Correlation of interleukin-2 and soluble interleukin-2 receptor with clinical activity of multiple sclerosis

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Abstract

Concentrations of interleukin-2 (IL-2) and soluble IL-2 receptor (sIL-2R) in serum and CSF samples were measured in 63 patients with multiple sclerosis (MS) to evaluate their usefulness as markers of disease activity. CSF concentrations of IL-2 and sIL-2R were significantly higher in MS relapse compared with MS patients in remission or with control subjects. These concentrations correlated with the clinical score by which disease severity was assessed, with the number of relapses per year, and with the total disease duration. Furthermore, there was evidence of intrathecal release of IL-2 and sIL-2R in clinically active MS. The results extend the notion that an activated cellular immune state parallels the evolution of the pathological process in MS and suggest that measurement of IL-2 and sIL-2R concentrations may provide an objective marker of disease activity in patients with MS.

There is increasing evidence that elevated concentrations of interleukin-2 (IL-2) and its soluble receptor may reflect the clinical course of multiple sclerosis (MS). T lymphocytes expressing IL-2 or IL-2 receptor have been detected in demyelinated plaques in brains obtained at necropsy of patients with active MS. Clinical studies have also reported increased concentrations of IL-2 in serum or CSF of patients with clinically active MS, and serum or CSF levels of soluble IL-2 receptor (sIL-2R) were shown to be significantly higher in patients with active MS compared with patients in remission. Moreover, Hartung et al reported that serum concentrations of sIL-2R apparently paralleled MS disease activity although these concentrations did not correlate with the clinical score by which disease severity was assessed.

For the clinician, assessment of disease activity in MS patients is important not only from a prognostic view point, but also to monitor the efficacy of therapeutic interventions. Although MRI can visualise lesion dissemination, assessment of disease activity in MS is essentially clinical, relying on evidence of a relapse or increasing disability. These clinical measures, however, do not suffice because of intrinsic variability of the disease and subjective differences between clinical observers. We therefore elected to determine whether intrathecal levels of IL-2 and sIL-2R in MS correlate with clinical disease activity. We measured concentrations of IL-2 and sIL-2R in serum and CSF samples from MS patients in relapse and remission, and compared the results with levels of IgG index which estimates the intrathecal humoral immune response.

Patients and methods

Patients

We obtained paired serum and CSF samples from 63 patients (39 women and 24 men; median age, 27-2 years; age range, 20-5 to 50 years) with clinically definite MS. The median duration of the illness was 5.2 years (range, 1-2 to 14-5 years). All had relapsing-remitting disease with high pretest relapse rates (at least 0-7 per year) and 42 patients were in clinical relapse during CSF collection. We defined the relapse phase as within 2 weeks of worsening of existing symptoms(s) provided that the course has been stationary or has improved during the previous month. Remission was defined as improvement in symptoms or signs for at least one month. No patient involved in the study has received immunosuppressive treatment for at least 8 months from the CSF collection. The degree of disability at the time of CSF collection was assessed with the expanded disability status scale (EDSS).

Controls

Twenty six patients with non-inflammatory nervous diseases were included in the study to serve as neurological controls. Their diagnoses included Alzheimer’s disease (5 patients), motor neuron disease (6 patients), benign intracranial hypertension (4 patients), cerebrovascular diseases (7 patients), and epilepsy (4 patients). Paired samples were also obtained from 14 normal subjects who presented with non-specific headache or neurotic syndromes to serve as normal controls. Neurological examination and detailed investigations of the normal controls had excluded an organic cause of their symptoms.

Sample preparation

We excluded xanthochromic CSF samples or samples containing more than 1 erythrocyte per μl at the time of collection. All samples were filtered through a 0.45-μm disposable sterile filter (Millipore) to remove contaminat-
ing particulate materials. One thousand kallikrein inhibitor units of protease inhibitor (Aprotinin, Sigma, UK) were added to each millilitre of CSF and serum samples to prevent protein degradation. Samples were then frozen in aliquots at −70°C and thawed just before use.

**CSF assays**

All assays were performed blind on coded sterile samples. Concentrations of IL-2 in native CSF and diluted serum were determined by a sensitive indirect enzyme-linked immunosorbent assay (ELISA). Inter-assay variation was a maximum of 8-2% and intra-assay variation was less than 5%. The assay allowed the detection of IL-2 concentrations above 0·05 units per ml (U/ML). Concentrations of sIL-2R in CSF and diluted serum specimens were measured by a sandwich ELISA using two different anti-IL-2R monoclonal antibodies; the first is adsorbed onto polystyrene microtitre wells and the other is peroxidase-conjugated. Inter-assay variation was less than 8-5% and intra-assay variation was a maximum of 2%. The lowest amount of sIL-2R detected by this assay was 0·1 U/ML.

Albumin and IgG concentrations in CSF and serum specimens were determined by electrophoresis assay. Synthesis of IgG within the central nervous system (that is, intrathecal) was determined by calculating the IgG index according to the following formula: CSF IgG/serum IgG ÷ (CSF albumin/serum albumin).

**Statistics**

Non-parametric Wilcoxon sum rank, Pearson correlation matrix, and chi-square tests were used, as appropriate, for statistical analysis. Confidence intervals (CI) for non-parametric data were calculated as described earlier.

**Results**

**Concentrations of IL-2 and sIL-2R in MS**

High concentrations of IL-2 were detected in the CSF of 32 (80%) patients with clinically active MS, 6 (29%) MS patients in remission and 3 (8%) controls (2 with acute stroke and 1 with post-traumatic epilepsy; fig 1). CSF IL-2 concentrations in MS relapse were significantly higher than MS patients in remission or controls, whereas serum concentrations of IL-2 in MS relapse were not significantly different from those in remission (fig 1). The IgG index also failed to differentiate between MS patients in relapse and those in clinical remission (p = 0·11). Indeed, high IgG index values were also seen in 4 neurological controls (fig 1: 2 strokes, 1 motor neuron disease, and 1 benign intracranial hypertension).

CSF concentrations of IL-2 in MS patients in relapse correlated with CSF concentrations of sIL-2R (r = 0·719, p < 0·001). MS patients in relapse had significantly high levels of sIL-2R in the CSF compared with MS patients in remission or controls (fig 2), whereas no significant difference was detected between serum levels of sIL-2R in MS relapse and remission (p = 0·07).

**Intrathecal cytokine release in clinically active MS**

We standardised levels of IL-2 and sIL-2R in CSF and serum of MS patients in relapse by calculating their ratios to albumin concentrations, as previously described, to correct for passive transudation through blood-CSF barriers. Standardised CSF concentrations of IL-2 (95% CI of 2·3 to 10·1 U/mg of albumin) were significantly higher than corresponding serum levels (95% CI of 0·17 to 0·73 U/mg of albumin), suggesting local release of IL-2 within the intrathecal compartment. Similarly, standardised sIL-2R levels in CSF (95% CI of 139 to 243 U/mg of albumin) were significantly higher than serum levels (95% CI of 1·4 to 5·4 U/mg of albumin), indicating intrathecal release of sIL-2R in clinically active MS. Calculation of cytokine index values also detected intrathecal release of IL-2 and sIL-2R in patients with active MS (data not shown).

**Cytokine levels and clinical features of MS**

CSF concentrations of IL-2 and sIL-2R correlated with the degree of disability, as manifested by EDSS, in patients with clinically active disease (table 1). In contrast, serum levels of IL-2 or sIL-2R in these patients failed to correlate with the EDSS score. Similarly, CSF levels of IL-2 and sIL-2R in remission did not correlate with degree of disability. IgG index values in patients with clinically active MS correlated with the EDSS score (table 1).

In addition to their correlation with the degree of disability, CSF concentrations of IL-2 and sIL-2R in clinically active disease showed good correlation with the total number of relapses per year, and correlated inversely with total disease duration. Interestingly, serum concentrations of IL-2 and sIL-2R in clinically active MS also correlated with total disease duration (r = 0·36 and 0·32 respectively), whereas IgG index values failed to correlate with total disease duration or the number of relapses per year (table 1).

**Discussion**

In this study, we detected higher CSF concentrations of IL-2 and sIL-2R in patients with...
clinically active MS compared with patients in remission or neurological controls. These results agree with several independent studies, which detected high concentrations of IL-2 or sIL-2R in the CSF of patients with clinically active MS (table 2). Fesenmeier et al., however, were the only research group who failed to detect sIL-2R in the CSF of patients with active disease, probably because of differences in patients selection or methodological variations. Adachi et al. and Kittur et al. detected sIL-2R in the CSF of all the MS patients they investigated.

The serum and CSF concentrations of IL-2 reported here are relatively higher than those published in an earlier unrelated study. This difference may be due to several factors. First, the samples utilised in the earlier study did not contain a protease inhibitor and may have endured spontaneous IL-2 and sIL-2R degradation since we have consistently shown that the protease inhibitor improves cytokine detection by more than fivefold. Second, commercial ELISA kits were used to detect IL-2 in the previous study whereas a highly sensitive immunoassay was employed in this study. Finally, differences in patients selection may have contributed to the variation in IL-2 concentrations between the two studies.

Our study shows significant correlation of CSF IL-2 and sIL-2R concentrations with the degree of disability in MS as assessed by EDSS. Trotter et al. have already reported significant correlation of serum IL-2 levels with the degree of disability in patients with progressive MS. They acknowledged, however,
that serum levels of IL-2 may not necessarily be derived from peripheral lymphocytes, since cells staining for IL-2 may be found in plaque areas in brains of MS patients. We further extend their findings by reporting a significant correlation of CSF levels of IL-2 and sIL-2R with the degree of disability and relapse activity in relapsing-remitting MS.

The other interesting finding of this study is the higher standardised CSF levels of IL-2 and sIL-2R patients with clinically active MS compared with corresponding serum levels. This finding suggests a local release of IL-2 and its soluble receptor within the intrathecal compartment. Interleukin-2 is usually detected in both active plaques and normal appearing white matter in MS brains,\textsuperscript{34} and IL-2R-bearing lymphocytes are found in the perivascular infiltrates in MS brain lesions.\textsuperscript{5} Thus intrathecal release of IL-2 or sIL-2R may result during an active immunological process.

Indeed, local central nervous system secretion of IL-2 or sIL-2R has been demonstrated in conditions associated with an intrathecal immune response.\textsuperscript{29-31}

A successful immune response involves a complex cascade of events which include the production of cytokines. IL-2, a pluripotent cytokine secreted by activated T lymphocytes,\textsuperscript{35} plays an essential role in promoting replication and differentiation of T lymphocytes, induction of B lymphocytes growth, and augmentation of immunoglobulin production. It exerts its pleiotropic effects via its specific high affinity receptor, which is present on activated T and B cells, natural killer cells, monocytes, oligodendrocytes\textsuperscript{34} and endothelial cells.\textsuperscript{35} Cell proliferation after the binding of IL-2 to its membrane receptor leads to the release of the soluble IL-2 receptor.\textsuperscript{36}

The mechanism by which intrathecal release of IL-2 and sIL-2R relates to the degree of
Correlation and this disease.  


31 Lang JM, Cournarios G, Levy S, et al. Elevated serum levels...