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## Mesenchymal Stem Cells Induce Suppressive Macrophages Through Phagocytosis in a Mouse Model of Asthma

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### ABSTRACT

Mesenchymal stem cell (MSC) immunosuppressive functions make them attractive candidates for anti-inflammatory therapy in allergic asthma. However, the mechanisms by which they ensure therapeutic effects remain to be elucidated. In an acute mouse model of house dust mite (Der f)-induced asthma, one i.v. MSC injection was sufficient to normalize and stabilize lung function in Der f-sensitized mice as compared to control mice. MSC injection decreased in vivo airway responsiveness and decreased ex vivo carbachol-induced bronchial contraction, maintaining bronchial expression of the inhibitory type 2 muscarinic receptor. To evaluate in vivo MSC survival, MSCs were labeled with PKH26 fluorescent marker prior to i.v. injection, and 1 to 10 days later total lungs were digested to obtain single-cell suspensions.  $91.5 \pm 2.3\%$  and  $86.6 \pm 6.3\%$  of the recovered PKH26<sup>+</sup> lung cells expressed specific macrophage markers in control and Der f mice, respectively, suggesting that macrophages had phagocytosed in vivo the injected MSCs. Interestingly, only PKH26<sup>+</sup>



COX-2 than before injection, suggesting in vivo MSC phenotype modulation. Together, the results of this study indicate that MSCs attenuate asthma by being phagocytosed by lung macrophages, which in turn acquire a M2 suppressive phenotype. *STEM CELLS* 2016;34:1836–1845

## SIGNIFICANCE STATEMENT

In a model of asthma, injected mesenchymal stem cells (MSCs) are in vivo phagocytosed by lung macrophages in the next 24 hours following i.v. injection. Lung macrophages that have phagocytosed MSCs, in turn, acquire an immunosuppressive phenotype, responsible for MSC anti-inflammatory in vivo efficacy.

## INTRODUCTION

Growing bodies of evidences support the potent role of mesenchymal stem cells (MSCs) in the suppression of exacerbated inflammation [1](#), [2](#). Based on these observations, MSCs are now used in preclinical animal models and human clinical trials as an alternative therapeutic strategy to suppress deleterious immune responses in the context of acute graft-versus-host disease [3](#), autoimmunity [4](#), [5](#) and interestingly in a variety of lung disorders [6](#), [7](#). Altogether, more than 150 clinical trials have been registered on the NIH clinical trial registry, including the injection of MSCs [8](#).

Allergic asthma is a chronic inflammatory disease characterized by airway hyper-responsiveness and deregulated inflammation in response to allergens. This pathology is essentially controlled by CD4<sup>+</sup> T helper 2 (T<sub>H</sub>2) lymphocytes, which cause cellular infiltration of the lungs, overproduction of mucus and hyper-responsiveness. Some recent reports have highlighted the therapeutic efficacy of MSC injection, in both acute and chronic mouse models of asthma, by notably inducing the production of TGF- $\beta$  [9](#), IL-10 [10](#), IFN $\gamma$  [11](#), [12](#), increasing T<sub>H</sub>1 cell number [13](#), and modulating the T<sub>H</sub>1-T<sub>H</sub>2 immunological balance [11](#), [14](#). However, despite these observations, very little is known about the exact mechanisms mediated by MSCs in the lung, as the largest part of injected cells does not integrate the lungs [9](#), [15](#). The therapeutic MSC effect has been attributed in part to paracrine effectors [16](#) including interaction with macrophages [15](#) via the PGE2 pathway [17](#), [18](#).

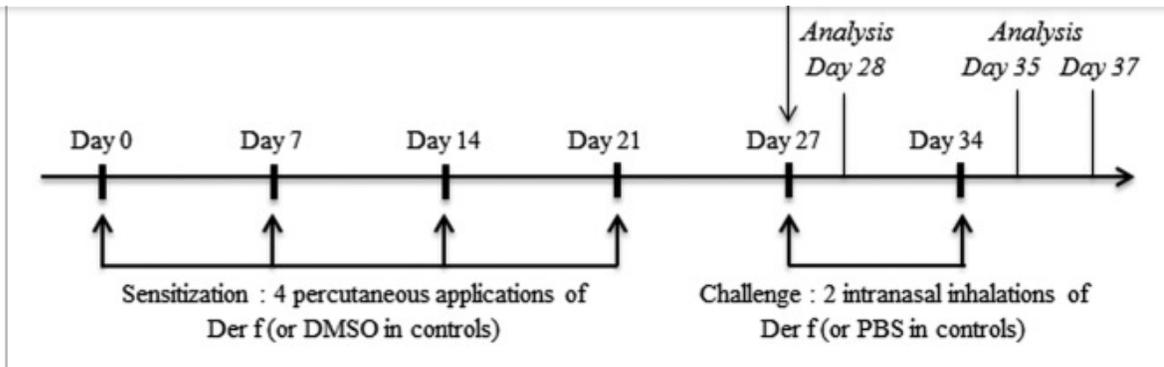


Injection of MSCs improved lung function, inhibited contractile response of bronchi, decreased lung inflammation, and MSCs were in vivo phagocytosed by lung macrophages which in turn acquired a M2 suppressor phenotype.

## MATERIALS AND METHODS

### Protocol

Allergic asthma was induced in 6- to 8-week-old BALB/c mice (Charles River Laboratories) using total Der f extracts (*Dermatophagoïdes farinae*) provided by Stallergenes as previously described [19](#). The Regional Ethical Committee for Animal Experiments of the Pays de la Loire (CEEA.2010.50) approved all animal protocols. In brief, mice were sensitized at day 0, 7, 14, and 21 by percutaneous application of 500 µg of Der f extracts in 20 µl of dimethylsulfoxide (DMSO, Sigma-Aldrich, St. Louis, <http://www.sigmaaldrich.com>) on the ears, and challenged intranasally with 250 µg of Der f extracts in 40 µl phosphate buffer saline (PBS) at day 27 and 34 (Fig. 1). Control mice received only percutaneous application of 20 µl DMSO and were challenged intranasally with PBS. During the first Der f challenge at day 27, mice also received  $5 \times 10^5$  MSCs in 200 µl of PBS via tail vein injection, or 200 µl PBS only. Lung function was analyzed by invasive method (Flexivent<sup>®</sup>) to evaluate airway resistance, in response to increased doses of methacholine (0, 5, 10, 15, 20 mg/ml), according to the manufacturer instructions. Data were normalized to the results at 0 mg/ml dose.



**Figure 1**

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Allergic asthma protocol. Mice were sensitized by percutaneous administrations of total house dust mite (Der f) extracts or DMSO for controls, once a week during 4 weeks, and challenged by intranasal instillations of Der f extracts or PBS for controls, once a week during 2 weeks.  $5 \times 10^5$  MSCs in 200  $\mu$ l PBS or 200  $\mu$ l PBS in control mice were injected in tail vein during the first challenge at day 27. Analyses were performed at day 28 (24 hours after MSC injection), at day 35 (1 day after the last challenge) or at day 37 (3 days after the last challenge). Abbreviations: DMSO, dimethylsulfoxide; MSCs, mesenchymal stem cells.

[Caption](#) v

## Bone Marrow MSC Culture

Total bone marrow was obtained from several BALB/c mice by flushing femurs and tibias with culture medium (alpha MEM with nucleosides, 10% FCS, 2 mM L-Glutamin, 100 U/ml penicillin, 100  $\mu$ g/ml streptomycin, 2 ng/ml human FGF2 [AbCys, <http://www.eurobio.fr/>]). Cells were cultured until confluence, detached by 0.5% trypsin-EDTA and passed for amplification. For passage 8, MSCs were characterized by flow cytometry (BD LSR II, BD Biosciences, BD FACSDiva™ software) for specific markers: Sca-1-PE (D7), CD11b-PE (M1/70, eBiosciences, <http://www.ebioscience.com/>), CD44-PE (IM7), CD29-FITC (Ha2/5), CD45-PE (30-F11) (BD Biosciences, <http://m.bdbiosciences.com>), and for adipogenic and osteogenic differentiation capacity (see Supporting Information Fig. 1).



isometric myograph (Danish Myo Technology, Aarhus, Denmark, <http://www.dmt.dk/>). The bronchi were maintained in an organ bath containing Krebs-Henseleit buffer at 37°C continuously aerated (95% O<sub>2</sub> and 5% CO<sub>2</sub>). A pretension of 0.5 mN was applied and maintained all along the protocol. After an equilibration period, cumulative dose-response curves in response to KCl were obtained. In a second time, cumulative dose-response curves were obtained in response to carbachol, an analog of methacholine (Sigma Aldrich, <http://www.sigmaaldrich.com>).

## Lung Histology

Mice were euthanized for histology analysis at day 28 and 37. Lungs were inflated via the trachea with OCT diluted ½ in PBS, cryopreserved and sliced into continuous 5 µm thick cryosections. Immunolabeling was performed to detect leucocytes with anti-CD45 antibody (Becton Dickinson, <http://www.bd.com>) and cell nuclei with DAPI (Sigma Aldrich, <https://www.sigmaaldrich.com>). After fluorescence microscopy analysis, the same sections were secondary stained with Hematoxyline-Eosin for light microscopy analysis.

## Bronchoalveolar Lavage and Lung Digestion

Bronchoalveolar lavage fluid (BAL) was obtained by instilling intratracheally 1 ml PBS until lungs were inflated uniformly, followed by slow aspiration. BAL was centrifuged, and cells were counted and labeled for flow cytometry. After blood cardiac puncture, lungs were removed, minced into small pieces, and digested in 10 ml PBS with 3 mg/ml collagenase type II (Gibco, <https://www.thermofisher.com/fr/fr/home/brands/gibco.html>) and 3 mg/ml DNase I (Roche, <http://www.roche-diagnostics.fr>) at 37°C for 1 hour under agitation, to obtain lung single-cell suspension. Lung suspensions were filtered through a 40 µm nylon filter. Red blood cells were lysed (BD FACS Lysing Solution 1X [Becton Dickinson, <http://www.bd.com>]) and the remaining cells were washed, counted and labeled for flow cytometry or lysed for RNA extraction.

## Flow Cytometry

BAL cells were stained for multiparameter flow cytometric analysis. Ly6G-PerCP.Cy5.5 (1A8), CD8-APC-H7 (53-6.7) (BD Biosciences, <http://m.bdbiosciences.com>), CD3-APC (145.2C11), CD4-PE-Cy7 (1D3), F4/80-FITC (BM8) (eBioscience, <http://www.ebioscience.com/>), CCR3-PE (83101, R&D systems, <https://www.rndsystems.com>), and DAPI were used to identify BAL-infiltrating cells, as previously described [20](#). Briefly, stained cells were acquired on a BD LSR™ II (BD Biosciences, <http://m.bdbiosciences.com>) and analyzed using BD FACSDiva™ software (BD Biosciences, <http://m.bdbiosciences.com>). Dead cells were excluded using DAPI. After gating



identified as follows: forward scatter (FSC)<sup>-</sup>, side scatter (SSC)<sup>-</sup>, F4/80<sup>-</sup>, Ly6C<sup>-</sup> and CD11b<sup>-</sup> (CD19<sup>-</sup> CD3<sup>+</sup>) and B (CD19<sup>+</sup> CD3<sup>-</sup>) cells were also identified.

To investigate the T helper responses,  $8 \times 10^5$  lung cells were transferred to a 96-well round-bottom plate and then stimulated for 5 hours with a mixture containing phorbol 12-myristate 13-acetate (PMA) (50 ng/ml; Sigma-Aldrich, <https://www.sigmaaldrich.com>) and ionomycin (5 ng/ml; Sigma-Aldrich, <https://www.sigmaaldrich.com>) together with either monensin (PMA + ionomycin + monensin; PIM) for T<sub>H</sub>17 analysis (2 mg/ml; BD Biosciences, <http://m.bdbiosciences.com>) or brefeldin A for T<sub>H</sub>2 assessment (1 mg/ml; BD Biosciences, <http://m.bdbiosciences.com>). For cytokine detection, the FcRs were blocked with mouse CD16/CD32 mAbs (eBioscience, <http://www.ebioscience.com>). Prior to surface-specific staining the cells were stained with Fixable Viability Dye 450 (BD Biosciences, <http://m.bdbiosciences.com>) to exclude dead cells. The following antibodies were used for surface staining: CD3-PeCy7 (145-2C11) and CD8-APC-H7 (53-6.7) (BD Biosciences, <http://m.bdbiosciences.com>). The cells were then fixed and permeabilized using a Cytotfix/Cytoperm kit (BD Biosciences, <http://m.bdbiosciences.com>) and stained intracellularly with anti-IL-4 (11B11; eBioscience, <http://www.ebioscience.com>), -IL-5 (TRFK5; BD Pharmingen, <http://www.bdbiosciences.com>), -IL-10 (JES5-16E3; BD Pharmingen, <http://www.bdbiosciences.com>), -IL-13 (eBio13A; eBioscience, <http://www.ebioscience.com>), -IL-17A (TC11-18H10; BD Biosciences, <http://m.bdbiosciences.com>) and -IFN $\gamma$  (XMG1.2, BD Pharmingen, <http://www.bdbiosciences.com>) antibodies.

For in vivo MSC detection, MSCs cells were labeled just before injection with PKH26 according to manufacturer instructions (Red Fluorescent Cell Linker Kits for General Cell Membrane Labeling (Sigma Aldrich, <https://www.sigmaaldrich.com>)). A total of  $5 \times 10^5$  PKH26<sup>+</sup> MSCs were injected in mice. Total lung cells were obtained 1 or 10 days later as indicated above and labeled with DAPI to select viable cells and CD11c-PeCy7 (N418) and F4/80-FITC (BM8) antibodies (eBioscience, <http://www.ebioscience.com>). Cells were sorted after gating for morphology (FSC-H vs. FSC-A) and viability (negative for DAPI). On these gates, cells PKH26<sup>+</sup> and PKH26<sup>-</sup> were identified and further selected for cell sorting by F4/80 and CD11c expression. MSCs were evaluated and purified as PKH26<sup>+</sup>CD11c<sup>-</sup>F4/80<sup>-</sup> cells (see Supporting Information Fig. 2) and counted in Malassez cell.

## RNA Isolation, Reverse Transcription, Real-Time PCR

Total RNA was extracted from lung homogenates, primary bronchi, and sorted cells using RNeasy mini and micro kit (Qiagen, <https://www.qiagen.com>) according to manufacturer's instructions. Total RNA was reversely transcribed to cDNA using High Capacity cDNA Archive



bioassays, <http://www.thermofisher.com>), using the Taqman® technology and commercial primers. Data were normalized to reference HPRT1 gene and were used for the  $2^{-\Delta\Delta CT}$  calculation.  $2^{-\Delta\Delta CT}$  corresponds to the ratio of each gene expression versus HPRT1 gene expression.

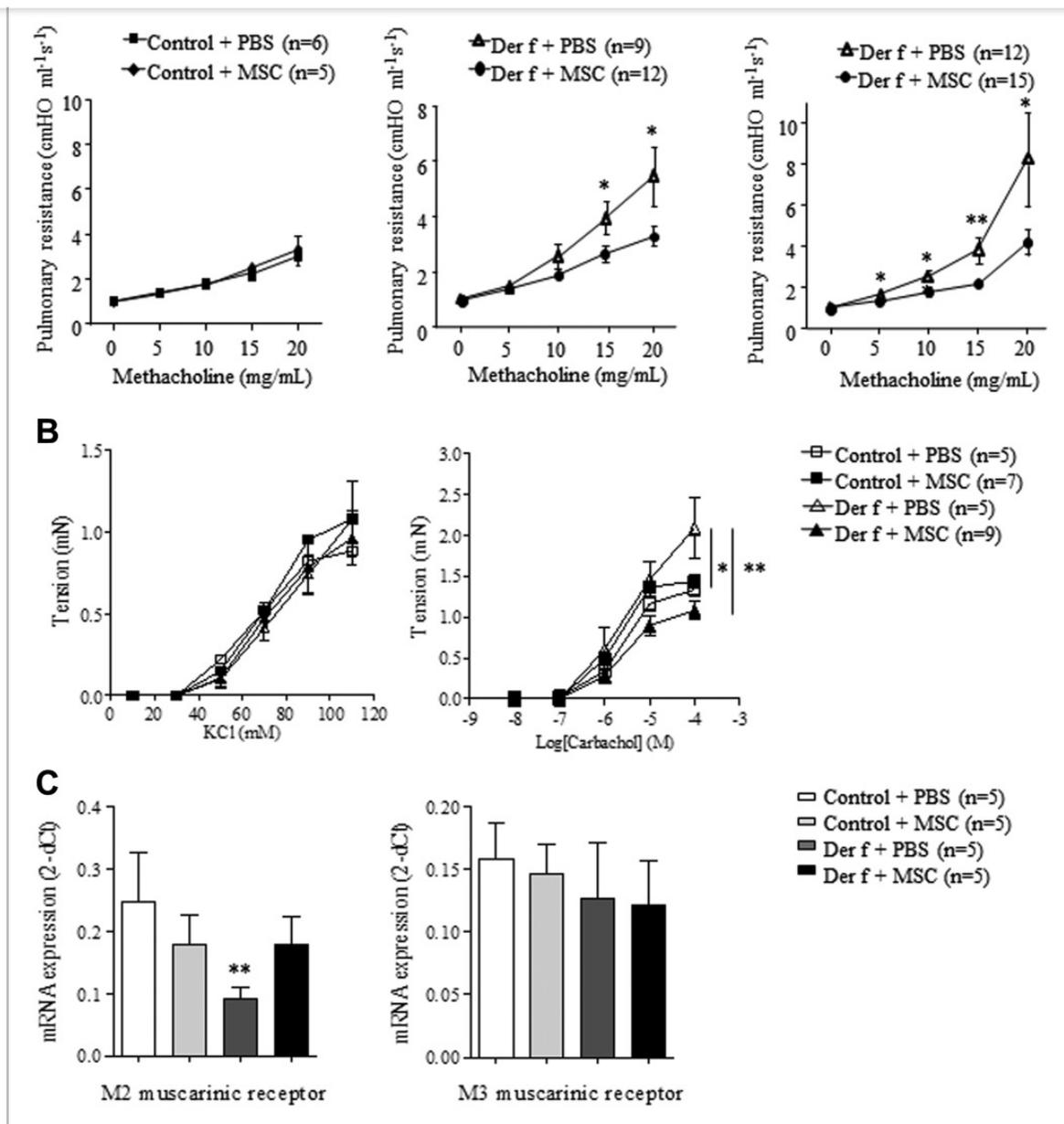
## Statistical Analysis

Comparisons of experimental values between two groups were analyzed using the Mann Whitney test. All statistical analysis were performed in GraphPad Prism v5. A  $p$ -value  $< .05$  was considered statistically significant.

## RESULTS

### Mesenchymal Stem Cells Inhibit Airway Hyper-Responsiveness and Bronchoconstriction

To investigate the effect of MSC injection on allergic asthma, we used a well-established house dust mite (Der f)-induced asthma model [19](#) (Fig. 1). Mice were sensitized with percutaneous Der f extracts and then twice challenged with intranasal Der f extracts. A single i.v. injection syngeneic MSCs was performed concomitantly to the first Der f challenge. One day after the second Der f challenge (day 35 postsensitization) a decrease in airway hyper-responsiveness was observed in Der f mice injected with MSCs as compared to Der f mice injected with PBS ( $3.3 \pm 1$  in Der f+MSC mice vs.  $5.5 \pm 2.1$  cmHO/ml/s in Der f+PBS mice at 20 mg/ml methacholine,  $p = .012$ , Fig. 2A), while MSC injection had no deleterious effect on lung function in control mice ( $3.3 \pm 1.05$  cmHO/ml/s in control+MSC mice vs.  $3.03 \pm 0.8$  cmHO/ml/s in control+PBS mice at 20 mg/ml methacholine,  $p = .3$ ). This beneficial effect on lung function was stable 3 days after the second challenge (day 37 postsensitization,  $4.2 \pm 1.9$  in cmHO/ml/s in Der f+MSC mice vs.  $8.2 \pm 3.1$  cmHO/ml/s in Der f+PBS mice at 20 mg/ml methacholine,  $p = .03$ ).



**Figure 2**

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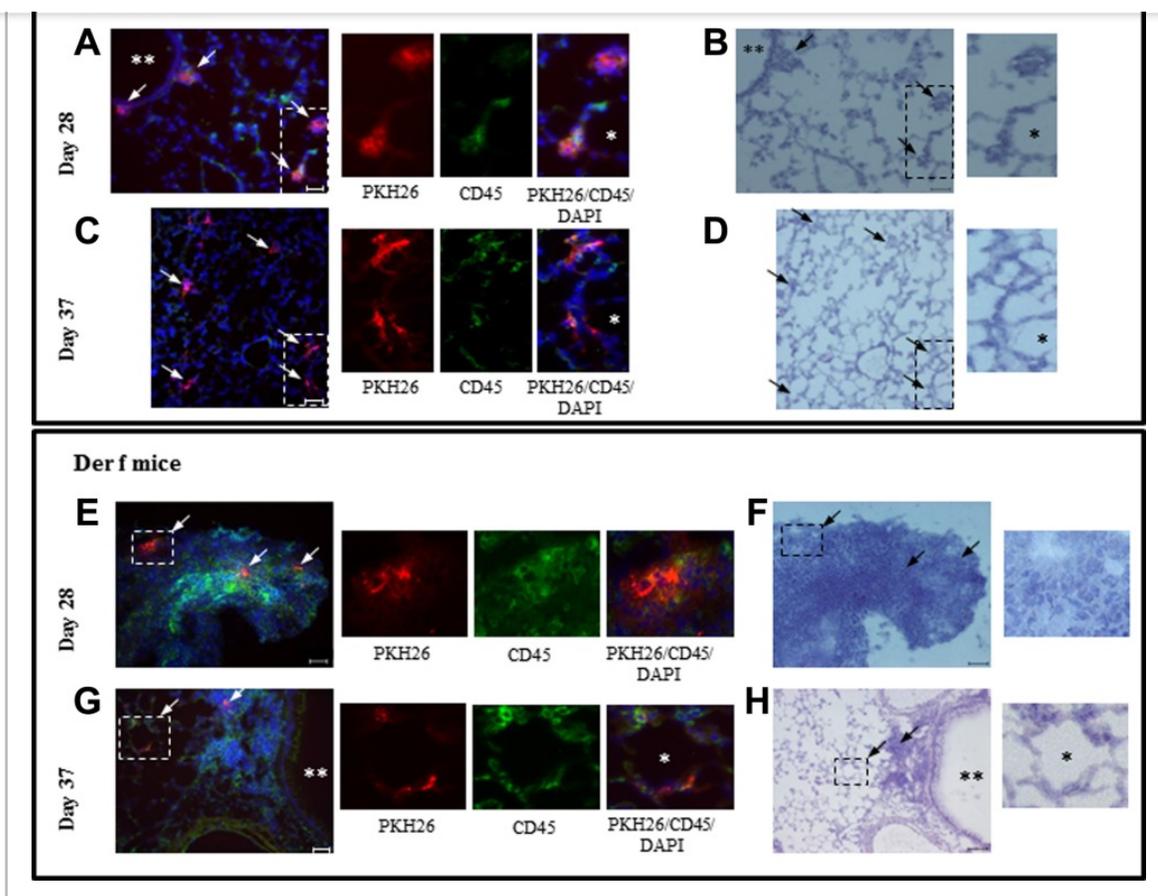
Mesenchymal stem cells inhibit airway hyper-responsiveness and bronchoconstriction. **(A)**: Airway resistance was measured using Flexivent<sup>®</sup> after instillation of 0–20 mg/ml methacholine, in control and asthmatic Der f mice that had received PBS (as a control) or  $5 \times 10^5$  MSCs, respectively, at day 27 following first Der f sensitization. Measurements were realized at day 35 in control mice, and at day 35 and 37 following first Der f sensitization (1 or 3 days after the second challenge, respectively) in Der f mice. Data are means  $\pm$  SEM. **(B)**: Contractile response of primary bronchi (2 mm-long rings) from



Contractile force was quantified *ex vivo* on primary bronchi from Der f and control mice injected with MSCs or PBS, in response to KCl and carbachol (Fig. 2B). Consistent with our *in vivo* data on lung function, MSC injection during the first Der f challenge reduced carbachol-induced contraction when compared to Der f mice injected with PBS ( $2.1 \pm 0.4$  vs.  $0.97 \pm 0.12$ ,  $p = .002$ ). Interestingly no difference was observed in KCl-induced contraction, suggesting that MSCs inhibited bronchoconstriction by regulating the muscarinic pathway. Der f mice injected with PBS displayed a decreased expression of the M2 muscarinic receptor in their bronchi, as compared to control mice injected with PBS or MSCs (Fig. 2C). In contrast Der f mice injected with MSCs displayed M2 muscarinic receptor expression similar to that of control mice injected with PBS or MSCs. MSCs had no effect on M3 muscarinic receptor expression. Collectively these data suggest that MSCs mediated their protective role in asthma in part by modulating the airway contractile response.

## Mesenchymal Stem Cells are Located in Lungs after i.v. Injection

The presence of MSCs in lungs after *i.v.* injection was investigated using immuno-histology analysis. MSCs were labeled prior injection with PKH26, a fluorescent red marker which stably incorporates into cell membrane lipids. Successive immunofluorescence and histological analyses showed PKH26<sup>+</sup> cell presence in alveolar and capillary walls, both in control and Der f mice (Fig. 3). PKH26<sup>+</sup> cells were also located in inflammatory infiltrates in Der f mice (Fig. 3E, 3F). In both groups PKH26<sup>+</sup> cells were still detected 10 days after MSC injection (Fig. 3C, 3D, 3G, 3H).



**Figure 3**

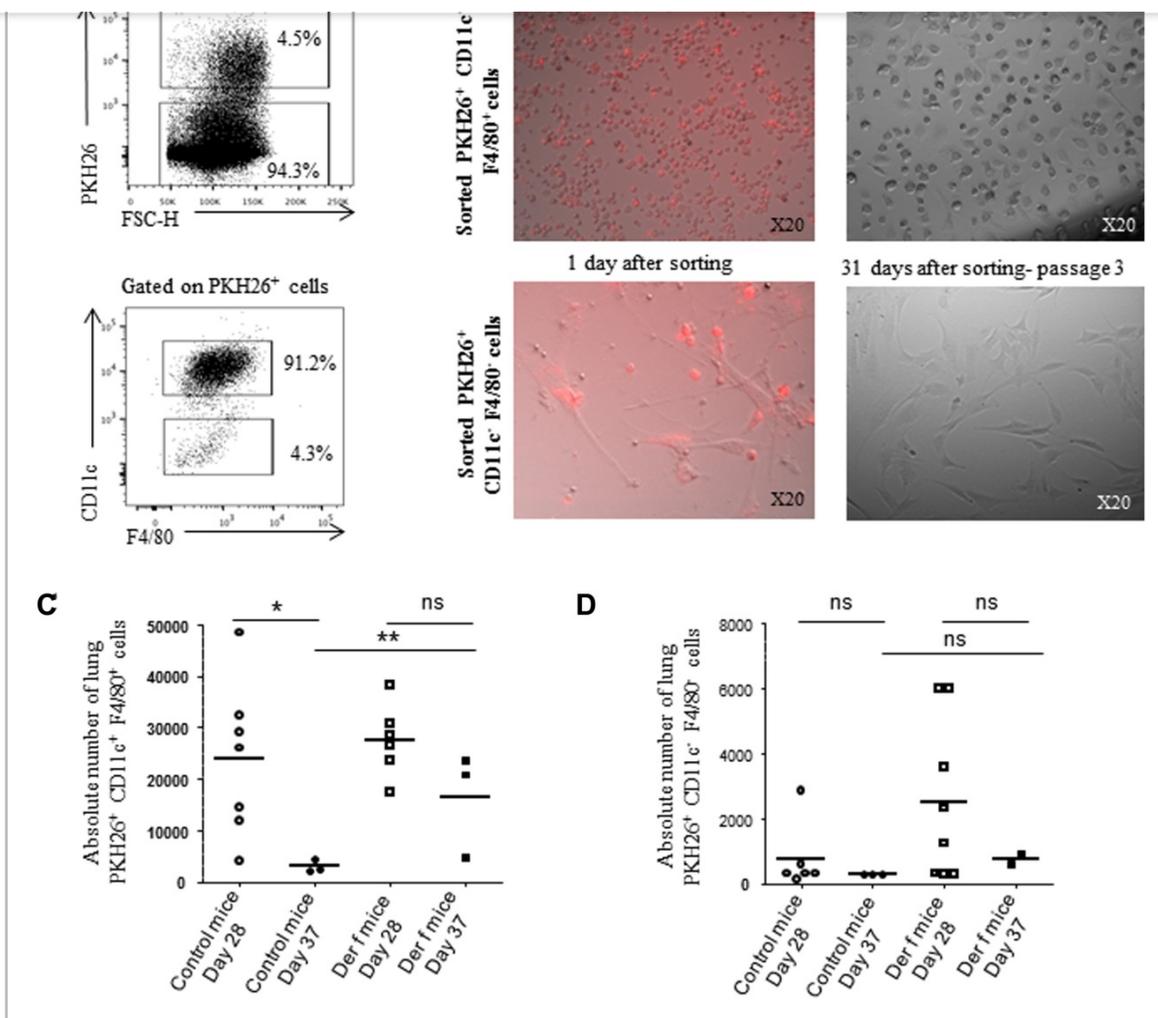
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Mesenchymal stem cells were located in alveolar walls and capillary walls after i.v. injection. Each panel shows representative images of histological fluorescence analysis (**A, C, E, G**), followed by H&E staining (**B, D, F, H**) of the same lung sections, from control and asthmatic Der f mice sacrificed 24 hours (Day 28) and 10 days (Day 37) after PKH26<sup>+</sup> mesenchymal stem cell (MSC) injection. Smaller panels are zoomed images of the dotted rectangles. DAPI (blue) stained nuclei and anti-CD45 antibody (green) stained leucocytes. PKH26<sup>+</sup> cells (arrow and red) were located in alveolar walls and capillary walls in both control and asthmatic mice, and in inflammatory infiltrates in asthmatic mice. \*, alveolus; \*\*, airway bronchiole. Scale bar: 50  $\mu$ m.

[Caption](#)  $\downarrow$



and digested, and lung cell suspensions were evaluated for the presence of PKH26<sup>+</sup> cells using flow cytometry (Fig. 4A, upper panel). A total of  $4 \pm 0.5\%$  and  $2.8 \pm 0.5\%$  lung cells were identified as PKH26<sup>+</sup> in control and Der f mice, respectively ( $n = 6$  in each group). Surprisingly, while  $5 \times 10^5$  PKH26<sup>+</sup> MSCs had been injected, the absolute number of PKH26<sup>+</sup> cells detected in the lungs was  $65 \pm 35 \times 10^3$  and  $58 \pm 26 \times 10^3$  cells in control and Der f mice, respectively, suggesting that a high proportion of injected MSCs were still present in the lungs ( $13 \pm 7$  and  $11.6 \pm 5\%$  in control and Der f mice, respectively). To evaluate if these cells were in fact macrophages, PKH26<sup>+</sup> cells were colabeled in lung cell suspensions with antibodies specific for macrophages (CD11c/F4/80). Importantly, two cell populations were easily distinguished into a PKH26<sup>+</sup> cell gate (Fig. 4A, lower panel), including a large majority of PKH26<sup>+</sup> cells positive for CD11c/F4/80 macrophage markers ( $91.5 \pm 2.3\%$  and  $86.6 \pm 6.3\%$  in control ( $n = 6$ ) and Der f ( $n = 6$ ) mice, respectively), and a minority of PKH26<sup>+</sup> cells negative for CD11c/F4/80 macrophage markers ( $4.27 \pm 0.7\%$  ( $n = 6$ ) and  $5.74 \pm 1.47\%$  in control ( $n = 6$ ) and Der f mice ( $n = 8$ ), respectively). The absolute number of PKH26<sup>+</sup>CD11c<sup>+</sup>F4/80<sup>+</sup> cells was  $23 \pm 15 \times 10^3$  cells and  $7 \pm 7 \times 10^3$  cells in control and Der f mice, accounting for  $4.8 \pm 2.9\%$  and  $5.5 \pm 1.4\%$  of  $5 \times 10^5$  PKH26<sup>+</sup> injected MSCs (Fig. 4C). The absolute number of PKH26<sup>+</sup>CD11c<sup>-</sup>F4/80<sup>-</sup> cells was  $763$ ,  $1,046$  and  $2,506 \pm 2,446$  in control and Der f mice, representing  $0.15 \pm 0.2\%$  and  $0.5 \pm 0.5\%$  of  $5 \times 10^5$  PKH26<sup>+</sup> injected MSCs (Fig. 4D). Absolute cell numbers of both cell populations were not significantly different between both groups, suggesting that airway inflammation in sensitized mice did not increase cell engraftment.



**Figure 4**

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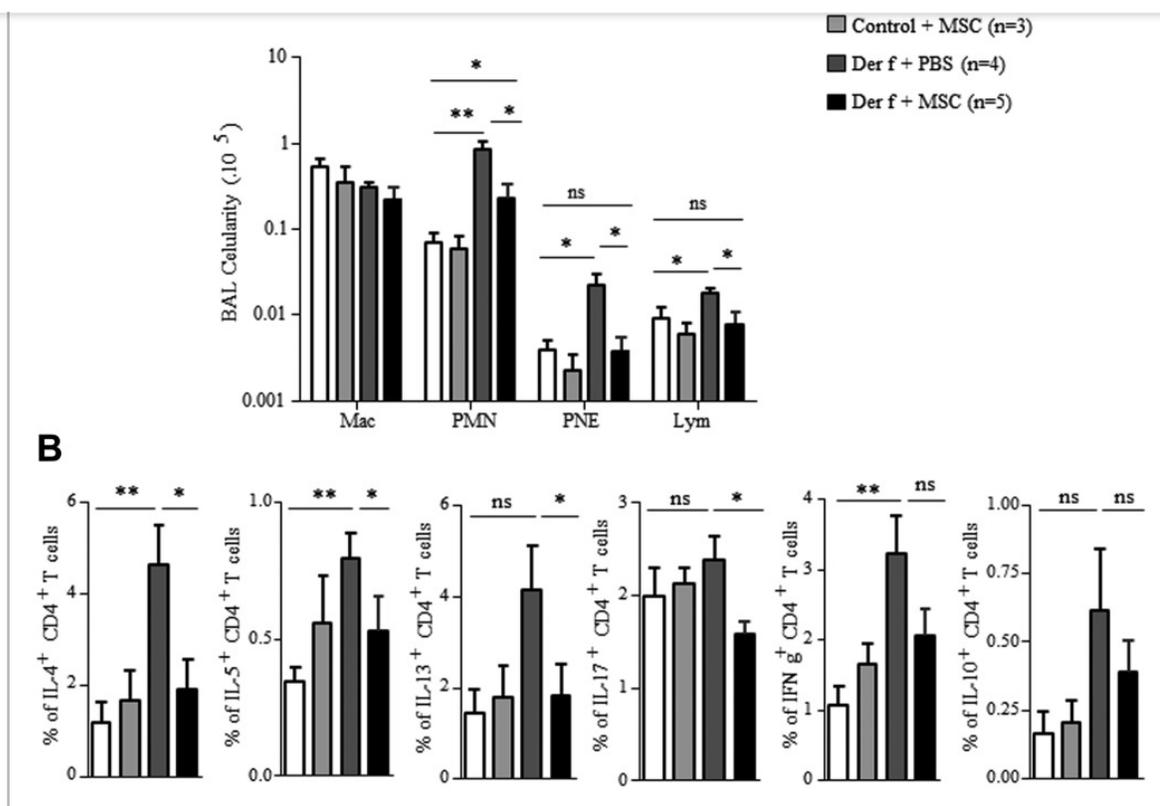
Characterization of the PKH26<sup>+</sup> injected mesenchymal stem cells (MSCs). Lungs were removed and digested with collagenase in control or Der f mice, 24 hours (Day 28) or 10 days (Day 37) after i.v. injection of PKH26<sup>+</sup> labeled MSCs, to obtain lung single-cell suspensions. Lung cells were then labeled with DAPI, CD11c and F4/80 antibodies. **(A)**: Representative example of flow cytometric analysis and sorting at day 28 in lung cell suspension from a control mouse injected with PKH26<sup>+</sup> labeled MSCs. PKH26<sup>+</sup> cells were identified in lung cell suspension (PKH26 vs. FSC-H, upper panel). After gating on this PKH26<sup>+</sup> cells, PKH26<sup>+</sup> cells were sorted according to the presence or absence of expression of both CD11c and F4/80 macrophage markers (CD11c vs. F4/80, low panel). **(B)**: Representative images of cell plates containing PKH26<sup>+</sup>CD11c<sup>+</sup>F4/80<sup>+</sup> and PKH26<sup>+</sup>CD11c<sup>-</sup>F4/80<sup>-</sup> sorted cells and cultured



4B), PKH26<sup>+</sup>CD11c<sup>-</sup>F4/80<sup>-</sup> cells proliferated and expressed MSC phenotype (Scd1<sup>+</sup>, CD29<sup>+</sup>, CD44<sup>+</sup>, CD45<sup>-</sup>, CD11b<sup>-</sup>; Supporting Information Fig. 3), confirming that these cells were injected PKH26<sup>+</sup> MSCs. In marked contrast, PKH26<sup>+</sup>CD11c<sup>+</sup>F4/80<sup>+</sup> cells did not proliferate in culture (Fig. 4B) and still expressed macrophage specific markers (CD11c<sup>+</sup>/F4/80<sup>+</sup>) confirming that these cells were macrophages (Supporting Information Fig. 3). Interestingly, PKH26<sup>+</sup>CD11c<sup>-</sup>F4/80<sup>-</sup> cells were also observed 10 days after i.v. injection (0.06% and 0.1 ± 0.09% of 5 × 10<sup>5</sup> PKH26<sup>+</sup> injected MSCs in control (*n* = 3) and Der f (*n* = 2) mice, respectively), suggesting a mid-term survival of a very small number of MSCs in the lungs of mice (Fig. 4D). Together these data suggest that the vast majority of PKH26<sup>+</sup> injected MSCs had been phagocytosed by lung macrophages during the 24 hours following i.v. injection.

## Injection of Mesenchymal Stem Cells Decrease Airway Inflammation

Airway inflammation is another important feature of allergic asthma. The first challenge with Der f extracts in Der f mice induced the infiltration of both eosinophils and neutrophils in BAL associated with the expansion of lung lymphocytes (Fig. 5A). MSCs did not alter immunological profile in control mice, suggesting no deleterious effect and no inflammation response due to MSC injection itself (Fig. 5A). Interestingly, 24 hours after the first Der f challenge (day 28), MSC injection inhibited airway inflammation with decreased absolute numbers of BAL neutrophils, eosinophils and lymphocytes. In parallel a decrease was observed in cytokine (IL-4, IL-5, IL-1 and IL-17) expression by lung CD4<sup>+</sup> T cells (Fig. 5B) while no significant effect was observed on IFN $\gamma$  and IL-10 expression. These data demonstrate that MSCs early constrained airway inflammation, however this suppressive effect declined after a second challenge (data not shown) despite the persistence of decreased hyper-responsiveness (Fig. 2A).



**Figure 5**

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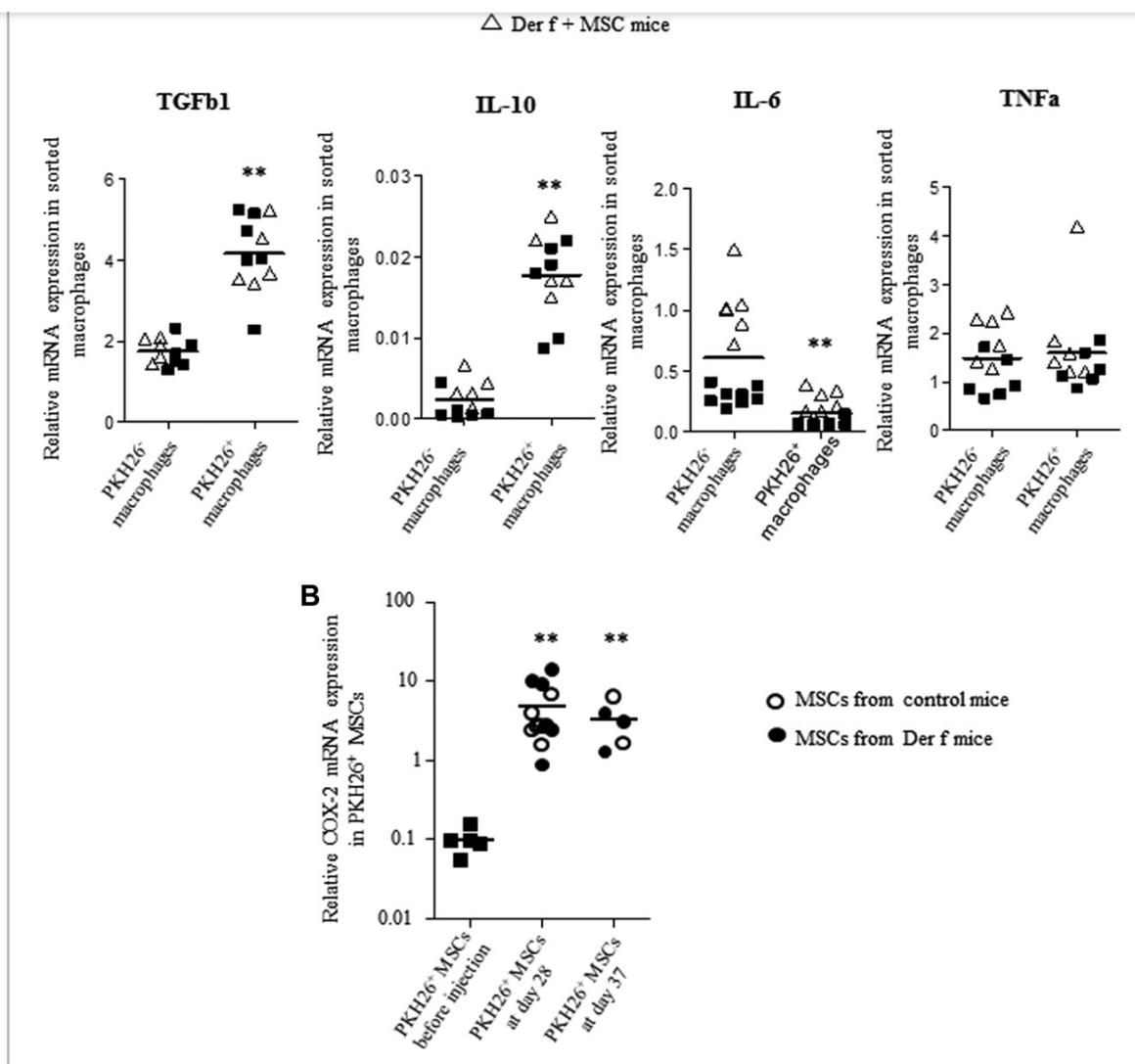
Injection of mesenchymal stem cells decreased airway inflammation. **(A)**: Total number of macrophages (Mac), neutrophils (PMN), eosinophils (PNE), and lymphocytes (Lym), were obtained by flow cytometry on bronchoalveolar lavages at day 28 in control and Der f mice injected with PBS or with MSCs. Data are expressed as means  $\pm$  SD. **(B)**: Percentage of IL-4, IL-5, IL-13, IL-17, IFN $\gamma$ , and IL-10 positive CD4<sup>+</sup> T cells isolated from the lungs at day 28, from control and Der f mice injected with PBS or with MSCs. Data are expressed as means  $\pm$  SD. Statistical differences were determined by a Mann Whitney test,  $**p < .01$ ;  $*p < .05$ , ns: not significant. Abbreviations: BAL, Bronchoalveolar lavage fluid; MSCs, mesenchymal stem cells.

[Caption](#)  $\downarrow$

## MSC Injection Induces Lung Macrophage Polarization into



explain MSC suppressive effects, total lung cells were obtained from control and Der f mice injected with PKH26-labeled MSCs as described above. Lung macrophages were then cell-sorted according to their specific co-expression of CD11c and F4/80, and divided into 2 subpopulations according to their differential PKH26 labeling. Both macrophage subpopulations were then evaluated for their gene expression in pro and anti-inflammatory cytokines. Interestingly, the functional profile of PKH26<sup>+</sup> and PKH26<sup>-</sup> macrophages was different (Fig. 6A). PKH26<sup>+</sup> macrophages expressed higher mRNA levels of TGFβ and IL-10, two immunosuppressive cytokines that are typically increased in M2 macrophages [21](#). In contrast, PKH26<sup>-</sup> macrophages expressed M1 macrophage phenotype with higher levels of IL-6. No difference in TNFα mRNA expression was observed. Importantly, no difference in cytokine expression in lung macrophages was observed between control and Der f mice both injected with MSCs, suggesting that the induction of M2 macrophage phenotype was due to MSC injection and not to Der f sensitization. We then evaluated if MSCs expressed in vivo COX-2, cyclo-oxygenase which catalyzes the rate-limiting step of prostaglandin formation, including PGE-2, a central molecule necessary for M2 macrophage activation [22](#). To answer this question, COX-2 gene expression was quantified in PKH26<sup>+</sup>CD11c<sup>-</sup>F4/80<sup>-</sup> cells, as these cells were demonstrated above as being MSCs (Fig. 4B). Sorted PKH26<sup>+</sup>CD11c<sup>-</sup>F4/80<sup>-</sup> cells expressed significantly higher mRNA levels of COX-2 than MSCs before their injection (Fig. 6B). The over-expression of COX-2 in MSCs was still observed 10 days after the first Der f challenge and MSC injection. No difference in COX-2 expression in PKH26<sup>+</sup>CD11c<sup>-</sup>F4/80<sup>-</sup> cells was observed between control and Der f mice injected with MSCs, suggesting that the increase in COX-2 expression was due to MSC injection and not to Der f sensitization.



**Figure 6**

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MSC injection induced macrophage polarization into suppressive phenotype in the lungs. **(A)**: Relative mRNA expression levels of TGFβ1, IL-10, IL-6, and TNFα in PKH26<sup>+</sup> (PKH26<sup>+</sup>CD11c<sup>+</sup>F4/80<sup>+</sup>) and PKH26<sup>-</sup> (PKH26<sup>-</sup>CD11c<sup>+</sup>F4/80<sup>+</sup>) macrophages sorted from lung cell suspensions using flow cytometry. Measurements were performed at day 28 (24 hours after PKH26<sup>+</sup> MSC injection) in control ( $n = 6$  to  $8$ ) and Der f mice ( $n = 5$ – $6$ ). **(B)**: Relative COX-2 mRNA expression levels in MSCs in vitro just before injection ( $n = 5$ ), and in PKH26<sup>+</sup>CD11c<sup>-</sup>F4/80<sup>-</sup> cells (PKH26<sup>+</sup> MSCs) cells sorted from lung cell suspensions using flow cytometry. Measurements were performed in control mice ( $n = 2$ – $7$ ) and in Der f mice ( $n = 3$ – $6$ ) at day 28 (24 hours after PKH26<sup>+</sup> MSC injection) and day 37 (10 days after PKH26<sup>+</sup> MSC injection). mRNA expression



airway inflammation and hyper-responsiveness [9](#), [11-13](#), [23](#), [24](#), but the lack of mechanistic explanation hampered this result, considering the very low quantity of cells that survive and graft in lung tissue after injection. In this study we showed that injected MSCs are in vivo phagocytosed by lung macrophages that, in turn, reprogram into an immunosuppressive phenotype.

Cell tracking after in vivo administration is one of the trickiest issues in cell therapy studies and results from lung studies remain controversial [25](#). The use of GFP as a marker of stem cells obtained from bone marrow of GFP<sup>+</sup> transgenic mice, can lead to errors in the presence of autofluorescent structures [26](#). Microscopy-based methods even when coupled with immunohistochemistry-based cell visualization and characterization suffer from low sensitivity and problems associated with reliable interpretation of images [27](#). To circumvent this issue, we injected MSCs labeled with PKH26 red fluorescent marker, and sorted PKH26<sup>+</sup> cells by flow cytometry from digested total lungs, 1–10 days after MSC injection. Our initial results suggesting high lung MSC engraftment were similar to that observed using the same methodology in a model of rat lung injury [28](#). Nevertheless, such high lung engraftment was discrepant with previous studies in numerous lung injury animal models of stem cell therapy [29](#), [30](#). By using sophisticated microscopy methods such as fluorescence confocal deconvolution microscopy, the participation to the lungs of adult stem cells from bone marrow was evaluated between 0.1 and 1% [31-34](#). On the other hand, a critical role of macrophages has been suggested as immune effector in MSC therapy models. Macrophages play an important role in acute allergic lung inflammation [35](#), [36](#), and interaction with macrophages is necessary for an optimal therapeutic effect of MSCs [15](#). Depletion of alveolar macrophages reverses the benefit of stem cell treatment [15](#) and increases inflammation [36](#). We, thus, raise the hypothesis that injected MSCs had been phagocytosed by macrophages. Using specific markers for macrophages we demonstrated that the sorted lung PKH26<sup>+</sup> cells were indeed mostly macrophages, whereas a small number of characterized MSCs were observed (0.15%–0.5% of MSC injected cells). This proportion of grafted MSCs in the lungs is in accordance with the current literature, and showed no increase in cell engraftment despite lung inflammation, a result that has already been observed in other animal models [37](#). On the other hand, the mechanisms by which such small MSC number suppresses airway hyper-responsiveness remain largely unexplained [38](#).

Recent observations suggest that under many conditions MSCs only transiently appear in injured tissues, but during their brief appearance they cross-talk with injured cells to limit tissue destruction or enhance repair by a variety of mechanisms [10](#), [38](#), [39](#). Activated MSCs



phenotype 22. M2 macrophages show high phagocytic activity, they produce low amounts of pro-inflammatory cytokines and higher amounts of the anti-inflammatory cytokine IL-10, and they contribute to inflammation resolution 21. In our study, MSC injection induced lung macrophage polarization into M2 suppressive phenotype, without inducing an increase in macrophage number, as already observed in ovalbumin-induced allergic model 40. In turn, injected MSCs expressed 10- to 100-fold more COX-2 than before injection, suggesting that MSC phenotype alteration occurred after in vivo injection, in presence or absence of inflammation. Interestingly, MSCs need to be viable when injected, as delivery of PFA-fixed MSCs to allergen-sensitized mice resulted in severe pathology 13. Importantly, the induction of M2 suppressive phenotype was observed in our study only in macrophages that had phagocytosed PKH26<sup>+</sup> MSCs and not in “naive” macrophages (i.e., PKH26<sup>-</sup> macrophages), suggesting that M2 suppressive phenotype was induced by MSC phagocytosis and not by simple cross-talk between macrophages and MSCs. In summary these data demonstrate that injected MSCs in vivo are phagocytosed in the lungs after i.v. injection, inducing a suppressive macrophage cellular phenotype. By doing this, MSCs promote the establishment of a tolerogenic microenvironment that might probably counterbalance T-cell mediated airway inflammation.

It is strongly believed that MSCs achieve a therapeutic effect in vivo via paracrine action, in particular the shedding of extracellular vesicles including exosomes and microvesicles 41. Under standard in vitro culture conditions, Phinney et al. recently demonstrated that MSCs undergo mitophagy and use microvesicles to unload mitochondria, which are engulfed by macrophages and reutilized to increase bioenergetics 42. In our study, to label MSCs prior to in vivo injection we used PKH26 labeling, a fluorescent red marker which stably incorporates in cell membrane lipids. Therefore, PKH26<sup>+</sup> macrophages in lung suspensions may be macrophages that have phagocytosed exosomes with PKH26<sup>+</sup> membranes, without phagocytosing whole MSCs. However, this mechanism cannot explain the low number of surviving MSCs 24 hours after in vivo administration (less than 0.5%), suggesting that MSC phagocytosis by macrophages is, at least in part, responsible for low MSC surviving.

We chose a house dust mite mice allergic asthma model, because house dust mite is the main indoor allergens responsible for human asthma, and this model being characterized by abnormal T<sub>H</sub>2 and T<sub>H</sub>17 immune response as observed in patients with severe asthma 19. MSC injection at day 0 before Der f sensitization did not prevent the alteration in respiratory function during subsequent Der f challenges in our model (data not shown). This suggests that MSC injection did not protect from sensitization to new allergen but could attenuate deleterious reaction to repeated allergen exposure and prevent further asthma exacerbation.



MSC administration decreased significantly airway hyper-responsiveness induced by methacholine only in asthmatic Der f mice, and this result correlated with the reduction of *in vivo* primary bronchial contraction. Furthermore MSC injection increased M2 muscarinic receptor expression in asthmatic mice. Low or dysfunctional M2 muscarinic receptor activity has been associated with airway hyper-responsiveness in mice [43](#). M2 muscarinic receptor inhibited the release of acetylcholine, a cholinergic neurotransmitter typically increased in asthmatic patients, promoting airway contraction [44](#). MSC injection induced a diminution of eosinophils and IL-5, two factors influencing the M2 muscarinic receptor expression [45](#), [46](#). In summary, our data suggest that the mechanism of airway hyper-responsiveness decrease by MSC injection was not limited to a modification of inflammation response as observed in numerous studies [47](#), but was also linked to a modification of airway contractility.

## CONCLUSION

Cell engraftment after *i.v* injection to repair injured tissue has always been a challenge since the beginning of cell therapy studies. We showed in a mouse model of asthma that most of injected MSCs, not only do not engraft into lungs but are *in vivo* phagocytosed by lung macrophages which, in turn, acquire a M2 suppressive phenotype. This mechanism was sufficient to decrease airway responsiveness and to observe MSC anti-inflammatory efficacy. As MSCs are being used for their immunomodulatory properties in the treatment of a number of immune-based disorders [48](#), further studies on such mechanisms in other models and to unravel early *in vivo* interactions between MSCs and lung macrophages are warranted.

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## Author Contributions

F.B. contributed to experiments, data acquiring and analysis, writing of the manuscript. S.D. contributed to experiments, writing of the manuscript. V.F.: contributed to the study design, experiments, data acquiring and analysis, writing of the manuscript. V.S. contributed to *in vivo* airway smooth muscle contraction experiments. D.H. contributed to lung function



and writing of the manuscript. F.E. contributed to the study design, data analysis and writing the manuscript. F.B., S.D., and V.F. contributed equally to this article.

## DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

The authors indicate no potential conflicts.

Supporting Information



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