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A Novel Adjuvant for Mucosal Immunity to HIV-1 gp120 in Nonhuman Primates[1]

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The development of a safe and effective mucosal adjuvant is a crucial step toward a mucosal HIV/AIDS vaccine. This study seeks to determine the promise of a nontoxic mutant of cholera toxin (mCT; E112K) as a mucosal adjuvant in nonhuman primates. HIV-1 gp120 was nasally administered together with mCT E112K or native CT (nCT) as adjuvant on five to six occasions over a 6- to 8-wk period to groups of four rhesus macaques and alone to two monkeys that acted as controls. Macaques given nasal gp120 with either mCT E112K or nCT showed elevated gp120-specific IgG and IgA Ab responses with virus-neutralizing activity in both their plasma and mucosal external secretions, as well as higher numbers of gp120-specific IgA Ab-forming cells in their mucosal and peripheral lymphoid tissues and of IL-4-producing Th2-type CD4-positive ($CD4^+$) T cells than did controls. Even though significant mucosal adjuvanticity was seen with both mCT E112K and nCT, neuronal damage was observed only in the nCT-treated, but not in the control or mCT E112K-treated groups. These results clearly show that mCT E112K is an effective and safe mucosal adjuvant for the development of a nasal HIV/AIDS vaccine. *The Journal of Immunology,* **2004, 173: 6850–6857.**

It is well known that HIV-1 infections occur through contact with contaminated blood or during unprotected vaginal or anal intercourse. Indeed, it is estimated that 70–85% of HIV-1 infections are transmitted sexually (1–3). Given that fact, immune responses at mucosal surfaces in which the virus crosses the epithelium of the genital or rectal tracts are an essential component of vaccine-induced protection. The evidence for an association between mucosal immune responses and protection in humans has stemmed from studies on the immune system of women who remained seronegative despite a high rate of exposure to HIV-1. High levels of secretory IgA were detected in the genital secretions of the protected women (4–7). Because the mucosa of the small and large intestine are the largest source of lymphocytes and APCs in the host (8, 9), they act as a potential reservoir for HIV-1-infected cells in viral pathogenesis (10). Studies to develop a HIV/AIDS mucosal vaccine have been conducted in nonhuman primate (NHP)[4] models by using recombinant SIV proteins or peptides (11–17), live-attenuated SIVs (18–23), SIV-encoded virus or bacterial vectors (24–29), DNA vaccines (30–33), and a prime/boost regimen (34–36). Collectively, these studies point to the importance of a mucosal HIV/AIDS vaccine for the prevention of HIV-1 infection.

Recent studies have shown that nasal immunization is the most effective approach for the induction of both mucosal and systemic immune responses (37). For example, nasal immunization with protein/peptide vaccines together with mucosal adjuvant more effectively induces mucosal immunity in the female reproductive tract than does oral immunization (38). Like its gut-associated lymphoreticular tissue counterpart in the gastrointestinal tract, the nasopharyngeal-associated lymphoreticular tissue-based immune system is key to the induction of Ag-specific mucosal and systemic immune responses (39–41). In this regard, we have shown that nasal immunization of rhesus macaques with SIV $p55^{gag}$ together with native cholera toxin (nCT) as mucosal adjuvant induced $p55^{gag}$-specific IgA and IgG Ab responses in vaginal secretions (16).

Although a potent mucosal adjuvant, nCT is not practical for use in humans because of its toxicity. Nasal application of CT B subunit (CT-B) or nCT resulted in its accumulation in the olfactory bulbs of the CNS through GM1 binding and in its subsequent retrograde axonal transport into the olfactory neurons (39). Furthermore, nCT is known to induce high levels of total and Ag-specific IgE Ab responses due to the nature of IL-4-dependent adjuvanticity (40–43). To overcome these potent pathological problems of nCT, we have developed and characterized two nontoxic mutants of cholera toxin (mCT; E112K and S61F) that retain adjuvant properties despite lacking the ADP-ribosyltransferase enzyme activity associated with toxicity (42, 43). Studies by our own group and by others have shown that mutant CT E112K is one of the most effective, safe, and stable adjuvants among the toxin-based mutants that have been tested (41–43).

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[4] Abbreviations used in this paper: NHP, nonhuman primate; AFC, Ab-forming cell; LP, lamina propria; mCT, nontoxic mutant of cholera toxin; MLN, mesenteric lymph node; nCT, native cholera toxin; NGF, nerve growth factor; NP, nasal passage; SMG, submandibular gland.

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Because HIV-1 is most often transmitted via mucosal surfaces, a mucosal vaccine capable of inducing protective Abs and/or CTLs in mucosal tissues and external secretions would act as a first line of defense at the site of initial invasion. We take the first step toward the ultimate goal of developing a safe and effective mucosal adjuvant for a mucsoal HIV/AIDS vaccine in humans by assessing in this study the efficacy and safety of mCT E112K as a mucosal adjuvant in nonhuman primates.

Materials and Methods

HIV-1 immunogen and adjuvant used

HIV-1_{LAI} *Env* gp120 was kindly provided by Quality Biologicals (Gaithersburg, MD) through Contract N01-AI 65278 of the Vaccine Research and Development Branch, Division of AIDS, National Institute of Allergy and Infectious Diseases, National Institutes of Health. *Escherichia coli* strains containing the plasmids for the mCT E112K were grown in Luria-Bertani medium (10 mg/ml NaCl, 5 mg/ml yeast extract, 10 mg/ml tryptone) with 100 μg/ml ampicillin (42, 43). The mCT E112K was purified using a D-galactose-immobilized column (Pierce, Rockford, IL) from a cell suspension prepared by sonication of the recombinant *E. coli*, as described previously (42, 43). The purity of mCT E112K was assessed by SDS-PAGE, and no contaminating proteins were noted. The nCT was purchased from List Biological Laboratories (Campbell, CA).

Rhesus macaques

Five mature female and seven male rhesus macaques (*Macaca mulatta*), bred in captivity and reproductively cycling, were obtained from the California Regional Primate Research Center (Davis, CA). They were confirmed negative for Abs to HIV-2, SIV, type D retrovirus, and simian T cell lymphotropic virus-1 (STLV-1), and were maintained in conditions that fully complied with the standards of the American Association of Accreditation of Laboratory Animal Care at the California Regional Primate Research Center.

Immunization methods and schedule used

Rhesus macaques were divided into four groups and nasally immunized with vaccine containing: 1) 100 μg of gp120 alone, 2) 100 μg of gp120 plus 10 μg of nCT, 3) 100 μg of gp120 plus 25 μg of mCT E112K, or 4) 100 μg of gp120 plus 100 μg of mCT E112K. Macaques were anesthetized with ketamine and placed in dorsal recumbancy with head tilted back so that the nares were pointed upward (16). Vaccine solution (0.5 ml) was instilled dropwise into each nostril without inserting the syringe into the nasal cavity. Macaques were kept in that position for 10 min and then placed in lateral recumbancy until they recovered from anesthesia, as described previously (16). Nasal immunization was conducted on days 0, 7, 14, 28, 42, and 56.

Collection of peripheral blood, tissues, and external secretion samples and lymphocyte isolation

Tissues and peripheral blood were harvested using sterile techniques, and appropriate biohazard precautions were observed. The PBMCs were isolated from heparinized peripheral blood using Lymphocyte-Mammal (Cedarlane Laboratories, Hornby, Canada) (44). Plasma, vaginal washes consisting of a mixture of cervical and vaginal secretions, rectal washes, nasal washes, and saliva were collected, as previously described (16). These four external secretions along with the plasma were stored at −80°C until used for the analysis of gp120-specific Ab responses. For isolation of lymphocytes from different mucosal tissues, a modified enzymatic dissociation procedure was used (15, 16). Nasal passages (NP) and submandibular glands (SMG) were dissociated using collagenase type IV (0.5 mg/ml; Sigma-Aldrich, St. Louis, MO) in RPMI 1640 (Mediatech, Washington, DC) for 30 min at 37°C. After removal of Peyer's patches, the small intestine was treated first with PBS containing 1 mM DTT and then with 1 mM EDTA, while lamina propria (LP) mononuclear cells were isolated using the same method as for the NPs. The lymphocytes from tissues were purified using a discontinuous 40 and 75% Percoll gradient (Amersham Biosciences, Piscataway, NJ), as described previously (15, 16).

Monoclonal Abs

The mAbs used for cell surface staining in flow cytometric analysis were as follows: FITC-, PE-, or PerCP-conjugated mAb to human CD3 (SP34; BD Biosciences, San Jose, CA), CD4 (SK3; BD Biosciences), and CD8 (SK1; BD Biosciences). Cross-reactivity of these mAbs for the rhesus macaque was determined using the method described previously (45). However, the observed cross-reactivity with IL-5, IL-10, and IL-13 is a new finding and has not been published previously.

HIV-1 env *gp120-specific ELISA and ELISPOT assays*

HIV-1 *env* gp120-specific IgG, IgM, and IgA Ab titers in plasma, saliva, nasal washes, as well as rectal and vaginal lavages were determined by ELISA, as described previously (15, 16). The HIV-1 *env* gp120-specific IgG, IgM, and IgA Ab-forming cells (AFCs) were also determined by ELISPOT assay, as described elsewhere (15, 16).

Cytokine-specific ELISPOT assay

The PBMCs or lymphoid cells from various tissues were cultured in 10% FCS containing RPMI 1640 (Mediatech) supplemented with HEPES buffer (10 mM), L-glutamine (2 mM), nonessential amino acid solution (10 ml/L), sodium pyruvate (10 mM), penicillin (100 U/ml), streptomycin (100 μg/ml), and gentamicin (80 μg/ml) (complete medium) with or without 5 μg/ml HIV-1 *env* gp120, 1 μg/ml anti-human CD28 (CD28.2; BD Biosciences), and anti-human CD49d (9F10; BD Biosciences) mAbs at 37°C with 5% CO_2. Nonadherent cells were harvested after 3 days of incubation and stained with anti-human CD3 and CD8 mAbs. The FACSVantage (BD Biosciences) was used to sort out a subset of $CD3^+CD8^-$ T cells. The frequencies of $CD4^+$ Th1- and Th2-type cytokine-producing cells were determined by using rhesus macaque cytokine-specific ELISPOT kits (U-CyTech, Utrecht, The Netherlands).

In vitro HIV-1 neutralization assay

The diluted plasma or appropriate mucosal secretion was heat inactivated (56°C for 30 min) and incubated with 20 $TCID_{50}$ (50% tissue culture infective dose) units of HIV-1_{LAI} overnight at 4°C. This mixture was then cocultured with 1×10^6 M8166 cells for 2 h (16, 46, 47). After being washed twice with PBS, the cells were cultured in complete medium for 4 days at 37°C. Following incubation, culture supernatants were subjected to Lumipulse (chemiluminescence enzyme immunoassay/full automatic analyzer; Fujirebio, Tokyo, Japan) for measurement of HIV p24. The results were expressed as the percent inhibition of p24 *gag* production in culture supernatants when compared with the cultures containing pre- or nonimmunized plasma or mucosal secretions (16, 46, 47).

Nerve growth factor-β1 (NGF-β1) production in macaque olfactory tissues

The nasal turbinate region of the olfactory tissues was obtained from each macaque at the time of sacrifice. At the termination of the study, the nasal turbinate was perfused with PBS at 25°C. This was followed by perfusion with 100 ml of Zamboni's fixative (4% paraformaldehyde, 15% picric acid) in 0.1 M phosphate buffer. The olfactory bulbs and tubinates were removed and placed in fresh 4% paraformaldehyde at 4°C overnight. The tissue was then transferred to a 30% sucrose solution at 4°C for 48 h to cryoprotect it before sectioning. The tissue was then frozen in OCT compound, and the frozen sections (6 μm) were placed on precoated microscope slides (10% BSA in saline). For staining of sections, all slides were pretreated with rabbit IgG Ab to block nonspecific binding, followed by a biotinylated rabbit anti-human NGF-β1 Ab (Chemicon International, Temecula, CA) used at a concentration of 2 μg. The Ab-stained sections were incubated at 4°C overnight. The slides were then rinsed in three changes of PBS for 2 min and then reacted with avidin-biotin conjugate for 30 min at 25°C. The tissues were rinsed three times with PBS, and then reacted with 3,3′-diaminobenzidine (Vector Laboratories, Burlingame, CA) for 5–10 min before being again rinsed three times and having sections counterstained with hematoxylin for 30 s. After being washed in distilled water, the slides were dehydrated in 100% alcohol and xylene. In some experiments, the anti-NGF-β1 Ab-stained sections were incubated with HRP-conjugated streptavidin-Alexa Fluor 488 (Molecular Probes, Eugene, OR). Sections were examined with a fluorescence microscope (BX50/BXFLA; Olympus, Tokyo, Japan) equipped with a digital image capture system (Olympus).

Statistics

The results are expressed as the mean ± SEM. Immunized NHP groups were compared with the controls using a Mann-Whitney *U* test with Statview II software (Abacus Concepts, Berkeley, CA) designed for Macintosh computers. A p value of <0.05 or less was considered significant.

Results

Plasma anti-gp120-specific Ab responses

In this study, we have assessed the mucosal adjuvanticity of mCT E112K in rhesus macaques nasally immunized with HIV-1 gp120. Eleven macaques were given 100 μg of gp120 by the nasal route. In addition to the gp120, five macaques were given two doses of mCT E112K as nasal adjuvant, two (Rh09 and Rh91) receiving a 25 μg dose and three (NHPs Rh16, Rh39, and Rh85) receiving a 100 μg dose. As a positive control, and because our previous research showed that nCT is a potent nasal adjuvant for NHPs (16), four other macaques (Rh07, Rh35, Rh60, and Rh88) were given 10 μg of nCT along with gp120. As a negative control, the two remaining macaques (Rh43 and Rh51) were given gp120 alone. The gp120-specific IgG and IgA Abs in plasma of individual macaques were sequentially assessed by an endpoint ELISA. As expected based upon our previous studies (16), significant levels of gp120-specific IgG Ab responses were detected in plasma of all macaques given gp120 with nCT (Fig. 1; $p < 0.01$). Interestingly, comparable gp120-specific IgG Ab responses were observed in macaques receiving 100 μg of mCT E112K as nasal adjuvant (Fig. 1; $p < 0.01$), while much lower levels of these responses were noted in macaques receiving 25 μg of mCT E112K as nasal adjuvant ($p > 0.1$). Furthermore, the group receiving 100 μg of mCT E112K showed comparable gp120-specific plasma IgA Ab responses to those receiving nCT as mucosal adjuvant. In contrast, the two macaques given gp120 alone or those receiving only 25 μg of mCT E112K showed low to undetectable IgA Ab responses. When gp120-specific plasma Ab responses were compared between the two groups given 25 or 100 μg of mCT E112K groups, the group given the higher dose showed greater IgG ($p < 0.01$) and IgA Ab responses than did the group given 25 μg of mCT E112K. Taken together, these results show that 100 μg of mCT E112K is an appropriate dose for inducing HIV-1 gp120-specific plasma Ab responses.

Induction of gp120-specific mucosal immune responses

The gp120-specific IgA and IgG Ab titers were assessed in the mucosal secretions (saliva; nasal, vaginal, and rectal lavages) of macaques given nasal gp120 and mCT. The peak titers of IgG and IgA Abs occurred 7 or 14 days after the last nasal immunization

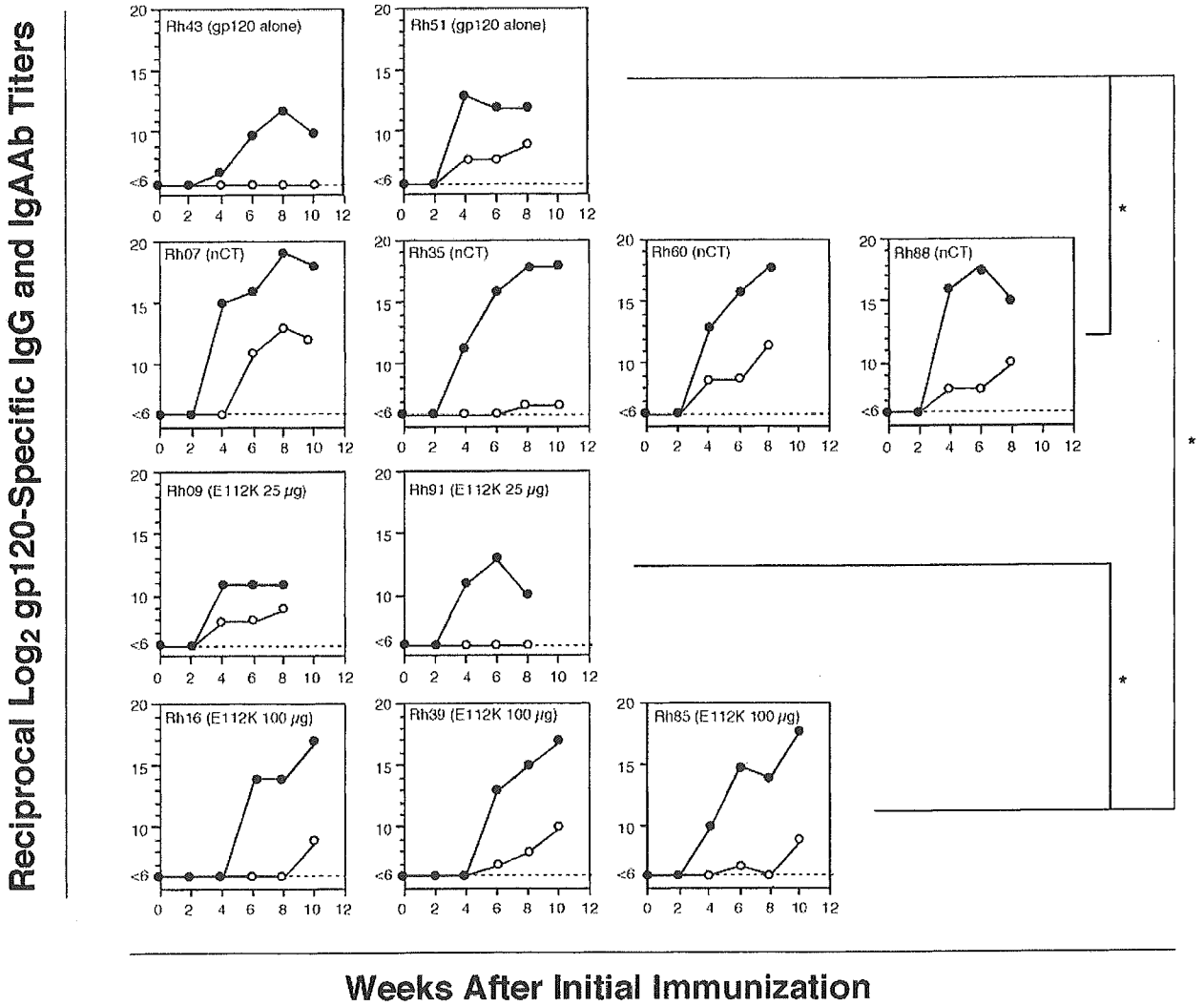

FIGURE 1. HIV-1 gp120-specific plasma IgG (●) and IgA (○) Ab titers were determined by endpoint ELISA. Rhesus macaques were nasally immunized with 100 μg of gp120 alone (Rh43 and Rh51), 100 μg of gp120 and 10 μg of nCT (Rh07, Rh35, Rh60, and Rh88), 100 μg of gp120 and 25 μg of mCT E112K (Rh09 and Rh91), or 100 μg of gp120 and 100 μg of mCT E112K (Rh16, Rh39, and Rh85). The data shown are endpoint titers for each macaque. *, $p < 0.01$ for IgG titers.

Table I. *gp120-specific Ab responses in mucosal secretions of rhesus macaques given a nasal vaccine*

Nasally Immunized with		Identification Number of Macaque	Anti-gp120-Specific Reciprocal Log_2 Ab Titers[a]							
			Saliva		Nasal washes		Vaginal washes		Rectal washes	
gp120	Adjuvant		IgA	IgG	IgA	IgG	IgA	IgG	IgA	IgG
100 (μg)	E112K (25 μg)	Rh09	<1[b]	2	NA[c]	NA	<1	3	NA	NA
		Rh91	2	2	NA	NA	<1	<1	NA	NA
	E112K (100 μg)	Rh16	6	5	5	3	NA	NA	3	<1
		Rh39	8	7	5	4	NA	NA	2	3
		Rh85	4	6	4	<1	NA	NA	3	<1
100 (μg)	nCT (10 μg)	Rh60	6	6	NA	NA	2	6	NA	NA
		Rh88	2	<1	NA	NA	<1	4	NA	NA
		Rh07	7	7	7	4	NA	NA	3	<1
		Rh35	5	5	2	<1	NA	NA	<1	<1
100 (μg)	None	Rh51	<1	<1	NA	NA	<1	2	NA	NA
		Rh43	3	2	<1	<1	NA	NA	<1	<1

[a] Saliva, nasal, vaginal, and rectal washes were collected 7 or 14 days after final immunization and were then subjected to gp120-specific ELISA.
[b] Endpoint titers were expressed as the last dilution giving an OD_{460} of 0.1 U above samples obtained from nonimmunized controls.
[c] NA, Not available.

(Table I). The findings for mucosal secretions paralleled those for plasma described above, with a dose of 100 μg of mCT E112K inducing gp120-specific IgA and IgG Ab levels comparable to those seen in macaques receiving nCT, but with a dose of only 25 μg of mCT E112K failing to support induction of gp120-specific Ab responses (Table I). These findings further support the notion that 100 μg of mCT E112K is the optimal dose for nasal adjuvanticity. Furthermore, our results demonstrate that a nasal vaccine of HIV-1 gp120 and mCT E112K as mucosal adjuvant would be an effective regimen for induction of anti-HIV-1 immune responses in external secretions of NHPs.

Induction of gp120-specific AFCs in mucosal lymphoid tissues

The induction of gp120-specific Ab responses was further confirmed at the level of plasma cell AFC responses. Comparable numbers of HIV-1 gp120-specific IgA and IgG AFCs were seen in the nasal passages of macaques immunized with gp120 plus either the optimal dose of mCT E112K (Rh39) or nCT (Rh60). Similarly, the numbers of gp120-specific IgA AFCs in SMGs and intestinal LP of macaques given the optimal dose of mCT E112K were comparable to those seen in positive controls given nCT as mucosal adjuvant (Fig. 2). These findings show that nasally coadministered mCT possesses adjuvant activity for the induction of gp120-specific AFCs in mucosal effector tissues.

gp120-specific $CD4^+$ Th1 and Th2 cell responses

Because nasal mCT showed adjuvant activity in both mucosal and systemic lymphoid compartments, HIV-1 gp120-specific $CD4^+$ Th1- and Th2-type responses were assessed using a cytokine-specific ELISPOT assay. When restimulated with gp120 in vitro, mononuclear cells from spleen and mesenteric lymph nodes (MLNs) of macaques immunized with gp120 and either mCT E112K or nCT induced both Th1 (IFN-γ)- and Th2-type (IL-4, IL-10, and IL-13) cytokine-producing $CD4^+$ T cells (Fig. 3). Both the group given mCT E112K and that given nCT showed higher numbers of IL-4- and IL-13-producing $CD4^+$ T cells in MLNs than those observed in the two macaques nasally immunized with gp120 alone. The nCT-immunized group exhibited higher numbers of IL-4- and IL-13-producing $CD4^+$ T cells than did the mCT E112K-immunized macaques, but the latter group showed higher numbers of IL-10-producing $CD4^+$ T cells were noted in their MLNs. A similar pattern of Th2-type cytokine production was seen in the spleens of these two groups of macaques. The IFN-γ-producing $CD4^+$ T cells were also seen in both MLNs and spleens

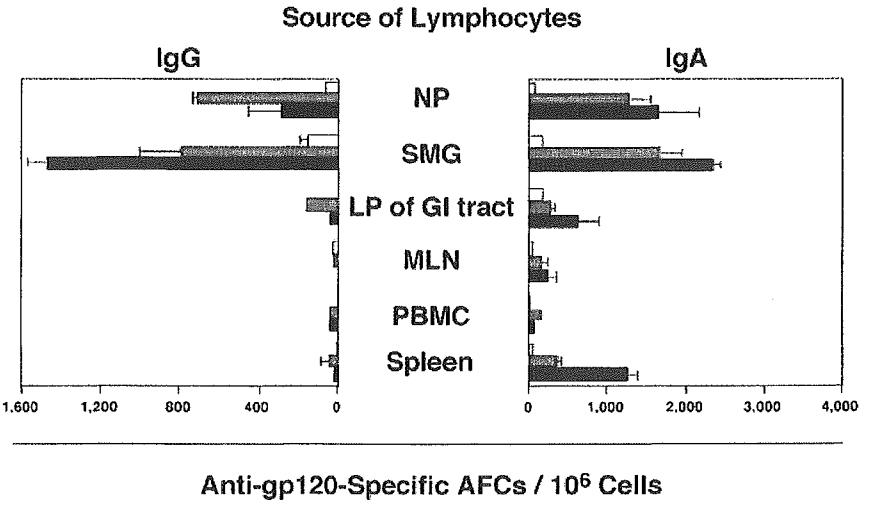

FIGURE 2. The gp120-specific IgG and IgA AFCs in mucosal and systemic lymphoid tissues of rhesus macaques (Rh51, □; Rh60, ▨; Rh39, ■) were determined by ELISPOT assay. Mononuclear cells were isolated from NPs, SMGs, the LP of the gastrointestinal tract; MLNs; spleen; and PBMC 2 wk following the final immunization. The results shown are the mean AFCs/10^6 cells ± SEM.

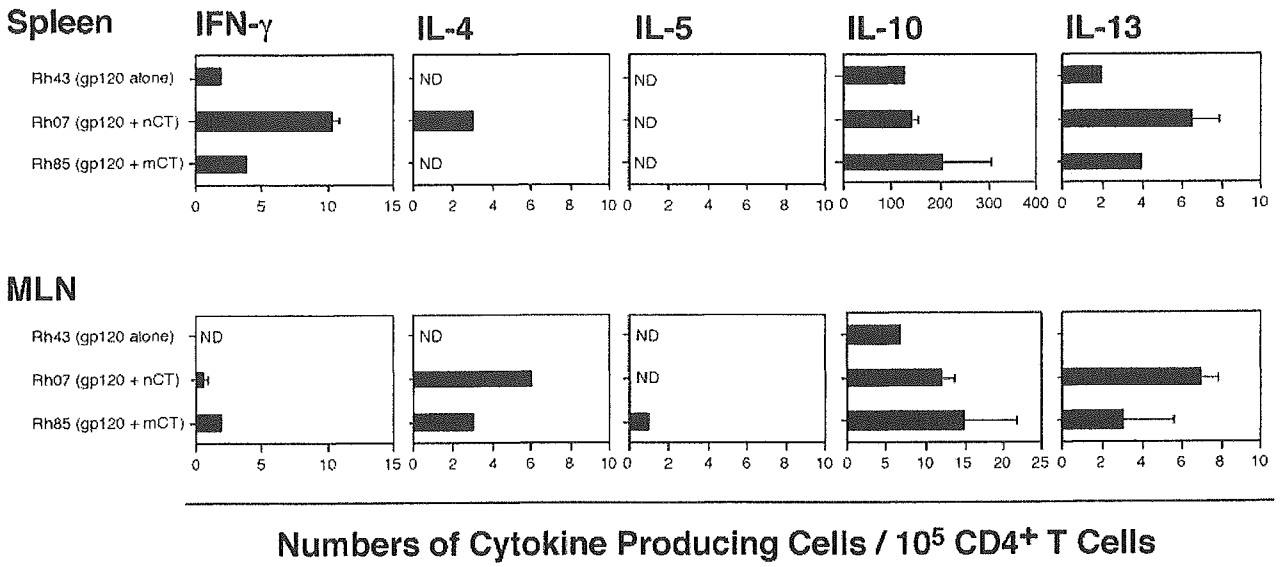

FIGURE 3. Th1 and Th2 cytokine production by gp120-stimulated $CD4^+$ T cells isolated from spleens and MLNs of rhesus macaques (Rh43, Rh07, and Rh85). Lymphocytes were cultured with or without gp120 for 3 days. Nonadherent cells were harvested and stained with anti-human CD3 and CD8 mAbs. A subset of $CD3^+$, $CD8^-$ T cells was purified using flow cytometry. The purified $CD4^+$ T cells were subjected to an array of macaque-specific cytokine (IFN-γ, IL-4, IL-5, IL-10, and IL-13) ELISPOT assays.

of macaques given either mCT E112K or nCT as mucosal adjuvant. Interestingly, the numbers of IFN-γ-producing $CD4^+$ T cells in the MLNs of both groups were lower than those seen in the spleens. These results suggest that mCT as nasal adjuvant preferentially induces Ag-specific Th2-type cytokine-producing $CD4^+$ T cells, while also somewhat enhancing the induction of Th1-type cytokine-producing $CD4^+$ T cells.

HIV-1_{LAI}-neutralizing Abs in external secretions and plasma

It was important to examine whether gp120-specific Abs in external secretions or plasma induced in NHPs given nasal gp120 and mCT E112K as mucosal adjuvant possessed HIV-neutralizing activity. To assess neutralizing activity, we performed an in vitro neutralization assay using HIV-1_{LAI}. The plasma (1/10 dilution) from macaques given nasal gp120 plus mCT E112K showed ~75–90% inhibition of HIV-1_{LAI}, a significantly higher rate than that seen in control plasma samples from either naive macaques or NHPs given gp120 only (Fig. 4*A*). Furthermore, the nasal lavages (1/10 dilution) from two rhesus macaques (Rh16 and Rh85) given nasal gp120 plus mCT E112K exhibited 35 and 55% inhibition of HIV-1_{LAI}, a rate of inhibition comparable to that seen in NHPs given nasal nCT as mucosal adjuvant. In contrast, control groups (naive macaques or those given gp120 alone) possessed little ability to inhibit HIV-1_{LAI} (<20%) (Fig. 4*B*). These results clearly show that nontoxic mCT E112K can be used as a mucosal adjuvant for the induction of HIV-1-specific neutralizing immunity in both external secretions and plasma.

Safety of mCT E112K when used as a nasal adjuvant in NHPs

To assess the threat of neuronal damage posed by nasal vaccines containing gp120 and mCT E112K, NGF-β1 production in nasal turbinates of olfactory tissues was examined. Macaques given gp120 with nCT exhibited areas of intense NGF-β1 production in the olfactory region, which was associated with neuronal damage

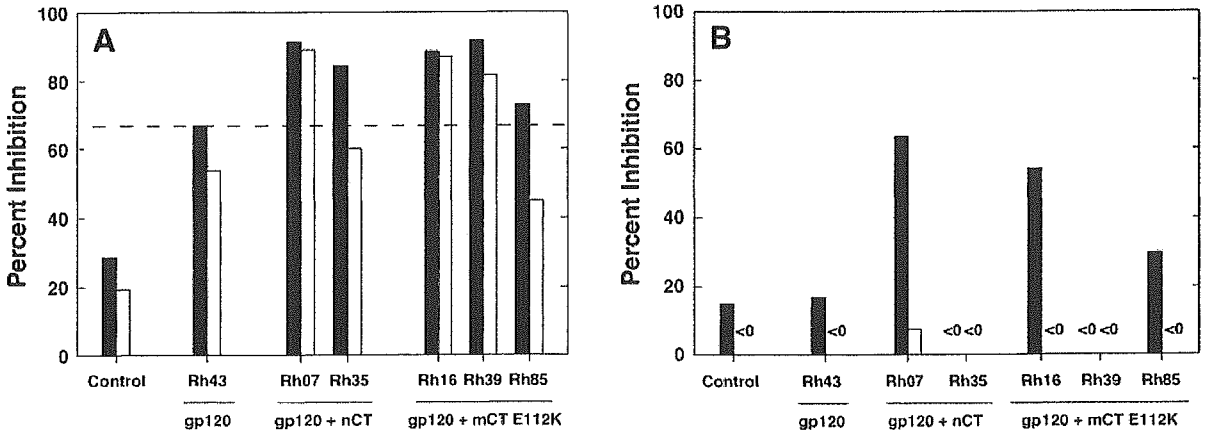

FIGURE 4. In vitro neutralization of HIV-1 was performed with a standard p24 release assay. The plasma (*A*) and nasal wash (*B*) samples were collected 2 wk after the final immunization. Samples were diluted 1/10 (■) or 1/100 (□) and were analyzed for the presence of neutralizing Abs against a homogenous laboratory strain (HIV-1_{LAI}). As controls, plasma samples were obtained from macaques before nasal immunization (preimmune sample). The results are the mean values of three separate assays.

and inhibition of apoptosis (Fig. 5*C*). In contrast, macaques given nasal gp120 plus mCT E112K (Fig. 5*B*) expressed very minimal levels of NGF-β1, which were essentially the same as those seen in olfactory tissues taken from the macaques given nasal gp120 alone (Fig. 5*A*). These results indicate that mCT E112K, although as effective a mucosal adjuvant as nCT, possesses none of its toxicity for neuronal tissues. As a safe and potent mucosal adjuvant, mCT E112K could speed the development of a nasal HIV-1 vaccine in humans.

Discussion

This study clearly provides direct evidence that mCT E112K is an effective mucosal adjuvant for the induction of HIV-1-specific immunity in the NHP model. When used as a nasal adjuvant, mCT E112K induced gp120-specific Abs possessing HIV-neutralizing activity in both external secretions and plasma, but showed negligible toxicity for the CNS-associated tissues of rhesus macaques. In contrast, nCT elicited increases in NGF-β production, a major manifestation of CNS inflammation. Thus, our study is the first to provide evidence establishing the efficacy and safety of an adjuvant for use in higher mammals. Collectively, our findings convincingly demonstrate the potential of mCT E112K as a mucosal adjuvant in humans and suggest that it may be time to take the next step toward the development of nasal vaccines, including those for HIV-1, by beginning clinical trials.

Our previous studies have already shown the efficacy and safety of mCT E112K as a nasal adjuvant in the murine system (43, 47, 48). In our earlier studies, we established that nasal immunization with pneumococcal surface protein A or diphtheria toxoid plus mCT E112K elicited sufficient Ag-specific immune responses to provide protection after lethal challenge with either *Streptococcus pneumoniae* bacteria or diphtheria exotoxin (48, 49). Furthermore, nasal application of mCT together with protein Ags elicited both Ag-specific IgA and IgG Ab responses in mucosal and systemic lymphoid tissue compartments (43, 47, 48). Among the different forms of mutant toxin-based adjuvants, mCT E112K was shown to be the safest and most effective in the murine model (41–43). However, until now, no studies assessing the mucosal adjuvanticity of different forms of toxin-based mutant adjuvants such as our mCT E112K had been performed in a large mammalian animal model, i.e., NHPs. Among the mammalian models, we chose the NHP experimental model as the most appropriate to and useful for the development of an HIV/AIDS mucosal vaccine.

AIDS is well known to be a sexually transmitted disease caused by HIV-1 infection via mucosal surfaces. The NHP experimental model of SIV infection has provided detailed evidence for the mucosal transmission of the virus, and has shown that the inhibition of its entry via the mucosa led to protection against disease development (50). Accordingly, an effective HIV/AIDS vaccine will be more readily developed if the potential of the common mucosal immune system is tapped, because mucosal immunization is known to induce effective protection against pathogens at mucosal surfaces as well as in lymphoid tissue compartments (37, 38, 51). Of note, our previous study showed that nasal immunization with SIV $p55^{gag}$ plus nCT as mucosal adjuvant induced in vaginal secretions of rhesus macaques Ag-specific Ab responses with virus-specific neutralizing Ab activity. In the case of the NHP experimental model, our studies have shown that mucosal (both oral or nasal) immunization with SIV $p55^{gag}$ plus nCT induced Ag-specific humoral and cellular immunity in both mucosal and systemic immune systems of rhesus macaques (15, 16, 52).

Despite its strong mucosal adjuvanticity, nCT is of little practical value as a mucosal adjuvant in humans because of its toxicity. Thus, much effort has been expended on the creation of genetically manipulated nontoxic mutants of CT that would retain adjuvanticity, but not toxicity. In the current study, we sought to examine the mucosal adjuvanticity of mCT E112K as nasal adjuvant when coadministered to rhesus macaques with HIV-1 gp120. In this study, we provide the first evidence that the nasal application of mCT E112K as a mucosal adjuvant effectively induces HIV-1 gp120-specific Ab responses in both mucosal and systemic lymphoid tissues of rhesus macaques. Furthermore, plasma and nasal

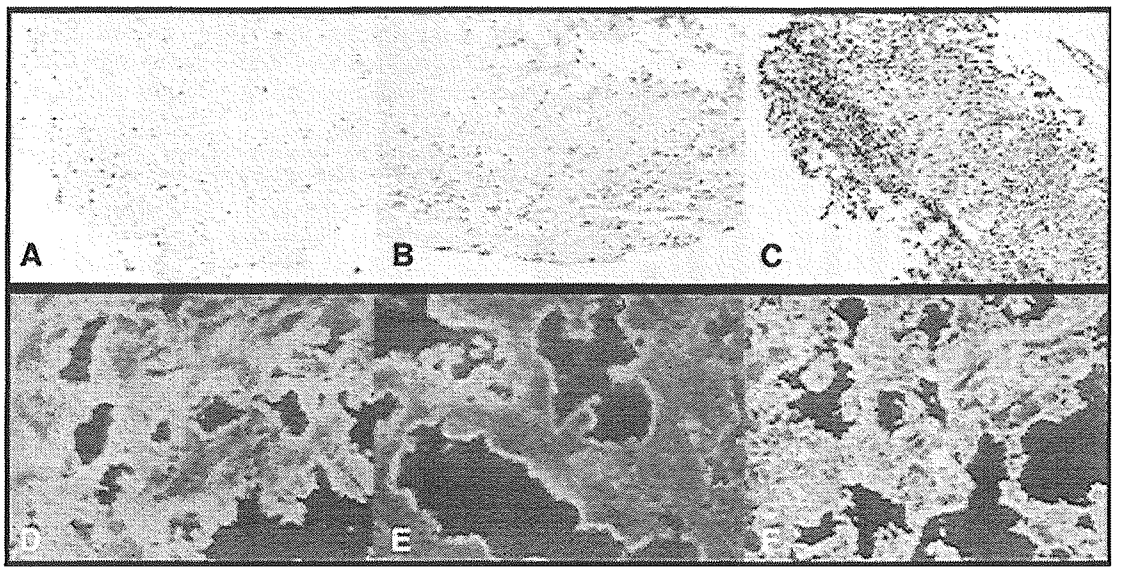

FIGURE 5. Detection of NGF-β1 expression in olfactory bulbs of rhesus macaques nasally immunized with gp120 and either nCT or mCT E112K as mucosal adjuvant. The anti-NGF-β1 Ab-stained sections were reacted with avidin-biotin conjugate, followed by 3,3′-diaminobenzidine (*A–C*), or incubated with HRP-conjugated streptavidin-Alexa Fluor 488 (*D–F*). *C* (×40) and *F* (×100), Show high expression of NGF-β1 along neuronal tracts when rhesus macaques were given nCT and gp120. *B* (×40) and *D* (×100), Show tissues from a macaque given gp120 plus mCT E112K. *A* (×40) and *D* (×100), Illustrate tissues from a macaque given gp120 alone.

washes from macaques given nasal gp120 plus mCT E112K contained HIV-1_{LAI}-neutralizing Abs. These findings clearly demonstrate the efficacy of mCT E112K as a mucosal adjuvant and suggest its potential for use in trial vaccines in humans.

However, nCT and even some of its nontoxic mutant forms pose additional, more specialized dangers when administered via the nasal route, the route of choice for mucosal vaccines because of its efficacy at inducing Ag-specific immune responses. Nasal vaccines using either nCT or one of its nontoxic mutants as adjuvant risk entering the CNS because of the proximity of the olfactory nerves/epithelium and olfactory bulbs to the brain. This potential for neurotoxicity has been a major obstacle for the use of enterotoxin-based mucosal adjuvants, even nontoxic mutant forms, in humans via the nasal route.

Our own studies have shown the potential toxicity of nCT for the olfactory nerves/epithelium and olfactory bulbs (39). Thus, neuronal association of CT-B through GM1 ganglioside binding appears to preclude efficient clearing of these enterotoxin-based mucosal adjuvants and to cause extended accumulation of them in neuronal tissues associated with the olfactory tract (39). These results show that nasally administered CT derivatives retain some toxicity and are targeted to the CNS, posing a serious obstacle to human use. Indeed, recent reports showed that a human vaccine containing inactivated influenza and native labile toxin as an adjuvant resulted in a very high incidence of Bell's palsy (53, 54). These results strongly indicate that it is essential to develop a more safe and effective nasal vaccine for human use.

Our current findings demonstrate the promise of the nontoxic form of mCT E112K as a safe and effective mucosal adjuvant and so point the way to the development of better nasal vaccines. The nontoxic form of mCT E112K did not elicit any increase in NGF-β expression by the olfactory tissues of NHPs. Only minimal NGF-β1 synthesis, comparable to that seen in NHP given nasal gp120 alone, was detected in the olfactory CNS tissues of rhesus macaques given nasal mCT E112K as nasal adjuvant.

Our previous study showed that nasal immunization with $p55^{gag}$ plus nCT induced $p55^{gag}$-specific T cell responses in both mucosal and systemic lymphoid tissue compartments (16). Thus, it was shown that both IFN-γ and IL-2 (Th1-type) expression as well as IL-5, IL-6, and IL-10 (Th2-type) production were seen in Ag-stimulated $CD4^+$ T cells isolated from NHPs given nasal $p55^{gag}$ and nCT. In this regard, our current study has shown that both Th1 (IFN-γ)- and Th2 (IL-10 and IL-13)-type cytokine-producing $CD4^+$ T cells were present in the MLNs and spleens of rhesus macaques given either mCT E112K or nCT as a nasal adjuvant. Although the viral Ags used in the current study are different from those in the previous report, our results also showed that mCT E112K provided adjuvanticity in NHPs through the generation of both Th1- and Th2-type cytokine responses by $CD4^+$ T cells. Induction of IFN-γ-producing $CD4^+$ T cells by nasally coadministered mCT E112K may be an additional benefit because it may lead to the generation of Ag-specific cell-mediated immunity responses. In viral infections including HIV and SIV, CTL activity has been shown to be of central importance for host defense and to correlate well with IFN-γ production (44). In this regard, we postulate that nasally coadministered mCT E112K would also induce CTL activity in various mucosal tissues. Confirming this prediction, rhesus macaques given nasal nCT as mucosal adjuvant showed SIV-specific CTL activity (16). We are currently testing Ag-specific CTL activity in macaques given nasal mCT E112K as mucosal adjuvant.

In conclusion, the current study has provided significant new information for a potential human phase I clinical trial using the nontoxic form of toxin mucosal adjuvant mCT E112K. Thus, nasal immunization of rhesus macaques with gp120 and mCT E112K resulted in the induction of Ab-neutralizing immunity against HIV-1 by inducing gp120-specific IgA and IgG Abs in both mucosal and systemic lymphoid tissue compartments, respectively. Furthermore, the safety of nasal mCT E112K was confirmed by the lack of CNS damage in this NHP model. This important new evidence supports the candidacy of mCT E112K as a potentially important mucosal adjuvant for use in humans.

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$CD4^+CD45RB^{Hi}$ Interleukin-4 Defective T Cells Elicit Antral Gastritis and Duodenitis

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We have analyzed the gastrointestinal inflammation which develops following adoptive transfer of IL-4 gene knockout (IL-$4^{-/-}$) $CD4^+CD45RB^{Hi}$ (RB^{Hi}) T cells to severe combined immunodeficient (SCID) or to T cell-deficient, T cell receptor β and δ double knockout ($TCR^{-/-}$) mice. Transfer of IL-$4^{-/-}$ RB^{Hi} T cells induced a similar type of colitis to that seen in SCID or $TCR^{-/-}$ recipients of wild-type (wt) RB^{Hi} T cells as reported previously. Interestingly, transfer of both wt and IL-$4^{-/-}$ RB^{Hi} T cells to $TCR^{-/-}$ but not to SCID mice induced inflammation in the gastric mucosa. Notably, $TCR^{-/-}$ recipients of IL-$4^{-/-}$ RB^{Hi} T cells developed a more severe gastritis with erosion, apoptosis of the antral epithelium, and massive infiltration of macrophages. This gastritis was partially dependent on the indigenous microflora. Recipients of both wt and IL-$4^{-/-}$ RB^{Hi} T cells developed duodenitis with multinuclear giant cells, expansion of mucosal macrophages, and dendritic cells. Full B cell responses were reconstituted in $TCR^{-/-}$ recipients of RB^{Hi} T cells; however, anti-gastric autoantibodies were not detected. We have now developed and characterized a novel model of chronic gastroduodenitis in mice, which will help in our understanding of the mechanisms involved in chronic inflammation in the upper gastrointestinal tract of humans. ***(Am J Pathol 2004, 165:1257–1268)***

A number of murine models of colitis involve either aberrant T cell or cytokine expression. For example, spontaneous colitis develops in T cell receptor (TCR)-α gene knockout mice where aberrant T cells producing Th2-type cytokines actually mediate disease.[1–3] Perhaps the most useful murine model for both T cell and cytokine regulation of inflammatory bowel disease (IBD) has involved adoptive transfer of $CD45RB^{Hi}$ T cells from normal mice to either SCID[4–6] or to RAG 2 gene knockout ($RAG^{-/-}$) mice.[7,8] The transfer of RB^{Hi} T cells into SCID mice results in development of a severe mononuclear cell infiltration, epithelial cell hyperplasia, and tissue damage. Strong evidence has emerged provided that colitis results from enteric bacterial antigen (Ag)-driven Th1 cell induction,[9] since RB^{Hi} T cell transfer into SCID mice with reduced bacterial flora failed to develop large bowel disease.[10,11] Interestingly, T cell subsets producing TGF-β[12] and IL-10[13] in the RB^{low} T cell population, when co-delivered with RB^{Hi} T cells, actually suppressed colitis. The RB^{low} T cell population was enriched in $CD4^+CD25^+$ T regulatory (Tr) cells.[14] Despite this compelling evidence that RB^{Hi} T cells give rise to effector Th1 cells which mediate colitis, this model had not allowed study of either normal or abnormal B cell participation in the pathogenesis of $CD4^+$ T cells. Since the majority of antibody forming cells (AFCs) in humans and higher mammals reside in the gastrointestinal (GI) tract mucosa,[15,16] the impact of the presence of B cells and plasma cells in the mucosal pathology cannot be ignored. For example, we recently showed that dysregulated Th2 cells cause villus atrophy and goblet cell transformation in the small intestinal epithelium. Further, a wasting disease was seen and was mediated by excess IL-4 and the presence of B cells.[17]

Chronic GI tract inflammation is one of the most common types of inflammatory processes. For many years, gastric ulcers were thought to occur in susceptible individuals, especially those hypersecreting gastric hydrochloric acid.[18,19] However, it has become clear that gas-

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tritis, peptic ulcer disease, and gastric cancer are the result of infection with the bacterium *Helicobacter pylori*.[19,20] Gastritis has been reproduced in experimental animals gastrically infected with either *H. pylori* or related bacteria.[21–24] Thus, gastritis and duodenitis are directly related to *H. pylori* infection; however, surprisingly little is known about what causes chronic inflammatory responses in the upper GI tract. Although many groups have shown that disease severity is related to certain virulence factors associated with *H. pylori*, only a minority of individuals infected with virulent strains of *H. pylori* develop severe disease.[25] In animal models, IL-10-deficient mice infected with *H. pylori* exhibited enhanced gastritis, lower bacterial loads, and higher serum IgG antibody (Ab) titers when compared with control mice.[26] These results have suggested the importance of the host immune system in perpetuating the gastritis and duodenitis. Indeed, a gastritis model in mice with *H. pylori* infection showed that $CD4^+$ T cells were both necessary and sufficient for gastritis, and IFN-γ contributed to this inflammation.[27] Further, oral immunization of mice with the *H. pylori* urease induced protection against *H. pylori* infection, but was often associated with corpus gastritis, which is now recognized as post-immunization gastritis.[28–30] In addition, *H. pylori*-infected SCID mice reconstituted with splenic T cells from *H. pylori*-infected, C57BL/6 mice developed severe gastritis, however, host colonization of *H. pylori* did not correlate to the severity of gastritis.[31] Thus, cell-mediated immunity appears necessary for gastritis development, and does not necessarily relate to the bacterial load. Although still controversial, there is significant evidence that $CD4^+$ Th1-type responses contribute to *H. pylori*-induced gastritis in humans.[32] For example, IFN-γ and TNF-α are the major cytokines produced by gastric T cells from *H. pylori*-infected subjects.[33,34]

In the murine colitis models induced by adoptive transfer of RB^{Hi} T cells, the microflora is necessary for disease; however, no priming of donor T cells with pathogens was required.[10,11] Furthermore, no specific colitogenic bacterial species has been identified to date. Nonetheless, regulation of colitis by Tr cells seems to occur in both innate and adaptive immunity.[35] These results indicate that T cells from normal mice have the potential to induce inflammation in response to the indigenous bacteria; however, the healthy host simultaneously develops Tr cells that attenuate the disease producing T cells. Similar mechanisms for upper GI tract inflammation may be present; however, there have been no reports of a gastritis model in the absence of infection or deliberate immunization, except for autoimmune gastritis induced by neonatal thymectomy[36,37] or ionizing radiation.[38]

In this study, we hypothesized that normal T cells prepared from pathogen-free mice would contain a subset, which potentially could cause inflammation in the upper GI tract, as well as colitis. We describe a new type of RB^{Hi} T cell transfer model in $TCR^{-/-}$ mice that allows assessment of RB^{Hi} T cells in the presence of responsive B cells. We discovered that transfer of RB^{Hi} T cells from IL-4 gene knockout ($IL\text{-}4^{-/-}$) mice resulted in gastroduodenitis in the absence of infection by pathogenic bacteria. Our results suggest the $CD4^+$ Th1-type T cells mediate both colitis and gastroduodenitis in $TCR^{-/-}$ mice reconstituted with RB^{Hi} T cells.

Materials and Methods

Mice

Normal wild-type (wt), $IL\text{-}4^{-/-}$, IFN-γ gene knockout ($IFN\text{-}\gamma^{-/-}$) TCR β and δ chain-defective ($TCR^{-/-}$) and SCID mice on the C57BL/6 background were originally obtained from the Jackson Laboratory (Bar Harbor, ME). This mouse colony was maintained under pathogen-free conditions in flexible Trexler isolators at the University of Alabama at Birmingham (UAB) Immunobiology Vaccine Center Mouse Facility. A separate colony was also maintained in the Immunocompromised Mouse Facility of the Research Institute, International Medical Center of Japan (IMCJ, Tokyo, Japan). We periodically and extensively performed health surveillance on these colonies. These tests were performed in laboratories with expertise in laboratory animal health care (Jackson Laboratories, Charles River Laboratories, Wilmington, MA and Central Laboratories for Experimental Animals, Kawasaki, Japan). This analysis included serological testing for viral infections, bacterial cultures of the nasopharynx, stomach and cecum, ecto- and endoparasitic examinations, and histology of all major organs and tissues. Feces and the stomach were also tested for *Helicobacter spp.* in these laboratories, including *H. hepaticus, H. bilis, H. muridarum, and "H. rappini"*, by PCR.[39–42] No lesions or pathogens including *Helicobacter spp.* and intestinal parasites have ever been detected in these two separate mouse colonies. We obtained essentially identical results in the mouse facilities of both UAB and the IMCJ, and these experiments are quite reproducible. Although original reports indicated that $TCR^{-/-}$ mice develop intestinal inflammation,[3] they did not develop histologically obvious gastritis, duodenitis, or colitis in our mouse facility until they were 24 weeks of age, which is well beyond the time frame of our experiments.

Purification of T Cells

Splenic T cells for adoptive transfer were purified as described previously.[17] In brief, following lysis of erythrocytes, splenic T cells were enriched by passage through a nylon wool column, and then stained with phycoerythrin (PE)-conjugated anti-CD45RB (23G2), FITC-labeled anti-B220, anti-CD11b, and anti-CD8 monoclonal antibodies (mAbs) (BD PharMingen, San Diego, CA). The $CD45RB^{Hi}$ T cell subset was separated by flow cytometry using a FACS Vantage (Becton-Dickinson Co., Sunnyvale, CA). Sorted, $CD45RB^{Hi}$ subsets were > 99% pure by the reanalysis using anti-CD4 Ab, anti-TCR $\gamma\delta$ Ab, anti-NK1.1 Ab, and anti-Gr-1 Ab.

Adoptive Transfer of T Cells

In these studies, purified populations of RB^{Hi} T cells were adoptively transferred to 6- to 8-week-old $TCR^{-/-}$ mice. We routinely transferred 1.0×10^6 T cells by the intrave-

nous (i.v.) route. Body weight was monitored weekly, and mice were taken for analysis when their weight became less than 75% of the initial weight, or at 12 weeks after adoptive transfer of RB^{Hi} T cells.

Histological Analysis

The stomach was removed by excising the esophagus and the anal side of the gastro-duodenal junction, opened along the greater curvature, washed and extended. Next the stomach was cut longitudinally in the middle first, and a 3- to 4-mm-wide strip was prepared. The lateral side of this strip included the fundus, antrum, and gastro-duodenal junction. This side was cut for preparation of sections for histological examination. At least one such section from each mouse prepared in this manner was examined. Duodenal tissues were obtained from 0.5 cm to 3 cm from the gastro-duodenal junction. Colonic tissue was taken from the middle and distal parts of the large intestine. The tissues were opened, fixed in 5% glacial acetic acid in ethanol, and paraffin-embedded. Tissue sections (4 μm) were prepared and stained with hematoxylin and eosin (H&E). In some experiments, 6 μm-frozen sections were prepared, dried and fixed with cold acetone for 10 minutes, and subjected to histological analysis. The immunohistochemical staining was performed using FITC- or biotin-labeled anti-CD3, anti-CD4, anti-B220, anti-CD11b, and anti-CD11c mAbs, respectively (all from BD PharMingen, San Diego, CA), followed by FITC- or TRITC-labeled streptavidin (BD PharMingen). For the detection of IgA^+, IgG^+ or IgM^+ plasma cells, sections were reacted with biotin-labeled anti-mouse IgA Ab, TRITC-labeled anti-mouse IgG Ab and FITC-labeled anti-mouse IgM Ab (BD PharMingen) followed by aminocoumarin-labeled streptavidin. Apoptotic cells were detected by TdT-mediated dUTP nick end labeling (TUNEL) using the Apoptosis *in Situ* Detection Kit *Wako* (Wako Pure Chemicals Industries, Ltd., Osaka, Japan) on paraffin-embedded sections, according to the vender's protocol. To detect myeloperoxidase in granulocytes, sections were directly incubated with a substrate solution, 3,3′-diaminobenzidine tetrahydrochloride (Sigma Chemical Co., St. Louis, MO) in the presence of H_2O_2. Histological scores for gastritis were based on a summation of scores for cell infiltration (0, none; 1, moderate; 2, severe), epithelial hypertrophy (0, none; 1, moderate; or 2, severe), erosion (0, none; 1, focal; or 2, diffuse), giant cells (0, none; 1, less than 2; or 2, more than 3 per section), and deformity of pits (0, none; 1, moderate; or 2, severe). Histological scores for duodenitis and colitis were determined by severity of the inflammation (0, none; 1, mild; 2, moderate; or 3, severe). For histological examination, two observers performed all of the scoring. One was a pathologist who was not involved in this research, and for this examiner, the samples were provided in blinded fashion.

Purification of Lamina Propria Lymphocytes

Peyer's patches were excised from the intestinal wall, and small intestinal lamina propria lymphocytes (LPLs) were prepared as described previously.[43] Briefly, the intestinal tissue was treated with 1 mmol/L EDTA in phosphate-buffered saline (PBS) for 20 minutes to remove the epithelium. The tissue was then digested with type V collagenase (Sigma) for 20 minutes, and this step was repeated once more. The mononuclear cells were further purified by using a discontinuous Percoll gradient of 75% and 40%.

ELISPOT Assay

Enumeration of antibody forming cells (AFCs) was performed as described previously.[44] In brief, 96-well nitrocellulose plates (Millititer HA, Millipore, Bedford, MA) were coated with goat anti-mouse Ig (H+L) [Southern Biotechnology Associates (SBA), Birmingham, AL]. After blocking with 1% bovine serum albumin (BSA) in PBS, the LPLs were incubated for 4 hours at 37°C in moisturized atmosphere of 5% CO_2 in an incubator. After washing the plates, the captured Ig was visualized using peroxidase-labeled anti-mouse IgG, IgA or IgM (SBA). The spots in the individual wells were counted with the aid of a stereomicroscope.

Quantification of Plasma Immunoglobulin Levels

Plasma immunoglobulin (Ig) levels were determined by a sandwich ELISA using the combination of anti-mouse Ig (H+L) (SBA) and peroxidase-labeled anti-mouse IgG, IgA, or IgM (SBA) as described previously.[17]

RT-PCR for mRNA Analysis

Total RNA was prepared from gastric tissue or from separated cells using an RNA-Bee RNA isolation reagent (Tel-Test, Inc., Friendswood, TX). Complementary DNA was synthesized from RNA by reverse transcription (RT). The PCR primers for murine GAPDH used were 5′-AGCCAAACGGGTCATCATCTC and 5′-TGCCTGCTTCACCACCTTCTT; for TNF-α, 5′-TTCTGTCTACTGAACTTCGGGGTCATCGGTCC-3′ and 5′-GTATGAGATAGCAAATCGGCTGACGTGTGCC. The step-cycle program was set for denaturing at 95°C for 45 seconds, annealing at 60°C for 45 seconds, and extension at 72°C for 45 seconds for a total of 40 cycles. Expression of mRNA was assessed by quantitative PCR using a SYBR Green PCR Master Mix (Applied Biosystems, Warrington, United Kingdom) and ABI PRISM 7700 Sequence Detector (Applied Biosystems). Quantification of mRNA for IFN-γ and IL-10 was performed using ABI Taqman probes (Applied Biosystems). The PCR primers for IFN-γ were 5′-TGATCCTTTGGACCCTCTGA and 5′-GCAAAGCCAGATGCAGTGT, for IL-10, 5′-GCTCTTGACTACCAAAGCCAC and 5′-CATGCCAGTCAGTAAGAGCAGG. The Taqman probes used for IFN-γ were 5′-CCTCCTGCGGCCTAGCTCTGAGAC and for IL-10, AAGAGAGCTCCATCATGCCTGGCTCA. Threshold cycle numbers (C_T) were determined with Sequence Detector Software (version 1.7; Applied Biosystems) and transformed using the $\Delta C_T/\Delta\Delta C_T$ method as described by the manufacturer, with GAPDH used as the calibrator gene.

Quantification of Cytokine Production and Intracellular Cytokine Analysis

For quantification of cytokines, $CD4^+$ T cells were purified from freshly prepared LPLs by staining with FITC-labeled anti-CD4 mAb (BD PharMingen) followed by flow cytometry with a FACS Vantage system. The purified $CD4^+$ T cells were added to wells of plates coated with anti-CD3 mAb (10 μg/ml, clone 145–2C11; BD PharMingen) and cultured in RPMI 1640 supplemented with 10% fetal calf serum (FCS), sodium pyruvate, L-glutamine, HEPES, and 50 μmol/L 2-mercaptoethanol (complete medium). Cultures were incubated for 48 hours at 37°C in 5% CO_2 in a moist air incubator. Cells in culture were removed, separated by centrifugation, and the supernatants were then subjected to a cytokine-specific ELISA, as described previously.[43] Briefly, microtiter plates were coated with mAbs to individual cytokines and blocked with 3% BSA in PBS at 37°C for 2 hours, and then diluted samples were added to well and incubated overnight at 4°C. Captured cytokines were detected using biotinylated detection mAbs and peroxidase-labeled anti-biotin mAb (Vector Laboratories Inc., Burlingame, CA). The following mAbs were used for coating and detection, respectively: anti-IFN-γ, R4–6A2 and XMG 1.2; anti-IL-2, JES6–1A12 and JES6–5H4 mAbs; anti-IL-4, BVD4-1D11 and BVD6–23G2. For intracellular cytokine analysis, LPLs were cultured in plates coated with anti-CD3 mAb in complete medium with anti-CD28 mAb. After 48 hours of culture, the cells were subjected to intracellular cytokine staining as described previously.[45] In brief, cells were stained with FITC-labeled anti-CD4 mAb (BD PharMingen), fixed, permealized, and then stained with PE-labeled anti-IFN-γ mAb (BD PharMingen) for analysis using flow cytometry.

Treatment with Antibiotics and Bacterial Culture

In some experiments, recipient mice were given a combination of antibiotics in their drinking water. Metronidazole (0.6 g/L, Wako Pure Chemical Industries Ltd.), neomycin (0.35 g/L, Wako), streptomycin (0.2 g/L, Wako), and bacitracin (0.35 g/L, Wako) were added to the drinking water, and the mice were continuously given this water *ad libitum* until the histological and cytological analyses were performed. To determine total colony forming units (CFU), mice were treated with antibiotics as above for 6 weeks, fasted for 6 hours and then the entire stomach was removed, washed three times with PBS, minced and homogenized with 2 ml of PBS in a Teflon-glass homogenizer. This homogenate was then subjected to serial dilution and spread over culture plates. Anaerobic bacteria were cultured on GAM agar plates (Nissui Pharmaceuticals, Tokyo, Japan) in culture jars (GasPack System BBL, Becton Dickinson) with AneroPac (Mitsubishi Gas Chemical Co, Inc., Tokyo, Japan). For aerobic cultures, brain-heart infusion agar (Difco, Becton Dickinson), chocolate agar, and sheep blood agar plates (both from Nissui) were used. To examine for the presence of indigenous microflora in the oral cavity, the mucosal surfaces of oral cavity were swabbed, and the swabs were placed in 300 μl of PBS. Then 100 μl of this suspension was spread over a culture plate. Anaerobic cultures were initiated within 20 minutes after taking samples. After 24 hours of incubation at 37°C, numbers of CFU were enumerated.

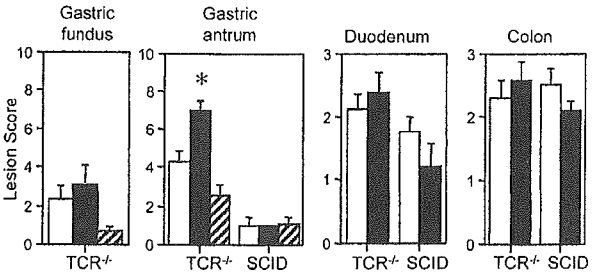

Figure 1. Histological scores of gastritis, duodenitis and colitis. $TCR^{-/-}$ or SCID mouse recipients were given RB^{Hi} T cells prepared from splenocytes of wt (**blank column**, $n = 8$), IL-$4^{-/-}$ (**solid column**, $n = 10$) or IFN-$\gamma^{-/-}$ (**hatched column**, $n = 7$) mice. The results shown are the mean and SEM. *, Difference between wt and IFN-$\gamma^{-/-}$ mice was statistically significant.

Statistics

The results were compared by the Mann-Whitney test using the Statview II statistical program (Abacus Concepts, Berkeley, CA) adapted for Macintosh computers. The results were considered to be statistically significant if P values were less than 0.05.

Results

Inflammation of the GI Tract in $TCR^{-/-}$ and SCID Mouse Recipients

Previous studies have shown that the transfer of RB^{Hi} T cells resulted in severe colitis in either SCID or $RAG^{-/-}$ mouse recipients, and the colitis was mediated by $CD4^+$ Th1-type cells.[4–6,9,46] A similar type of colitis was induced in $TCR^{-/-}$ recipients of wt RB^{Hi} T cells. Recipients of IL-$4^{-/-}$ RB^{Hi} T cells also developed a severe colitis (Figure 1). We noted that $TCR^{-/-}$ recipients of either wt or IL-$4^{-/-}$ RB^{Hi} T cells developed a duodenitis with a heavy cell infiltration, which was rarely described in SCID recipients previously. These changes were limited to the duodenum within 5 cm of the pylorus, and both the jejunum and ileum remained normal. We also found that these mouse recipients developed an inflammation of the stomach, especially in the antral region. When recipients of wt, IL-$4^{-/-}$, or IFN-$\gamma^{-/-}$ RB^{Hi} T cells were compared, recipients of IL-$4^{-/-}$ T cells developed the most severe gastritis and those mice receiving IFN-$\gamma^{-/-}$ T cells showed only minimal changes (Figure 1). Interestingly, SCID recipients of either wt or IL-$4^{-/-}$ RB^{Hi} T cells showed mild lesions in the stomach, with only slight cell infiltration. Adoptive transfer of wt or IL-$4^{-/-}$ $CD45RB^{low}$ T cells did not result in gastritis, duodenitis, or colitis (data not shown).

Pathological Features of Gastritis

In all 10 $TCR^{-/-}$ recipients of IL-$4^{-/-}$ RB^{Hi} T cells, the gastric antral and duodenal mucosa were increased in

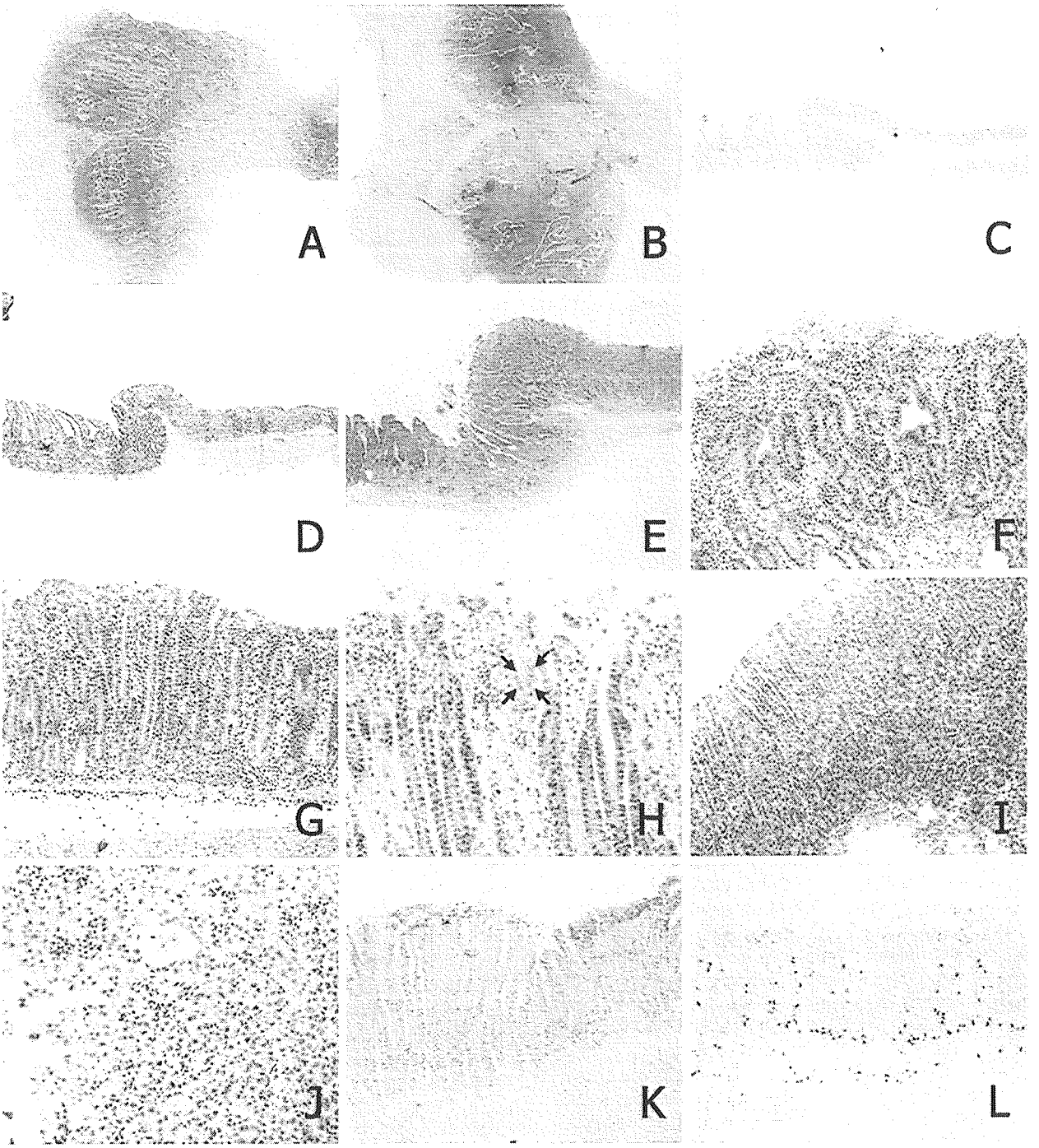

Figure 2. Macroscopic and histological features of murine gastritis. **A:** Normal stomach tissue taken from naïve $TCR^{-/-}$ mice. **B:** Inflamed stomach from $TCR^{-/-}$ mice after adoptive transfer of IL-$4^{-/-}$ RB^{Hi} T cells. **C:** The gastroduodenal junction of naïve $TCR^{-/-}$ mice. **D:** The gastroduodenal junction of the SCID recipients given IL-$4^{-/-}$ RB^{Hi} T cells. **E:** The gastroduodenal junction of the $TCR^{-/-}$ recipients given IL-$4^{-/-}$ RB^{Hi} T cells. **F:** The inflamed gastroduodenal junction with erosion. **G** and **H:** Antral gastritis with surface erosion and elongation of pits of $TCR^{-/-}$ recipients of IL-$4^{-/-}$ RB^{Hi} T cells. **Arrows** indicate a multinuclear giant cell. **I:** The fundic lesion with mild changes was taken from the same specimen as shown in **G**. **J:** Cell infiltration and dilated pits including migrating cells in the surface of the gastric fundic region in $TCR^{-/-}$ recipients of IL-$4^{-/-}$ RB^{Hi} T cells. **K:** Histochemistry for peroxidase of the antral region $TCR^{-/-}$ recipients of IL-$4^{-/-}$ RB^{Hi} T cells. As positive control, a section from a mouse with colitis induced by dextran sulfate with neutrophil infiltration was used (**L**). Sections were counterstained with methylgreen. Images were captured using a ×4 objective lens (**C**, **D** and **E**), ×20 lens (**G**, **I**, **K**, and **L**) or ×40 lens (**F**, **H**, and **J**).

thickness and exhibited an overall turbid appearance. In five recipients of IL-$4^{-/-}$ RB^{Hi} T cells, the gastric fundic area was also edematous, and erosions with petechiae were seen (Figure 2, A and B). Histological examination revealed that the inflammation was accompanied by hypertrophy of glands and elongation of pits, and these changes were most evident at the gastro-duodenal junction (Figure 2, C to F). Most typically, the antral glands were elongated more than twofold longer than their normal length with pit dilatation in some parts, and mononuclear cell infiltration in the

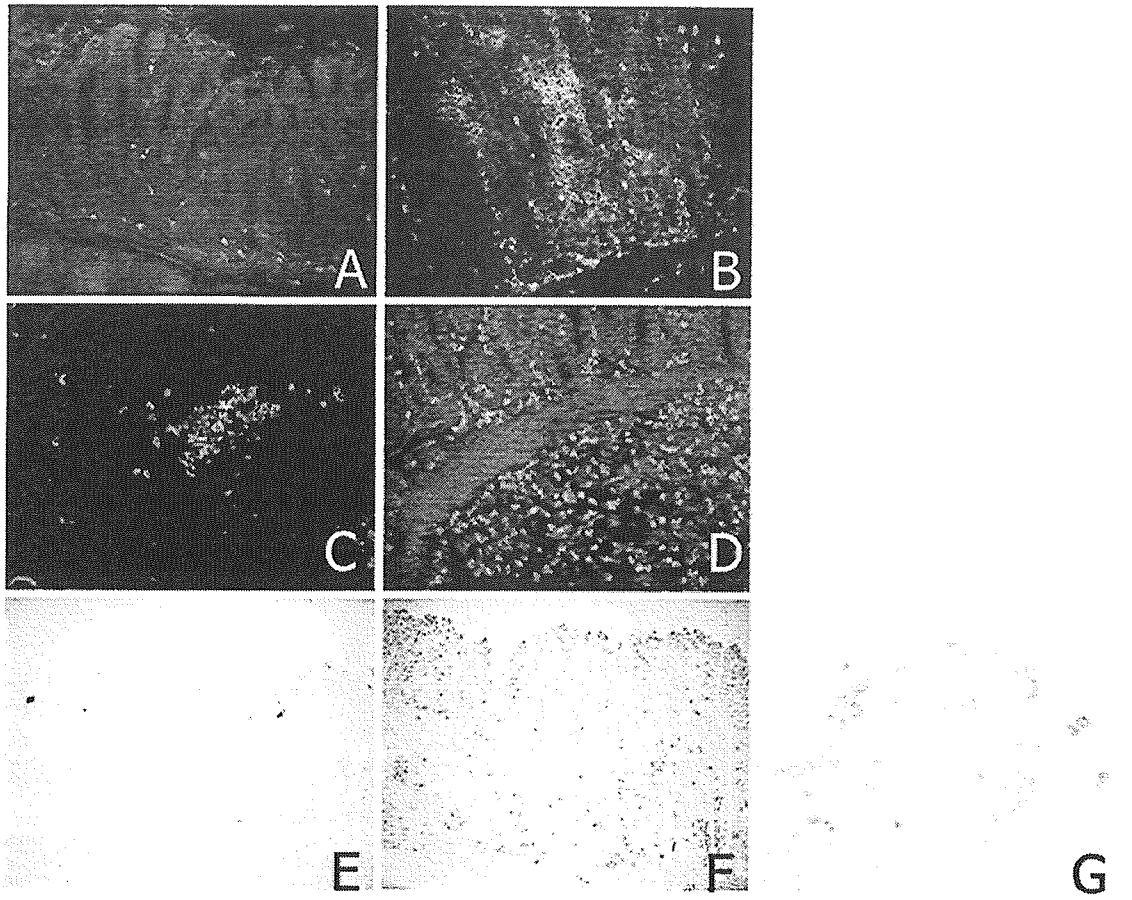

Figure 3. Immunohistochemistry and detection of apoptosis. $CD4^+$ T cells in the antrum of a SCID recipient of IL-$4^{-/-}$ RB^{Hi} T cells (**A**). $CD4^+$ T cells (**B**), $B220^+$ cells (**C**), and $CD11b^+$ cells (**D**) in the inflamed antrum of $TCR^{-/-}$ mouse recipients of IL-$4^{-/-}$ RB^{Hi} T cells. Apoptotic cells were detected by TUNEL in $TCR^{-/-}$ recipients of wt RB^{Hi} T cells (**E**) or IL-$4^{-/-}$ RB^{Hi} T cells (**F** and **G**). Images were captured using a ×20 objective lens (**A-F**) or ×100 lens (**G**).

recipients of wt and IL-$4^{-/-}$ RB^{Hi} T cells was seen (Figure 2G). In addition to these findings, recipients of IL-$4^{-/-}$ RB^{Hi} T cells developed surface erosions with multinuclear giant cell infiltration (Figure 2H). Neutrophil infiltration was not frequent in the stomach or the duodenum as shown in the histochemical reaction of myeloperoxidase (Figure 2, K and L). In 50% of IL-$4^{-/-}$ T cell recipients, a fundic inflammation with mononuclear cell infiltration and deformity of glandular pits with cells migrating into the dilated pits were seen (Figure 2J), while the other 50% of mice showed only mild changes (Figure 2I). In both cases, destruction specific for parietal cells was not seen. In the inflamed stomach, a massive infiltration of $CD4^+$ T cells occurred (Figure 3B), an event scarcely seen in SCID recipients (Figure 3A). Furthermore, B cell aggregates were also detected by staining with anti-B220 mAb (Figure 3C). We also assessed the presence of plasma cells in the inflamed areas; however, no IgG-, IgA- or IgM-containing cells were seen in the gastric mucosa by immunostaining (data not shown). The infiltrating cells were mostly macrophage-like cells as shown by staining with anti-CD11b Ab (Figure 3D). On the other hand, there was no expansion of $CD11c^+$ dendritic cells in the inflamed stomach (data not shown). Since surface erosion was enhanced in the gastric mucosa of recipients of IL-$4^{-/-}$ RB^{Hi} T cells, we also assessed apoptosis. In recipients of wt RB^{Hi} T cells, although there was elongation of glands and a cell infiltration, apoptotic cells were rare in the epithelium (Figure 3E). In contrast, in recipients of IL-$4^{-/-}$ RB^{Hi} T cells, the numbers of apoptotic cells were clearly increased. Apoptosis was readily detected in the infiltrating cells in all layers of the mucosa and especially in the surface epithelium (Figure 3, F and G).

Pathological Features of Duodenitis

Duodenal inflammation was seen in $TCR^{-/-}$ mouse recipients of both wt and IL-$4^{-/-}$ RB^{Hi} T cells. The villi and crypts were both remarkably elongated, and the villi were dilated due to the cell infiltration (Figure 4, B and C). In the lamina propria, multinuclear giant cells were frequently seen; however, granulomas were absent (Figure 4D). Immunohistological analysis revealed an infiltration of $CD4^+$ cells (Figure 4E), expansion of dendritic cells and an infiltration of macrophages (Figure 4F), which were not seen in naive $TCR^{-/-}$ mice.

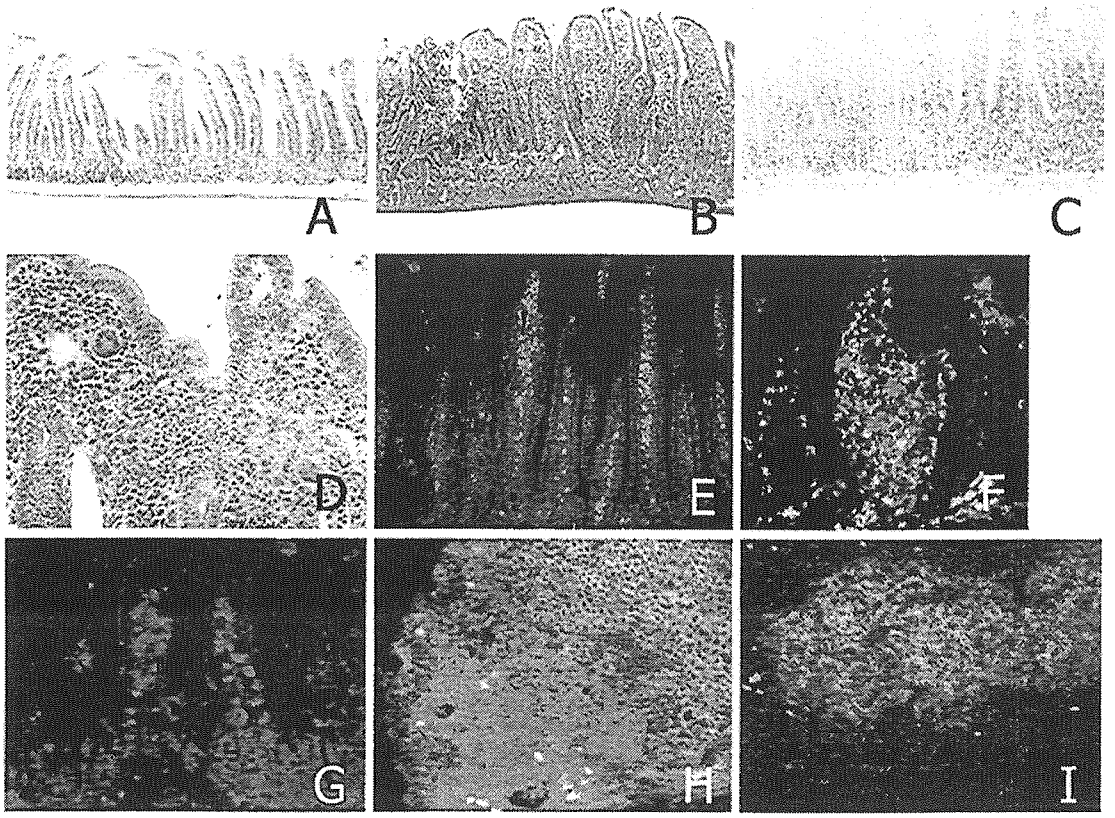

Figure 4. Histological features of murine duodenitis. **A:** H&E staining of duodenum of $TCR^{-/-}$ mice without cell transfer. **B:** Inflamed duodenum of $TCR^{-/-}$ recipients of wt RB^{Hi} T cells. **C** and **D:** Inflamed duodenum of $TCR^{-/-}$ recipients of IL-$4^{-/-}$ RB^{Hi} T cells. Dilated villus of duodenal tissue was stained with anti-CD4 (green, **E**), and anti-CD11b (green) and anti-CD11c (red) mAbs (**F**). Some $CD11c^{+}$ cells also express CD11b. **G:** IgA AFCs in the duodenum of recipients of wt RB^{Hi} T cells. **H:** Peyer's patches from recipients of wt RB^{Hi} T cells stained with anti-B220 (green) and anti-CD3 (red) mAbs. **I:** Peyer's patches of $TCR^{-/-}$ mice without T cell transfer. Images were captured using a ×10 objective lens (**A-C**), ×20 (**E**), or ×40 lens (**D**, **F–I**)

Production of Cytokines

To assess cytokine production by T cells that infiltrated the mucosa of adoptive hosts, $CD4^{+}$ T cells were isolated from LPLs of the small intestine. The $CD4^{+}$ T cells recovered from recipients of wt or IL-$4^{-/-}$ RB^{Hi} T cells released both IFN-γ and IL-2 (Figure 5A). It should be noted that T cells from the recipients of wt RB^{Hi} T cells also produced high levels of IL-4 (Figure 5A). We also noted that T cells infiltrating the gastric mucosa produced IFN-γ in the $TCR^{-/-}$ recipients of IL-$4^{-/-}$ T cells (Figure 5B), although T cells from recipients of IL-$4^{-/-}$ T cells tended to contain slightly more IFN-γ producing cells than recipients of wt RB^{Hi} T cells, as determined by flow cytometry (Figure 5B). Thus, IFN-γ release by T cells recovered from recipients of wt or IL-$4^{-/-}$ RB^{Hi} T cells were, for the most part, comparable. However, the lack of IL-4 secretion resulted in a remarkable phenotype, which contributed to the distinct and severe gastritis in $TCR^{-/-}$ recipients of IL-$4^{-/-}$ RB^{Hi} T cells. Further, to prove that the milder gastritis in SCID than in $TCR^{-/-}$ recipients of IL-$4^{-/-}$ RB^{Hi} T cells, we quantitatively assessed TNF-α, IFN-γ, and IL-10 by RT-PCR from total RNA extracts taken from the gastric antrum. Expression of IFN-γ and TNF-α in $TCR^{-/-}$ recipients was higher than those seen in SCID recipients (Figure 5C).

Mucosal and Systemic B Cell Responses in $TCR^{-/-}$ Recipients of RB^{Hi} T Cells

It should be noted that $TCR^{-/-}$ recipients of either wt or IL-$4^{-/-}$ RB^{Hi} T cells exhibited IgA-positive cells in the small intestine, including the duodenum (Figure 4G). Peyer's patches were also reconstituted with distinct T and B cell zones (Figure 3H), which were filled with $B220^{+}$ cells in $TCR^{-/-}$ mice before T cell transfer (Figure 3I). The plasma Ig levels were also elevated following adoptive transfer of either wt or IL-$4^{-/-}$ RB^{Hi} T cells. The IgG levels were comparable in both groups; however, the IgA levels were lower in recipients of IL-$4^{-/-}$ RB^{Hi} T cells than recipients of wt RB^{Hi} T cells (Figure 6A). The numbers of AFCs in the small intestine in $TCR^{-/-}$ recipients were also reconstituted by adoptive transfer of RB^{Hi} T cells. Numbers of IgG and IgA secreting cells were much less frequent in $TCR^{-/-}$ recipients of IL-$4^{-/-}$ T cells than those mice given wt T cells (Figure 6B). Thus, systemic IgG responses were fully reconstituted in both groups of mice; however, recipients of IL-$4^{-/-}$ T cells exhibited little class switching to the IgG or IgA isotypes. Plasma from these mice did not contain autoreactive Abs when assessed by the binding capacity to sections prepared from the stomach of naïve mice.

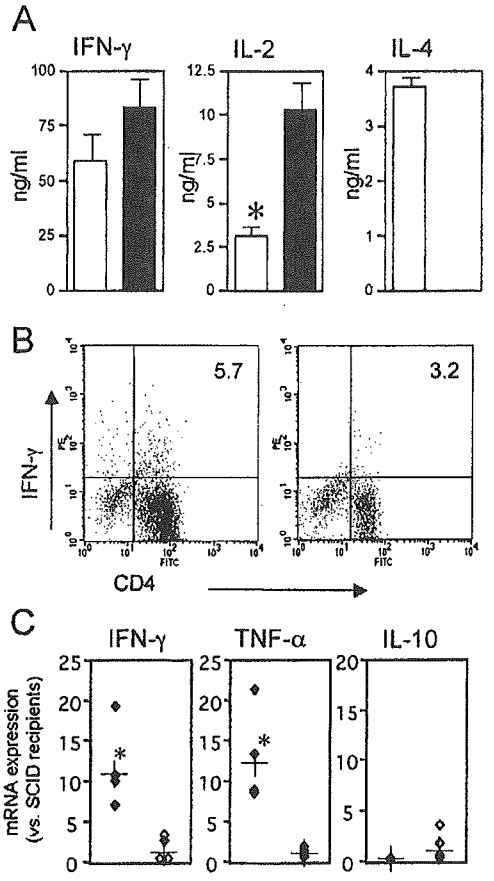

Figure 5. Production of cytokines by CD4$^+$ T cells infiltrating the GI tract. **A:** CD4$^+$ T cells were isolated from the small intestine of TCR$^{-/-}$ recipients of wt (**blank column**) or IL-4$^{-/-}$ (**solid column**) RB^{Hi} T cells and stimulated with anti-CD3 mAb for 48 hours. Culture supernatants were subjected to a cytokine ELISA. Values shown are the mean of three experiments obtained from pooled cells from three mice in each group. The results shown are the mean and SD. The difference was statistically significant. **B:** Production of IFN-γ by infiltrating cells. LPLs were prepared from the inflamed gastric mucosa of TCR$^{-/-}$ recipients of IL-4$^{-/-}$ (**left**) or wt (**right**) RB^{Hi} T cells, stimulated with anti-CD3 and anti-CD28 mAbs for 48 hours, and subjected to intracellular cytokine analysis. **C:** Relative expression of mRNA for cytokines in the stomach in TCR$^{-/-}$ and SCID recipients of IL-4$^{-/-}$ RB^{Hi} T cells determined by quantitative RT-PCR. Total RNA was extracted from the antral mucosa, and mRNA for individual cytokines and GAPDH were analyzed. Based on the average ΔC_T value of four SCID recipients, data from individual mice were shown as relative expression to SCID mice. Results from four mice are shown and the results indicated as (+) are the average of relative expression for each group. *, Statistically significant difference from SCID recipients.

Gastritis Was Dependent on the Presence of a Microflora

To this point, we found that gastritis was induced in the TCR$^{-/-}$ recipients of RB^{Hi} T cells without infection of pathogenic bacterial strains. However, the indigenous microflora in the upper GI tract or bacteria in ingested food may play a role in the induction of gastritis. To clarify this, we gave mice neomycin, streptomycin, bacitracin, and metronidazole in their drinking water following transfer of IL4$^{-/-}$ RB^{Hi} T cells. This treatment essentially eliminated the indigenous flora in the oral cavity and the stomach (Table 1), and efficiently suppressed the gastritis. Interestingly, the effect on gastritis was efficient but

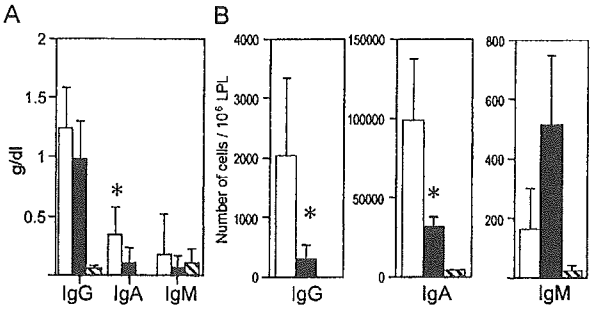

Figure 6. Reconstitution of systemic and mucosal Ig production. **A:** Plasma Ig levels in TCR$^{-/-}$ recipients of wt RB^{Hi} T cells (**blank column**), IL-4$^{-/-}$ RB^{Hi} T cells (**solid column**) or naïve TCR$^{-/-}$ mice (**shaded column**). **B:** Numbers of IgG, IgA, or IgM secreting cells in the small intestinal LPLs isolated from TCR$^{-/-}$ recipients of wt (**blank column**), IL-4$^{-/-}$ RB^{Hi} (**solid column**) or naïve TCR$^{-/-}$ mice (**hatched column**) was determined by ELISPOT assay. Values shown are the mean and a SD of each group containing 4 to 7 mice.

only partial, whereas colitis was completely blocked in these mice (Figure 7). These results indicated that induction of gastritis was partially dependent on the indigenous microflora, while colitis essentially required its presence.

Discussion

We have established a new model for gastritis that is induced by adoptive transfer of RB^{Hi} T cells incapable of production of IL-4 (Th1-prone T cells). The gastritis and duodenitis develops in the absence of a particular bacterial pathogen, such as *Helicobacter spp.* and is also distinct from autoimmune models of gastritis. The first major finding was that this pathogen-free gastritis developed after adoptive transfer of IL-4$^{-/-}$ RB^{Hi} T cells into TCR$^{-/-}$ mice. Gastritis did not occur after transfer of IL-4$^{-/-}$ RB^{Hi} T cells into SCID mice, clearly suggesting a requirement for B cell responses for full-blown gastric inflammation. Finally, adoptive transfer of IL-4$^{-/-}$ RB^{Hi} T cells yielded greater mucosal damage when compared with TCR$^{-/-}$ recipients of wt RB^{Hi} T cells. Each of these significant new findings is discussed in more detail below.

Numerous studies have attempted to establish *in vivo* models for gastric inflammation following infection with *H. pylori*. In our model, we successfully induced gastritis without bacterial infection or specific immunization. Of course, several models for autoimmune gastritis are induced in the absence of pathogens. Autoimmune disease induced by thymectomy[36,37] or ionizing radiation[38] have both resulted in gastritis. These types of gastritis were associated with damage of parietal cells or loss of parietal and chief cells by autoantibodies to the gastric H$^+$/K$^+$-ATPase.[47,48] A similar type of autoimmune gastritis occurs spontaneously in C3H/He mice.[49] "Autoimmune gastritis" and "colitis induced in SCID/Rag2$^{-/-}$ recipients of RB^{Hi} T cell transfer" are both caused by the absence of CD4$^+$CD25$^+$ regulatory T cells, because gastritis was induced in nu/nu mice recipients of CD25$^-$ T cells prepared from CD25$^+$ cell-depleted mice.[50] However, these two models have not been compared with each other very often. Importantly, autoimmune gastritis

Table 1. Total Viable Aerobic and Anaerobic Counts of the Whole Stomach and the Oral Mucosa of Antibiotic-Treated and Nontreated $TCR^{-/-}$ Mice (or mean CFU ± SD of 3 mice)

	Untreated	Treated
Aerobes		
Stomach (10^3 CFU/a whole stomach)		
Brain-heart infusion agar	159.3 ± 67.2	1.1 ± 0.7
Chocolate agar	167.0 ± 98.7	1.0 ± 0.6
Blood agar	80.3 ± 25.5	1.0 ± 0.5
Oral mucosa (CFU/swab)		
Brain-heart infusion agar	1969 ± 309	35 ± 36
Anaerobes		
Stomach (10^3 CFU/a whole stomach)	305.6 ± 119.7	1.2 ± 0.4
Oral mucosa (CFU/swab)	1444 ± 287	39 ± 30

induced by neonatal thymectomy was not dependent on a microflora.[51] Autoimmune gastritis was seen in germ-free mice with similar severity of inflammation, and autoantibody levels were comparable to those seen in conventional mice. In contrast, as shown in Figure 7, our gastritis model was dependent, in a significant way, on the microflora. Further, no anti-parietal cell autoantibody could be detected. Besides a requirement for a microflora and the absence of autoantibody, our model is different from autoimmune gastritis in several important ways. For example, although neonatal thymectomy caused gastritis as well as autoimmune oophoritis, orchitis, thyroiditis, pancreatitis, and prostatitis,[37,52] colitis has not been described previously. In contrast, the colon was a major organ affected by RB^{Hi} T cell transfer in SCID/$RAG2^{-/-}$/$TCR^{-/-}$ recipients, which requires the presence of a microflora. Further, in autoimmune gastritis, lesions are limited to the gastric corpus, and parietal cell destruction was the main histological feature. On the other hand, our model showed more severe inflammatory changes in the antral mucosa. Since other autoimmune disease models such as spontaneous gastritis in MRL-lpr mice were also independent of a microflora or infection,[37,52] it seems that different subsets of T regulatory cells are affected in autoimmune models and RB^{Hi} T cell-induced colitis/gastritis models. Thus, our model is quite distinct from autoimmune gastritis reported previously.

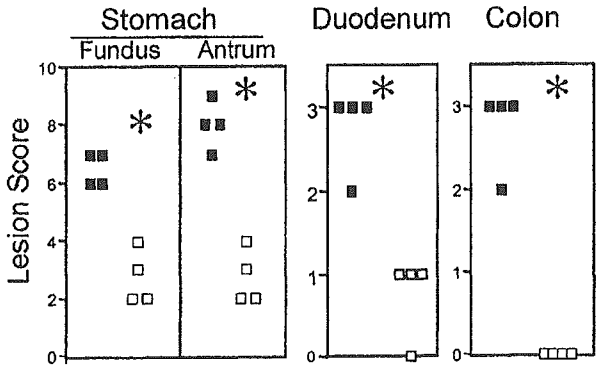

Figure 7. Treatment of recipient mice with antibiotics. A preparation of $IL\text{-}4^{-/-}$ RB^{Hi} T cells was transferred to eight $TCR^{-/-}$ mice (including two sets of male littermates in each experimental group). Four of these mice were given a combination of antibiotics in their drinking water (**blank squares**), and after 10 weeks histological scores were compared with control mice without treatment (**solid squares**).

$TCR^{-/-}$ recipients of wt or $IL\text{-}4^{-/-}$ T cells developed gastroduodenitis as well as colitis; however, no obvious changes in the jejunum or ileum were seen. This anatomical localization suggests the possible involvement of lumenal foreign antigens in the development of this type of inflammation. Colitis induced in SCID or $RAG2^{-/-}$ mice by adoptive transfer of RB^{Hi} T cells does not occur in the absence of an indigenous flora.[10,11] Through extensive testing for *Helicobacter spp.*, no pathogenic strains (including *Helicobacter* spp.) were detected in mice, which developed gastritis and duodenitis. In addition, neutrophil infiltration, which generally indicates bacterial infection, was not seen in the stomach or the duodenum in our model. On the other hand, $TCR^{-/-}$ recipients of $IL\text{-}4^{-/-}$ RB^{Hi} T cells developed a milder form of gastritis when they were treated with antibiotics. Of note, colitis was totally blocked in this group of mice. These results indicate that gastritis was partially dependent on an indigenous microflora, while colitis essentially required its presence. We speculate that orally ingested microbes or indigenous microflora in upper GI tract, in addition to food antigens, which have not been fully degradated in the stomach or duodenum, may play a similar role in this type of inflammation.

Another novel aspect of our model is the use of $TCR^{-/-}$ mice, as opposed to SCID or $RAG^{-/-}$ mice. Thus, $TCR^{-/-}$ mice lack T cells but have a fully responsive B cell repertoire. Indeed, after adoptive transfer of RB^{Hi} T cells, $TCR^{-/-}$ mice exhibit increased plasma IgG levels, and AFCs were seen in the mucosal tissues. The fact that transfer of RB^{Hi} T cells resulted in colitis and duodenitis but not gastritis in SCID mice clearly suggests the involvement of B cells in the pathogenesis of gastritis. In this regard, a different colitis model has also shown that B cells play protective roles from inflammation.[53] However, no AFCs were seen in the inflamed stomach tissues themselves, although small B cell aggregates were detected. Further, mucosal IgA production and IgA AFCs were actually lower in $TCR^{-/-}$ recipients of $IL\text{-}4^{-/-}$ RB^{Hi} T cells when compared with recipients of wt RB^{Hi} T cells, despite the more significant gastritis which characterize $IL\text{-}4^{-/-}$ RB^{Hi} T cell recipients. On the other hand, plasma IgG levels in $IL\text{-}4^{-/-}$ RB^{Hi} T cell recipients were comparable to recipients of wt RB^{Hi} T cells. The role of B cells and Ab production in our model certainly needs to be further investigated. We speculate that the presence of B cells and antibody production increases the sensitivity of

T cells to be triggered into an inflammatory expansion as well as the activation of macrophage-type cells. Our results suggest that TCR$^{-/-}$ recipients were more sensitive than SCID recipients and the former mice would be able to fully respond to the foreign antigens in the upper GI tract. To increase this sensitivity, T/B cell interactions are likely involved, although this interaction may not necessarily occur in the local mucosa but could occur in any lymphoid tissue, such as spleen or mesenteric lymph nodes. In the case of *H. pylori* infection, it is known that the presence of anti-*H. pylori* Abs are not required for the exclusion of bacteria,[53] but rather the Abs are actually involved in the pathogenesis of gastritis in humans[54] and mice due to antigenic mimicry.[55] Although we could not detect autoantibodies against the gastric parietal cells or H^+/K^+-ATPase, the presence of elevated Ig levels of particular idiotypes could play a role in the gastritis. In this regard, for our model of gastritis in the absence of infection or immunization, one could implicate molecular mimicry between any bacterial LPS and host blood group determinants[56–59] as an attractive hypothesis, although there is no direct evidence that this phenomenon actually occurs.

There is now clear evidence for a central role of T cell-mediated immunity in gastric inflammation. In the RB^{Hi} T cell transfer model described here, Th1-type cytokine production was required for the induction of colitis and gastroduodenitis, since transfer of IFN-$\gamma^{-/-}$ RB^{Hi} T cells resulted in much milder gastroduodenal inflammation (Figure 1) and colitis.[17] On the other hand, it is well known that IL-4 suppresses cytokine gene expression induced by IFN-γ and IL-2 in murine peritoneal macrophages.[60,61] The severe tissue damage in recipients of IL-4$^{-/-}$ RB^{Hi} T cells was likely caused by enhanced IFN-γ and IL-2 production by IL-4$^{-/-}$ T cells due to their predisposition toward a Th1-phenotype. However, the levels of IFN-γ release by isolated T cells were comparable in these mice. These quantitative differences in Th1 cytokines may not fully explain the fact that the epithelial cell apoptosis and surface erosion was much more frequent in IL-4$^{-/-}$ than in wt RB^{Hi} T cell recipients. Since IL-4 is a cytokine that has pleiotropic effects on a variety of cell types, including epithelial cells and other non-hematopoietic cells, a lack of IL-4 production by infiltrating T cells may have an impact on tissue repair in addition to a cytokine imbalance. Gastritis induced by infection with pathogenic *H. pylori* in IL-4$^{-/-}$ mice was more severe than that in IFN-$\gamma^{-/-}$ mice.[62] In a rat acute gastric ulcer model, healing was accompanied by a rapid rise in tissue IL-4 levels.[63] IL-4$^{-/-}$ mice were more susceptible to the colitis induced by administration of trinitrobenzene sulfonic acid, and tended to develop focal but penetrating ulcers, which were not frequently seen in IFN-$\gamma^{-/-}$ mice.[64] It is also known that fibroblasts express the IL-4 receptor, and Th2-type cells activate lung fibroblasts with resultant increase in deposition of collagen and fibronectin.[65,66] In the airway or ileal epithelium, IL-4 induces mucin gene expression[67] and goblet cell metaplasia.[17,67] Thus, IL-4 may be significantly involved in the epithelial cell turnover and tissue protection required for the maintenance of the gastrointestinal tract architecture, in addition to its role as a mediator for allowing immunological homeostasis in the gut.

In summary, we have established a novel murine model for the upper gastrointestinal tract, which does not require pathogen infection or deliberate immunization. The inflammation was mediated by Th1-type immune responses restricted to a particular subset of T cells isolated from normal mice. This model also points to the significance of the host immune system in gastric lesions and should be of importance to help better understand the pathophysiology of chronic gastroduodenitis seen in *H. pylori* infection of humans.

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