The ECL intensity at each addressable point was found to be linear with the concentration of $Ru(bpy)_3^{2+}$ in the range of $1 \times 10^{-8}$–$2 \times 10^{-7}$ mol $L^{-1}$ with a detection limit of $4 \times 10^{-9}$ mol $L^{-1}$ (shown in Fig. 4(B)).

In summary, this is the first report of an addressable ECL detection system based on the redox-cycling system. The detection can be performed in a 'direct way' without adding any co-reactant. The device is simple but can provide ECL responses with redox-cycling at each addressable point easily. Though the system developed in this study was carried out in an organic solution, it can also be carried out in aqueous medium, which makes is possible to develop immunoassays involving redox-cycling type ECL as the detection principle.

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# Myomectomy reduces endometrial T2 relaxation times

Magnetic resonance imaging was used to measure the endometrial T2 relaxation times of patients with infertility with fibroma. Although the location of fibromas did not influence the T2 relaxation times, we did observe a significant decrease in endometrial T2 relaxation times after myomectomy. (Fertil Steril® 2011; ■: ■–■. ©2011 by American Society for Reproductive Medicine.)

**Key Words:** MRI, T2 relaxation time, fibroid, myomectomy, endometrium

Although uterine fibroids, which occur in 20% to 50% of women, are the most common type of solid pelvic tumor (1), the relationship between fibroids and infertility is not well established (2, 3). It has been reported that myomectomy can increase the pregnancy rate for patients with infertility (4). However, the mechanisms by which this occurs are not well understood. Several theories have been proposed. First, it is possible that fibroids alter uterine cavity contour, resulting in mechanical pressure. Alternatively, the fibroids may induce abnormal uterine contractility (5, 6). Finally, local inflammation associated with the presence of fibroids may give rise to a hostile endometrial environment that impairs sperm transport and embryo implantation (5). It has been reported that excessive concentrations of inflammatory cytokines have deleterious effects on embryonic development and implantation (7, 8). Inagaki et al. (9) demonstrated that uterine cavities containing fibroids exhibit a state of excess inflammation, with up-regulation of matrix metalloproteinases and inflammatory cytokines such as interleukin-1 and tumor necrosis factor $\alpha$.

Magnetic resonance imaging (MRI) is a high-resolution method of differentiating soft tissues. In MRI, the nuclei of atoms in samples first are aligned along a static magnetic field, then are excited to a higher-energy state by a radiofrequency signal, and then return to a lower-energy equilibrium state. T2 relaxation time is a parameter that describes the relaxation to the equilibrium state once the radiofrequency signal is turned off. As an assessment of inflammatory status, T2 relaxation time is a useful way to detect the inflammatory status of rheumatoid disease (10, 11), dermatomyositis (12), and Graves' orbitopathy in Graves' disease (13, 14). In the present study, we investigated the endometrial T2 relaxation times of patients with infertility with fibroma. We compared T2 relaxation times before and after surgery to examine the effect of myomectomy on the endometrium of patients with uterine fibroids.

A total of 35 patients with uterine fibroids who desire pregnancy were examined by MRI between September 2008 and October 2010 at Takinogawa Clinic. Inclusion criteria were as follows. First, patients had intramural- or submucosal-type fibroid. Second, in advance of MRI all patients underwent screening for ovulation and corpus luteum function. Patients had regular menstrual cycles of approximately 28 days. Basal levels of serum FSH, LH, and PRL on menstrual cycle day 3 through 5 were within normal range (criteria: FSH 3.5–12.5 mIU/mL, LH 2.4–12.6 mIU/mL, and PRL 4.9–29.3 ng/mL). Serum $E_2$ and P concentration in midluteal phase were >100 pg/mL and 10 ng/mL, respectively. After the screening test, ovarian functional status was monitored by basal body temperature (BBT) chart. An analysis was performed of BBT graphs, in which a rise in temperature of at least 0.2°C above that of the preceding 6 days that was completed in <48 hours and sustained for at least 11 days would indicate the occurrence of ovulation (15). All patients included in this study showed unequivocal biphasic cycles in their BBT chart. We designated the first day showing elevated temperature of at least 0.2°C as luteal phase day 1. Third, MRI was performed during the time of implantation window (luteal phase day 5–day 9), judged retrospectively by BBT chart (judged by gynecologists O.Y. and H.T.).

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By routine MRI study, the information retrieved included the location, number, and size of fibroids. Magnetic resonance studies were performed with use of a 1.5-T magnet unit (MRI machine from Siemens Japan, Shinagawa, Japan). Subsequently, conventional axial and sagittal T2–weighted images (repetition time [TR]/echo time [TE] = 4560–4720/107–111 milliseconds) and axial T1–weighted images (TR/TE = 550/8.5 milliseconds) were obtained with use of fast spin-echo techniques. T2 relaxation times of endometrium were measured on the same slice (350-mm field of view, 132 × 192 matrix, 3-mm slice thickness, bandwidth 362 Hz) with use of a spin-echo sequence. Eight images were acquired at each of the following TEs: 1.7, 23.4, 35.1, 46.8, 58.5, 70.2, 81.9, 93.6, 105.3, 117, and 128 milliseconds. The TR was 3 seconds, giving a total of 509 seconds acquisition time.

Ten out of 35 patients underwent myomectomy at Teikyo Mizonokuchi hospital. Among these 10 patients, 9 patients underwent laparoscopic-assisted myomectomy, and 1 patient underwent transcervical resection of fibroma. Four to 6 months after surgery, patients underwent a second MRI to evaluate T2 relaxation times during the implantation window. For statistical analysis, the Mann-Whitney *U* test was used for comparing between groups, and the paired *t*-test was used for comparing results before and after surgery.

T2 relaxation times in uterine endometrium obtained from patients with infertility who had intramural-type (n = 24) and submucosal-type (n = 12) fibroids were compared. We examined data from the midluteal phase. As shown in Figure 1A, the median value and minimum to maximum data of the two groups were 213 milliseconds (99–368 milliseconds) and 187 milliseconds (111–455 milliseconds) in intramural fibroids and submucosal fibroids, respectively. There was no statistical difference between groups ($P$=.9).

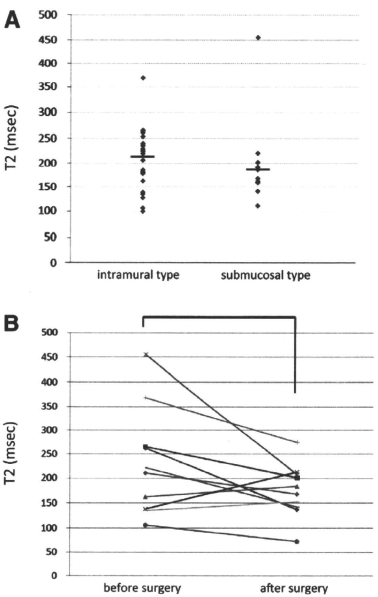
Because T2 relaxation times in the endometrium were comparable between intramural and submucosal fibroids (Fig. 1A), the data from both groups were combined in the subsequent study. After myomectomy, 10 patients underwent MRI at midluteal phase, and T2 relaxation times in the endometrium before and after surgery were compared. Of the 10 patients, 7 underwent surgery for intramural-type fibroids, and 3 underwent surgery for submucosal-type fibroids. As shown in Figure 1B, T2 relaxation times were decreased significantly after surgery ($P$=.03).

In the present study, we investigated the endometrial T2 relaxation times of patients with infertility with fibroma. We found that the endometrial T2 relaxation times were comparable regardless of the location of fibromas. Moreover, endometrial T2 relaxation times obtained after myomectomy were shortened significantly compared with the results before surgery.

Management of fibroids continues to present difficulties when used to treat infertility, because of a lack of understanding of the mechanisms by which fibroids impede pregnancy. Although myomectomy is recognized as a method to increase the rate of pregnancy (4), the precise mechanism of its contribution to fertility remains uncertain. It has been reported that the local inflammation associated with the presence of fibroids may result in a hostile endometrial environment that impairs fertility (7–9). Inagaki et al. (9) proved that the uterine cavities of patients with fibroids exhibited excessive inflammatory status. Accordingly, myomectomy might increase the fertility rate by decreasing the inflammatory status of the endometrium. In that study, 5 mL of saline solution was injected into the uterine cavity, and matrix metalloproteinase and cytokine levels of the fluid were measured to determine the inflammatory status directly (9). However, the volume of the uterine cavity can be decreased after removal of fibroids, making it difficult to compare precisely the inflammatory status before and after surgery. Therefore, it is necessary to develop less-invasive techniques that can estimate the inflammatory status of the uterine cavity. In the present study, we focused on T2 relaxation times obtained by MRI. This technique has proved useful in detecting the inflammatory activity of rheumatoid disease (10, 11), dermatomyositis (12), and Graves' orbitopathy in Graves' disease (13). Here, we observed a significant decrease in T2 relaxation times in patients examined after myomectomy. This suggests that myomectomy may suppress inflammatory activity in the endometrium.

**FIGURE 1**

(**A**) T2 relaxation times in uterine endometrium obtained from patients with infertility who had intramural-type (n = 24) and submucosal-type (n = 12) fibroids were compared. The data from the midluteal phase were examined. (**B**) Ten patients underwent myomectomy and received MRI examination at the midluteal phase before and after surgery. T2 relaxation times in the endometrium were compared $P$=0.03.

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T2 relaxation times in the human endometrium have been examined throughout the menstrual cycle. Varpula et al. (16) reported that a rapid increase in T2 relaxation times occurred during the proliferative phase, followed by little or no increase through the middle of the secretory phase. Hoad et al. (17) also reported that, during the periovulatory phase, T2 relaxation times were longer than in the other phases. They also observed that the variation in uterine tissue relaxation times between subjects was greater than the intrasubject cycle variation. Because of the large "normal" range, it might be very difficult to compare subjects or determine pathologic changes in the tissues from just a single measurement. However, because individuals exhibited similar increases and decreases over the menstrual cycle, the changes in T2 relaxation times within the same subject can be evaluated (17). Therefore, by comparing T2 relaxation times at the same menstrual phase obtained before and after myomectomy, the effect of surgery could be estimated. In our experiment, T2 relaxation times were measured during the "implantation window," the luteal phase day 5 to 9. We observed that there is no significant difference in T2 relaxation times between patients with fibroma and healthy volunteers (data not shown). Thus, measurement of T2 relaxation times would not be an effective way to detect uterine abnormalities, but it can be used to assess the success of myomectomy and is valuable in increasing our understanding of the pathophysiology of uterine fibroids in infertility. Other than inflammation (12, 14), iron content (18) is also known to increase T2 relaxation times. Therefore, further study is needed to confirm that T2 changes after myomectomy actually represent the change of inflammatory status in endometrium. This work represents a first step toward better understanding the relationship between T2 relaxation times and uterine fibroids in patients with infertility.

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# High Mobility Group Box 1 (HMGB1) Levels in the Placenta and in Serum in Preeclampsia

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**Keywords**
Apoptosis, hypoxia, inflammation, oxidative stress, receptor for advanced glycation end products, toll-like receptors

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**Problem**
Preeclampsia is a pregnancy disorder characterized by systemic inflammation. High mobility group box 1 (HMGB1) is a molecule known to act as a 'danger signal' by participating in various inflammatory processes, but data in regard to preeclampsia are sparse. The aim of this study was to analyze placental and serum HMGB1 levels in normal pregnancy and preeclampsia.

**Method of study**
Sera were collected from women with preeclampsia soon after the manifestation of the disease and before commencing any medication. Placental samples were collected immediately after delivery. Expressed isoforms of HMGB1 (28- and 30-kDa) in the placenta were evaluated by Western blot analysis. Serum HMGB1 concentrations were measured using enzyme-linked immunosorbent assays (ELISA).

**Results**
Two isoforms of HMGB1 are expressed by the human placenta. The 28- and 30-kDa HMGB1 isoforms were expressed highly in preeclamptic placental tissue; however, compared with normotensive control tissue, differences in detected expression levels did not reach statistical significance. No significant difference was observed in serum HMGB1 levels between control and preeclampsia.

**Conclusion**
Inflammation provoked by HMGB1 is likely to be involved in the proinflammatory process in preeclamptic placenta. Further studies are needed to elucidate the precise role of HMGB1 in preeclampsia.

## Introduction

Preeclampsia is a placenta-originated disorder and affects 3–5% of all pregnancies. It remains as one of the leading contributors to maternal and fetal morbidity and mortality.[1] It is a disorder characterized by intravascular inflammation and endothelial cell dysfunction. Despite recent progress in research, the biology of preeclampsia is still poorly understood.[2]

High mobility group box 1 (HMGB1), a non-histone chromatin-associated protein, was discovered three decades ago as a nuclear protein that migrates quickly during electrophoresis and was named according to this property.[3] HMGB1 is released from damaged cells and acts as a 'danger signal' by

participating in various inflammatory processes, including maturation of immune cells, release of cytokines and other inflammatory mediators, and tissue remodeling.[4,5] HMGB1 mediates its inflammatory responses by signaling via receptors such as the receptor for advanced glycation end products (RAGE)[6] and toll-like receptor (TLR) 2 and TLR4.[7] Ligation for these receptors results in activation of nuclear factor kappa B (NFκB), which induces upregulation of leukocyte adhesion molecules and the production of proinflammatory cytokines in both hematopoietic and endothelial cells, thereby promoting inflammation.

It has been demonstrated that HMGB1 is involved in the pathogenesis of a variety of both infectious and non-infectious inflammatory conditions. Elevated levels of HMGB1 in serum and tissues are observed during infection and tissue injury, and targeting HMGB1 with specific antagonists can have protective effects in established inflammatory diseases. For instance, circulating HMGB1 levels are markedly increased during severe sepsis,[8] pneumonia,[9] systemic lupus erythematosis,[10] and in the synovial fluid of patients with rheumatoid arthritis.[11] Administration of HMGB1 antagonists has been reported to decrease organ damage and mortality in models of systemic inflammation such as sepsis,[12,13] brain infarction,[14] arthritis,[15] acute pancreatitis,[16] and lung inflammation.[17]

Preeclampsia is characterized by an inflammatory state that includes elevated levels of proinflammatory molecules in the placenta and maternal serum.[18] The expression of RAGE, one of the receptors for HMGB1, was reported to be significantly higher in preeclamptic placenta when compared with normal placental tissue.[19,20] TLR4, also a receptor for HMGB1, is expressed higher in trophoblasts from patients with preeclampsia compared to normal pregnancies.[21,22] As for HMGB1, Holmlund et al.[23] demonstrated its expression in the trophoblasts by immunohistochemistry. Further immunohistochemical analysis demonstrated higher expression levels of cytoplasmic HMGB1 in the decidua from women with preeclampsia compared with normal pregnancy, but the difference was not conclusive in trophoblasts.[23] The circulating level of HMGB1 in pregnant women has never been elucidated.

In this study, we measured HMGB1 levels in the placenta and serum in normal pregnancies and pregnancies complicated by preeclampsia to ascertain whether this molecule is involved in the pathogenesis of preeclampsia.

## Materials and methods

### Serum and Tissue Collection

The study was approved by the ethical committee of the University of Tokyo and Musashino Red Cross Hospital, and written informed consent was obtained from all women. Placentas and maternal venous blood were obtained from women with uncomplicated, normotensive pregnancies and pregnancies complicated by preeclampsia. Preeclampsia was diagnosed by the presence of hypertension (an absolute blood pressure ≥140 mmHg systolic and/or 90 mmHg diastolic after 20 weeks of gestation) with proteinuria (≥300 mg/24-hr). Patients with preeclampsia did not have any prior history of hypertension or renal disease. All women in control group did not show clinical or pathological signs of preeclampsia, infections, or any other maternal or placental disease.

Blood samples were collected from women with preeclampsia soon after the manifestation of the disease and before commencing any medication. Sera were separated by centrifugation and stored at −70°C before use. Placental samples were collected immediately after delivery. Placental tissue was taken from the middle part of the placenta to avoid amnion and decidual tissue contamination. All samples were stored at −70°C until assayed.

### Western Blot Analysis

Placental tissues were homogenized and then sonicated in lysis buffer [10 mM Tris–HCl, 50 mM NaCl, 2 mM EDTA, 1% Triton X-100, (pH 7.0)] with protease inhibitor cocktail (Roche Diagnostics GmbH, Mannheim, Germany). The protein concentration was determined using a modified Bradford protein assay with bovine serum albumin (Sigma-Aldrich, St Louis, MO, USA) as a standard. Thirty micrograms of protein was separated on 12.5% sodium dodecyl sulfate polyacrylamide electrophoresis gel and then transferred onto polyvinylidene fluoride (PVDF) transfer membranes (Amersham Biosciences, Piscataway, NJ, USA). Protein extracted from human endometrium was used as a positive control.[24] The blots were blocked in tris-buffered saline – 0.1% Tween-20 containing 5% nonfat milk and then incubated with antibodies at 4°C overnight. The membranes were incubated with primary antibodies: anti-human HMGB1 antibody (final concentration 2 μg/mL; R & D

systems, Minneapolis, MN, USA) or goat anti-human actin antibody (1/1000; Santa Cruz Biotechnology, Inc. Santa Cruz, CA, USA) as a loading control. Normal mouse IgG2B (Amersham Biosciences, Little Chalfont, UK) was used as an isotype control. The secondary antibody was horseradish peroxidase-conjugated anti-mouse (1/1000; Amersham Biosciences) or anti-goat (1/5000; Santa Cruz) IgG, which was incubated for 1 hr at room temperature. Signals were developed using ECL Western blotting system (Amersham Biosciences). Densitometric analysis was performed using ImageJ Image Software (National Institutes of Health, Bethesda, MD, USA). Each HMGB1 band was normalized to the densitometric value obtained from the same lane by blotting for actin, the internal reference.

### Enzyme-linked Immunosorbent Assay (ELISA) Measurement of HMGB1

The concentration of HMGB1 in serum was measured in duplicate by a specific ELISA kit (Shino-test Corporation, Kanagawa, Japan). The minimum detectable dose of HMGB1 was 1 ng/mL. The intra- and inter-assay coefficients of variation were all <10%.

### Statistical Analysis

Data analysis was performed using the statistical software package SPSS for Windows (Chicago, IL, USA). All data were checked for their normal distribution by submission to the Kolmogorov–Smirnov test, and if significant, non-parametric statistical analysis was applied. Parametric variables underwent the Student's *t*-test. Statistical significance was considered as $P < 0.05$.

## Results

We firstly analyzed HMGB1 expression in the placenta. Western blot analysis showed that the human term placenta expresses HMGB1 and is detected as a 28- and 30-kDa band corresponding to two distinct isoforms of the molecule (Fig. 1). The latter band corresponds to biologically active acetylated isoform.[5,24]

We then compared the placental expression levels of the two isoforms between normal pregnancy and pregnancy complicated by preeclampsia. Maternal age, gestational age, parity, and mode of in delivery were comparable in both groups (Table I). Compared

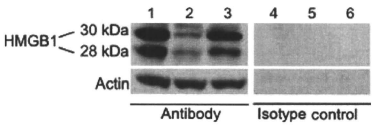


**Fig. 1** A representative result of Western blot analysis in the placenta in preeclampsia (1, 4), normal pregnancy (2, 5) and human endometrium as a positive control (3, 6) for anti-high mobility group box 1 (HMGB1) or anti-actin antibody (1, 2, 3) and isotype negative control (4, 5, 6). Note there are two bands (28- and 30-kDa) specific for HMGB1.

**Table I** Clinical Backgrounds and Serum High Mobility Group Box 1 (HMGB1) Concentrations in Women With or Without Preeclampsia

| | Normal pregnancy ($n$ = 32) | Preeclampsia ($n$ = 35) | $P$ |
|---|---|---|---|
| Maternal age, year* | 32.94 ± 3.58 | 33.49 ± 4.09 | NS |
| Gestational age, week* | 34.40 ± 4.90 | 33.50 ± 4.78 | NS |
| HMGB1, ng/mL | | | |
| Median (IQR) | 4.757 (2.592–6.861) | 4.312 (2.451–6.011) | |
| Mean ± S.D. | 5.119 ± 2.773 | 4.511 ± 2.537 | NS |

IQR, interquartile range.
*Data are presented as mean ± S.D.

to normal pregnancy, the level of 28- and 30-kDa HMGB1 expression was higher in preeclampsia, especially in the 28-kDa isoform (normal versus preeclampsia: 0.176 ± 0.112 versus 0.363 ± 0.296, 0.463 ± 0.332 versus 0.581 ± 0.379; 28-, 30-kDa, respectively: mean ± S.D.), although the difference did not reach statistical significance ($P = 0.087$, $P = 0.471$; 28-, 30-kDa, respectively) (Fig. 2, Table II).

Secondly, we measured the level of serum HMGB1 in normal pregnancy and pregnancy complicated with preeclampsia. As shown in Table II, maternal age and gestational age were comparable between the normal and preeclampsia group. When we compared serum HMGB1 concentrations, there was no significant difference between controls and women with preeclampsia.

Fig. 3 shows the correlation between serum HMGB1 concentration and gestational ages for both groups. There was no correlation between gestational

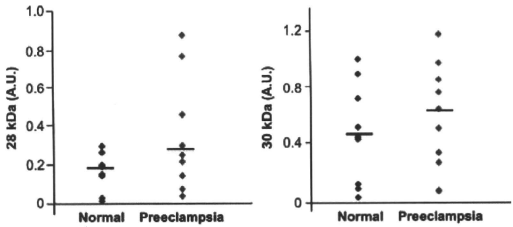


**Fig. 2** A scatter plot of placental high mobility group box 1 (HMGB1) protein expression level in both 28- and 30-kDa bands in normal pregnancy and pregnancy complicated with preeclampsia. The data are presented as arbitrary densitometric units (A.U.). The horizontal bars indicate the mean. The expression level of HMGB1 protein in both isoforms was higher in preeclampsia, although the difference did not reach statistical significance ($P = 0.087$, $P = 0.471$; 28-, 30-kDa, respectively).

**Table II.** Clinical Backgrounds and Placental High Mobility Group Box 1 (HMGB1) Expression Levels in Women With or Without Preeclampsia

| | Normal pregnancy ($n = 10$) | Preeclampsia ($n = 10$) | $P$ |
|---|---|---|---|
| Primigravid ($n$) | 7 | 7 | NS[b] |
| Maternal age, year* | 30.00 ± 5.14 | 33.40 ± 3.69 | NS[b] |
| Gestational age, week* | 38.81 ± 1.18 | 36.20 ± 3.26 | NS[b] |
| Vaginal delivery ($n$) | 7 | 3 | NS[a] |
| HMGB1 28 kDa (A.U.)* | 0.176 ± 0.112 | 0.363 ± 0.296 | NS[b] |
| HMGB1 30 kDa (A.U.)* | 0.463 ± 0.332 | 0.581 ± 0.379 | NS[b] |

*Data are presented as mean ± S.D.
[a]Fisher's Exact test.
[b]Student's $t$-test.

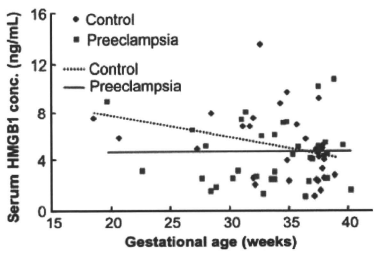


**Fig. 3** A scatter plot of serum high mobility group box 1 (HMGB1) levels versus gestational age (weeks) in normal pregnancy (blue diamond dots) and women with preeclampsia (pink square dots). No statistically significant correlation was found between gestational age and serum HMGB1 level in either normal pregnancy (broken line; $r = -0.338$, $P = 0.058$) or women with preeclampsia (unbroken line; $r = 0.002$, $P = 0.993$).

age and serum HMGB1 level in normal pregnancies (Pearson correlation, $r = -0.338$, $P = 0.058$) or in women with preeclampsia ($r = 0.002$, $P = 0.993$).

## Discussion

In the present study, we showed that the expression of HMGB1 in the placenta was higher in preeclampsia compared with normal pregnancy, although the difference did not reach statistical significance. There was no difference in serum HMGB1 levels between groups. These findings add to our understanding of the possible involvement of HMGB1 in the pathology of preeclampsia.

Firstly, a quantitative evaluation of HMGB1 expression in the placenta by Western blot demonstrated that the expression of 28- and 30-kDa isotypes in the placenta from women with preeclampsia was higher compared to healthy pregnancies, although the difference did not reach statistical significance. A variety of factors are reported to induce the expression of HMGB1 such as necrosis,[25] apoptosis,[26] oxidative stress,[27] and hypoxia,[15] which are all known to be enhanced in the placenta in preeclampsia. Therefore, we speculate that the expression of HMGB1 is increased in the damaged preeclamptic placenta as a 'danger signal', further enhancing the immune response.

Given the observation that placental HMGB1 is higher in preeclampsia, together with the fact that its receptors, RAGE and TLR4, are upregulated in the placenta in preeclampsia,[19,20,22,28] we suggest that the proinflammatory axis provoked by HMGB1 is enhanced in the preeclamptic placenta. Indeed, changes that may be induced by HMGB1 include NFκB activation, followed by the production of pro-inflammatory cytokines such as TNF alpha,[29] IL-6,[30] and endothelin,[31] or induction of apoptosis[32,33] are all events observed in the preeclamptic placenta. Although other endogenous and exogenous factors besides HMGB1 may also bind to RAGE and TLRs, such as advanced glycation end products (AGE) to RAGE, lipopolysaccharides and heat-shock protein 70 to TLR4, or peptidoglycan to TLR2, our result suggests that HMGB1 is one of the contributors modulating the development of preeclampsia.

There are several explanations for the lack of significant difference in placental HMGB1 levels between preeclampsia and control. Firstly, the sample number in this study was so small that the statistical study was underpowered. It is also possible that Western blotting followed by densitometry analysis has a limitation in detecting subtle difference. Another explanation could be that even in the healthy condition, the placenta is exposed by a mild inflammation, which is a nature of normal pregnant uterine environment,[34] and HMGB1 is constitutively expressed regardless of whether healthy or preeclamptic condition.

We then measured the circulating levels of HMGB1 in pregnancy. Our observation that placental HMGB1 is slightly higher in preeclampsia, and given a greater amount of trophoblast fragments are detected in the maternal circulation in preeclampsia compared to normal pregnancy,[35] prompted us to hypothesize that the circulating level of HMGB1 is higher in preeclampsia. Contrary to our hypothesis, there was no difference in the serum level of HMGB1 between normal pregnancy and pregnancy complicated by preeclampsia. One explanation could be that the level of circulating HMGB1 does not reflect its release from the placenta. This is partially supported by our finding that serum HMGB1 levels did not positively correlate with gestational age, yet HMGB1 levels should be in proportion to placental size and the number of shedding trophoblasts entering the maternal circulation. It is also possible that some component present in serum may bind HMGB1 and interfere with the ELISA system, as reported by Urbonaviciute et al.[10] Indeed, this interference resulted in an underestimation of serum HMGB1 levels in rheumatoid arthritis.[36] In addition, soluble RAGE (sRAGE), which is reported to capture and eliminate circulating HMGB1,[37] may have affected our results because circulating sRAGE levels are known to be elevated in preeclampsia.[28] Therefore, our results do not exclude the possibility that circulating HMGB1 is elevated in preeclampsia and could be a therapeutic target for preeclampsia.

In summary, we have demonstrated that the levels of HMGB1 in the placenta were slightly higher in preeclampsia. Inflammation provoked by HMGB1 is likely to be involved in the proinflammatory event, which is a prominent feature found in preeclamptic placenta. Further studies are needed to elucidate the precise role of HMGB1 in preeclampsia.

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# Dienogest, a new conservative strategy for extragenital endometriosis: a pilot study

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**Abstract**

Extragenital endometriosis severely impairs the quality of life for affected women but its standard management has not yet been well established because of its relatively low incidence. As extragenital organs, intestine, followed by urinary tract, is the most common place affected by endometriosis, for which surgical treatment is sometimes difficult and accompanied by severe complications. Recently, dienogest, a novel progestin, has emerged as a new alternative for endometriosis, especially for endometriosis-associated pain. In this report, we presented four cases with rectosigmoidal and one with bladder endometriosis, treated with oral 2 mg/day dienogest for over 6 months. For all cases, the measurable extragenital lesions exhibited the reduction in their size after 10 to 11 months of use, accompanied with immediate relief of subjective symptoms related with extragenital lesions. This report suggests that dienogest can be a novel conservative alternative for extragenital endometriosis.

**Keywords:** *Endometriosis, extragenital endometriosis, dienogest, conservative therapy*

## Introduction

Endometriosis is a chronic and common condition, affecting 6–10% women of reproductive age [1]. It is defined as a presence of functionally and morphologically endometrium-like tissue outside of the uterine cavity, causing various symptoms. Although the site most commonly involved is ovary, extragenital organs are also affected. The intestine is involved in 5–37% of women with endometriosis [2]. Out of them, sigmoidal and rectal endometriosis concern 70% of cases of intestinal endometriosis [3]. Following the bowel, the urinary tract is also vulnerable, with 1–15% of reported prevalence of bladder endometriosis in patients with endometriosis [4]. The colorectal endometriosis lesion often causes defecation pain and hematochezia, typically most severe at menstrual phase. With the progression of disease, progressive constipation and diarrhea alternating with constipation occur. The bladder endometriosis, sometimes complicated with colorectal endometriosis, often causes pollakiuria and urodynia, sometimes hematouria, also typically pointed out at menstrual phase. These symptoms, together with dysmenorrhea caused by coincidental peritoneal endometriosis and/or adenomyosis [5], severely compromised quality of life of patients. Surgical treatment has its certain role but the surgical burden and complications, and incomplete removal of lesions, especially with lower rectal lesions, should be problems. As conservative therapies, gonadotropin releasing hormone (Gn-RH) agonists and oral contraceptives (OCs) are currently used, both of which have high therapeutic effects. However, both therapies have their own limitations. The therapeutic period of Gn-RH agonists is limited because of bone mineral loss as an adverse effect [6]. As for OCs, because the risk for thrombosis increases with age [7], we should be careful and sometimes refrain from prescribing combined OCs for patients in their 40s or 50s.

Dienogest, a novel 19-nortestosterone derivative, is a progestin that is highly selective for progesterone receptors [8]. In addition to its antiovulatory effect, which indirectly inhibits progression of endometriosis, dienogest has direct inhibitory effect on proliferation of endometriotic stromal cells [9] and inflammatory cytokine production from these cells [10]. Based on these findings, dienogest has been recently investigated as a new therapeutic agent against endometriosis. After 24 weeks of treatment with oral 2 mg/day dienogest, Momoeda et al. showed significant reduction in painful symptoms of entometriosis and in diameter of ovarian endometriomas [11]. Other studies showed that dienogest is as effective as buserelin acetate [12] or leuprolide acetate [13] and significantly more effective than placebo [14] in relieving the painful symptoms of endometriosis. But there is no report addressing the effect of dienogest on extragenital endometriosis.

In this context, we examined the effect of dienogest on patients with extragenital endometriosis as a pilot study

## Methods

Cases were collected from patients attending to our university hospital. A retrospective case analysis was undertaken by the authors.

### *Patients*

Inclusion criteria were as follows: (i) ≥ 20 years of age, (ii) regular menstrual cycles before dienogest was given, (iii) extragenital endometriosis diagnosed with the use of

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imaging analysis (combination of magnetic resonance imaging and ultrasonography, sometimes with colon fiber or cystoscopy); (iv) presence of subjective symptoms associated with extragenital endometriosis (defecation pain or hematochezia for rectosigmoidal endometriosis and urodynia or pollakiuria for bladder endometriosis); (v) dienogest had been given in oral dose (1 mg twice daily) for at least 6 months before the case analysis was undertaken.

Exclusion criteria were as follows: (i) pregnant or nursing; (ii) use of Gn-RH agonists, testosterone derivatives, progestins, estrogens, estrogen antagonists, or aromatase inhibitors within 3 months prior to the start of administration with dienogest; (iii) having undergone surgical therapy or surgical examination for genital or extragenital endometriosis within a menstrual cycle prior to the start of dienogest.

*Measurements*

The size of extragenital endometriosis was evaluated by ultrasongraphy with the interval of 1–3 months [15,16]. After defining the largest sagittal view of the lesion, the longest part of the lesion (*A*) and the orthogonal part (*B*) were measured. $A \times B$ was calculated and defined as an 'maximal area index'. The change in subjective symptoms was also assessed by interview.

*Results*

Five patients met criteria described above. Four cases had rectosigmoidal endometriosis and the other one had bladder endometriosis. Table I summarizes these cases. All the cases with rectosigmoidal endometriosis were complicated with genital endometriotic lesion. The changes in the size of extragenital lesions were shown in Figure 1. All the patients experienced the reduction in the size of the lesions after 10 to 11 months of oral dienogest. [6] Figure 2 shows the ultrasonographic images of rectosigmoidal endometriotic lesion in case 2. The response to dienogest appears to differ between individuals. The reduction rates in the size of the lesions at 10 or 11 months varied from 25% to 80% depending on individuals.

Table I. Summary for cases.

| Case | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Age, y | 39 | 38 | 44 | 48 | 46 |
| G/P | 0/0 | 0/0 | 2/1 | 0/0 | 2/2 |
| Site of ex EMosis | rectosigmoid | rectosigmoid | rectosigmoid | rectosigmoid | bladder |
| Maximal area index before treatment ($mm^2$) | 1295.1 | 910.1 | 209.7 | 623.1 | 298.4 |
| Symptoms associated with ex EMosis | hematochezia defec. pain | hematochezia defec. pain | defec. pain | defec. pain | urodynia |
| Other endometriotic lessions | adenomyosis | i) adenomyosis ii) EM cyst in uterine cervix | Post LH+RSO due to EMoma and adenomyosis | i) adenomyosis ii) bilateral ovarian EMoma | negative |
| ADR | spotting | spotting | gastralgia, hot flush | depression, hot flush, spotting | spotting |

Note: ex EMosis, extragenital endometriosis; defec. pain, defecation pain; EM cyst, endometriotic cyst; LH, laparoscopic hysterectomy; RSO, right salpingo-oophorectomy; EMoma, endometrioma; ADR, adverse drug reactions.

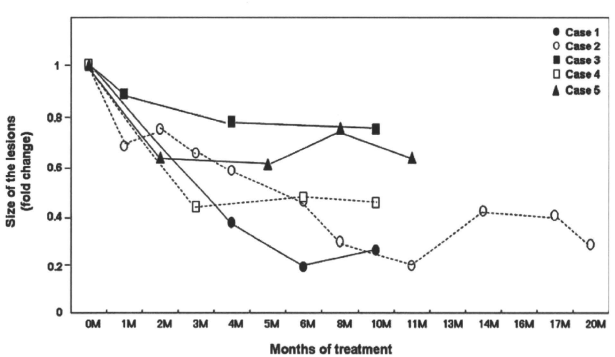


Figure 1. Changes in the size of extragenital endometriosis in each case. The size of the lesions was evaluated by ultrasonography as mentioned in methods. The graph shows the fold change in 'maximal area index' of each lesion.

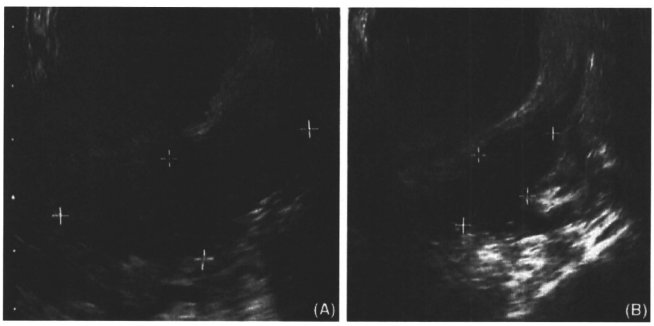


Figure 2. Ultrasonographic images of rectosigmoidal endometriotic lesions in Case 2 (A) before and (B) after 20-months of treatment. Magnifications of the two pictures are the same.

In addition, the period during which the lesions kept shrinking differed between individuals. For case 3, 4, and 5, dienogest caused the lesions to shrink only up to couple of months after the start of treatment, while the lesions of case 1 and 2 kept shrinking until 6 to 8 months. For the both groups, dienogest was effective in maintaining the size of the lesions after the first shrinking period, at least up to 10 to 11 months of use. As for subjective symptoms associated with extragenital endometriosis, all the cases with rectosigmoidal endometriosis had defecation pain before treatment, complicated with hematochezia for case 1 and 2. Case 5 had urodynia. For all cases, painful symptoms were dramatically relieved within a month after the start of taking dienogest. Both case 1 and 2 experienced no more hematochezia after the start of dienogest. As for the compliance of dienogest, case 1, 2, and 5 still continued. Case 3 and 4 quitted taking dienogest after 10 to 11 months of use, because of gastralgia and depression, respectively.

## Discussion

We experienced five cases with extragenital endometriosis, for those dienogest 2 mg daily orally was effective in reducing the size of the lesions and relieving the symptoms associated with these lesions. To our knowledge, this is the first series of extragenital endometriosis patients treated with the novel drug, dienogest.

Although the extragenital endometriosis is relatively rare, the quality of life for women with extragenital lesions is severely impaired. Because of its low incidence, standard management has not yet been well established. The effect of dienogest on shrinkage of the lesions shown in this report suggests its possibility as a novel approach to extragenital endometriosis. Although the effect of treatment with dienogest for more than 1 year is difficult to address in the present study, a patient who took dienogest over 1 year (case 2) showed no additional shrinkage of the lesion after 1 year. As for subjective symptoms such as defecation pain or urodynia, dienogest exerted its effect immediately within a month after start of treatment. In terms of the safety or tolerability, two out of five patients discontinued after 10 to 11 months because of adverse drug reactions. This rate is considerably high compared to the one (5.2%) reported in the only existing clinical trial assessing the safety of long-term use of dienogest [11]. This high withdrawn rate is probably due to the limited number of the patients in this report. All four cases with uterus experienced spotting, as expected, but it was tolerable.

In conclusion, dienogest may become a promising alternative for treatment against extragenital endometriosis. Further studies are necessary to establish the efficacy and safety of dienogest for patients with extragenital endometriosis.

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# Recruitment of CCR6-Expressing Th17 Cells by CCL 20 Secreted from IL-1β-, TNF-α-, and IL-17A-Stimulated Endometriotic Stromal Cells

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In a novel paradigm of T cell differentiation, type 17 T helper (Th17) cells may play a significant role in endometriosis, a chronic inflammatory disease. However, the mechanism regulating the accumulation of Th17 cells in endometriotic tissues remains unknown. We hypothesized that Th17 cells migrate to endometriotic tissues through an interaction of the chemokine CC chemokine ligand (CCL)20 and its receptor CCR6. Using endometriotic tissues from women with endometriosis, we demonstrated, by flow cytometry, that Th17 cells in endometriotic tissues express CC chemokine receptor (CCR)6. Immunohistochemistry also revealed that CCL20 was expressed in the epithelial cells and stromal cells beneath the epithelium of endometriotic tissues. CCR6+ cells were small and round and scattered in the stroma in which abundant CCL20+ cells were detected. CCL20 caused selective migration of Th17 cells in the peripheral blood in a migration assay. IL-1β, TNF-α, and IL-17A increased the secretion of CCL20 in cultured endometriotic stromal cells. Inhibitors of p38- and p42/44-MAPKs, and stress-activated protein kinase/c-Jun kinase suppressed the secretion of CCL20 increased by IL-1β, TNF-α, and IL-17A. This suggests that the CCL20/CCR6 system is involved in the migration of Th17 cells to endometriotic tissues and that proinflammatory cytokines contribute to the development of endometriosis via up-regulation of CCL20 secretion from endometriotic stromal cells. (***Endocrinology*** **151: 5468–5476, 2010)**

Endometriosis is an enigmatic disease that deteriorates the health of women during their reproductive years by causing pain, infertility, and adnexal mass. Although the etiology of the disease still remains to be elucidated, a large volume of evidence indicates that inflammatory mediators and immune responses play crucial roles in the development of endometriosis (1, 2). In particular, various immune cells present in endometriotic tissues and their cytokines have been noted to play a significant role in the pathogenesis of endometriosis (3). Whereas the macrophage has been reported to be a typical immune cell involved in endometriosis, accumulating evidence in recent years extends the types of endometriosis-associated immune cells (4). Type 17 T helper (Th17) cells, regulatory T cells, and dendritic cells are new members of the group of immune cells suggested to contribute to the pathophysiology of the disease (5–7). We have already reported that Th2 cells and Th17 cells are potent inducers of inflammation associated with endometriosis (5, 8, 9).

Th17 cells are a novel subset of T lymphocytes that were thought to be composed of only Th1 and Th2 cells (10). A pivotal contribution of Th17 cells has been demonstrated in many chronic inflammatory diseases, such as rheumatoid arthritis, psoriasis, Crohn's disease, and multiple sclerosis as well as in host defenses against certain pathogens (11–14). Th17 cells exert multiple functions via their specific cytokine, IL-17A, which provokes a wide range of inflammatory reactions. We have detected Th17

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Abbreviations: CCL, CC chemokine ligand; CCR, CC chemokine receptor; DMEM/F12, DMEM/Ham's F12 medium; EMMC, mononuclear cells from endometriotic lesions; ESC, endometriotic stromal cell; FBS, fetal bovine serum; JNK, c-Jun kinase; PBMC, peripheral blood mononuclear cell; PMA, phorbol 12-myristate 13-acetate; SAPK, stress-activated protein kinase; Th17, type 17 T helper.

cells in endometriosis-associated peritoneal fluid and endometriotic tissues and demonstrated the significant role of IL-17A in endometriosis by showing that IL-17A stimulates IL-8 and cyclooxygenase-2 expression and cell proliferation of endometriotic stromal cells (ESCs) (5).

Despite the important role of Th17 cells in endometriotic tissues, the mechanism by which these cells appear in the endometriotic tissues is unknown. A recent study in a mouse model of rheumatoid arthritis has shown that Th17 cells express CC chemokine receptor (CCR)6 and synoviocytes express CC chemokine ligand (CCL)20, the only chemotactic ligand for CCR6, suggesting CCL20-induced recruitment of Th17 cells to the inflamed joints (15). This study led us to hypothesize that endometriotic cells may express CCL20, causing CCR6-expressing Th17 cells to be recruited to the lesion. To address this issue, we examined the expression of CCR6 in Th17 cells and CCL20 in stromal cells in endometriotic tissues. We then studied the regulatory mechanism of secretion of CCL20 from cultured ESCs to address the involvement of the CCL20/CCR6 system in the pathophysiology of endometriosis.

## Materials and Methods

### Patients and samples

Endometriotic tissues and peripheral blood were obtained from patients with ovarian endometriomas undergoing laparoscopy. The severity of the disease was determined according to the revised classification of the American Society for Reproductive Medicine. The diagnosis of endometriosis was confirmed by histopathological examination. Laparoscopic excision of ovarian endometriomas was performed as follows. After inspection of the pelvis, the ovary was freed from any adhesions. The endometrioma cyst wall was stripped away from the normal ovarian tissue gently and completely. Endometriotic tissue samples were obtained from the excised cyst wall of the ovarian endometrioma and transported to the laboratory in DMEM/Ham's F12 medium (DMEM/F12; Invitrogen, Rockville, MD) on ice under sterile conditions. Peripheral blood was obtained from patients who were diagnosed as stage III or IV. All patients had regular menstrual cycles, and none had received hormonal treatment for at least 6 months before surgery. Peripheral blood was collected under sterile conditions before any manipulative procedure. Peripheral blood mononuclear cells (PBMCs) were isolated by standard Ficoll-Paque density centrifugation. The experimental procedures were approved by the Institutional Review Board of the University of Tokyo (Tokyo, Japan), and signed informed consent for use of the endometriotic tissues and blood samples was obtained from each patient.

### Isolation of mononuclear cells from endometriotic lesions

Fresh endometriotic tissues collected in sterile medium were rinsed to remove red blood cells. The tissues were minced into small pieces and incubated in phenol red-free DMEM/F12 containing 0.25% type I collagenase (Wako Pure Chemical Industries, Osaka, Japan) and deoxyribonuclease I (15 IU/ml; Invitrogen) for 120 min at 37 C. The resulting dispersed cells were separated by filtration through 100- and 70-$\mu$m nylon cell strainers (Becton Dickinson and Co., Franklin Lakes, NJ). The filtrate was washed twice with PBS. This pellet was resuspended in 40% Percoll (5 ml), layered gently onto 70% Percoll, and centrifuged at 1800 rpm for 20 min. The interface was recovered and washed in PBS, resuspended in RPMI 1640 medium containing 10% charcoal-stripped fetal bovine serum (FBS; Hyclone, Logan, UT), and plated into 100-mm plates (Iwaki; Asahi Technology Co., Tokyo, Japan) and allowed to adhere at 37 C overnight. Nonadherent cells were collected and used for the experimental procedures as mononuclear cells from endometriotic lesions (EMMCs).

### Immunohistochemistry

Paraffin-embedded specimens were sliced at 5-$\mu$m thickness and the sections placed on slides that were then deparafinized and rehydrated. Antigens were retrieved by buffer at 98 C. Endogenous peroxidase was blocked by incubation for 10 min with a solution of 0.3% hydrogen peroxidase. Immunohistochemical tissue labeling for CCL20 was performed using the avidin-biotin peroxidase method. After blocking with normal rabbit serum (Vector Laboratories, Burlingame, CA), the sections were incubated with 2 $\mu$g/ml goat antihuman CCL20 antibody (R & D Systems, Minneapolis, MN) or goat IgG (R & D Systems) for 60 min at room temperature and incubated with the avidin-biotin peroxidase complex (Vectastain Elite; Vector Laboratories), according to the manufacturer's instructions. The pattern of immunoreactivity was visualized using Vector VIP (Vector Laboratories) as substrate. Immunohistochemical tissue labeling for CCR6 was performed using EnVision+ (Dako, Glostrup, Denmark). After blocking with a nonspecific staining blocking reagent (Dako), the sections were incubated with 2 $\mu$g/ml rabbit antihuman CCR6 antibody (GeneTex, Irvine, CA) or rabbit IgG (Dako) for 60 min at room temperature and then incubated with peroxidase-conjugated secondary antibody for 30 min. Staining was detected using diaminobenzidine chromogen for a few minutes. All sections were counterstained with hematoxylin and evaluated under a light microscope.

### Flow cytometric analysis

PBMCs or EMMCs were resuspended in 10% FBS in RPMI 1640 medium. The cells were stimulated with 50 ng/ml of phorbol 12-myristate 13-acetate (PMA; Sigma, St. Louis, MO) and 1 $\mu$g/ml of ionomycin (Sigma) for 5 h in the presence of Goldistop (BD Biosciences, San Jose, CA). Cells were first stained extracellularly with anti-CD3, anti-CD4, or anti-CCR6 antibodies (BD Biosciences) and then fixed and permeabilized with Perm/Fix solution (eBioscience, San Diego, CA) and finally stained intracellularly with antihuman IL-17A antibody (eBioscience). Samples were analyzed using FACSCalibur (BD Biosciences) and Cell Quest Pro (BD Biosciences).

### Migration assay

Migration assays were performed on PBMCs using the Transwell system (5 $\mu$m pore size; Corning, Acton, MA). PBMCs ($1 \times 10^6$) in 100 $\mu$l of RPMI 1640 medium containing 0.5% BSA (RPMI 1640–0.5% BSA) were placed in each Transwell insert. The Transwell inserts were placed in 24-well plates containing 600 $\mu$l of RPMI 1640–0.5% BSA with or without CCL20. After

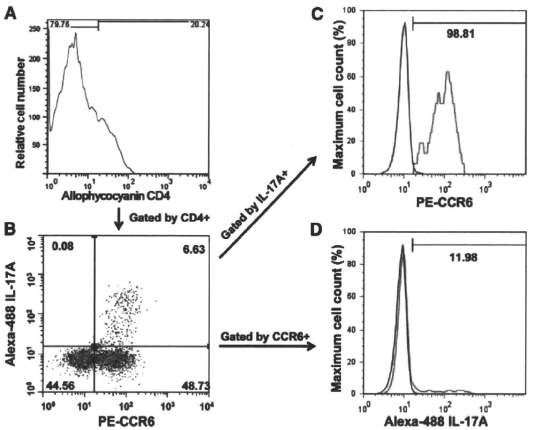


**FIG. 1.** Expression of CCR6 in Th17 cells in endometriotic tissues. Mononuclear cells from endometriotic lesions were stimulated with PMA (50 ng/ml) and ionomycin (1 $\mu$g/ml) and labeled with antibodies specific to lymphocytes (CD3 and CD4), IL-17A, and CCR6. A, The frequency of CD4+/CD3+ T cells from the lymphoid gates was determined by forward scatter and side scatter and by CD3+. B, Th17 cells were positive for CD3, CD4, and IL-17A; 6.63% of CD3+/CD4+ T cells were CCR6+/IL-17A+ cells. C, Of the Th17 cells, 98.81% were CCR6+ cells (*green line*). The *red line* represents the isotype-matched control. D, Th17 cells are 11.98% of CD3+, CD4+, and CCR6+ cells (*green line*). The *red line* represents the isotype-matched control. The data shown are representative of four separate experiments using samples from four different women.

incubation at 37 C in 5% $CO_2$ for 2 h, cells in the lower wells were collected. These cells were stimulated with PMA (50 ng/ml) and ionomycin (1 $\mu$g/ml) for 5 h in the presence of Goldistop and then stained with anti-CD3, anti-CD4, and anti-IL-17A, as described above. The absolute number of cells was counted and calculated using the Perfect Count System (Cytognos, Salamanca, Spain) (16). To calculate the migration index, the number of migrated cells for CCL20 was divided by the number of migrated cells for the control medium.

### Isolation and culture of ESCs

Isolation and culture of human ESCs were performed as described previously (5, 17, 18). Briefly, fresh endometriotic tissues collected in sterile medium were rinsed to remove blood cells and then minced into small pieces and incubated in phenol red-free DMEM/F12 containing type I collagenase (0.25%) and deoxyribonuclease I (15 IU/ml) for 120 min at 37 C. The resulting dispersed endometriotic cells were separated by filtration through 100- and 70-$\mu$m nylon cell strainers. Stromal cells remaining in the filtrate were collected by centrifugation, resuspended in phenol red-free DMEM/F12, and plated into 100-mm dishes (Iwaki; Asahi Technology) and allowed to adhere at 37 C for 12 h. At the first passage, the cells were plated into 48-well plates at $1 \times 10^5$ cells/well. The cells reached confluence in 2–3 d and were then used for the experiments. The purity of ESCs was more than 95%, as judged by positive cellular staining for vimentin and negative cellular staining for cytokeratin, CD45, CD68, and von Willebrand factor.

### Treatment of cultured ESCs

First, to examine the effect of IL-1$\beta$, TNF-$\alpha$, or IL-17A on CCL20 production, the ESCs were incubated for 24 h in 5% FBS in DMEM/F12 with varying doses of IL-1$\beta$, TNF-$\alpha$, or IL-17A (R & D Systems). Second, to examine the effects of MAPK inhibitors, three MAPK inhibitors (SB202190, PD98059, and SP600125; Calbiochem, La Jolla, CA) were added 1 h before the addition of IL-1$\beta$, TNF-$\alpha$, or IL-17A, and the cells were incubated for 24 h. Finally, to evaluate the synergistic effect of TNF-$\alpha$ and IL-17A on CCL20 production, the cells were stimulated with varying doses of IL-17A (1–100 ng/ml) with or without TNF-$\alpha$ (1 ng/ml).

### Measurement of CCL20

The concentration of CCL20 in conditioned media was measured using a specific ELISA kit (R & D Systems). The sensitivity of the assay was 0.5 pg/ml. The intraassay and interassay coefficients of variation were less than 5%.

### Statistical analysis

Data were evaluated using ANOVA with Scheffé's *post hoc* analysis for multiple comparisons and *t* tests for two groups. $P < 0.05$ was accepted as statistically significant.

## Results

### Expression of CCR6 on Th17 cells in endometriotic tissues

Representative data showed that 20.24% of the CD3+ mononuclear cells in the EMMC samples were also CD4+ (Fig. 1A). Of these CD3+/CD4+ cells, 6.63% were IL-17A+/CCR6+ cells (Fig. 1B). Sequential gating revealed that expression of CCR6 was detected in 98.8% of Th17 cells (CD3+/CD4+/IL-17A+ cells, Fig. 1C) and that 11.98% of CD3+/CD4+/CCR6+ EMMCs were Th17 cells (Fig. 1D). The percentages of each figure were 38.1 ± 15.6, 7.85 ± 2.04, 97.6 ± 3.1, and 14.7 ± 5.1 (mean ± SD) for Fig. 1, A–D, respectively, from four independent experiments using samples from different women.

### *In vivo* expression of CCL20 and CCR6 in endometriotic lesions

As shown in Fig. 2A, the presence of CCL20 immunoreactivity was detected in the cyst wall of endometriomas. Intense CCL20 immunoreactivity was detected in the epithelial cells and the stromal cells immediately beneath the epithelium. A few CCL20-immunoreactive cells were detected in fibrotic stromal cells, far from the

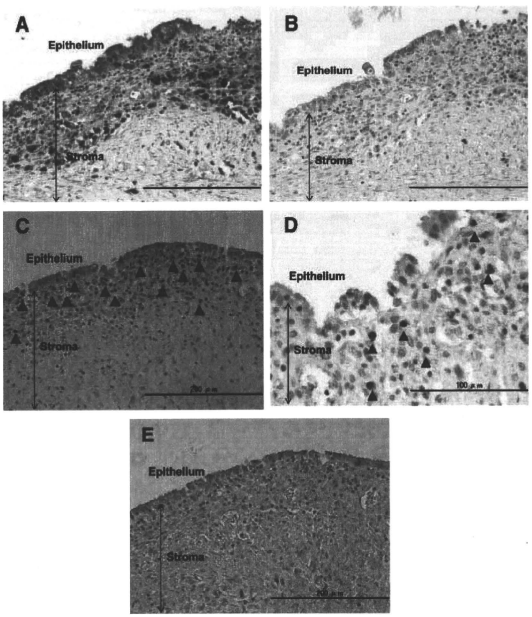


**FIG. 2.** Immunohistological localization of CCL20 and CCR6 in human endometriotic tissues. A and B, CCL20 expression (*purple*) was detected in human endometriotic tissues. Sections were immunostained with antihuman CCL20 antibody (A) or control goat IgG (B). Magnification, × 200; *scale bars*, 200 $\mu$m. C, D, and E, CCR6 expression (*brown*) was detected in human endometriotic cells. Sections were immunostained with antihuman CCR6 antibody (C and D) or control rabbit IgG (E). *Orange arrows* show CCR6+ cells. Magnification, × 200 (C and E), ×400 (D); *scale bars*, 200 $\mu$m (C and E), 100 $\mu$m (D).

epithelium. No staining was observed when normal goat IgG was used as a primary antibody, as shown in Fig. 2B. CCR6 immunoreactivity was also detected in the cyst wall of endometriomas (Fig. 2, C and D). CCR6+ cells were localized in the stroma immediately beneath the epithelium. These cells were round in shape and appeared to be bone marrow-derived cells. No staining was observed when normal rabbit IgG was used as a primary antibody, as shown in Fig. 2E.

### Preferential migration of Th17 cells to CCL20

The function of CCR6 on T cells from PBMC samples was tested by migration assays using the Transwell system. Migrated cells were stimulated by PMA and ionomycin, and stained with CD3, CD4, and IL-17A antibodies. As shown in Fig. 3A, Th17 cells were more plentiful among the cells migrating to CCL20 (1000 ng/ml) than to the control medium. The absolute number of Th17 cells and CD4+ T cells was counted using Perfect Count (Cytognos). In Fig. 3B the data are presented as migration indexes. CCL20 (1000 ng/ml) significantly increased the migration index of the Th17 cells to 18.2-fold of control. In contrast, CCL20 at the same dose appeared to slightly increase the migration index of CD4+ cells, although without reaching statistical significance, indicating that CCL20 selectively enhances the migration of Th17 cells.

### Effect of IL-1$\beta$, TNF-$\alpha$, and IL-17A on CCL20 secretion by ESCs

The cytokines IL-1$\beta$, TNF-$\alpha$, and IL-17A all enhanced CCL20 secretion from ESCs in a dose-dependent manner. IL-1$\beta$, at doses of 1 ng/ml and higher, significantly enhanced the secretion of CCL20 from ESCs (Fig. 4A). TNF-$\alpha$ (0.1 ng/ml and higher) and IL-17A (1 ng/ml and higher) also significantly enhanced the secretion of CCL20 from ESCs (Fig. 4, B and C).

### Effect of MAPK inhibitors on IL-1$\beta$-, TNF-$\alpha$-, and IL-17A-induced CCL20 secretion

We have previously demonstrated that IL-1$\beta$, TNF-$\alpha$, and IL-17A activate p42/44-MAPK, p38-MAPK, and stress-activated protein kinase (SAPK)/c-Jun kinase (JNK). Thus, we examined in this study whether activation of these MAPKs was functionally linked to IL-1$\beta$-, TNF-$\alpha$-, or IL-17A-induced production of CCL20. ESCs were treated with specific inhibitors of these pathways before stimulation with IL-1$\beta$, TNF-$\alpha$, or IL-17A. As shown in Fig. 5, A–C, the addition of inhibitors for p38-MAPK, p42/44-MAPK, or SAPK/JNK significantly diminished the IL-1$\beta$-, TNF-$\alpha$-, and IL-17A-induced increases in CCL20 secretion.

### Synergistic effect of IL-17A and TNF-$\alpha$ on CCL20 secretion from ESCs

We examined the effect of TNF-$\alpha$, a representative proinflammatory cytokine in endometriosis, on IL-17A-induced CCL20 secretion. TNF-$\alpha$, together with IL-17A, triggered CCL20 secretion greater than the combined levels generated by each stimulus alone (Fig. 6). This synergistic effect was apparent when TNF-$\alpha$ was combined

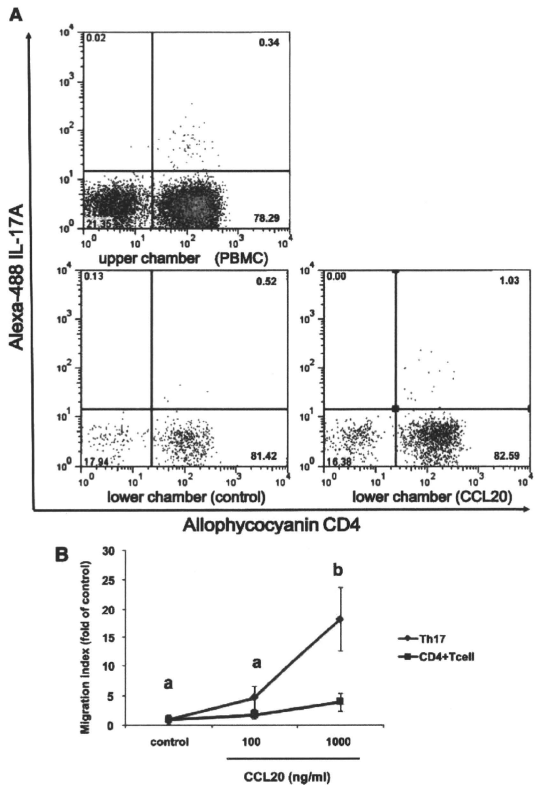


**FIG. 3.** Migration of Th17 cells in PBMCs to CCL20. A, Flow cytometry analysis of PBMCs from endometriotic women. PBMCs were applied to the upper chamber, and the cells migrated to the lower chamber with control medium (RPMI 1640–0.5% BSA) or medium containing CCL20 (1000 ng/ml). The cells were stimulated with PMA (50 ng/ml) and ionomycin (1 $\mu$g/ml) and stained with CD3, CD4, and IL-17A antibodies before flow cytometry. The percentage of cells in each quadrant was noted. B, Migration of Th17 cells or CD4+ cells to CCL20. Migrated cells were counted using Perfect Count (Cytognos). The data are presented as the migration index (ratio of cells migrating to CCL20 divided by cells migrating to the control medium). Values are expressed as the mean ± SEM of five independent experiments using samples from five different women. For CD4+ cells, there is no significant difference between the groups. *Different letters* denote significant differences between the groups ($P < 0.05$).

with 1 ng/ml IL-17A, and maximal synergy was obtained at the highest dose of IL-17A tested (100 ng/ml). Furthermore, we examined whether the MAPK inhibitors diminished TNF-$\alpha$- and IL-17A-induced CCL20 secretion. CCL20 secretion induced by a combination of TNF-$\alpha$ and IL-17A was significantly suppressed by inhibitors for p38-MAPK, p42/44-MAPK, and SAPK/JNK (Fig. 6B).

## Discussion

In the present study, we have demonstrated that Th17 cells express CCR6 in endometriotic tissues. Expression of CCL20, a ligand for CCR6, was also detected in the endometriotic stromal cells and epithelial cells, and CCL20 induced chemotaxis of Th17 cells from peripheral blood. IL-1$\beta$, TNF-$\alpha$, and IL-17A increased secretion of CCL20 from cultured ESCs, and these effects were diminished by three MAPK inhibitors. Furthermore, TNF-$\alpha$ and IL-17A synergistically induced secretion of CCL20 from ESCs.

This study provides a possible explanation for why Th17 cells are present in endometriotic tissues. First, almost all of the Th17 cells in the endometriotic lesions expressed CCR6, consistent with reports describing this chemokine receptor as a marker for the identification of Th17 cells (19–22). Second, CCL20 and CCR6 expression was detected in the same part of the endometriotic lesion. Accordingly, we suggest that CCL20 expressed in endometriotic tissues recruits Th17 cells expressing CCR6. Indeed, CCL20 stimulated migration of Th17 cells in the peripheral blood of women with endometriosis. This notion is also supported by the localization of IL-17A+ cells. Our previous data showed that IL-17A+ cells were present mainly in the stroma just beneath the epithelium. The present study demonstrates that CCR6+ cells are also abundant in the stroma close to the epithelium. Because intense CCL20 immunostaining was observed in the epithelia and its nearby stroma, it is plausible that a CCL20/CCR6 interaction recruits Th17 cells to endometriotic tissues.

Today it is well established that endometriosis is an inflammatory disease. A large body of evidence indicates that TNF-$\alpha$ and IL-1$\beta$, typical inflammatory cytokines,

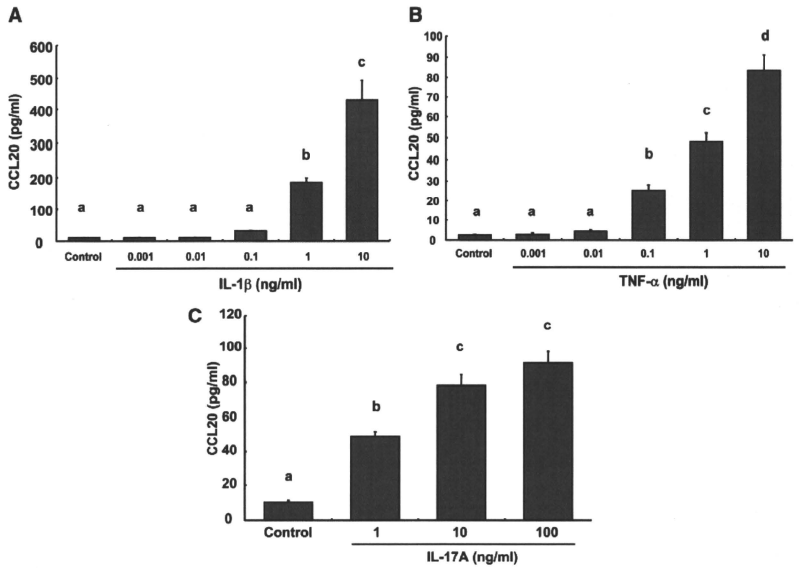


**FIG. 4.** The effect of IL-1β (A), TNF-α (B), and IL-17A (C) on secretion of CCL20 in ESCs. ESCs were cultured in 5% FBS with different doses of IL-1β, TNF-α, or IL-17A for 24 h. The concentration of CCL20 in the conditioned medium was measured using a specific ELISA. Values are expressed as the mean ± SEM of five identical cultures. These results are representative of five (A) or four (B and C) separate experiments using samples from different patients. *Different letters* denote significant differences between the groups ($P < 0.05$).

are involved in macrophage activation, inflammatory change, and enhanced angiogenesis to develop endometriosis (3). A pivotal role of TNF-α in endometriosis is corroborated by the finding that TNF-α-targeted suppression by specific drugs inhibits the development of endometriosis in baboons (23, 24). In addition to TNF-α and IL-1β, we have recently shown that IL-17A is also involved in the pathogenesis of endometriosis, stimulating IL-8 secretion, cyclooxygenase-2 expression, and cell proliferation of ESCs (5). The present study revealed a novel function of these inflammatory cytokines: enhancement of CCL20 secretion from endometriotic stromal cells. Collectively, these results suggest that CCL20 expression in endometriotic tissues is regulated by these cytokines and that local inflammation may up-regulate CCL20 expression through these cytokines. In this context, Th17 cells themselves may sustain a positive feedback loop by secreting IL-17A, which further induces the accumulation of Th17 cells via an increase in CCL20 in endometriotic lesions.

Inspired by the finding that IL-1β, TNF-α, and IL-17A increased secretion of CCL20 from ESCs, we examined whether these cytokines stimulated CCR6 expression on Th17 cells using flow cytometry. However, these cytokines did not affect the CCR6 expression level on Th17 cells in endometriotic tissues (data not shown).

The synergistic effect of IL-17A and TNF-α to increase CCL20 secretion from ESCs is interesting. TNF-α, a proposed key molecule in the progression of endometriosis, as mentioned above, is produced by a range of leukocytes including neutrophils, activated lymphocytes, and macrophages. Of these cells, the macrophage is a well-known resident of endometriotic tissues and is suggested to play a central role in the immunobiology of endometriosis (25). Given that TNF-α is secreted from macrophages, it is possible that Th17 cells secreting IL-17A may act synergistically with macrophages to enhance CCL20 secretion and lead to enforced recruitment of Th17 cells. Consequently, this synergistic effect may augment the various effects of IL-17A on ESCs through the enhanced recruitment of Th17 cells.

We have previously shown that IL-1β, TNF-α, and IL-17A induce the phosphorylation of p42/44-MAPK, p38-MAPK, and SAPK/JNK in ESCs (5, 26). Inhibitors of these