Pentoxifylline and its active metabolite lisofylline attenuate transforming growth factor $\beta_1$-induced asthmatic bronchial fibroblast-to-myofibroblast transition*

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INTRODUCTION

Bronchial asthma is one of the most common chronic airway diseases, developing rapidly in recent years (GINA 2015). Asthma is considered to be an immune-mediated disorder due to its pathophysiological mechanism. It is commonly believed that irreversible changes in the structure of the bronchial tree, i.e. bronchial wall remodeling, are the consequences of chronic and protracted inflammation. However, not only immune cells and the variety of inflammatory mediators that they secrete are involved in triggering and prolongation of inflammation, but also different bronchi structural cells. There are some explicit indications that fibrotic lesions in the bronchi may appear before the first asthma symptoms (Baldwin & Roche, 2002; Beckett & Howarth, 2003). The process of bronchial wall remodeling underlines onerous and dangerous symptoms such as wheezing, coughing, shortness of breath and finally bronchial obstruction (Shifren et al., 2012). Bronchial wall remodeling includes defective epithelium regeneration, mucus hypersecretion, smooth muscle cell hypertrophy and hyperplasia, increased deposition of extracellular matrix (ECM) proteins, and significant increase in myofibroblast populations (Al-Muhсен et al., 2011). Myofibroblasts can originate from different sources but predominantly are formed by fibroblast-to-myofibroblast transition (FMT) from tissue-specific fibroblasts (Bergeron et al., 2010). Myofibroblasts, due to $\alpha$-SMA expression, contractile properties and enhanced ECM synthesis, display a phenotype intermediate between fibroblasts and smooth muscle cells and are principally responsible for bronchial wall stiffening and fibrosis (Phan, 2008). A wide variety of cytokines and growth factors cause FMT in vitro and in vivo but the most common and potent FMT inducer is transforming growth factor type $\beta_1$ (TGF-$\beta_1$) (Batra et al., 2004, Michalik et al., 2009, 2011). An increased level of this growth factor has been described in the airways of asthmatics (Makinde et al., 2007). Our previous studies indicate that TGF-$\beta_1$ is responsible for increased FMT in asthmatics (Michalik et al., 2009). Moreover, the two isoforms of this growth factor, TGF-$\beta_1$ and TGF-$\beta_2$, are equally responsible for increased HBFs predisposition to FMT in asthmatics (Michalik et al., 2009). TGF-$\beta$ is a pleiotropic factor and can activate a number of different signalling pathways among which the most important is the chemical, Smad-dependent pathway. The primary TGF-$\beta$ effector is a substrate of TGF-$\beta$ receptor serine-threonine kinase, R-Smad protein (Smad-2 and 3). The phosphorylated R-Smad interacts with Smad-4 (2:1) and translocates to the nucleus where they affect target gene transcription (including profibrotic genes) (Dijke & Hill, 2004). TGF-$\beta$ signalling activity can be modulated by other signalling systems (Makinde et al., 2007; Michalik et al., 2012).

Received: 01 April, 2016; revised: 09 May, 2016; accepted: 01 June, 2016; available on-line: 30 July, 2016

Key words: theophylline, pentoxifylline, lisofylline, transforming growth factor type $\beta_1$, fibroblast-to-myofibroblast transition, asthma

Bronchial asthma is characterized by persistent airway inflammation and airway wall remodeling. Among many different cells and growth factors triggering changes in bronchi structure, transforming growth factor $\beta_1$-induced fibroblast to myofibroblast transition is believed to be very important. The aim of this study was to evaluate whether theophylline (used in asthma therapy) and two other methylxanthines (pentoxifylline and its active metabolite lisofylline), may affect transforming growth factor $\beta_1$-induced myofibroblast formation in asthmatic bronchial fibroblasts derived from asthmatic patients. We show here for the first time that selected methylxanthines effectively reduce transforming growth factor $\beta_1$-induced myofibroblast formation in asthmatic bronchial fibroblast populations. PTX was found to be the most effective methylxanthine. The number of differentiated myofibroblasts after PTX, LSF and THEO administration was reduced at least twofold. Studies on the use of methylxanthines opens a new perspective in the development of novel strategies in asthma therapy through their two-pronged, anti-inflammatory and anti-fibrotic action. In the future they can be considered as promising anti-fibrotic drugs.

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A preliminary report on the same subject was presented at the XLIII Winter School “Biomolecules: from structure to function” organized by the Faculty of Biochemistry, Biophysics and Biotechnology, Jagiellonian University, 16–20 February, 2016, Zakopane, Poland.

Abbreviations: $\alpha$-SMA, $\alpha$-smooth muscle actin; AS, asthmatic; BSA, bovine serum albumin; CGF, connective tissue growth factor; CV, crystal violet; ECM, extracellular matrix; FDA/EB, fluoresceine diacetate/ethidium bromide; FMT, fibroblasts to myofibroblasts transition; GAPDH, glyceraldehyde 3-phosphate dehydrogenase; HBFs, human bronchial fibroblasts; LSF, lisofylline; PIC, protease inhibitor cocktail; PTX, pentoxifylline; TGF-$\beta_1$, transforming growth factor type $\beta_1$; THEO, theophylline.
Bronchial asthma pharmacotherapy is based mainly on anti-inflammatory drugs. Most commonly, inhaled or systemic glucocorticosteroids are used. Typical treatment also involves β2-agonists, cromones, methylxanthines, antileukotrienes and antihistamine drugs (GINA 2015). All these drugs affect inflammation extinction, but only marginally influence remodeling changes (Mauad et al., 2007). Due to a smaller number of reports dealing with remodeling as one of the causes of asthma, challenges in obtaining airway tissue and lack of non-invasive markers, there is still no available therapy aimed directly against the fibrotic response of bronchi.

Methylxanthines are bronchodilating drugs sometimes used in asthma pharmacotherapy, but currently only theophylline (THEO) is used in clinical practice (GINA 2015). Because of THEO side effects, there have been attempts to synthesize analogues which could be safer for patients. Methylxanthines are successfully used in the treatment of difficult cases related to pediatric lung diseases (Oratibia-Astibia et al., 2016). They are reported to exhibit anti-inflammatory properties (Fredholm, 1985; Ito et al., 2002; Tilley, 2011). The mechanism of action of methylxanthines has not been fully elucidated, but it is presumably based on their ability to inhibit cellular phosphodiesterases, enzymes responsible for the cAMP degradation. Consequently this second messenger is accumulated inside the cell.

There are reports showing that some anti-inflammatory drugs may decrease subepithelial reticular basement membrane thickening and subepithelial fibrosis (Ward et al., 2002, Kasahara et al., 2002). One possible explanation of these observations may be a direct inhibitory effect on bronchial wall remodeling. Following proceedings and reports indicating that remodeling may develop much earlier than the first asthma symptoms, we investigated the effects of selected methylxanthines on human bronchial fibroblasts (HBFs) isolated from asthmatic (AS) patients. Our study was aimed to assess THEO currently used in asthma therapy, and two other methylxanthines – pentoxifylline (PTX) and its active metabolite – lisofylline (LSF) on TGF-β-induced FMT in HBFs cultures derived from asthmatics. We investigated the effect of selected methylxanthines on the TGF-β1-induced α-SMA level and myofibroblasts number. We also checked the influence of the studied compounds on the canonical TGF-β/Smad signalling pathway, in particular TGF-β1-induced Smad-2 phosphorylation and translocation to the nucleus.

**MATERIALS AND METHODS**

Cell culture. The study was performed on human bronchial fibroblasts (HBFs) derived from asthmatic patients (n=5). All patients were treated in the Department of Medicine of Jagiellonian University. The study was approved by the University’s Ethics Committee (KBET 122.6120.69.2015). Informed, written consent was obtained from all study participants. HBFs were isolated from patients diagnosed with bronchial asthma (2 males, 3 females; average age: 43.4±8.7 years; mean FEV1%: 79.5±12.1% of predicted). All patients were under inhaled glucocorticosteroid therapy, and samples were collected in remission of disease. The protocol of HBFs isolation were described previously (Pierzchalska et al., 2003; Michalk et al., 2009). HBFs were cultured between 5–20 passages in DMEM supplemented with glucose (4.5 g/L), 10% fetal bovine serum (FBS), antibiotics and antimycotics in standard culture conditions (5% CO2, 37°C, 95% humidity). Apart from viability and proliferation tests, all experiments were carried out in serum-free culture medium supplemented with 0.1% bovine serum albumin (BSA).

**Compounds preparation.** HBFs were exposed to TGF-β1 (5ng/ml), PTX, LSF and THEO (5-100μM). TGF-β1 was obtained from BD Bioscience, THEO and PTX (Fig. 1) were obtained from Sigma Aldrich. LSF (PTXM1/Rj) was prepared by the biotransformation method (Fig. 1). Details are described in Pękala and coworkers (2007). In brief, stereoreduction of PTX to LSF was conducted using whole cells of *Lactobacillus kefiri* strain DSM 20587 which is a natural source of R-specific alcohol dehydrogenase. Biotransformation was performed with regeneration of the cofactor NADPH, in 0.2 M potassium phosphate buffer, pH 6.5 with 5 mM MgCl2, and with glucose as a co-substrate. PTX and LSF identification was determined by HPLC analysis and optical rotation of the LSF was confirmed by polarimetric analysis. TGF-β1 working solution was prepared according to manufacturer’s protocol in 1mg/ml of BSA. THEO, PTX and LSF were dissolved in water to 1mg/ml stock solution (logS –0.78, –1.18, –1.69 respectively). No compound aggregation or precipitation was observed. Cells were preincubated with THEO, PTX and LSF for 3h and then exposed to TGF-β1.

**Cell viability and proliferation assays.** For viability assay, cells were seeded at an initial density of 5×10⁴ cells/cm², in standard medium. After 24 hrs of culture, cells were incubated with selected methylxanthines and cultured for a further 24 or 48 hrs. Cell viability was determined by fluorescein diacetate/ethidium bromide (FDA/EtBr) staining using a Leitz Orthoplan fluorescence microscope and expressed as percent of fluoresceine-positive/EtBr-negative cells. Cells were counted in different, representative fields of view (10–20). At least 500 cells were counted in triplicates.

For proliferation assay, cells were seeded at an initial density of 5×10⁴ cells/cm², in standard medium. After 24 hrs of culture cells were incubated with selected methylxanthines and cultured for the next 1, 3, 5 or 7 days. After incubation, cells were fixed with 3.7% formaldehyde and then stained with 0.05% crystal violet (CV; in methanol/water (1:4)) solution. Then CV solution excess was removed and cells were carefully rinsed with distillate water. CV was eluted by 1.33% citric acid/1.09% sodium citrate in methanol/water (1:1). Absorbance was read at 540nm.

**Immunocytochemical staining.** Visualization of α-SMA positive cells was made by immunocytochemical staining. HBFs were fixed with 3.7% paraformaldehyde, permea-
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**RESULTS**

To investigate the potential effects of theophylline, pentoxifylline and lysofylline on bronchial wall remodeling, we first evaluated the effect of selected methylxanthines (administered at concentrations which can be achieved in vivo in patient serum, i.e. 5–100 μM and which are acceptable in therapy), on HBFs viability and proliferation rate. The results of the experiments revealed that the investigated methylxanthines did not exhibit a significant cytotoxic effect on HBFs in culture (Fig. 2A). Furthermore, we show that fibroblast proliferation was not greatly affected by THEO, PTX and LSF (Fig. 2B). These observations suggest that methylxanthines do not have any harmful, cytotoxic or cytostatic effects at the cellular level.

We next investigated selected methylxanthines impact on TGF-β₁-induced FMT in our experimental model. As illustrated in Fig. 3A, the percentage of myofibroblasts in TGF-β₁-treated HBFs populations was lower after THEO, PTX and LSF treatment. The number of myofibroblasts (cells with α-SMA incorporated into F-actin stress fibers) in HBFs populations was gradually reduced by increasing concentrations (10–100 μM) of all tested compounds in the culture medium (Fig. 3B). PTX proved to be the most effective methylxanthine. All compounds administered alone did not affect the FMT potential of HBFs (Fig. 3A, B). Subsequently we investigated whether the observed reduced number of myofibroblasts after methylxanthine exposure is reflected in the amount of α-SMA protein level. As measured by ELISA and Western Blot assays, the TGF-β₁-induced α-SMA level in HBFs decreased moderately but significantly after PTX and LSF exposure when compared to TGF-β₁-administered alone (Fig. 4A, B respectively).

In order to confirm whether the observed differences in FMT efficiency (number of myofibroblasts) and the level of α-SMA in TGF-β₁-induced HBFs were associated with activation of the TGF-β₁/Smad pathway, we measured the level of Smad-2 phosphorylation and p-Smad translocation into the nucleus (Fig. 5). As illustrated in Fig. 5C none of the investigated methylxanthines reduced TGF-β₁-induced Smad-2 phosphorylation, however all of them caused inhibition in p-Smad-2 translocation to the nucleus (Fig 5A, B). Among all studied methylxanthines, again the most potent compound was PTX.

**DISCUSSION**

Methylxanthines are bronchodilatory drugs that are not usually used as first-line drugs in asthma and chronic ob-

Figure 2. THEO, PTX and LSF do not influence HBFs viability and proliferation rate. (A) HBFs (n=2) were exposed to growing concentrations (5–100 μM) of THEO, PTX and LSF. HBFs viability was measured after 24 and 48 h of incubation. For each single experiment at least 500 cells were counted in triplicates. (B) HBFs (n=2) were exposed to growing concentrations (10–100 μM) of THEO, PTX and LSF. HBFs proliferation rate was measured by crystal violet staining. Experiments were run in triplicates. Values represented as means with S.E. No statistical significance was noticed. THEO, theophylline; PTX, pentoxifylline; LSF, lysofylline; HBFs, human bronchial fibroblasts.
structive pulmonary disease (Tilley, 2011; Margay et al., 2015). Although the first reports of beneficial methylxanthine effects in asthma come from the nineteenth century when intake of strong coffee was recommended in order to prevent asthmatic symptoms (Persson, 1985), their mechanism of action has been still not fully elucidated. However, it is known that by inhibiting phosphodiesterase activity, ac-
cumulate cAMP inside the cells (Tilley, 2011). Theophylline used at low doses has been shown to exert immunomodu-
latory function by activation of histone deacetylases (Ito et al., 2002). Recently, increasing data have shown that some methylxanthines have anti-inflammatory, neuroprotective and cardioprotective effects (Ohta & Sitkovsky, 2011; Gu & Lambert, 2013; Saglani & Lloyd, 2015) and may have great potential in prevention and therapy of different dis-
eases, including asthma (Oñatibia-Astibia et al., 2016).

The majority of drugs currently available in bronchial asthma therapy were designed to extinguish inflammation. However, they do not affect (or affect only marginally) the process of remodelling (Berair & Brightling, 2014). De-
spite intensive research on the process of remodelling in asthma, no drug can directly inhibit fibrotic changes in the bronchial tree. The anti-inflammatory drugs used in asth-
a (glucocorticosteroids, β2-adrenergic receptor agonists, leukotriene modifiers et al.) can potentially affect bronchial wall remodelling (sub-epithelial fibrosis, ECM protein depo-
sition, ASM hyperplasia and proliferation) indirectly by their action on inflammatory cells and mediators that are known as effectors in the remodelling process (Berair & Brightling, 2014). Methylxanthines have also been shown to reduce eosinophils and improve lung function in asthma (Sullivan et al., 1994; Wang et al., 2011) but their direct effect on air-
way remodelling is unknown. With this in mind, we veri-
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ACKNOWLEDGEMENTS

Faculty of Biochemistry, Biophysics and Biotechnology of Jagiellonian University is a partner of the Leading National Research Center (KNOW) supported by the Ministry of Science and Higher Education.
Conflict of interest

Authors declare no conflict of interest.

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