A Novel In Vitro Model of Villitis of Unknown Etiology Demonstrates 1 Altered Placental Hormone and Cytokine Profile

DOI:
10.1111/aji.12725

Document Version
Accepted author manuscript

Link to publication record in Manchester Research Explorer

Citation for published version (APA):

Published in:

Citing this paper
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<th><em>American Journal of Reproductive Immunology</em></th>
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<td>AJRI-01-17-011.R1</td>
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<tr>
<td>Manuscript Type:</td>
<td>Technical Report</td>
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<td>Date Submitted by the Author:</td>
<td>04-Apr-2017</td>
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| Keywords: | T cells, Placental dysfunction, Inflammation, VUE |
A Novel In Vitro Model of Villitis of Unknown Etiology Demonstrates Altered Placental Hormone and Cytokine Profile

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Running Title: Placental inflammation in vitro

Summary statement: Co-culture of human placental explants with matched maternal T-cells elicits an inflammatory reaction that mimics villitis of unknown etiology and detrimentally affects placental function.

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Abstract

Problem: Placental dysfunction is present over 50% of cases of stillbirth and fetal growth restriction (FGR). Villitis of unknown etiology (VUE), an inflammatory condition of the placenta characterised by maternal T cell infiltrates in the villous stroma and dysregulation of inflammatory cytokines, is more frequent in FGR and stillbirth.

Method of Study: A novel in vitro model of placental inflammation was developed to test the hypothesis that inflammatory cells seen in VUE and/or cytokines impair placental function.

Results: Co-culture of placental explants with maternal leukocytes resulted in increased leukocytes in villous tissue and elevated concentrations of IL-1β, IL-1Ra, IL-6, IL-10 and IFN-γ (p≤0.05). Human chorionic gonadotrophin secretion was reduced following co-culture with leukocytes (p≤0.01) and cytokines (p≤0.05).

Conclusions: These observations support the hypothesis that altered placental inflammation has deleterious effects on placental function. This model could be used to further understanding about the pathophysiology of VUE and to test potential therapies.

Keywords: VUE, Inflammation, Placental dysfunction, T cells
1 Introduction

Placental dysfunction is cited as a cause of death in up to 65% of stillbirths (Flenady et al., 2011; Helgadóttir, 2012). Until recently, investigations of the origins of placental dysfunction have generally concentrated on the implications of failure of spiral artery remodelling as seen in early onset pre-eclampsia and fetal growth restriction (FGR) (Burton et al., 2009). However, interest has grown in the consequences of placental inflammation and its contribution as a cause of stillbirth and FGR. Infectious agents such as cytomegalovirus or toxoplasmosis can lead to placental inflammation, though such cases are usually in the minority (Redline, 2007). More frequently, placental inflammation occurs in the absence of infection (Girard et al., 2014). Villitis of unknown etiology (VUE) is one such inflammatory condition of the villous tissue. As its name suggests, the origin of VUE is unknown, but it is not attributable to infectious agents.

VUE occurs in approximately 15% of term placentas, with a higher incidence in FGR (Derricott et al., 2013). Increased severity of inflammation has been linked to stillbirth (Redline, 2007) and it has been reported that VUE may recur in subsequent pregnancies (Redline and Abramowsky, 1985). VUE is characterised by infiltration of the placental villous stroma by maternal CD4 and CD8 T-cells (Kapur et al., 2004; Kim et al., 2008) and expansion of the placental macrophage (Hofbauer cell) population (Derricott et al., 2016; Kim et al., 2008, 2009; Redline and Patterson, 1993; Tang et al., 2011). The mechanisms by which this inflammatory infiltrate negatively affects placental function are unknown. We recently demonstrated altered cytokine protein levels in VUE lesions, including reduced interleukin (IL)-4 and elevated IL-2 and -12, indicating a localised pro-inflammatory environment in these placentas, which could disrupt normal placental viability and function (Derricott et al., 2016).

We hypothesised that the presence of maternal CD4 and CD8 T-cells and/or their related cytokines in the villous stroma damages trophoblast, the key functional cell layer, leading to impaired placental function. As VUE is diagnosed on histological examination of the placenta after delivery it cannot be detected before birth. This limits the ability to assess the effects of VUE on placental function using a traditional case-control or cohort study design. In the current study we developed a novel in vitro model of VUE, whereby maternal T cells (CD4
and CD8) were co-incubated with, and infiltrated, villous tissue explants from matched placentas to assess the impact on placental function. We also utilised an established placental explant model to perturb specific cytokine levels, to reproduce the cytokine environment found in VUE in vivo (Abumaree et al., 2012; Audette et al., 2010; Benyo et al., 1997; Derricott et al., 2016; Heazell et al., 2008; Simán et al., 2001). In both cases a range of established placental analyses were used to assess the impact on trophoblast viability and placental function including: cell turnover, nutrient transport and endocrine function.

2 Materials and Methods

2.1 Sample Collection

Term (37-42 weeks) placentas (n=14), with matched maternal blood samples (n=8), were obtained within 30 minutes of delivery from women undergoing elective caesarean section. Tissue was donated with informed written consent in accordance with North West NHS REC approval (Ref: 08/H1010/55+5). Placental tissue was taken from uncomplicated pregnancies with the following exclusion criteria: maternal body mass index ≥30, maternal disease (e.g. pre-eclampsia, hypertension, gestational diabetes mellitus), fetal anomalies, small for gestational age (SGA) infants (defined as individualised birthweight centile (IBC) <10th centile), or multiple pregnancies.

2.2 Explant Culture with Cytokines

Full thickness villous biopsies of ~1cm³ were randomly sampled from four different areas of placenta and dissected into 4-5mm² fragments. An established method of placental explant culture that has been extensively utilised to assess placental viability and function was employed (Audette et al., 2010; Lager and Powell, 2012; Simán et al., 2001). Explants were cultured for 4 days in CMRL-1066 culture medium (Gibco, Paisley, UK) supplemented with 5% heat-inactivated FBS, 100 IU mL⁻¹ penicillin, 100 µg mL⁻¹ streptomycin, 1 µg mL⁻¹ insulin, 0.1 µg mL⁻¹ hydrocortisone, and 0.1 µg mL⁻¹ retinyl acetate (Sigma Aldrich, Dorset, UK). On day 4, explants were cultured in reduced serum Opti-MEM® medium (Gibco, Paisley, UK) and treated with recombinant human IL-2 (rhIL-2, 10 ng mL⁻¹), recombinant human IL-12 (rhIL-12, 10 ng mL⁻¹) (Life Technologies, Paisley, UK) or IL-4 neutralising antibody (1µg/mL, R&D Systems, Oxford, UK) individually or all three in combination. Opti-MEM® alone served
as the control. Conditioned culture medium was collected after 4 and 6 days of culture. On day 6, explants were processed for analyses of placental viability, cell turnover, nutrient transport, endocrine section and cytokine expression.

2.3 Placental Explant and Maternal T Cell Co-Culture

Villous tissue explants were prepared as above. To enhance the accessibility of villous stroma to T cells, a mild trypsin treatment was carried out to lift areas of syncytiotrophoblast (STB), the endocrine/nutrient transporting epithelium that surrounds the villous stroma, without compromising tissue integrity and function. Concentration of trypsin and incubation times were optimised by modifying a previously described treatment (Forbes et al., 2008) (see Derricott et al., 2015 for the full protocol). Following trypsinisation, explants were cultured for 24 hours in RPMI 1640 medium (Gibco, Paisley, Scotland) supplemented with 5% fetal bovine serum (FBS), 1 µg mL⁻¹ insulin, 100 µg mL⁻¹ streptomycin sulphate, 100 IU mL⁻¹ penicillin G, 0.1 µg mL⁻¹ retinol acetate, 25 µg mL⁻¹ L-alanine, 200 µg mL⁻¹ L-cysteine and 50 µg mL⁻¹ ascorbic acid. After 24 hrs, RPMI culture medium was aspirated and isolated CD4 and CD8 T-cells were applied to each explant in 10 µL suspensions (approximately 10⁵ cells per explant). RPMI medium alone was applied to control tissue. After 24 hours, 300 µL medium was added to each well, with a further media change after a further 24 hours. Conditioned medium was collected on days 3 and 4. To ensure T cells remained viable for the duration of the culture, explants were harvested on day 4 and processed for analyses of placental function.

2.4 CD4 and CD8 T Cell Isolation

CD4 and CD8 T-cells were isolated from maternal blood samples with EasySep Human T Cell Isolation Kit (STEMCELL Technologies, Cambridge, UK) following the manufacturers’ protocol. CD8 T cells were isolated from peripheral blood mononuclear cells (PBMCs) by positive selection, followed by negative selection of CD4 T cells. Isolated CD4 and CD8 T-cells were incubated for 24 hours on anti-CD3 (BD Pharmingen, Oxford, UK) coated 12-well plates in RPMI 1640 medium with 1 µg mL⁻¹ anti-CD28 antibody (BD Pharmingen) and 10 ng mL⁻¹ recombinant IL-2 and IL-15 (Gibco, Paisley, UK) to activate and stimulate proliferation of T cells (Derricott et al., 2015).
Cultured CD4 and CD8 T-cells were harvested after 24 hours by application of ice-cold Dulbecco's PBS (without Ca$^{2+}$ and Mg$^{2+}$) and gentle scraping. The manufacturer's protocol for CellTracker$^{TM}$ fluorescence (Life Technologies, Paisley, UK) was followed to label CD4 T cells red and CD8 T-cells green. Cell suspensions were re-suspended in RPMI supplemented with rhIL-2 and rhIL-15 before application to placental explants. Intracellular fluorescence was verified by viewing cells with a fluorescence microscope. Cell number and viability was assessed by counting using a haemocytometer and staining with Trypan Blue (Sigma Aldrich, Poole, UK).

2.6 Cell Migration

Explants that had been co-cultured with maternal CD4 and CD8 T-cells were fixed in 10% NBF, embedded in OCT and frozen at -80°C. 10 µm sections were mounted with aqueous DAPI-containing mountant and viewed with a Zeiss fluorescence microscope (Zeiss, Welwyn Garden City, UK) to determine the presence of labelled CD4 and CD8 T-cells in the villous stroma.

2.7 Assessment of System A Amino Acid Transporter Activity

Following the culture period, placental explants were incubated in buffer with the radiolabelled amino acid analogue N-methylated aminoisobutyric acid ($^{14}$C-meAIB) at 0.5 µCi mL$^{-1}$ (8.5µM) as previously described (Audette et al., 2010). The incubation buffer was either control Tyrode's or Na$^+$-free Tyrode's (NaCl replaced with equimolar (135 mM L$^{-1}$) choline chloride. Co-culture explants were incubated for 10, 30 or 60 minutes; explants cultured with cytokines were incubated for 60 minutes only. Following incubation, explants were lysed in dH$2$O then denatured in 0.3 M NaOH for assessment of protein content by Bio-Rad protein assay (Bio-Rad Laboratories, Hemel Hempstead, UK). The radioactivity of the explant lysate was determined using a β-scintillation counter. System A is a Na$^+$-dependent nutrient transporter and its activity was calculated by subtracting $^{14}$C-meAIB uptake in Na$^+$-free Tyrode's from uptake in control Tyrode's buffer, with adjustment for explant protein content.

2.8 hCG and PLGF Hormone Secretion
Conditioned culture medium was assayed for hCG and PlGF concentrations by ELISA (hCG: DRG Diagnostics, Marburg, Germany, PlGF: Duoset ELISA, R&D Systems, Oxford, UK) according to the manufacturers’ protocol. Plates were read on a FLUOSstar Omega microplate reader (BMG Labtech, Aylesbury, UK), values corrected for explant protein content and expressed as mIU/mL/mg protein (hCG) or pg/mL/mg protein (PlGF).

2.9 Proliferation, Apoptosis, STB Regeneration and Leukocytes in Explants

Proliferation and apoptosis were assessed in formalin-fixed explants using immunostaining and quantification of markers of proliferation (Ki67; Dako, Cambridge, UK) and apoptosis (M30, Roche, West Sussex, UK). STB regeneration was investigated by assessing area of immunostaining for cytokeratin 7 (CK7, Dako). The presence of leukocytes in explants was determined by immunostaining for the cell surface marker CD45 (leukocyte common antigen, (Dako)). A standardised laboratory protocol for immunostaining with colorimetric detection was followed, as described previously (Derricott et al., 2016; Hamilton et al., 2012). Primary antibodies were applied at the following concentrations: CK7 0.9 µg mL⁻¹, Ki67 0.4 µg mL⁻¹, M30 0.01 µg mL⁻¹, and CD45 0.46 µg mL⁻¹. Each tissue section had a corresponding negative control on which mouse IgG (Sigma Aldrich, Dorset, UK) was applied at the same concentration as the primary antibody.

2.10 Image Capture and Analysis

Explant sections were visualised using the x10 objective of an Olympus BX41 light microscope (Southend-on-Sea, UK). Images were captured with QiCam Fast 1394 camera (QImaging, BC, Canada) and Image Pro Plus 6.0 (Media Cybernetics Inc., MD, USA). Quantitative, unbiased quantification of staining area was completed using HistoQuest image analysis software (TissueGnostics, Vienna, Austria) (Chu et al., 2015; Derricott et al., 2016). Image pixels were converted to greyscale (0-256 scale) and assigned an arbitrary number following detection of DAB and haematoxylin and optimisation of staining intensity ranges. Results are presented as histograms or dot plot scattergrams to which staining area and/or intensity thresholds can be applied to differentiate between cell populations.

2.11 Cytokine Analysis in Culture Supernatant and Tissue Lysates (Bio-Plex Assay)
Tissue lysates were prepared using a Bio-Plex cell lysis kit (Bio-Rad Laboratories, Hemel Hempstead, UK). Tissue culture medium and tissue lysates were analysed for a panel of 10 inflammation-related cytokines by Bio-Plex assay (Bio-Rad Laboratories, Hemel Hempstead, UK) following manufacturers’ instructions. The cytokines selected for assay were IL-1β, IL-1Ra, IL-2, IL-4, IL-6, IL-10, IL-12A (p70), IL-17, IFN-γ and TNF-α. Cytokine levels were extrapolated from fluorescence values based on supplied standards.

2.12 Statistical Analysis

A power calculation using prior data on hCG secretion, system A activity and cytokine production and secretion from culture in hypoxic conditions or with dexamethasone determined that 4-6 samples per group would be required with an 80% power, α=0.05 (Audette et al., 2010; Heazell et al., 2008). Statistical analyses were carried out using GraphPad Prism 6.0 software (San Diego, CA, USA). Non-parametric continuous data were analysed with Mann Whitney U-test or Kruskal-Wallis test with Dunn's post-hoc test. Comparisons between groups of non-parametric data were analysed using Wilcoxon signed rank test or Friedman test. Due to considerable variability in the basal values of control placentas, ELISA and immunohistochemistry results are presented as fold change from control.

3 Results

3.1 An In Vitro Model of VUE Shows Altered Placental Function

Representative images of the co-culture explants (n=6) illustrate CD4 and CD8 T-cells in the intervillous space, the equivalent of the maternal blood space, and within the villous stroma (Figure 1). Flow cytometry demonstrated that positive (CD8) and negative (CD4) antibody selection techniques yielded T cell populations with ~91% and ~83% purity respectively. An average of ~12,000 cells (range 800-24,500) was applied to each villous tissue fragment, with the T cell yield dependent on blood volume obtained. Isolated cells had an average viability of 97.9% (range 95.2-99.6%). Immunohistochemistry for CD45 demonstrated a significant increase in leukocyte numbers in explants co-cultured with CD4/CD8 T-cells compared to controls (ps≤0.05; Figure 2A). Significant increases were detected in the concentrations of IL-1β (ps≤0.01), IL-10 (ps≤0.05), IFNγ (ps≤0.05) and IL-1Ra (ps≤0.05) secreted
into culture medium from explants cultured with CD4/CD8 T-cells on day 3. These differences were diminished by day 4 of culture (data not shown). Significantly greater concentrations of IL-6 (p≤0.01) and IL-1β (p≤0.05) were detected in the lysates of placental explants cultured with T-cells compared to controls after 4 days of culture (Figure 2F,G). No significant differences were detected in IL-2, -4, -12, -17 or TNFα in either culture supernatant or tissue lysate samples.

There was a significant decrease in hCG concentrations in conditioned culture medium at day 3 in the explants cultured with CD4/CD8 T-cells compared to those cultured in medium alone (p≤0.01; Figure 3A). A similar trend was detected for PlGF; however, in this group there was a limited sample size (n=3; Figure 3B). No significant differences were recorded in hCG concentrations at day 4. There was no significant difference in system A activity of the placental tissue or in proliferation, apoptosis or STB regeneration/area in the explants cultured with CD4/CD8 T-cells compared to control (Figure 3D-F).

3.2 Explant Culture with VUE-Associated Cytokines Alters Placental Function

There was a significant decrease in human chorionic gonadotropin (hCG) concentrations in conditioned culture medium at day 6 in the explants cultured with rhIL-2, rhIL-12 and IL-4 neutralising antibody in combination compared to control (n=8, p<0.05) (Figure 4A). There was a trend towards decreased placental growth factor (PlGF) in conditioned culture medium at day 3 in the explants cultured with all treatments, but this did not reach statistical significance (p=0.16; Figure 1B). Treatment with individual cytokines did not affect hCG production.

Placental system A activity was not significantly affected by independent or combined rhIL-2, rhIL-12 and IL-4 neutralising antibody treatment compared to control (Figure 1C). A significant reduction in proliferation (Ki67 staining) was detected in the explants treated with IL-2 (p<0.05). No significant differences were seen in apoptosis or STB regeneration/area in any of the experimental conditions compared to control (Figure 1D-F).

No significant differences were observed in cytokine levels in explant lysates or conditioned culture medium under any of the treatment conditions (Supplementary Figure 1).

4 Discussion
VUE is a well-documented inflammatory condition of the placenta in late pregnancy and its association with poor pregnancy outcome (particularly FGR) is accepted (Aviram et al., 2010; Derricott et al., 2013; Vedmedovska et al., 2011). Despite these associations, little is known about the mechanisms by which VUE may cause placental insufficiency and adverse pregnancy outcome. Here we present new insights into the possible functional consequences of immune cell interaction with the placenta. This was possible due to the development of a novel \textit{in vitro} model of placental inflammation involving co-culture of placental explants with matched T-cells obtained from maternal peripheral blood samples.

We successfully introduced maternal immune cells into normal placental tissue and demonstrated induction of a localised pro-inflammatory response. Furthermore, both the presence of maternal immune cells within the villous core and treatment with VUE-associated cytokines detrimentally affect placental endocrine and/or syncytiotrophoblast function, as identified by the significant reduction in hCG secretion. As well as being a critical placental-derived hormone for the maintenance of pregnancy, hCG is a sensitive marker of syncytiotrophoblast renewal and viability (Evain-Brion and Malassine, 2003; Gude et al., 2004; Omata et al., 2013). These findings were supported by \textit{in vitro} modulation of cytokine levels to mimic the altered cytokine profile detected in VUE lesions (Derricott et al., 2015). Deficiencies in hCG following inflammatory insult therefore indicate adverse effects on syncytiotrophoblast function or integrity. Consistent with this, hCG concentrations in maternal serum are reduced in pregnancy pathologies characterised by placental dysfunction, including intrauterine fetal demise and FGR (Dutton et al., 2012; Haddad et al., 1999; Londero et al., 2013). These findings support the hypothesis that VUE can adversely affect placental function, and provides a potential mechanistic link for the increasing susceptibility to FGR and/or stillbirth.

Increased expression and/or secretion of IL-1β, IL-1RA, IL-6, IL-10 and IFN-γ were detected from explants co-cultured with maternal T-cells. These data are consistent with our identification of IL-1 as a central mediator of inflammatory-induced placental dysfunction (Girard et al., 2014). Women reporting a reduction in fetal movements (RFM) have a 3-fold increased risk of stillbirth or FGR (Heazell and Frøen, 2008; Warrander et al., 2012); the placentas from these pregnancies exhibit marked syncytiotrophoblast dysfunction, including reduced nutrient transport capacity, accompanied by altered trophoblast proliferation and...
apoptosis, and impaired endocrine function, including a reduction in hCG (Dutton et al., 2012; Warrander et al., 2012). We recently identified elevated placental inflammation in these pregnancies, including increased expression of placental IL-1 family members, in the absence of infection (Girard et al., 2014). In trophoblast, as in other cell types, IL-1 potently stimulates the expression of other pro-inflammatory cytokines, e.g. IL-6 and CCL2, highlighting a coordinating role in mediating placental inflammation (Girard et al., 2015; Kandere-Grzybowska et al., 2003; Parikh et al., 1997). Furthermore, in vitro treatment with IL-1 impairs trophoblast fusion, viability, hCG secretion and system A activity (Girard et al., 2015). In the co-culture model in the current study, elevated concentrations of IL-1Ra were detected in the culture medium; this supports that the elevated IL-1β produced is functional, as IL-1Ra expression is stimulated as a consequence of IL-1R activation (Girard et al., 2014). These data, therefore, extend in vivo evidence of the contribution of placental inflammation to placental dysfunction and adverse pregnancy outcome.

Representative images of isolated T-cells in co-culture confirm that the cells were present in the intervillous space, and a proportion of T cells had migrated across the STB and infiltrated the placental villus. Chronic intervillositis of unknown etiology (CIUE), another inflammatory placental condition, describes the presence of lesions that are confined to the intervillous space (maternal blood space between placental villus structures) and comprise monocytes, CD4 and CD8 T cells of exclusively maternal origin (Capuani et al., 2013). Therefore, this in vitro model provides an overlapping model of VUE and CIUE and has functional relevance, as T-cells in the intervillous space and those in the villous stroma will have distinct interactions with placental cells. In CIUE, interactions will be between immune cells and the microvillous membrane of the syncytiotrophoblast, whereas in VUE immune cells within the villus core can interact with multiple cell types, including trophoblast, stromal cells and placental vasculature. The responses to these situations may vary depending on cell-cell interaction or cytokine receptor localisation on STB, stromal cells, endothelium, monocytes and macrophages. In VUE there is also the potential for interactions between maternal T-cells and fetal macrophages (Hofbauer cells). VUE has been likened to immune rejection; either the mother rejects the semiallogeneic placenta (host-versus-graft) (Redline, 2007; Rudzinski et al., 2013) or maternal T-cells infiltrate the placenta acting in a graft-versus-host manner (Hulthén Varli et al., 2012; Kim et al., 2006). What remains to be elucidated is the manner of
maternal-fetal cell interaction. It is not yet known whether maternal T-cells can be activated
by fetal Hofbauer cells or whether they recognise fetal MHC as non-self. It is perhaps unsurprising that exogenous treatment with VUE-associated cytokines did not
completely mirror those changes detected in the co-culture experiments. Culturing explants
with cytokines alone would not necessarily reflect a complex inflammatory phenomenon
such as VUE. Moreover, the physical presence of maternal immune cells within the placental
villus is likely to affect placental cell viability and function. It is highly likely that both the cell
and cytokine milieu is ultimately responsible for a cascade of events resulting in placental
dysfunction.

It should be noted that all of the placentas used in this study were from uncomplicated,
healthy pregnancies in which it is likely that maternal tolerance of the feto-placental unit
was well established. In addition, it was not possible to determine the Hofbauer cell
population in the placentas prior to culture, a factor which may influence maternal T cell
interactions in VUE (Kim et al., 2008). This may be a reason why experimental lesions were
not as extensive as those seen in the high grade villitis described in the literature (Redline,
2007; Russell, 1980). Other factors that may have influenced the extent of T cell infiltration
include the duration of the culture experiments compared to the duration of a pregnancy
and the lack of blood flow in the in vitro model. The study was limited by the length of time
the co-culture could be sustained. A culture period of 4 days was chosen in order that the
viability of the isolated T-cells could be maintained. The cytokine culture experiments could
be extended by using a cytotrophoblast culture model rather than an explant culture model,
although this would be more representative of the effect of generalised inflammation on
trophoblast rather than VUE on the placenta.

If chronic disruption of the syncytiotrophoblast had occurred, then a change in nutrient
transport capacity via system A may have been expected. The absence of a significant
alteration in system A activity is potentially related to the relatively short exposure to
cells/cytokines compared to that in utero. In this study, system A was chosen because of its
pivotal role in supporting fetal growth; placental system A activity is reduced in FGR
pregnancies compared to normal (Glazier et al., 1997) and in pregnancy associated with
RFM (Warrander et al., 2012). However, there are multiple other nutrient transporter systems present in the placenta that could have been affected.

This study provides the first evidence for functional consequences in the placenta of inappropriate maternal immune responses, by the development and use of a novel in vitro model of VUE. As VUE is a post-partum histopathological diagnosis, previous investigations have been limited to descriptive studies, thus the scope for functional interpretation has been limited. Furthermore, although VUE is reported to have an increased risk of recurrence, there is no proposed treatment. The co-culture of placental villous tissue with maternal T-cells demonstrates that the presence of maternal lymphocytes in the placenta, and/or their derived cytokines, adversely affects placental function, which builds on previous evidence highlighting that trophoblast fusion and syncytiotrophoblast renewal is particularly susceptible to placental inflammation. Further use and development of in vitro models of VUE and associated placental inflammation has the potential to determine the mechanisms underlying associations between VUE and FGR and stillbirth, and to provide an in vitro model to identify and test targets for therapeutic intervention.
Acknowledgements:

We wish to express our gratitude to the mothers who donated their blood and gave consent for us to use the placentas that we studied, the recruiters who consent the participants and Dr Mark Wareing who co-ordinates the MFHRG Biobank. This work forms part of a PhD project for HD funded by Tommy’s – The Baby Charity.

Competing Interests:

No competing interests declared.

Author Contributions:

HD, RLJ, SLG and AEPH conceived and designed the experimental concept. HD and SLG carried out the preliminary studies, HD carried out the experimental work. HD compiled the manuscript, RLJ, SLG and AEPH provided editorial advice.
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doi:10.1016/j.jri.2012.03.488


doi:10.1016/j.earlhumdev.2010.01.020


doi:10.1210/jcem.82.5.3916


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doi:10.1177/1933719114528275

Derricott, H., Jones, R., Heazell, A., Greenwood, S., 2015. Co-culture of placental explants with isolated CD4 and CD8 T cells: a functional model to define the consequences of


Glazier, J.D., Cetin, I., Perugino, G., Ronzoni, S., Grey, A.M., Mahendran, D., Marconi, A.M.,


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**Table 1: Demographic information of the study participants.** Results are median (range).

IBC – individualised birthweight centile, BMI – body mass index at time of booking to antenatal care.
Figure 1: Representative images of explants at day 4 after culture with isolated T-cells. Red arrows highlight CD4 T-cells, green arrows highlight CD8 cells, A, C and D) nuclei stained blue with DAPI. A-C) Isolated maternal T-cells are visible in the villous stroma (V) and intervillous space (IVS). A-B) Scale bar represents 100 µm, original magnification x200, C) Scale bar represents 20 µm, original magnification x630, D) explant cultured without isolated cells, scale bar represents 20 µm, original magnification x630. Dotted lines delineate the perimeters of villi in cross-section where these can be accurately discerned.
Figure 2: Effect of explant co-culture with matched maternal CD4 and CD8 T-cells on leukocyte number, cytokine release and tissue cytokines. (A) increased area of DAB+ staining for CD45 leukocytes presented as fold change compared to control (p<0.05). Levels of IL-1β (B), IL-1Ra (C), IL10 (D) and IFNγ (E) in culture medium were significantly elevated in the presence of CD4/CD8 T-cells compared to control. IL-1β (F) and IL-6 (G) were significantly higher in the tissue lysates of explants co-cultured with T-cells compared to control. Wilcoxon signed rank test, n=8.

231x300mm (150 x 150 DPI)
Figure 3: The effects of explant co-culture with matched maternal CD4 and CD8 T-cells on placental function and cell turnover. (A) hCG concentration in culture medium, (B) PIGF concentration in culture medium (n=3), (C) system A activity (amino acid transporter). DAB+ staining area presented as fold change compared to control of (D) Ki67 (proliferation), (E) M30 (apoptosis) and (F) cytokeratin 7 (syncytiotrophoblast). Lines represent median. (A, C-E) Wilcoxon signed rank test, n=8 (B) no statistical analysis performed, n=3.

234x235mm (150 x 150 DPI)
Figure 4: The effects of placental explant culture with cytokines and/or neutralising antibodies. (A) hCG concentration in culture medium, (B) PIGF concentration in culture medium, (C) System A activity (amino acid transporter). DAB+ staining area presented as fold change from control: (D) Ki67 (proliferation), (E) M30 (apoptosis) and (F) cytokeratin 7 (syncytiotrophoblast). CTRL: no treatment, IL-2: treatment with 10ng/mL rhIL-2, IL-12: treatment with 10 ng/mL rhIL-12, ANTI-IL4: treatment with 1 mg/mL anti-IL4 neutralising antibody, ALL: treatment with 10 ng/mL IL-2, IL-12 and 1 mg/mL anti-IL4. Lines represent median. (A-B, D-F) Wilcoxon signed rank test, (C) Kruskal-Wallis test, n=6.

267x265mm (150 x 150 DPI)
Figure S1: The effects of placental explant culture with recombinant cytokines and/or neutralising antibodies on cytokine concentrations in tissue lysate and culture supernatant samples as measured by Bio-Plex assay. No significant differences were observed in levels of (A-B) IL-1β in lysates or culture medium, (C-D) IL-1Ra in lysates or medium, (E-F) IL-6 in lysates or medium. CTRL: no treatment, IL-2: treatment with 10 ng mL$^{-1}$ recombinant human IL-2, IL-12: treatment with 10 ng mL$^{-1}$ recombinant human interleukin-12, ANTI-IL4: treatment with 1 mg mL$^{-1}$ anti-IL4 neutralising antibody, ALL: treatment with 10 ng mL$^{-1}$ IL-2, IL-12 and 1 ng mL$^{-1}$ anti-IL4. Friedman test, n=6.