# Original article

# Interleukin-31 promotes pathogenic mechanisms underlying skin and lung fibrosis in scleroderma

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## Abstract

**Objectives.** Cytokines released by infiltrating T cells may promote mechanisms leading to fibrosis in scleroderma. The aim of this study was to investigate the role of the Th2 cytokine IL-31, and its receptor IL-31RA, in scleroderma skin and lung fibrosis.

**Methods.** IL-31 was measured by ELISA of plasma, and by immunochemistry of fibrotic skin and lung tissue of scleroderma patients. The receptor, IL-31RA, was assayed by qPCR of tissue resident cells. Next-generation sequencing was used to profile the responses of normal skin fibroblasts to IL-31. In wild-type Balb/c mice, IL-31 was administered by subcutaneous mini pump, with or without additional TGF$\beta$, and the fibrotic reaction measured by histology and ELISA of plasma.

**Results.** IL-31 was present at high levels in plasma and fibrotic skin and lung lesions in a subset of scleroderma patients, and the receptor overexpressed by downstream cells relevant to the disease process, including skin and lung fibroblasts, through loss of epigenetic regulation by miR326. In skin fibroblasts, IL-31 induced next generation sequencing profiles associated with cellular growth and proliferation, anaerobic metabolism and mineralization, and negatively associated with angiogenesis and vascular repair, as well as promoting phenotype changes including migration and collagen protein release via pSTAT3, resembling the activation state in the disease. In mice, IL-31 induced skin and lung fibrosis. No synergy was seen with TGF$\beta$, which supressed IL-31RA.

**Conclusion.** IL-31/IL-31RA is confirmed as a candidate pro-fibrotic pathway, which may contribute to skin and lung fibrosis in a subset of scleroderma patients.

**Key words:** fibrosis, IL-31, systemic sclerosis

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## Introduction

Scleroderma (systemic sclerosis, SSc) is a heterogeneous disease in which dysregulation of the immune system is linked to microvascular damage and fibrosis [1]. This triad can manifest in multiple organs, including the skin, lungs, kidneys, heart and gastrointestinal tract. Lung involvement is a major clinical feature linked to long-term outcomes and reduced survival in SSc [2]. Although the definite aetiology that evokes the consecutive pathogenic response is not completely understood, recent epigenetic and genome-wide association studies (GWAS) have reported several genetic variants in immunoregulatory genes associated with susceptibility to the disease [3–5].

The underlying mechanisms that link SSc-associated genetic variants with the initiation or progression of the disease are yet to be fully evaluated. However, many studies

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**Rheumatology key messages**
- IL-31 is a four-helix bundle cytokine of the IL-6 family, secreted by Th2 cells.
- Plasma IL-31 levels are elevated in a subset of SSc patients.
- IL-31 is pro-fibrotic, activating fibroblasts in tissue culture, and inducing skin and lung fibrosis in mice.

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have investigated the negative impact of the cross-talk between immune cells, inflammatory cells and mesenchymal cells during SSc pathogenesis. The initial examination of cellular infiltrates in skin and lung biopsies isolated from SSc disclosed an involvement of T cells and macrophages in the onset of early disease [6, 7]. Further studies have confirmed elevated levels of cytokines in SSc and have implicated T-cell derived factors in the cross-talk with fibroblasts [8–10]. Aligned with an autoimmune process, placebo controlled studies have indicated benefit from immunosuppressive drugs as well as autologous haematopoietic stem cell transplantation [11–13].

IL-31 was identified by Dillon in 2004 as a 4 alpha-helix IL-6 family cytokine synthesized by activated Th2 cells [14]. IL-31 acts via a heterodimeric receptor comprising IL-31RA and oncostatin M, expressed by multiple cell types, and signalling via PI3K, ERK and JAK/STAT pathways [15]. IL-31 has a role in pruritic skin conditions such as atopic dermatitis and T-cell lymphoma, where elevated plasma levels may correlate with itch severity [16, 17]. Moreover, nemolizumab, a monoclonal anti-IL31RA, reduced itch severity and corticosteroid use in patients with atopic dermatitis [18]. However, the precise role of the IL-31/IL-31RA axis in promoting skin pathology is not fully understood. Aside from provoking itch behaviour, this pathway induces chemokines, enhances recruitment and activation of inflammatory cells, and may cause tissue remodeling [19–21]. Because Th2 cells have been implicated in initiating fibrosis, and because severe and resistant pruritus affects 40–60% of SSc patients [22, 23] the IL-31/IL31RA axis may be of relevance to this disease. Here, we investigate IL-31/IL31RA as a candidate pathway in SSc skin and lung fibrosis.

## Methods

Studies were performed in concordance with the Helsinki agreement. Clinical material used in this study, such as skin biopsies and blood samples, were collected by clinical research fellows from SSc patients recruited via the Royal Free Hospital, who met internationally agreed criteria for diagnosis [24]. Ethical Committee approval for this study was obtained from the NHS Health Research Authority, NRES Committee London, Hampstead, Research Ethics Committee London Centre, reference number 6398. Clinical characteristics of the patients studied by plasma analysis are shown in the Supplementary Tables S1 and S2, available at *Rheumatology* online.

### Assays for IL-31

All blood samples were taken into EDTA tubes and stored as aliquots of plasma at –80°C, prior to assay by ELISA. The first group of patients and controls were studied prospectively (Supplementary Table S1, available at *Rheumatology* online) and plasma IL-31 was assayed by ELISA (R&D systems, #DY2824). In a replicate group (Supplementary Table S2, available at *Rheumatology* online), patients were identified via a database, and stored plasma samples were assayed by a second ELISA (Human IL-31 ELISA MAX Deluxe #445704, Biolegend).

*Cell culture*
Primary human dermal fibroblasts were established from explants of the forearm skin punch biopsies (4 mm) from healthy controls and from the involved skin of SSc patients (both $n = 4$ cell lines). Primary adult pulmonary fibroblasts were cultured from control tissue samples (unaffected lung peripheral to resected cancer) and from surgical lung biopsy samples of patients with SSc (both $n = 4$ cell lines). Dermal and lung fibroblasts were cultured by explant of minced tissue, as described previously [25] and treated as follows: TGFβ (4 ng/ml, #240-B, R&D system), IL-31 (1–100 ng/ml, R&D system), 1 μM 5-azacytidine (5-aza, #A1287 Sigma).

*Quantitative PCR*
SSc and healthy control fibroblast cell lines (both $n = 4$), were lysed for RNA extraction and purification by Qiagen RNeasy Plus Mini Kits (# 74134). Qiagen Quantifast SYBR green kit was used to prepare the qPCR reaction and Rotogene6000 series software 1.7 was used to analyse the results. The TBP gene was used as the housekeeping gene to normalize the studied genes' expression. Forward and reverse primers used for each gene are listed in (Table 1).

*Western blotting*
Fibroblast cell lines were lysed using radioimmunoprecipitation assay (RIPA) buffer containing phosphatase inhibitors. Total protein concentration in the lysates was determined using the Bicinchoninic Assay Kit (Life Technology). Protein extracts were separated by SDS–PAGE, and then transferred to a nitrocellulose blot membrane, then probed with antibodies as follows: CTGF (1:500/1:1000, #sc14939, Santa Cruz, TX, USA), Collagen I (1:3000, #ab34710, Abcam, Cambridge, UK), AKT (1:1000, #9272, Cell Signalling Technology, MA, USA), pAkt (1:1000, #9271, Cell Signalling Technology, MA, USA), STAT3 (1:1000, #9145, Cell

TABLE 1 Forward and reverse primers

| Gene | Forward primer | Reverse primer |
| --- | --- | --- |
| TBP | 5'- AGTGACCCAGCATCACTGTTT -3' | 5'-GGCAAACCAGAAACCCTTGC -3' |
| IL31RA | 5'- GATGTGCGGTCAAGGAGTCA -3' | 5'- GCCACATGGAGCTTCTTCCT -3' |
| CTGF | 5'-GACCTGGAAGAGAACATTAAGAAGG -3' | 5'- TGAGTATGTCTTCATGCTGGTG -3' |
| COL1A2 | 5'- TGCTTGCAGTAACCTTATGCCTA -3' | 5'- CAGCAAAGTTCCCACCGAGA -3' |

TBP: TATA box binding protein; IL-31RA: interleukin 31 receptor alpha; CTGF: connective tissue growth factor.

Signalling Technology, MA, USA), pSTAT3 (1:2000, #9145 s, Cell Signalling Technology, MA, USA) and GAPDH (1:50 000/1:10 000, #ab8245, Abcam, Cambridge, UK) overnight at 4°C. Species-specific secondaries were used followed by development with the ECL western blotting detection system (GE Healthcare Life Sciences, Amersham, UK).

*Immunostaining of skin and lung biopsies*
4 mm punch biopsies were removed from the anterior forearm from healthy controls and SSc patients (both $n = 6$). Lung tissue was obtained from surgical biopsies of SSc involved fibrotic lung and from healthy tissue adjacent to cancer lung biopsies (both $n = 10$). The biopsies were frozen in optical cutting temperature compound (OCT) and sectioned. Rabbit polyclonal anti-human IL-31 primary antibody (1:50, #PA5-26394, Invitrogen) and anti-rabbit secondary antibody labelled with horse raddish peroxidase (HRP) were used for immunostaining.

In the lung studies, cellular type was identified morphologically by an experience lung pathologist (A.R.). A semiquantitative four-tiered scoring system of absent, mild, moderate and marked (0–3) was used to evaluate the number of positively stained cells for each cell type, including alveolar macrophages, inflammatory cells, alveolar epithelial cells, type 2 pneumocytes and bronchial epithelial cells.

*Next generation sequencing*
Healthy control dermal fibroblasts ($n = 4$ replicate skin fibroblast cell lines) were cultured in 24 well plates until they reached 100% confluence, transferred to low serum overnight and then treated for 16 h with media only or IL-31(50 ng/ml) suspended in 0.2% serum with DMEM. RNA extraction was by Qiagen RNeasy extraction kit, assayed by UCL Genomics Centre using Illumina TrueSeq standards library with 15 million reads per sample. High Sensitivity Tapestation kit and 43 paired end sequencing were used as the quality control of the samples.

*Transcriptome analysis*
Paired end reads were mapped to the Ensembl human transcriptome reference sequence (latest version available during analysis: GRCh38[47]). Mapping and generation of read counts per transcript were done using Kallisto [26] based on the novel idea of pseudoalignment. R/Bioconductor package tximport was used to import the mapped counts data and summarize the transcripts-level data into gene level as described in this paper. Further analyses were run using DESeq2 package. Normalization and differential analysis were carried out according to the DESeq2 model by use of negative binomial generalized linear model. The estimates of dispersion and logarithmic fold changes incorporate data-driven prior distributions. Using this method, the results for the two experimental conditions were compared, and shown as a results with $\log_2$ fold changes, Wald test $P$-values and adjusted $P$-values (according to false discovery rate). Mapped reads for each sample ranged between 12 and 21 million. Principal component analysis was used as a quality control assessment.

Functional classification of differentially expressed genes was performed using Ingenuity Pathway analysis (IPA, www.qiagenbioinformatics.com/). The 'core analysis' function was used to interpret the data in the context of biological processes, pathways and networks. Significance of the biofunctions and the canonical pathways were tested by the Fisher Exact test $P$-value. Networks were constructed using the focus molecules from the dataset obtained from the next generation sequencing and the database used by the IPA software, Knowledge Base, used to fill areas lacking connectivity with predicted non-focus molecules. Countplots of differentially expressed genes were produced using Graphpad prism 7.0.

*Migration assay*
Migration was studied using a standard scratch migration assay [27], during which cells were treated with 0.2% serum (negative control), 10% serum (positive control), 50 ng/ml of IL-31 in 0.2% serum, or IL-31 (50 ng/ml) plus Wortmannin (100 nM, PI3K inhibitor) or U0126 10 μM (ERK pathway inhibitor), in SSc and control dermal fibroblasts (both $n = 4$ dermal fibroblast cell lines), and migration quantified by Axioscope imaging. Scratch area was measured using NIH ImageJ software.

*Mouse model*
Male Balb/c mice aged 6–8 weeks (Charles River Laboratories, CA) were used to study the *in vivo* pro-fibrotic effect of IL-31. A mini ALZA osmotic pump implanted in the skin pumped one of the following treatments continuously over 14 days: saline control ($n = 7$ mice), 200 ng of IL-31 (#210–31-10, Peprotech) per day ($n = 6$), 800 ng TGFβ per day (cyt-8585b, Prosec) ($n = 7$) or IL-31 with TGFβ($N = 6$). On day 14, the mice were

Fɪɢ. 1 Relevance of IL-31/IL-31RA to skin and lung fibrosis in scleroderma
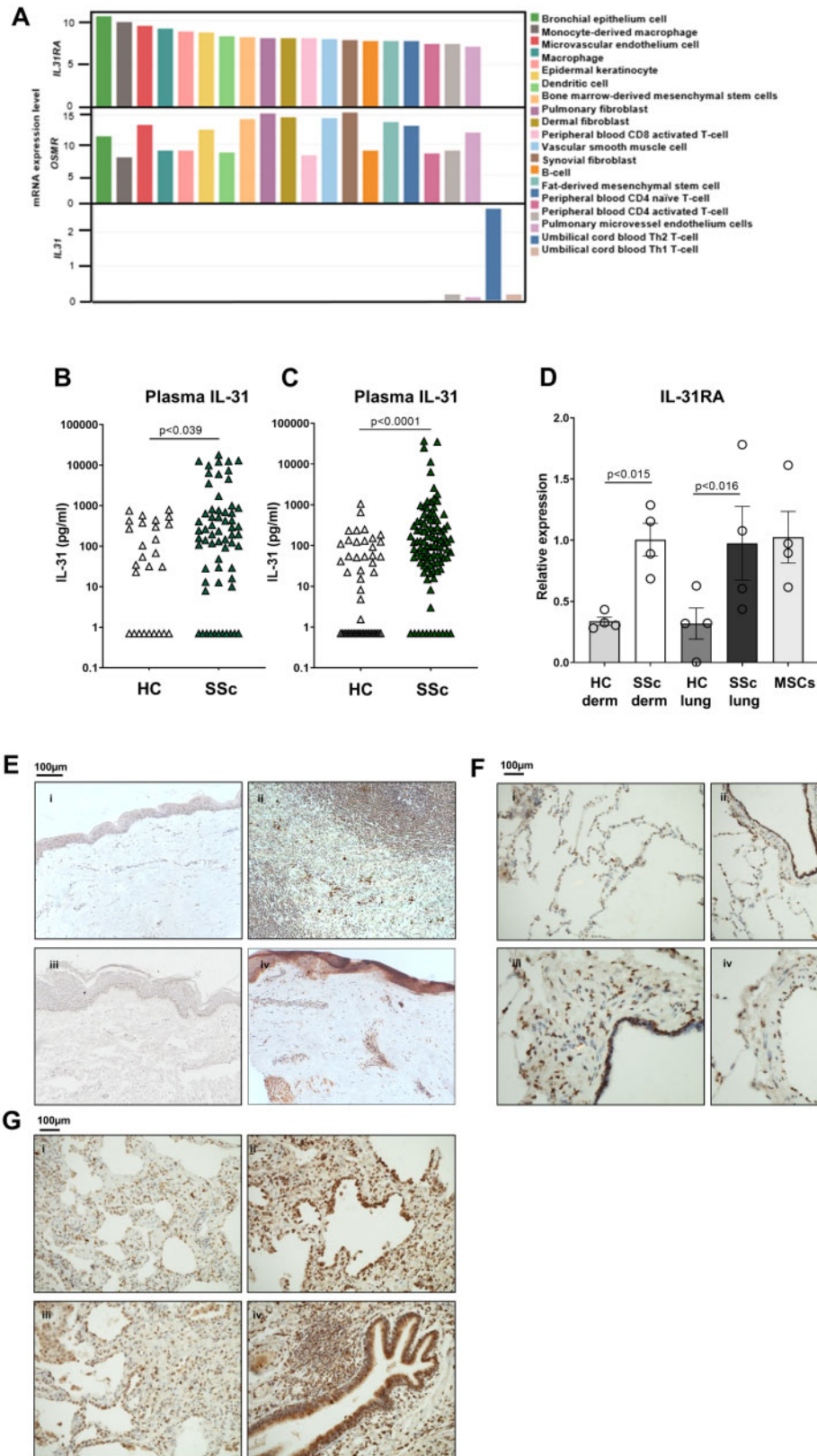
(**A**) Expression levels of IL31, OSMR, IL31RA by genevestigator, gene database software, showing the log2 mean gene expression. IL-31 expression appears specific to peripheral blood activated CD4+ Th2 cells, whereas the

anaesthetized and the pump was removed. On day 21, mice were euthanised and skin sections adjacent to the mini-pump, as well as the lungs, were obtained and stained by picrosirius red (PSR) and Masson's Trichrome. Plasma samples from day 21 were assayed for PDGF-BB (#MBB00, PDGF-BB ELISA, R&D), TGFβ 1 (#MB100B, TGFB1 ELISA, R&D) and IL-6 (#M6000B, IL-6 ELISA, R&D).

The same protocol was followed to obtain and study lung tissue at a later timepoint with $n = 5–6$ mice per treatment group and euthanasia performed on day 42. Ashcroft scoring was used to quantify central and peripheral pulmonary fibrosis [28].

### Statistical analysis

Plasma and BF levels of IL-31 were compared by non-parametric analysis using Mann–Whitney $U$ test. In tissue culture and mouse biology experiments, ANOVA followed by Tukey's *post hoc* test was used to compare multiple groups. Correlation between level of IL-31 and clinical parameters were assessed using Pearson correlation test. $P$-values $\leq 0.05$ were considered significant. GraphPad prism 8.1.1 was used to carry out these analyses.

## Results

### Gene database analysis of IL-31 and IL-31 receptor expression by cell type

Genevestigator analysis indicated that IL-31 expression was specific to Th2 cells, whereas the receptors IL31RA and OSMR were expressed by multiple tissue resident cell types, including dermal fibroblasts, pulmonary fibroblasts, fat-derived mesenchymal stem cells (MSCs), monocyte-derived macrophages and vascular smooth muscle cells (Fig. 1a). These data support a model in which IL-31 is synthesized predominantly by Th2 cells,

but potentially acting on multiple tissue resident cells relevant to fibrosis.

### Levels of IL-31 in plasma, blister fluid and fibrotic tissue of SSc patients
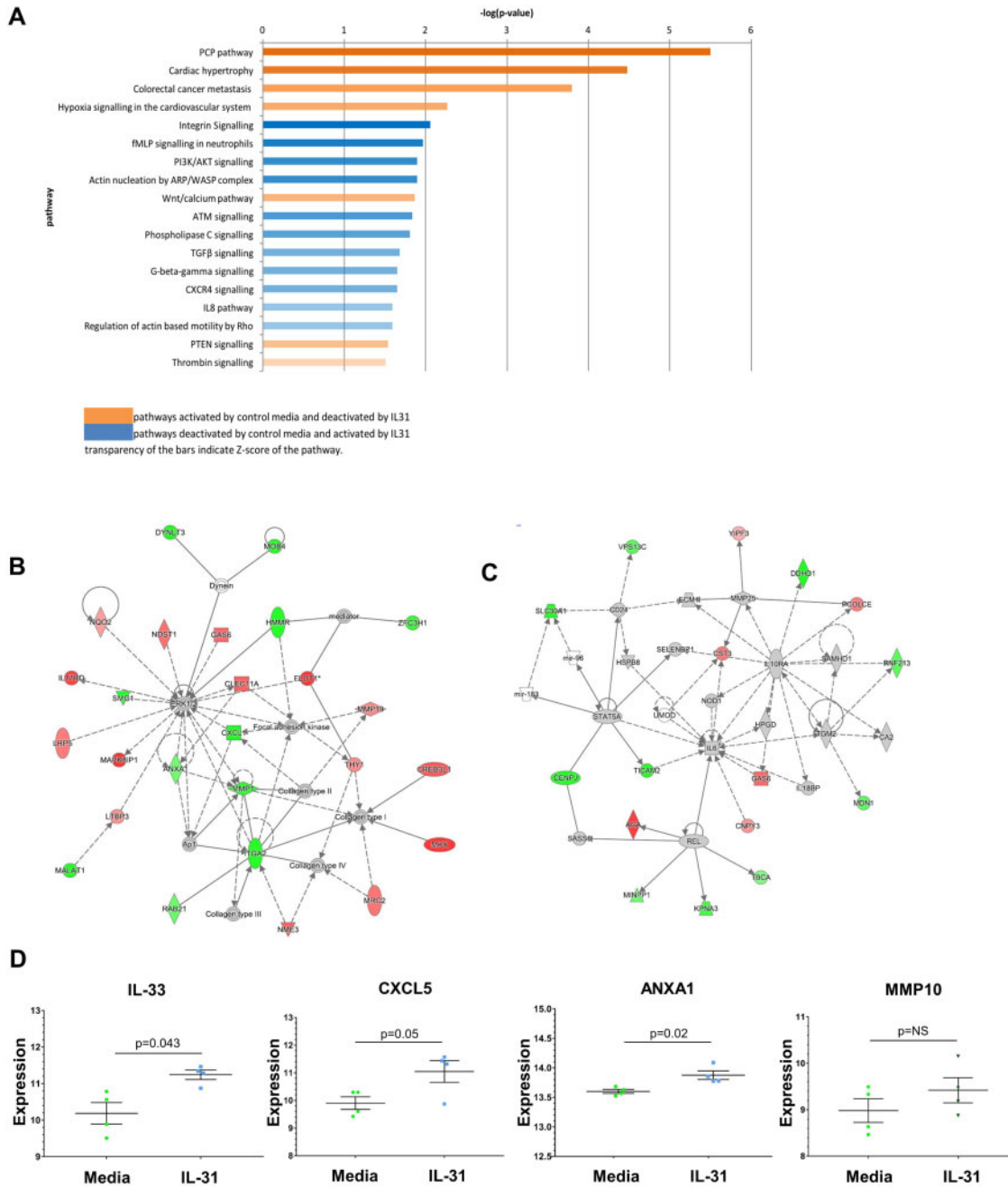
Initially, levels of IL-31 were measured in plasma samples collected prospectively from 27 healthy controls (HC) and 62 SSc patients, revealing elevated IL-31 in SSc (HC: 0.7–793, median 55; SSc: 0.7–17764 median 194 (pg/ml), $P < 0.039$, Mann–Whitney $U$ test); (Fig. 1b). For validation, a further analysis of stored plasma samples was performed using plasma from 49 HC and 100 SSc patients (50 limited cutaneous and 50 diffuse cutaneous subset), confirming elevated plasma IL-31 in SSc (HC: 0.7–1056, median 8, SSc 0.7–36564, median 117 pg/ml, $P < 0.0001$ Mann–Whitney $U$ test) (Fig. 1c). However, plasma IL-31 levels did not correlate with disease subset, modified Rodnan Skin Score, disease duration or ESR (data not shown). Of interest, plasma IL-31 was below the limit of detection of the assay in nine of 27 HC $vs$ 11 out of 62 SSc in the first assay ($\chi^2$ test NS), and in 22 out of 49 HC $vs$ 11 out of 100 SSc in the second assay ($\chi^2$ test $P < 2.8 \times 10^{-6}$). Dichotomous presence or absence of IL-31 detection in plasma samples is a well-established finding in previous studies [16, 17, 29].

In tissue, IL-31 positive cells were identified in inflammatory infiltrates in the perivascular areas and epidermis of the involved SSc skin but not in biopsies from healthy controls (seen in two out of six SSc skin biopsies) (Fig. 1e). Histologic scoring of the 10 SSc and HC lung biopsies indicated significant elevation of IL-31 positive inflammatory cell infiltrates in SSc ($P < 0.035$, Fisher's exact test), and a trend towards increased epithelial staining in SSc ($P < 0.07$) (Supplementary Material, section Lung tissue immunostaining for IL-31, available at *Rheumatology* online, and Fig. 1f and g).

FIG. 1 Continued
receptors IL31RA and OSMR are expressed by multiple tissue resident cells of potential relevance to fibrosis. (B) Plasma samples from HC and SSc patients were collected prospectively and assayed by ELISA for IL-31, showing elevated levels in SSc patients. (C) Further stored samples from SSc patients and controls identified via a database were assayed by ELISA, confirming the elevated plasma levels. (D) Potential downstream cellular targets of IL-31 were profiled for the receptor IL-31RA expression by qPCR. IL-31RA was elevated in both skin and lung fibroblasts from SSc $vs$ healthy controls (all $n = 4$ cell lines per group) and expressed to a similar level by adipose-derived MSCs (a single pooled cell line). (E) Immunostaining of skin biopsies taken from the affected area of the forearm skin from SSc patients and HCs ($n = 6$ biopsies for HC and SSc). (i) Negative control with no primary IgG, (ii) positive control with normal spleen tissue, (iii) HC with anti-IL-31, (iv) SSc involved skin with anti-IL-31, indicating positive IL-31 expressing cells in perivascular infiltrates and in the epidermis seen in two out of six patient samples and 0 of 6 control samples. (F) HC lung sections were examined ($n = 10$) showing as follows: (i) alveolar tissue showed only weak expression, (ii) in bronchial tissue positive staining of bronchial epithelial cells, and (iii) in peribronchial interstitial lymphocytes and (iv) some vascular endothelial and smooth muscle cells. (G) However, in SS lung biopsies ($n = 10$) variable but in some cases strong immunostaining seen in (i) interstitial lymphocytes, ($P < 0.035$, Supplementary Table S3, available at *Rheumatology* online for histologic scoring) (ii) and (iii) type 2 pneumocytes, as well as in (iv) bronchiolar epithelium ($P < 0.07$) and peribronchial lymphoid aggregates. P-values indicate Mann–Whitney $U$ test for B and C, and ANOVA and Tukey's test were used for D.

Table 2 Analysis of disease and functional gene expression in IL-31 treated dermal fibroblasts

| Categories | Functions | Diseases or Functions Annotation | P-value | Z-score | Number of molecules involved/561 |
|---|---|---|---|---|---|
| Carbohydrate Metabolism, Small Molecule Biochemistry | production | production of lactic acid | 0.00368 | −2.021 | 5 |
| Cellular Growth and Proliferation | proliferation | proliferation of cells | 4.5E-13 | −1.589 | 200 |
| Cell Morphology | mineralization | mineralization of connective tissue cells | 0.000473 | −1.358 | 5 |
| Cell Death and Survival | apoptosis | apoptosis of fibroblast cell lines | 0.000175 | −1.219 | 23 |
| Cell Death and Survival, Organismal Injury and Abnormalities | cell death | cell death of endothelial cells | 0.00612 | −0.904 | 11 |
| Cellular Development, Connective Tissue Development and Function | differentiation | differentiation of fibroblast cell lines | 0.00419 | −0.73 | 12 |
| Cell Death and Survival | apoptosis | apoptosis of fibroblasts | 0.000117 | −0.694 | 17 |
| Cardiovascular System Development and Function, Organismal Development | angiogenesis | angiogenesis | 6.71E-05 | 0.085 | 52 |
| Cardiovascular System Development and Function | development | development of vasculature | 6.12E-06 | 0.106 | 62 |
| Cardiovascular System Development and Function, Organismal Development | vasculogenesis | vasculogenesis | 0.000631 | 0.254 | 41 |

This analysis predicts the affected physiological process in response to IL-31 treatment, based on gene expression and the directional changes. Upon IL-31 stimulation, 561 molecules were differentially activated. Each category shows the functional or the pathological process and the number of molecules involved in the process. P-values less than <0.05 were considered significant and activated processes are indicated by negative z-scores. Functions highlighted by shading are predicted to be upregulated by IL-31, and non-shaded rows refer to downregulated functions. P-values were generated by Fisher Exact test.

## Expression levels of the IL-31 receptor in SSc pathogenic cells

As assessed by qPCR of SSc and control cell lines ($n = 4$ cell lines per group), the IL-31RA receptor was expressed at a higher level by both the dermal ($P <0.015$, ANOVA followed by Tukey's test) and lung fibroblast ($P <0.016$) from SSc patients when compared with controls, and to a similar level by fat-derived MSCs (single pooled HC MSC culture) (Fig. 1d).

## IL-31 induces differential RNA expression in skin fibroblasts

IL-31-treated healthy dermal fibroblast ($n = 4$ normal dermal fibroblast cell lines cultured with or without IL-31 (50 ng/ml)) were analysed by next generation sequencing, revealing significantly altered gene expression patterns (Fig. 2A); integrin signalling pathway, fMLP in neutrophils, PI3K/AKT signalling and actin nucleation by ARP-WASP complex were all upregulated. In contrast, the canonical pathways which were deactivated, included planar cell polarity (PCP), colorectal cancer metastasis, cardiovascular associated-hypoxia signalling, Wnt signalling and others. Moreover, the IPA software was used to predict the possible biological consequences of IL-31 stimulation of fibroblasts, based on grouping the activated molecules into different functional categories (shown in Table 2). 561 molecules were reported to be expressed differentially in IL-31 treated dermal fibroblasts. Of these, 200 molecules

associated with cell proliferation and growth were found to be upregulated. Other upregulated molecules were related to functions including lactic acid production, apoptosis and differentiation of fibroblasts, cell death of endothelial cells, and mineralization of connective tissue cells. Meanwhile, the suppressed molecules were involved in vasculature development, angiogenesis and vasculogenesis.

To put the data obtained from next generation sequencing into context, the knowledge-based feature in IPA was used to construct a hypothetical map network. The network with the highest score and significance, displayed proteins involved in cellular movement, cell-to-cell signalling and interaction, and cellular development (Fig. 2B). The second highest score was for the network responsible for functions categorized as inflammatory response, and hematological system development and function (Fig. 2C). The first network had 26 focus molecules and ERK1/2 as the central node, whereas the second network showed 16 focus molecules and IL-6 was the central node. Various candidate genes relevant to SSc were induced by IL-31, including: IL-33 ($P =0.043$), C-X-C motif chemokine 5 (CXCL5, $P =0.005$) and Annexin 1 (ANXA1, $P =0.02$) (all by Wald's statistic test) (shown in Fig. 2D).

## Phenotype changes induced by recombinant IL-31

Initially a dose-response was obtained by treating healthy dermal fibroblasts ($n = 2$ cell lines studied) to

**Fɪɢ. 3** Phenotype changes induced in dermal fibroblasts by IL-31
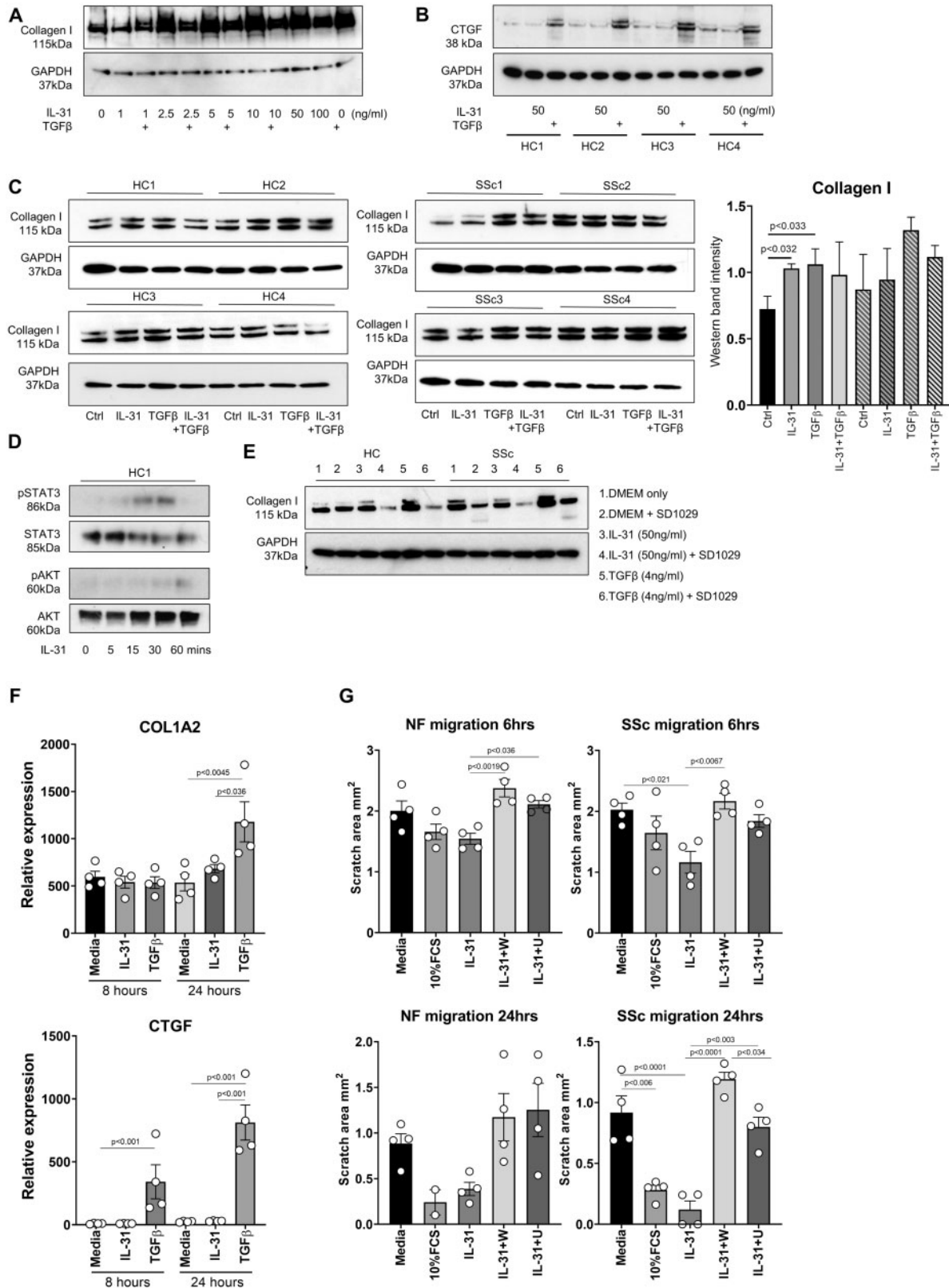


Collagen I and CTGF protein levels were used to assay the fibrotic responses of human skin fibroblasts, after treatment with increasing doses of IL31 (1–100 ng/ml), with or without the known pro-fibrotic TGFβ (4 ng/ml). (**A**) IL-31

increasing concentrations of IL-31 (1–100 ng/ml) in the presence or absence of the known pro-fibrotic TGFβ (4 ng/ml), using collagen I protein as readout for the fibrotic response. IL-31 treatment led to induction of collagen I, which was maximal with 50 ng/ml of the recombinant protein (Fig. 3a). However, no induction of the matricellular fibrotic protein CTGF was seen in normal dermal fibroblasts (n = 4 cell lines) treated with IL-31 50 ng/ml (Fig. 3B). As expected, TGFβ induced the production of both collagen I and CTGF (Fig. 3A and B). Unlike the collagen I protein, mRNA levels of type I collagen were not increased by the IL-31 treatment, indicating non-transcriptional regulation of collagen I protein synthesis (n = 4 cell lines) (Fig. 3F). In replicate experiments (n = 4 cell lines) normal dermal fibroblasts exhibited elevated collagen I following treatment with IL-31 (50 ng/ml) (mean Western band intensity, basal 0.723, IL-31 treated 1.03 (P <0.032), TGFβ 1.06 (P <0.033), IL-31+TGFβ 0.98 (p NS) (paired t test) (Fig. 3C)). SSc dermal fibroblasts demonstrated more variable and higher basal collagen I and no significant induction when stimulated by IL-31 (basal 0.87, IL-31 0.95, TGFβ 1.32, IL-31+TGFβ 1.11 (all P NS vs basal) (Fig. 3C)). This pattern of high basal activity and less marked induction by profibrotic stimuli is a known feature of SSc fibroblasts. No positive synergy between IL-31 and TGFβ was observed; in fact the effects of adding both agents together reduced the maximal collagen I protein response (Fig. 3C).

Furthermore, phosphorylated STAT3 bands were seen after 5 min of treatment with IL-31, reduced by 60 min, whereas pAkt was seen after 30 min, indicating active signalling through STAT3 and PI3K/Akt pathways (n = 2 normal dermal fibroblast lines) (Fig. 3D). When dermal fibroblasts were treated with the STAT3 inhibitor SD1029, collagen I induction by both IL-31 and TGFβ was blocked, confirming the role of STAT3 signalling in the fibrotic response (n = 1 dermal fibroblast lines for SSc and controls) (Fig. 3E).

Moreover, IL-31 was found to increase the migratory behaviour of HC and SSc dermal fibroblasts (both n = 4), reduced when PI3K inhibitor (Wortmannin, 100 nM) or MEK/ERK inhibitor (U0126, 5 μM) were added

(both studied at a single known inhibitory dose) (P <0.001) (Fig. 3G).

## Assessing the in vivo pro-fibrotic activities of recombinant IL-31

In wild type Balb/c mice, IL-31-treatment resulted in dermal thickening, and increased cross-linked dermal collagen as assayed by PSR stain, whereas TGFβ alone failed to induce comparable results, and showed no synergy when combined with IL-31(Fig. 4A and B). In lung tissue no significant fibrotic pathology or cellular infiltrate was seen on day 21 (data not shown). However, on day 42, IL-31 treatment resulted in significant fibrosis most apparent in the central lung area (Fig. 4C). Also, in IL-31 treated mice there was a non-significant trend towards elevated plasma levels of IL-6, TGFβ1 and PDGF, compared with saline receiving mice (Fig. 4D).

IL-31RA regulation can be found in the Supplementary Material, section Regulation of IL-31RA, available at *Rheumatology* online.

## Discussion

Whereas initial interest focused on its role as a pruritogenic factor in atopic conditions, more recent studies have indicated pro-inflammatory and tissue remodeling effects, and demonstrated increased expression levels of IL-31 in autoimmune connective tissue disorders such as SLE and dermatomyositis [30, 31]. Here, in the first study of IL-31 in SSc, we show elevated levels in a subgroup of patients. Current concepts indicate that SSc is a heterogeneous disease with distinct pathogenic subgroups, emphasising the potential for complex and variable underlying disease processes [32], which in this instance may involve this Th2 cytokine in the immune-fibrotic pathology. Our findings indicate very high plasma levels of IL-31 in around 10% of patients, with levels in the ng/ml range likely to influence target cells. However, we were unable to identify a clear clinical pattern for this subgroup, which is a limitation of the study.

Furthermore, because the precise reason for the widespread tissue distribution of the IL-31RA receptor is not

Fɪɢ. 3 Continued

induced collagen I with maximal effect at 50 ng/ml (n = 2 HC cell lines studied). (B) However, the matricellular protein CTGF was not induced by IL-31 (50 ng/ml) (n = 4 HC cell lines studied). TGF*β*, as expected, induced both collagen I and CTGF protein levels, but did not appear to synergise with IL-31. (C) IL-31 (50 ng/ml) was used to stimulate n = 4 HC and n = 4 SSc dermal fibroblast lines with or without TGF*β* (4 ng/ml). In HC cell lines IL-31 led to a significant increase in collagen I Western band intensity (plain bars, P <0.032) as did TGF*β* (P <0.033). In SSc dermal fibroblasts, basal collagen I appeared higher and less responsive to IL-31 and TGF*β* (hatched bars, both P NS). (D) IL-31 (50 ng/ml) induced signalling in normal dermal fibroblasts, causing transient phosphorylation of STAT3 and increased phosphorylation of Akt (n = 2 HC fibroblast lines studied). (E) The STAT3 inhibitor, SD1029, substantially decreased the production of collagen I in healthy and SSc dermal fibroblasts treated with IL-31 or TGF*β* (n = 1 cell line for both). (F) IL-31 did not alter collagen I or CTGF mRNA levels in HC fibroblasts (n = 4 cell lines) unlike TGF*β*, indicating post-transcriptional induction of collagen I by IL-31. (G) IL-31 strongly enhanced migration of control and SSc dermal fibroblasts (both n = 4 cell lines) at 24 h, inhibited by Wortmannin (PI3K inhibitor, 100 nM) or U0126 (MEK/ERK inhibitor, 5 μM).

Fɪɢ. 4 IL-31 induces dermal and lung fibrosis in mice
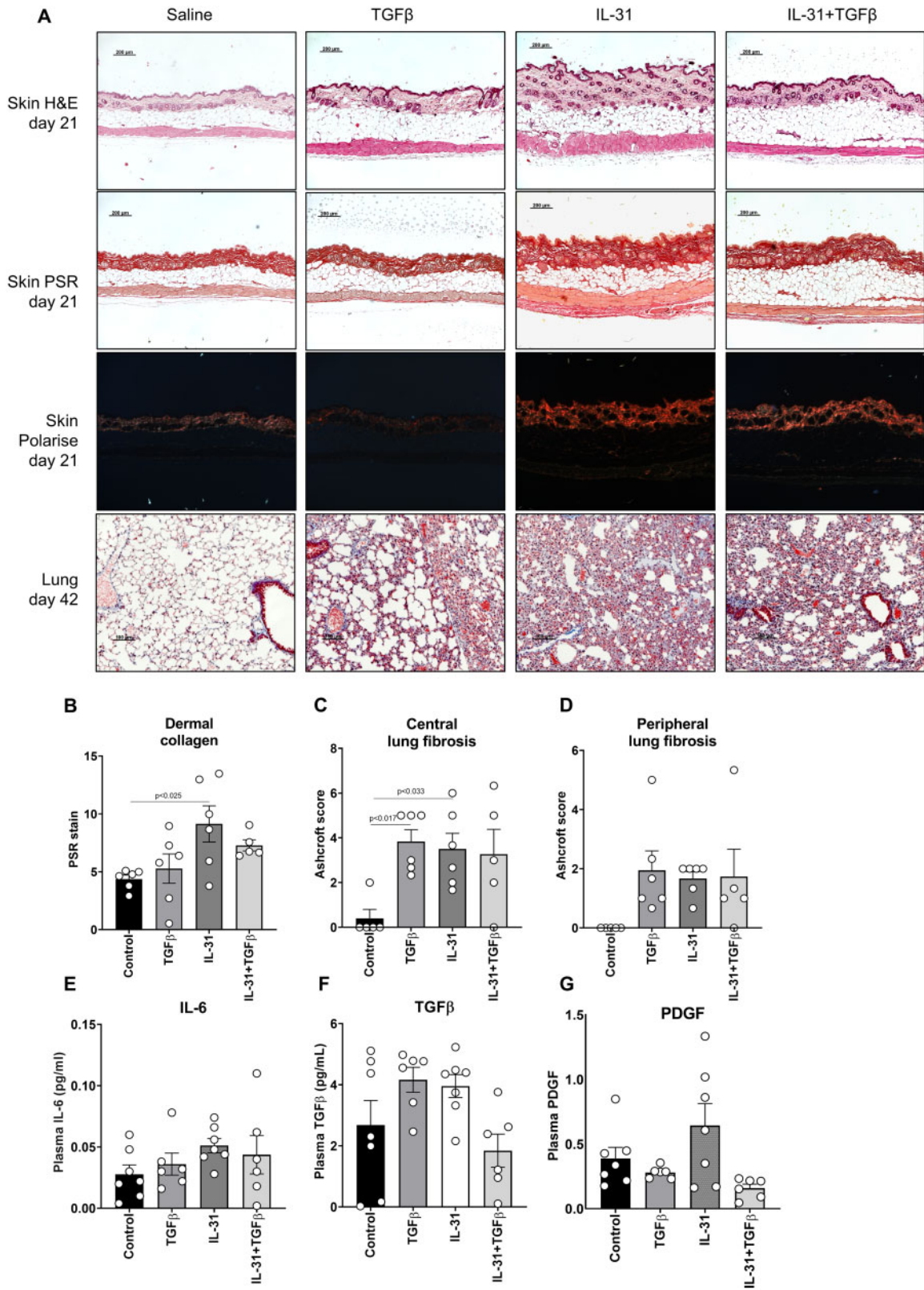
(**A**) Wild type Balb/c mice were treated as follows: saline control (*n* = 7 mice), TGFβ (800 ng per day) (*n* = 7), IL-31(200 ng per day) (*n* = 6) or IL-31 plus TGFβ (*n* = 7). Each treatment was delivered continuously by an implanted

Fɪɢ. 4 Continued

subcutaneous mini pump, which was removed at day 14. At day 21, skin sections were stained for H&E or picrosirius red (PSR), revealing enhanced dermal thickening by IL-31 treatment. (**B**) Collagen cross-linking, as assessed by polarized images of PSR stain, was also enhanced by IL-31 treatment, which reached statistical significance. TGF$\beta$ alone did not cause significant increase in dermal thickness or cross-linked collagen and did not synergise with IL-31. (**C**) In further experiments using $n = 5$–6 mice per treatment group, lung tissue sampled at day 42 demonstrated interstitial lung disease in mice treated with IL-31, similar to TGF$\beta$ treated mice, most marked in the central lung areas. Again, positive synergy was not seen. (**D**) Plasma cytokine and growth factor levels at day 21 indicated a trend towards elevated of IL-6, TGF$\beta$1 and PDGF in IL-31 treated mice, consistent with an SSc-like fibrotic process. In general a trend towards negative synergy with TGF$\beta$ was seen in most experiments. *P*-values for (**B**)–(**D**) were obtained using ANOVA and Tukey's multiple comparison test. *P*-values <0.05 were considered significant. H&E: heamtoxylin & eosin; PSR: piscosirius red (PSR) staining.

fully understood, we investigated and confirmed a tissue remodeling effect. Treatment with IL-31 in fact led to the differential expression of multiple genes and SSc disease-relevant pathways in dermal fibroblasts. Also, IL-31 elevated collagen I protein release via pSTAT3, a known SSc-like phenotype [33]. The fibrotic activation by IL-31 did not synergise with that induced by the classical pro-fibrotic factor TGFβ, which reduced IL-31RA receptor levels. It is possible that the IL-31-induced fibroblast activation, and that induced by TGFβ, represent different phases of a disease process, which are only partially overlapping.

The receptor IL-31RA appeared increased in skin and lung fibroblasts from SSc. Persistent elevation of IL-31RA in pathogenic cells could be explained through epigenetic mechanisms, and consistent with this, we demonstrated that IL-31RA is regulated by a microRNA in healthy control cells, an effect that is reduced in SSc.

In fact, a pro-fibrotic role for IL-31was confirmed, inducing dermal and lung fibrosis in mice, and resembling certain aspects of the clinical disease such as thickening of the dermis and increased local collagen, but not leading to loss of subcutaneous fat. Furthermore, any effect on vascular health was not evaluated, as a limitation of the study.

Treating progressive skin and organ-based fibrosis in SSc remains a significant unmet need despite recent progress [34]. The underlying complex pathology, the diverse involvement of inflammatory and immune cells that act upstream of signalling events in fibroblasts, and the heterogeneity from patient to patient are ongoing challenges. It is possible that in certain SSc patients IL-31 is promoting the inflammatory-fibrotic pathology seen. Targeting T-cell-derived cytokines such as IL-31 is achievable with current therapies, and might reduce the burden of pruritus and fibrosis in this severe disease [18].

## Supplementary data

[Supplementary data](#) are available at Rheumatology online.

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