IL-17A is functionally relevant and a potential therapeutic target in bullous pemphigoid

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\textbf{ARTICLE INFO}

\textbf{Keywords:}
Autoantibody
BP180
Bullous pemphigoid
IL-17A

\textbf{ABSTRACT}

IL-17A has been identified as a key regulatory molecule in several autoimmune and chronic inflammatory diseases followed by the successful use of anti-IL-17 therapy, e.g. in ankylosing spondylitis and psoriasis. Bullous pemphigoid (BP) is the most frequent autoimmune blistering disease with a high need for more specific, effective, and safe treatment options. The aim of this study was to clarify the pathophysiological importance of IL-17A in BP. We found elevated numbers of IL-17A+ CD4+ lymphocytes in the peripheral blood of BP patients and identified CD3+ cells as the major source of IL-17A in early BP skin lesions. IL17A and related genes were upregulated in BP skin and exome sequencing of 51 BP patients revealed mutations in eleven IL-17-related genes in 18 patients. We have subsequently found several lines of evidence suggesting a significant role of IL-17A in the BP pathogenesis: (i) IL-17A activated human neutrophils in vitro, (ii) inhibition of dermal-epidermal separation in cryosections of human skin incubated with anti-BP180 IgG and subsequently with anti-IL-17A IgG-treated leukocytes, (iii) close correlation of serum IL-17A levels and disease activity in a mouse model of BP, (iv) IL17A-deficient mice were protected against autoantibody-induced BP, and (v) pharmacological inhibition of IL-17A reduced the induction of BP in mice. Our data give evidence for a pivotal role of IL-17A in the pathophysiology of BP and advocate IL-17A inhibition as potential novel treatment for this disease.

\section{1. Introduction}

Bullous pemphigoid (BP) is a chronic subepidermal blistering autoimmune disease of the elderly associated with autoantibodies against two structural components of the dermal-epidermal junction, BP180 (type XVII collagen, Col17) and BP230 [1]. In BP, binding of anti-Col17 antibodies to the dermal-epidermal junction is a prerequisite for blister formation as shown in various experimental models [2–6]. These data are supported by the close correlation of anti-Col17 antibody serum levels with disease activity in BP patients [2,7–11]. The activation of complement and the subsequent influx of inflammatory cells into the upper dermis are crucial for the dermal-epidermal splitting that is finally mediated by reactive oxygen species and proteases such as matrix-metalloproteinase-9 (MMP-9) and neutrophil elastase [6,12–15]. The mechanisms and key mediators that lead to the infiltration of inflammatory cells and orchestrate the inflammatory milieu in the upper dermis are still largely elusive.

In contrast, in other chronic inflammatory diseases such as psoriasis, rheumatoid arthritis, and more recently, atopic dermatitis, the identification of central inflammatory mediators including TNFα, IL-6, IL-17A, IL-23, and IL-4/IL-13 have allowed the development of more specific, effective, and safe therapies [16–21]. In experimental pemphigoid diseases, inhibition of TNFα, IL-6, and IL-1β led to no or only modest reduction of diseases activity [22–24].

The aim of the present study was to (i) identify the cellular source of IL-17A in BP skin, (ii) analyze IL-17A and related genes as risk factors for BP, and (iii) explore the functional relevance of IL-17A in experimental models of BP.

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https://doi.org/10.1016/j.jaut.2018.09.003
Received 23 July 2018; Received in revised form 4 September 2018; Accepted 7 September 2018
Available online 13 September 2018
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2. Materials and methods

2.1. Human material

BP patients (n = 15) were diagnosed based on a compatible clinical picture, linear deposits of IgG and/or C3 at the dermal-epidermal junction by direct IF microscopy of a perilesional skin biopsy, and circulating autoantibodies by indirect IF microscopy on human salt-split skin (epidermal binding) and BP180 NC16A ELISA (Euroimmun, Lübeck, Germany). Whole blood and perilesional skin biopsies were taken at the time of diagnosis before therapy was initiated.

Whole blood was taken from patients with non-inflammatory dermatoses (mostly non-melanoma skin cancer) aged above 75 years (n = 12). Perilesional skin was used from patients with other inflammatory dermatoses (n = 7). Skin biopsies were stored at −80 °C. Peripheral blood cells were assayed on the same day when blood was taken. DNA from the peripheral blood of 51 BP patients diagnosed by the same criteria as outlined above, was isolated following the manufacturer's instruction (Qiagen, Hilden, Germany). DNA samples were stored at −80 °C until analyzed. The study was performed in accordance with the Declaration of Helsinki and was approved by the ethics committee of the University of Lübeck (08-156, 11-234, 12-178, 15-051). Blood from healthy volunteers for the in vitro and ex vivo studies was used on the same day. Latter studies were approved by the ethics committee of the University of Lübeck (09-140).

2.2. Cytokines in peripheral blood cells

1 × 10^6 cells from heparin-NH4-treated patient/control blood were suspended in 100 μl RPMI 1640 medium and stimulated with 250 ng/ml phorbol myristate acetate (PMA) plus 5 μg/ml ionomycin in the presence of brefeldin A (all Biolegend), a protein transport inhibitor, for 6 h at 37 °C with 5% CO2. The cells were incubated with Brilliant Violet 510™ anti-CD3 (clone UCHT1), Alexa Fluor® 700 anti-CD8a (clone RPA-T8), Brilliant Violet 711™ anti-CD14 (clone M5E2), Brilliant Violet 421™ anti-CD25 (clone M-A251), Brilliant Violet 785™ anti-CD45 (clone HI30), and Brilliant Violet 605™ anti-CD127 antibodies (clone A019D5, all Biolegend) for 30 min at room temperature (RT) and subsequently subjected to live/dead staining with Zombie NIR™ Fixable Viability Kit (1:1,000, Biolegend). Using the True Nuclear Transcription Kit (Biolegend) cells were fixed and permeabilized at RT for 75 min. Subsequently, for intracellular staining the following antibodies were incubated for 30 min at RT: PerCP/Cy5.5 anti-CD4 (clone RPA-T4), PE/Dazzle® 594 anti-IL-17A (clone BL168), Alexa Fluor® 647 anti-IL-21 (clone 3A3-N2), PE anti-IL-22 (clone BG-IL2), Alexa Fluor® 488 anti-FOX3 (clone 259D; all Biolegend), and anti-IL-17F PerCP-eFluor® 710 (clone SHL917, ebioscience, Waltham, USA). The following matched isotype antibodies were used as controls: Brilliant Violet 510™ mouse IgG1 (clone MOPC21, Biolegend), SAV-Brilliant Violet 711™ mouse IgG2a (clone MG2a-53; Biolegend), and PerCP-eFluor 710 rat IgG1 (clone eBRG1, ebioscience). After stringent washes, samples were measured by flow cytometry using Benchtop analyzer LSRII (BD Biosciences, Franklin Lakes, USA). Data were analyzed by FlowJo (Tristar, Ashland, USA).

2.3. mRNA levels of IL-17A and related mediators in the skin

Total RNA was extracted from frozen perilesional skin biopsies using RNase Mini Kit (Qiagen) according to the manufacturer’s protocol. cDNA was amplified in concentration of 500 ng using First Strand cDNA Synthesis Kit (Thermo Fisher Scientific, Waltham, USA). RT-PCR was performed using SYBR Green-gene expression assay (BioRad, Munich, Germany). Results were calculated using the 2−ΔΔCT method. Primers used to detect CCL2, CCL20, CCR6, CD4, CD8a, CSF2, CSF3, CXCL1, CXCL2, ELANE, ICAM1, IFNγ, IL10, IL12B, IL12RB1, IL17A, IL17F, IL17RA, IL17RC, IL2, IL21, IL22, IL23A, IL23R, IL27, IL4, IL6, IRF4, KLRB1, RORe, SOCS3, and TNF are detailed in Table S2.

2.4. Immunofluorescence microscopy and histopathology

H&E staining was performed according to standard protocols. For immunostaining of infiltrating cells in the perilesional skin, paraffin sections of perilesional skin biopsies were blocked with 3% bovine serum albumin (Carl Roth, Karlsruhe, Germany) in TBS. All washing steps were performed three times for 5 min in PBS-T (PBS + 0.05% Tween). The following primary antibodies were applied: rabbit anti-myeloperoxidase (1:150), mouse anti-CD3 (clone F7.2.38, 1:50), mouse anti-tryptase (clone AA1, 1:150), mouse anti-CD68 (clone PG-M1, 1:100; all Dako, Glostrup, Denmark), and rat anti-CD4 (clone YNB46.1.8, 1:300; Novusbio, Colorado, USA). As detection antibodies, donkey anti-mouse IgG Alexa Fluor® 594 (1:300; Abcam, Cambridge, USA) and chicken anti-rabbit IgG Alexa Fluor® 594 (1:200; Invitrogen, Carlsbad, USA) were used. IgG1 kappa (1:200; Biolegend) served as isotype control. DAPI staining was performed for all sections. Specimens were mounted in Fluoromount-G (Southern Biotech, Birmingham, USA) and kept at −20 °C until analyzed. Cell numbers were determined by counting fluorescent cells in relation to DAPI-positive cells in 5 visual fields of 2 sections using the BZ-9000 fluorescence microscope (Keyence, Frankfurt, Germany) and inverse confocal microscope FV 1000 (Olympus, Tokyo, Japan).

2.5. Exome sequencing

Samples were enriched using Illumina’s TruSeq Rapid Exome Enrichment Kit. Sequencing of 2 × 75 bp paired-end reads was then performed on the Illumina HiSeq 4000. Whole exome sequencing raw data was quality filtered using Trimomatic (version 0.36) [25]. Subsequently, trimmed reads were mapped to the human genome (hg19) using bwa mem (version 0.7.15) [26]. Resulting mappings were further improved by identifying duplicates (Picard tools, version 1.141), realignment around insertions and deletions (GATK, version 3.5.0) and base quality recalibration (GATK) [27]. Variant calling (single nucleotide polymorphisms and insertions/deletions) was performed using VarScan (version 2.4.3) and variants were annotated using Annovar (version 2017Jul16) and Combined Annotation Dependent Depletion (CADD, version 1.3) [28,29].

2.6. Stimulation of peripheral neutrophils with IL-17A

Neutrophils were isolated from peripheral blood of healthy adult volunteers by Polymorphprep™ (Axis-Shield, Dundee, UK) as described previously [30]. Neutrophils were left unstimulated or activated by 500 ng/ml recombinant IL-17A (Peprotech) and 10 ng/ml PMA (positive control), respectively, for 1 h at 37 °C before stained with Brilliant Violet 510™ anti-CD45 (clone HI30), Pacific Blue™ anti-CD16 (clone 3G8), APC anti-CD66b (clone G10F5), PerCP/Cy5.5 anti-CD62L (clone DREG-56), PE/Cy7 anti-CD14 (clone HCD14), PE anti-CD193 (CCR3), clone SE8), FITC annexin V, and Zombie NIR™ (all Biolegend). The activation status of neutrophils was determined by the expression of CD62L measured by MACS Quant Analyzer 10 (Miltenyi Biotec, Bergisch Gladbach, Germany).

2.7. Cryosection assay

Separation of the dermal-epidermal junction in cryosections of normal human skin was evaluated using an ex vivo model as previously described [31–33]. Briefly, normal human skin was incubated with BP patient and normal human serum, respectively, for 1 h at 37 °C. Human leukocytes purified by a sedimentation gradient with dextran 500 (Carl Roth) were added together with 100 μg, 200 μg and 300 μg neutralizing anti-IL-17A antibody and an isotype control (Novartis), respectively, and incubated for 3 h at 37 °C before intense washing with PBS. Skin
sections were stained with hematoxylin and eosin (H&E), and dermal-epidermal separation was evaluated microscopically (Keyence).

2.8. Mice

C57BL/6J mice were bred and housed at 12-h light-dark cycle at the experimental animal facility in the University of Lübeck. IL17A−/− mice were kindly provided by Yoichiro Iwakura (Tokyo University of Science, Tokyo, Japan) and bred at the experimental animal facility of the Christian-Albrechts-Universität zu Kiel. All injections and bleedings were performed on eight to twelve-week old mice narcotized by intraperitoneal (i.p.) injection of a mixture of ketamine (100 μg/g) and xylazine (15 μg/g). Animal experiments were approved by the Animal Care and Use Committee of Schleswig-Holstein (Kiel, Germany; 21–2/11) and performed by certified personnel.

2.9. Antibody transfer-induced BP in adult mice

Experimental murine BP was performed as previously described [5]. Briefly, affinity-purified rabbit anti-murine BP180 IgG was injected subcutaneously into the neck of 6- to 8-week-old mice every other day over a period of 12 days at individual doses of 10 mg IgG/injection/mouse. At the time of IgG injections, mice were weighed and examined for their general condition and evidence of cutaneous lesions (i.e., erythema, blisters, erosions, and crusts). The percentage of affected body surface area was determined on days 4, 8, and 12. Cutaneous lesions were scored as involvement of the skin surface as previously described, assigning a certain percentage of body surface to particular body parts [5].

Calculating the total percentage of affected body surface area resulted in an overall clinical score. At day 12, the mice were sacrificed, sera and biopsies were taken and stored at −20 °C until used. The anti-IL-17A antibody (clone 1F7F, BioXCell, West Lebanon, USA) and IgG1 isotype control antibody (clone MOPC-21, BioXCell) were injected at a dose of 200 μg/injection as detailed below. Serum levels of IL-17A were determined by BioPlex (BioRad).

2.10. Statistics

The data are presented as the median or mean ± standard deviation. Statistical calculations were performed using GraphPad Prism version 6 (GraphPad Software Inc, San Diego, USA). For comparison of more than two groups Two-way ANOVA with Sidak’s multiple comparisons test was used. When data were nonparametric Mann-Whitney-U test or Kruskal-Wallis test were applied followed by a Dunn posthoc comparisons test was used. When data were nonparametric Mann-Whitney-U test or Kruskal-Wallis test were applied followed by a Dunn posthoc test for multiple comparisons. Pearson product moment correlation was used to test for correlations. In all tests, a p-value of \( p = 0.001 \) but not in CD8+ cells, neutrophils, and monocytes (\( p = 0.14, p = 0.17, p = 0.19, \) respectively; Fig. 1A–D). In addition to

Fig. 1. CD4+ cells are the main producers of IL-17A in the peripheral blood of patients with bullous pemphigoid (BP). A-D, When CD4+ cells, CD8+ cells, neutrophils, and monocytes of the peripheral blood from treatment-naive BP patients and age-and sex-matched controls were analyzed by flow cytometry for their potential to produce IL-17A, significantly more IL-17A+CD4+ cells were found in BP patients compared to controls (A). No difference in the number of IL-17A producing cells between BP patients and controls were seen for CD8+ cells, (B), neutrophils (C), and monocytes (D). ***, \( p < 0.001 \).

3. Results

3.1. CD4-positive lymphocytes are the major source of IL-17A in the peripheral blood of BP patients

When CD4+ cells, CD8+ cells, neutrophils, and monocytes in the peripheral blood of BP patients (n = 15) and age- and sex-matched controls (n = 12) were analyzed for their capacity to generate IL-17A, IL-17A was only found to be significantly increased in CD4+ cells (\( p = 0.001 \)) but not in CD8+ cells, neutrophils, and monocytes (\( p = 0.14, p = 0.17, p = 0.19, \) respectively; Fig. 1A–D). In addition to

3.2. mRNA levels of IL-17A and related mediators are upregulated in perilesional skin of BP patients

mRNA levels of IL-17A and selected related cytokines, chemokines, and regulatory factors (n = 32) were analyzed in perilesional skin biopsies from patients with BP and other inflammatory dermatoses, respectively (Table S2). Eighteen genes including IL-17A were significantly upregulated while one gene, CD8, was significantly less expressed in perilesional skin of BP patients compared to controls (Fig. 2A; Table S1). When the gene regulatory network was visualized IL-17A and related cytokines, e.g., IL-22 and the neutrophil-active chemokine CXCL1 were localized in the center (Fig. 2b).

3.3. CD3-positive T lymphocytes are the main source of IL-17A in perilesional skin of BP patients

Perilesional skin biopsies of 7 BP patients were stained with antibodies against IL-17A and CD3, CD4, CD68, tryptase, and myeloperoxidase (Fig. 3A). 41% of CD3+ cells, 61% of CD4+ cells, 45% of monocytes/macrophages, 45% of mast cells, and 35% of neutrophils showed IL-17A reactivity (Fig. 3B). Since on some cells, IL-17A staining only appeared on the cell surface, only those cells were counted as IL-17A producers that showed intracellular staining for IL-17A as determined by confocal microscopy (Fig. 3A). When the IL-17A producing cells of a certain cell population were analyzed in relation to the total number of IL-17A producing cells, CD3+ cells appeared to be the main source of IL-17A representing 60% of the IL-17A producers followed by

Fig. 2. A list of proteins and genes module [34]. In this analysis, significant genes identified by RT-PCR were provided as input. STRING database within the database for searching interacting partners [35]. We only considered zero degree or direct interaction. The output “SIF” files were visualized using Cytoscape software [36].

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3.4. BP is associated with mutations in IL17A and related genes

To evaluate whether dysregulation of the IL-17 pathway in BP might be caused by genetic predisposition, we performed whole exome sequencing of 51 patients. 157 genes of the IL-17 pathway, transcription factors of IL-17, IL-17 inhibitors, and related cytokines were analyzed for germline mutations, single nucleotide variants as well as small insertion and deletions (Table S3). Using this approach in 18 (35%) of the 51 BP patients, mutations in at least one of 12 IL-17-related genes were found (Fig. 4, Table S4). Only non-synonymous mutations having a CADD score > 5 as well as known rare mutations (minor allele frequency [MAF] < 0.01) are reported (Fig. 4, Table S4).

3.5. IL-17A activates human neutrophils in vitro

When neutrophils derived from peripheral blood of healthy volunteers (n = 3) were incubated with recombinant human IL-17A (500 ng/ml for 1 h) expression of CD62L on neutrophils was significantly decreased compared with unstimulated cells indicating a higher activation of IL-17A-treated cells (Figs. S2A and B). As expected, treatment of neutrophils with PMA also led to a significant reduced CD62L expression compared to untreated cells (Figs. S2A and C).

3.6. Anti-Col17 IgG-mediated dermal-epidermal splitting is prevented by inhibition of IL-17A

Incubation of cryosections of normal human skin with anti-Col17 IgG and subsequently with leukocytes from healthy volunteers pre-treated with an isotype control antibody resulted in dermal-epidermal splitting (Fig. 5D). When leukocytes were pre-treated with 100 μg anti-IL-17A antibody dermal-epidermal split formation occurred (Fig. 5A), whereas pre-treatment with 200 μg and 300 μg prevented splitting (Fig. 5B, C).

3.7. In the antibody transfer mouse model of bullous pemphigoid, IL-17A serum levels correlate with diseases severity

When sera of wildtype mice injected with anti-murine Col17 IgG (n = 34) were assayed for IL-17A, IL-17A levels significantly correlated with the extent of lesion formation in mice (r = 0.531; p = 0.001; Fig. S3).

3.8. IL-17A−/− mice are protected from the pathogenic effect of anti-Col17 IgG

When IL-17A−/− (n = 8) and wildtype mice (n = 11) were injected with anti-Col17 IgG, wildtype mice developed significantly more erythema and erosions on the neck and ears compared to IL-17A−/− animals that were largely protected (day 4, p = 0.007; day 8, p = 0.0003; day 12, p < 0.0001) (Fig. 6A, B, E, F, I, J). No difference was seen in the deposition of IgG and C3 (data for C3 not shown) at the dermal-epidermal junction by direct IF microscopy of perilesional skin biopsies (Fig. 6C, G). While a dense inflammatory infiltrate was seen in the upper dermis of both IL-17A−/− and wildtype mice, dermal-epidermal splitting was only found in wildtype mice (Fig. 6D, H).

3.9. Pharmacological inhibition of IL-17A significantly reduced anti-Col17 IgG-induced skin lesions in mice

Wildtype mice were injected with anti-Col17 IgG on days 0, 2, 4, 6, 8, and 10. On days −2, 0, 2, 4, and 6 mice were injected with anti-IL-17A and isotype control antibody, respectively (Fig. 6K, M). After day 8, skin lesions in anti-IL-17A-treated mice (n = 8) were reduced compared to mice that received the isotype control antibody (n = 8; day 14, p = 0.01; Fig. 6K). When the same experiment was repeated with 6 mice/group and a longer observation period, again after day 8 less skin lesions were observed in the anti-IL-17A-injected compared to isotype control antibody-injected mice antibody (day 14, p = 0.04; day 16, p = 0.004, day 18, p = 0.0002; day 8–18, p = 0.02; Fig. 6 M, N).
4. Discussion

BP is the most frequent autoimmune blistering disease in Central Europe and North America with a prevalence of about 21,000 patients in Germany [37–39]. The only demonstrably effective therapies are systemic or superpotent topical corticosteroids that are, however, associated with considerable adverse events [40]. The number of severe adverse events and the increased mortality of BP patients are, at least in part, due to the corticosteroid treatment [1,41]. While recent randomized controlled clinical trials suggested some effect of doxycycline and dapsone [42,43], more specific, effective, and safe treatment options for BP are lacking.

IL-17A is a pleiotropic cytokine with particular significance at epithelial barrier sites including the skin and oral cavity. It has the ability to induce the expression of proinflammatory cytokines and chemokines in various stromal and innate immune cells [44,45]. IL-17A is of
columns have been hierarchically clustered by complete linkage. Annotation of all mutations is detailed in Table S4.

particular importance for the initiation of the immune response by mediating the influx of neutrophils and monocytes and keeping these cells at the site of inflammation [45]. In addition to its role in host defense against microorganisms the importance of IL-17A in autoimmunity and chronic inflammatory disorders such as inflammatory bowel disease and psoriasis has previously been highlighted [45-47].

Here, we explored the cellular sources and functional relevance of IL-17A and related inflammatory mediators in the pathophysiology of BP and probed IL-17A inhibition in the treatment of this disease. In the peripheral blood of BP patients, CD4+ lymphocytes, but not CD8+ cells, neutrophils, and monocytes generated IL-17A. Peripheral CD4+ cells from BP patients also produced elevated levels of IL-22. These data indicate that inflammation in BP is not confined to the skin but also involves circulating Th17 cells. To address the IL-17 network in the skin, mRNA levels of IL-17A and related inflammatory mediators in the perilesional skin of BP patients were compared to levels in patients with other inflammatory dermatoses. Upregulation of IL17A, IL17RC, CCR6, and IL23R point to an activated IL-17 network at the site of blister formation. IL-17A is a strong inducer of CXCL1 and CXCL2 expression [44] and the finding of upregulated CXCL1 and CXCL2, encoding powerful chemoattractants for neutrophils, and upregulated ELANE, encoding for neutrophil elastase, validate previous data about the importance of neutrophils and neutrophil elastase in the pathogenesis of BP [13,48-50].

The central role of IL-17A, IL-22, and CXCL1 in the dermal immune network of BP was also highlighted by the gene regulatory network of significantly regulated genes in BP patient skin. Of interest, although not in the focus of this study, increased mRNA levels of anti-inflammatory mediators, such as IL-10 were found in BP skin indicating that mechanisms of resolution of inflammation maybe in place.

To identify the major producer of IL-17A in early skin lesions, the most abundant cell populations that are known to express IL-17A, i.e. neutrophils, macrophages, CD3+ lymphocytes, and mast cells were analyzed for IL-17A expression. By confocal microscopy, we excluded cells that showed IL-17A staining on the cell surface [51] assuming that in these cells, IL-17A was bound to the ubiquitously expressed IL-17RA/IL-17RC e.g. on different T cell subsets and neutrophils [52,53]. By this method, we found CD3+ lymphocytes to be the major source of IL-17A in BP skin accounting for 60% of the IL-17A-producers. Since here, early BP lesions without split formation were analyzed and cells bearing IL-17A on their surface were not counted our data may reconcile contradictory findings of previous studies that described lymphocytes [54], Th17 cells [55,56], and neutrophils [48] as major source of IL-17 in BP skin.

Since BP is a relatively rare disease with an incidence of about 14–42 new patients/million/year in Central Europe and the UK [1], we decided to perform exome sequencing of 51 BP patients to detect rare mutations associated with BP. One third of the patients showed rare, but mostly severe mutations in the coding regions of 12 IL-17-related genes. While none of the mutations was homozygous, they could have a modulatory effect on the IL-17 pathway activity. The most prevalent genes were related to NFKB signaling, such as IKKB, NFKB1 and MUC5B. Incorrect activation of NFKB is associated with inflammatory diseases and constant inhibition of NFKB leads to incorrect immune cell development or delayed cell growth. MUC5B was most commonly mutated in our patients. It has been shown to play a role in the airway defense and its deficiency leads to chronic infection [57]. Further studies will need to validate these findings in other BP patient cohorts and analyze whether mutations in IL-17-related genes are associated with certain clinical or immunopathological characteristics.

We then explored the functional relevance of IL-17A for BP in five different approaches. We showed that (i) IL-17A activated normal human neutrophils in vitro, (ii) the dermal-epidermal splitting induced by anti-Col17 IgG was abrogated by incubation of leukocytes with anti-IL17A antibody, and (iii) serum levels of IL-17A closely correlate with the extent of skin lesion in experimental BP in adult mice. Our findings are in line with previous reports on the increased secretion of MMP-9 from neutrophils by IL-17A and CXCL10 [48,58]. MMP-9-deficient mice
were resistant to anti-Col17 IgG-induced skin lesions and CXCL10 expression in macrophages and keratinocytes was shown to be induced by IL-17A [58–60].

In additional two approaches (iv), and (v), further evidence for the importance of IL-17A in the pathophysiology of BP was generated. IL-17A−/− mice were nearly completely protected against the otherwise pathogenic effect of anti-Col17 IgG and anti-Col17 IgG-injected mice showed significantly reduced skin lesions when treated with an anti-IL-17A antibody compared to animals that received the isotype control antibody. Latter finding suggested pharmacological inhibition of IL-17A being a rational treatment approach in BP. Further studies in experimental murine BP will aim at identifying the main target cell of IL-17A in skin lesions to further explore how IL-17A exerts its effect in BP.

The presented data indicate that IL-17A has a functional role in BP and suggest anti-IL-17A therapy being a rational and promising therapeutic approach in patients with severe BP.

Conflicts of interest

D.T. has received honoraria or fees for serving on advisory boards, as a speaker, as a consultant for Lilly, Leo-Pharma, Novartis and UCB,
and grants from Novartis. D.Z. received honoraria from UCB and travel fees from Novartis and UCB. R.J.L. and E.S. received honoraria and travel fees from Novartis as well as honoraria from UCB.

Acknowledgement

We are grateful to Vanessa Krull and Ingrid Dahlke, Lübeck, for excellent technical support. We thank Franziska Schulze, Lübeck, for help with the animal experiments and supervision of L.C. and Yask Gupta, Lübeck, for generating the gene regulatory network. We also thank Yoichiro Iwakura for providing breeding pairs of IL-17A⁻/⁻ mice and greatly appreciate the effort of Sarah Vieten, Gerhard Schulteß, animal care takers at the Christian-Albrechts-Universität zu Kiel. The study was supported by Deutsche Forschungsgemeinschaft through the Research Training Group 1727 Modulation of Autoimmunity (to C.M.M.H., C.H., and E.S.), the Clinical Research Unit 303 Pemphigoid Diseases (to S.M.I., C.D.S., D.Z. and E.S.), and structural funding through the Excellence Cluster Inflammation at Interfaces (to D.T., S.I., D.Z., R.L., and H.B.). The in vitro studies were funded in part by a research grant of Novartis (to E.S.).

Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.jaut.2018.09.003.

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