosus. With the advent of the new drug tocilizumab, a humanized anti-human IL-6 receptor antibody, IL-6 now becomes a realistic new option for SLE treatment. Tocilizumab reduced disease activity in a group of 419 patients with rheumatoid arthritis and is currently in preliminary trials in patients with SLE. Another option for treatment might be found in selective blockade of IL-6 transsignaling. Hence, IL-6 will continue to be in the focus of SLE research and therapy.

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