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Delphine Staumont-Sallé, Sébastien Fleury, Anne Lazzari, Olivier Molendi-Coste, Nicolas Hornez, et al.. CX CL1 (fractalkine) and its receptor CX CR1 regulate atopic dermatitis by controlling effector T cell retention in inflamed skin.. Journal of Experimental Medicine, Rockefeller University Press, 2014, 211 (6), pp.1185-96. <inserm-01116365>

**HAL Id: inserm-01116365**

**<http://www.hal.inserm.fr/inserm-01116365>**

Submitted on 13 Feb 2015

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**CX<sub>3</sub>CL1 (Fractalkine) and its receptor CX<sub>3</sub>CR1 regulate atopic dermatitis by  
controlling effector T cell retention in inflamed skin**

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Sentence caption: Fractalkine interactions with its receptor, CX<sub>3</sub>CR1, regulate CD4<sup>+</sup> T cell retention in atopic dermatitis and offer a potential therapeutic target in allergic disease.

**Source of funding:** This study was in part funded by grants from the Agence Nationale de la Recherche (ANR) ANR-06-MIME-008, ANR-10-LABX-46, from the AVIESAN Institut Thématique Multiorganisme (ITMO) Immunologie and from the Fondation pour la Recherche Médicale (FRM).

The authors declare no financial conflict of interest.

**Abbreviations used:**

AD: Atopic dermatitis

AHR: Airway hyperresponsiveness

BAL: Bronchoalveolar lavage

LACK: Leishmania homolog of receptors for activated C kinase

WT: wild-type

## **ABSTRACT**

Atopic dermatitis (AD) is a chronic allergic dermatosis characterized by epidermal thickening and dermal inflammatory infiltrates with a dominant Th2 profile during the acute phase, while a Th1 profile is characteristic of the chronic stage. Among chemokines and chemokine receptors associated with inflammation, increased levels of CX<sub>3</sub>CL1 (fractalkine) and its unique receptor, CX<sub>3</sub>CR1, have been observed in human AD. We have thus investigated their role and mechanism of action in experimental models of AD and psoriasis. AD pathology and immune responses, but not psoriasis, were profoundly decreased in CX<sub>3</sub>CR1-deficient mice and upon blocking CX<sub>3</sub>CL1/CX<sub>3</sub>CR1 interactions in wild type mice. CX<sub>3</sub>CR1 deficiency neither affected antigen presentation nor T cell proliferation *in vivo* upon skin sensitization, but CX<sub>3</sub>CR1 expression by both Th2 and Th1 cells was required to induce AD. Surprisingly, unlike in allergic asthma, where CX<sub>3</sub>CL1 and CX<sub>3</sub>CR1 regulate the pathology by controlling effector CD4<sup>+</sup> T cell survival within inflamed tissues, adoptive transfer studies established CX<sub>3</sub>CR1 as a key regulator of CD4<sup>+</sup> T cell retention in inflamed skin, indicating a new function for this chemokine receptor. Therefore, while CX<sub>3</sub>CR1 and CX<sub>3</sub>CL1 act through distinct mechanisms in different pathologies, our results further evidence their interest as promising therapeutic targets in allergic diseases.

## INTRODUCTION

Atopic dermatitis (AD) is a common, chronic inflammatory dermatosis frequently occurring in individuals with a personal or family history of atopic diseases. AD pathophysiology is complex and results from skin barrier dysfunction and a dysregulated immune response, influenced by genetic and environmental factors (Guttman-Yassky et al., 2011a; Guttman-Yassky et al., 2011b). Indeed, most patients with AD have increased serum IgE levels, with specific IgE directed against allergens or microbial proteins such as *Staphylococcus aureus* (Leung et al., 2004). Lesions in AD are characterized by increased epidermal thickness and a dermal inflammatory cell infiltrate, consisting of mast cells, eosinophils and T lymphocytes. In acute AD lesions, a preferential recruitment of Th2 cells occurs, whereas in the chronic lesions a Th1 profile is predominant (Grewe et al., 1998), while allergic asthma or allergic rhinitis are more exclusively Th2-dominated diseases.

Chemokines and their receptors play a key role in leukocyte recruitment to inflamed skin (Schall and Proudfoot, 2011). Eotaxins 1, 2 and 3 (CCL11, 24, 26) bind to CCR3 and attract eosinophils, and CCL26 appears to be particularly involved in AD (Kagami et al., 2003; Owczarek et al., 2011). CCL27 together with CCR10 and CCR4 expression insure T cell skin domiciliation (Homey et al., 2002; Reiss et al., 2001). More recently, CCR8 and CCL8 have been elegantly demonstrated to direct Th2 cell recruitment into allergen-inflamed skin and draining lymph nodes in a murine model of AD (Islam et al., 2011).

Besides chemoattraction, chemokine - chemokine receptor interactions also regulate other functions. Indeed, we have recently demonstrated that CX<sub>3</sub>CR1, the receptor for CX<sub>3</sub>CL1 (fractalkine -CX<sub>3</sub>-), identified also as a receptor for CCL26 (Nakayama et al., 2010) in humans, controls the development of allergic asthma by providing a survival signal to the CD4<sup>+</sup> effector T lymphocytes in the inflammatory airways (Julia, 2012; Mionnet et al., 2010). In AD patients, CX<sub>3</sub>CL1 is upregulated in both endothelial cells and skin lesions and serum

CX<sub>3</sub>CL1 levels are positively associated with disease severity (Echigo et al., 2004). Another study reported that, while CX<sub>3</sub>CR1 mRNA expression is consistently upregulated in AD skin, CX<sub>3</sub>CL1 mRNA levels are only increased in some patients with a significant correlation to the disease severity (Nakayama et al., 2010), a result likely to explain the earlier failure to detect CX<sub>3</sub>CL1 in skin lesions (Fraticegli et al., 2001). Furthermore, two CX<sub>3</sub>CR1 single nucleotide polymorphisms have been associated with asthma and atopy in French-Canadian populations (Tremblay et al., 2006) and German children (Depner et al., 2007).

Thus, in order to functionally delineate the role of CX<sub>3</sub>CL1/CX<sub>3</sub>CR1 in AD, we used a mouse model of epicutaneous sensitization, by a protein antigen in the absence of adjuvant, faithfully mimicking features of human AD. Unexpectedly, we found that CX<sub>3</sub>CL1/CX<sub>3</sub>CR1 controlled atopic dermatitis to an even greater extent than allergic asthma through a new and distinct mechanism.

## RESULTS

### **Upon skin sensitization, CX<sub>3</sub>CR1-deficient mice develop neither AD nor subsequent lung inflammation.**

To assess the contribution of CX<sub>3</sub>CR1 to AD development, we used a previously described model of AD based on repeated epicutaneous sensitizations (Spergel et al., 1998) with *Leishmania major activated C Kinase* (LACK) as antigen and compared the response of CX<sub>3</sub>CR1-deficient (<sup>gfp/gfp</sup>) mice, in which the CX<sub>3</sub>CR1 gene has been replaced by *gfp* (Jung et al., 2000), to that from their proficient (<sup>+/+</sup>) WT counterparts. Neither strain exhibited an inflammatory phenotype in the absence of LACK sensitization (**Fig. 1A**). Compared to vehicle (i.e. PBS)-sensitized CX<sub>3</sub>CR1<sup>+/+</sup> mice, LACK-sensitized CX<sub>3</sub>CR1<sup>+/+</sup> mice exhibited a significant skin inflammatory response, characterized by a 50% increase in epidermal thickening (**Fig. 1B**) associated with more pronounced hyperkeratosis, spongiosis and dermal cellular infiltrates including mast cells, eosinophils, MHC-II<sup>+</sup> and CD4<sup>+</sup> T cells (**Fig. 1C**) as well as increased skin and inguinal lymph node (LN) expression of inflammatory and Th1- and Th2-associated cytokines, chemokines and chemokine receptors (**not shown**). In sharp contrast, CX<sub>3</sub>CR1<sup>gfp/gfp</sup> mice did not develop a skin inflammatory response upon LACK sensitization (**Fig. 1A-B**). Compared with PBS-sensitized CX<sub>3</sub>CR1<sup>gfp/gfp</sup> mice, only MHC-II<sup>+</sup> cell numbers were increased, but to a lesser extent than in LACK-sensitized CX<sub>3</sub>CR1<sup>+/+</sup> animals (**Fig. 1C**). Furthermore, expression of Th1- and inflammatory response genes was also significantly decreased (**not shown**).

Humoral response was also altered in CX<sub>3</sub>CR1<sup>gfp/gfp</sup> compared to CX<sub>3</sub>CR1<sup>+/+</sup> mice, with decreased total Th2-associated IgE concentrations (but not IgG<sub>1</sub> titers), as well as decreased Th1-associated antigen-specific IgG<sub>2a</sub> titers (**Fig. 1D**).

As in the human pathology, epicutaneous sensitization also induced lung inflammation and airway hyperreactivity (AHR) following a single antigenic airway challenge. Airway resistance upon LACK-sensitization was significantly lower in CX<sub>3</sub>CR1<sup>gfp/gfp</sup> compared to CX<sub>3</sub>CR1<sup>+/+</sup> animals (**Fig. 1E**). Furthermore, cellular inflammatory infiltrates in the bronchoalveolar fluid (BALF) of LACK-sensitized CX<sub>3</sub>CR1<sup>gfp/gfp</sup> mice were decreased by 32% for macrophages, 70% for lymphocytes and eosinophils, and 40% for neutrophils compared to BALF from CX<sub>3</sub>CR1<sup>+/+</sup> mice (**Fig. 1F**).

### **A CX<sub>3</sub>CL1 antagonist strongly reduces features of AD.**

To further confirm the key role of CX<sub>3</sub>CR1 in AD development, we next investigated whether inhibition of CX<sub>3</sub>CL1/CX<sub>3</sub>CR1 interactions would inhibit the pathology in WT animals. We investigated the efficacy of a CX<sub>3</sub>CR1 antagonist (CX<sub>3</sub>-AT), whose potency was already validated in an allergic asthma model (Mionnet et al., 2010), using prophylactic or therapeutic administration protocols (**Fig. 2A**). Both administration schedules fully inhibited antigen-induced epidermal thickening (**Fig. 2B**), as well as dermal mast cell, eosinophil and CD4<sup>+</sup> T cell infiltration (**Fig. 2C**). Upon LACK aerosol challenge, AHR and inflammatory cell infiltration in the airways were also significantly decreased upon both prophylactic and therapeutic treatments (**Fig. 2C-D**). Taken together, these results confirm the key role of CX<sub>3</sub>CR1/CX<sub>3</sub>CL1 in AD in non-genetically manipulated mice and further demonstrate that pharmacological inhibition of CX<sub>3</sub>CL1/CX<sub>3</sub>CR1 interactions abrogate skin and lung inflammation.

### **CX<sub>3</sub>CR1 is neither required for antigen presentation nor for naïve T cell proliferation but regulates both Th1- and Th2- induced skin inflammation**

As CX<sub>3</sub>CR1 is expressed by various myeloid cells, such as blood monocytes, dendritic cell



(DC) progenitors, plasmacytoid DC, and macrophages (Bar-On et al., 2010; Kim et al., 2011; Zhang et al., 2012), we next assessed whether antigen presentation was affected in the absence of CX<sub>3</sub>CR1. To this aim, antigen-specific CD4<sup>+</sup> T cells from WT15 TCR transgenic mice (Wang et al., 2001), were labeled with CFSE and injected to both CX<sub>3</sub>CR1<sup>+gfp</sup> and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> mice that were further sensitized via epicutaneous LACK administration. Frequencies of divided antigen-specific CD4<sup>+</sup> T cells in the draining LN were comparable in both CX<sub>3</sub>CR1<sup>+gfp</sup> and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> mice (**Fig. 3A**), suggesting that, upon epicutaneous sensitization, CX<sub>3</sub>CR1 deficiency does not affect antigen presentation. We next investigated whether CX<sub>3</sub>CR1 deficiency affected T cell proliferation induced upon epicutaneous antigen sensitization. To address this issue, we generated Thy1<sup>+/-</sup> CX<sub>3</sub>CR1<sup>+gfp</sup> and Thy1<sup>+/+</sup> CX<sub>3</sub>CR1<sup>gfp/gfp</sup> LACK-specific TCR transgenic mice that respectively expressed the Thy1.1 and Thy1.2 antigens or the Thy1.1 antigen only. CD4<sup>+</sup> T cells from both genotypes were prepared, stained with CFSE and co-injected into WT Thy1.1<sup>-/-</sup> Thy1.2<sup>+/+</sup> mice. Upon epicutaneous sensitization with LACK, frequencies of dividing CX<sub>3</sub>CR1<sup>+gfp</sup> and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> WT15 cells were comparable (**Fig. 3B**). Altogether these results suggest that CX<sub>3</sub>CR1 deficiency does not alter naïve T cell proliferation.

### **CX<sub>3</sub>CR1 expression regulates both Th1- and Th2- induced skin inflammation.**

As both Th2 and Th1 cells are associated to the acute and chronic phases of AD, respectively (Spergel et al., 1999), we investigated whether CX<sub>3</sub>CR1 expression was required by Th1, Th2 cells or both to induce skin inflammation. LACK-specific CD4<sup>+</sup> T cells were prepared from either Thy1<sup>+/-</sup> CX<sub>3</sub>CR1<sup>+gfp</sup> or Thy1<sup>+/+</sup> CX<sub>3</sub>CR1<sup>gfp/gfp</sup> WT15 mice, differentiated *in vitro* into Th1 or Th2 cells and injected into WT mice that were further sensitized to LACK. While both CX<sub>3</sub>CR1-proficient Th1 and Th2 cells alone were able to induce a 4 to 5-fold epidermal thickening upon a single round of epicutaneous antigen exposure, CX<sub>3</sub>CR1-deficient Th2

cells only induced a less than 2- fold increase in epidermal thickness and injection of CX<sub>3</sub>CR1-deficient Th1 cells barely led to epidermal thickening compared to PBS-treated animals (**Fig. 3C**). Likewise, dermal mast cell infiltration was also induced by both CX<sub>3</sub>CR1-proficient Th1 and Th2 cells, but not upon injection of CX<sub>3</sub>CR1-deficient effector T cells (**Fig. 3D**). Eosinophil infiltration was only induced upon transfer of CX<sub>3</sub>CR1-proficient Th2 cells and strongly reduced when CX<sub>3</sub>CR1-deficient Th2 cells were injected (**Fig. 3D**). Taken together, these results suggest that CX<sub>3</sub>CR1 expression by Th2- and Th1-cells regulates the key features of AD.

### **CX<sub>3</sub>CR1 expression confers a selective advantage to skin-infiltrating T cells.**

To decipher the mechanisms accounting for the role of CX<sub>3</sub>CR1 expression by T helper cells in skin inflammation, we monitored the recruitment and proliferative capacities of both CX<sub>3</sub>CR1-proficient and CX<sub>3</sub>CR1-deficient LACK-specific Th1 and Th2 cells upon co-injection into WT mice that were exposed to LACK and further fed with BrdU. Three days following antigen exposure, while Th1 and Th2 donor cells of both genotypes had not yet incorporated BrdU (data not shown), CX<sub>3</sub>CR1-proficient and CX<sub>3</sub>CR1-deficient LACK-specific donor cells were detected at the same frequency in skin, suggesting that early migration of effector T cells into the skin did not require CX<sub>3</sub>CR1 (**Fig. 4A**). It is worth noting that antigen-induced recruitment of LACK-specific Th1 cells was more pronounced than recruitment of Th2 cells as early as 3 days after antigen exposure. In sharp contrast, frequencies of CX<sub>3</sub>CR1-proficient donor cells outnumbered CX<sub>3</sub>CR1-deficient cells on day 7 (**Fig. 4B**). However, donor cells of both genotypes proliferated at the same rate (**Fig. 4C**). Therefore, as observed for naïve T cells, CX<sub>3</sub>CR1 deficiency neither affects the early recruitment, nor the proliferation of Th1- and Th2- effector cells.

We next monitored CX<sub>3</sub>CR1 expression using GFP as a surrogate marker for CX<sub>3</sub>CR1

expression (Geissmann et al., 2003; Jung et al., 2000). Upon differentiation, antigen-specific effector cells remained GFP<sup>-</sup> as previously described (Mionnet et al., 2010). At day 3 after initial sensitization, less than 0.3% of antigen-specific effector cells expressed CX<sub>3</sub>CR1 (i.e. GFP) in draining LN, and around 4% of these cells expressed CX<sub>3</sub>CR1 (i.e. GFP) in skin (**Fig. 4D**). At day 7, while the frequencies of CX<sub>3</sub>CR1-expressing Th1 and Th2 cells in the draining LN slightly increased to 3.6 and 1.4 %, respectively, their frequencies in skin steadily increased to 12.3 and 8.3 %, respectively (**Fig. 4D**). These latter results suggest that CX<sub>3</sub>CR1 expression is likely to be induced early in skin.

### **CX<sub>3</sub>CR1-deficiency impairs effector T cell retention into inflamed skin.**

The higher frequency of CX<sub>3</sub>CR1-proficient CD4<sup>+</sup> effector cells in skin could be explained by several hypotheses: the preferential late recruitment of CX<sub>3</sub>CR1<sup>+</sup> effector T cells into the skin, their prolonged survival, or their selective advantage for residence in the inflamed skin. As CX<sub>3</sub>CR1 is involved in effector T cell survival in allergic lung inflammation (Mionnet et al., 2010), and as the role of CX<sub>3</sub>CR1/CX<sub>3</sub>CL1 in microglial cell (Meucci et al., 1998) and monocyte survival (Landsman et al., 2009) has also been reported, we next assessed whether this was also the case in inflamed skin. WT mice were co-injected with CX<sub>3</sub>CR1-proficient and -deficient antigen-specific Th1- or Th2- donor cells, sensitized by epicutaneous antigen administration and the frequencies of apoptotic and/or necrotic donor cells were measured. Similar frequencies of annexin-V<sup>+</sup> and/or 7-AAD<sup>+</sup> CX<sub>3</sub>CR1<sup>+/gfp</sup> and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> donor cells were found in both skin and draining LN (**Fig. 5A and not shown**), suggesting that CX<sub>3</sub>CR1 is not involved in T cell survival. However, as Th2 donor cells were difficult to monitor in skin due to their low frequencies, additional experiments were performed to confirm these data. CX<sub>3</sub>CR1<sup>+/gfp</sup> and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> antigen-specific Th2 cells were transduced with a retroviral construct leading to the expression of anti-apoptotic BCL-2 (an empty vector was

used as control) and transferred into WT recipients that were sensitized by LACK. While overexpression of BCL-2 led to a decrease, and respectively an increase in the recovery of transduced cells in the skin and draining LN, it did not affect the ratio between CX<sub>3</sub>CR1-proficient and -deficient Th2 cells within these tissues, ruling out a role of CX<sub>3</sub>CR1 in T cell survival (**Fig. 5B**).

We next compared the migration of CX<sub>3</sub>CR1-proficient and -deficient effector T cells into the inflamed skin and draining LN of WT mice with established AD. Recipient mice were submitted to two rounds of epicutaneous sensitization prior to the injection of CX<sub>3</sub>CR1-proficient and -deficient Th1 or Th2 cells the day before the third and last antigen application. Three days later, while BrdU incorporation was very low, frequencies of donor cells of both genotypes were similar (**Fig. 5C**), demonstrating that CX<sub>3</sub>CR1 is not required for the late migration of effector T cells into the inflamed skin.

To investigate whether CX<sub>3</sub>CR1 was required for T cell retention into the inflamed skin, mice were co-injected with CX<sub>3</sub>CR1-proficient and -deficient LACK-specific effector T cells, challenged for 4 days with LACK, and further challenged with the antigen while topically treated with CX<sub>3</sub>-AT for 3 days. Upon topical CX<sub>3</sub>-AT treatment, frequency of skin CX<sub>3</sub>CR1-proficient T cells decreased to the level of co-injected CX<sub>3</sub>CR1-deficient cells, while their frequency increased in draining LN (**Fig. 5D**), demonstrating that blocking CX<sub>3</sub>CR1-CX<sub>3</sub>CL1 interactions *in situ* prevents CX<sub>3</sub>CR1<sup>+</sup> T cell retention.

Next, to further corroborate these findings with endogenously generated T cells, WT mice were treated topically with CX<sub>3</sub>-AT for the last 3 days of the third and last round of epicutaneous sensitization. CX<sub>3</sub>-AT strongly decreased epidermal thickening, mildly inhibited mast cell infiltration and did not significantly affect eosinophil infiltration (**Fig. 5E-G**). Finally, to further confirm that the effect of CX<sub>3</sub>CR1 in AD was due to its expression on T cells, we adoptively transferred CX<sub>3</sub>CR1-proficient or -deficient naïve T cells into CX<sub>3</sub>CR1-

deficient animals and induced AD. After 7 weeks, animals reconstituted with CX<sub>3</sub>CR1-proficient T cells developed a pathology (epidermal thickening, mast cell and eosinophil infiltration) that was comparable to that of CX<sub>3</sub>CR1-proficient animals. Reconstitution with CX<sub>3</sub>CR1-deficient T cells did not induce symptoms of AD (**Fig. 5H-J**). Furthermore, topical application of CX<sub>3</sub>-AT during the last 3 days of sensitization, to CX<sub>3</sub>CR1-deficient mice reconstituted with CX<sub>3</sub>CR1-proficient T cells, the only cells expressing CX<sub>3</sub>CR1 in this experimental setting, exerted similar effect than on (non-reconstituted) CX<sub>3</sub>CR1-proficient animals (**Fig. 5H-J**).

Altogether, these data demonstrate that blocking interactions between CX<sub>3</sub>CR1 and CX<sub>3</sub>CL1 *in situ* prevents disease symptoms by impairing effector T cell retention in inflamed skin.

#### **Human Th2 - and Th1- CX<sub>3</sub>CR1<sup>+</sup> cells infiltrate AD skin lesions.**

In order to assess the human relevance of our observations, we investigated whether CX<sub>3</sub>CR1<sup>+</sup> CD4<sup>+</sup> T cells could be detected in AD patients. In agreement with the absence of CX<sub>3</sub>CR1 expression on circulating mouse CD4<sup>+</sup> T cells, even upon antigenic sensitization, in human, we detected a very low expression on circulating CD4<sup>+</sup> T from AD patients. In addition, no significant differences were found between healthy individuals, AD and psoriasis patients ~~patients~~ in agreement with previously published work (Echigo et al., 2004) (**Fig. 6A**). About 7% of skin isolated CD4<sup>+</sup> T cells expressed CX<sub>3</sub>CR1, in keeping with our findings in the murine model of AD. As CX<sub>3</sub>CR1<sup>-</sup> cells, CX<sub>3</sub>CR1<sup>+</sup> CD4<sup>+</sup> T cells display a very heterogeneous cytokine profile with the Th1 and Th2 subsets being the most represented as compared to Th17 (**Fig. 6B, C**). Taken together, these data confirm the presence and functional properties of CX<sub>3</sub>CR1 cells in human.

## DISCUSSION

We have demonstrated that in an AD model based on epicutaneous antigen sensitization, CX<sub>3</sub>CR1 deficiency prevented skin inflammatory response and severely reduced the pulmonary symptoms as well as humoral responses. This defect was solely due to CX<sub>3</sub>CR1 expression by CD4<sup>+</sup> T cells as demonstrated by reconstitution experiments in which transfer of WT CD4<sup>+</sup> T cells in CX<sub>3</sub>CR1-deficient mice restored skin disease that could be further blocked upon CX<sub>3</sub>CR1 antagonist treatment. Paradoxically for an allergic disease and unlike asthma, the most pronounced inhibitory effects were observed on the Th1-associated rather than Th2-associated response (Fig. 3A and not shown). These findings further underline the major role exerted by CX<sub>3</sub>CR1 on Th1 cells, prominently associated to the chronic phase of the disease, which adds to its key effect on Th2 cells in allergic asthma (Mionnet et al., 2010). CX<sub>3</sub>CL1 and expression of its unique receptor, CX<sub>3</sub>CR1 on T cells play a crucial role in the development of AD by retaining effector T cells in the inflamed skin. Indeed, neither proliferation, early or late migration, nor survival were affected by CX<sub>3</sub>CR1 deficiency on CD4<sup>+</sup> effector T cells, while blocking CX<sub>3</sub>CR1/CX<sub>3</sub>CL1 interactions *in situ* prevented WT allergen-specific T cell accumulation in skin and induced their accumulation in draining LN (Fig. 5D). Interestingly, upon such treatment, while allergen-specific T cells were more abundant in the periphery, this later also prevented the development of pulmonary symptoms observed upon intranasal antigen challenge. A phenomenon that might suggest that residence into inflammatory skin leads to further T cell education and subsequent preferential access to the lungs. This hypothesis fits with our unpublished observations in which T-cell containing lung inflammatory foci develop even in the absence of the single terminal airway antigen challenge in AD mice. Such "reprogramming" for distal mucosal homing is reminiscent of previously reported reprogramming from gut to skin homing (Oyoshi et al., 2011). Furthermore, it was recently shown that lung DC promotes T cell lung homing through

induction of CCR4, which is also a skin-homing receptor (Mikhak et al., 2013). These findings illustrate the mechanisms at play to insure lymphocyte (re)circulation between distinct sites within the common mucosal immune system (Lazarus et al., 2003).

Chemokines known so far to be involved in skin diseases contribute to the pathology by inducing migration of inflammatory cells towards the skin and not by facilitating their retention in the inflammatory sites. Indeed, Islam *et al* demonstrated that CCL8 is involved in skin homing of CCR8-expressing Th2 cells in the same animal model of AD (Islam et al., 2011). Likewise, Homey *et al* showed that intradermal CCL27 injection attracted lymphocytes *in vivo* and, conversely, neutralization of interactions between CCL27 and its receptor CCR10 impaired lymphocyte recruitment to the skin leading to the suppression of DNFB (dinitrofluorobenzene)-induced skin inflammation in a murine model of contact hypersensitivity (Homey et al., 2002). While the membrane form of CX<sub>3</sub>CL1 had been previously shown to mediate adhesion of CX<sub>3</sub>CR1-expressing leukocytes *in vitro*, to our knowledge this is the first report demonstrating such a role *in vivo*. It remains, however to be determined which cell types interact with CD4<sup>+</sup> T cells to retain them within the skin and why/how the CX<sub>3</sub>CR1 pathway plays a different role in the skin compared to the lung. To this latter point, we can hypothesize that CX<sub>3</sub>CL1-expressing cells required for the delivery of CX<sub>3</sub>CR1 signaling are different in skin and lung. While in skin CX<sub>3</sub>CL1 is expressed in epithelial cells, endothelium as well as in lesional skin of AD patients, in asthmatic lungs it is also highly upregulated within airway smooth muscle (El-Shazly et al., 2006). Indeed, we have also found in our LACK-induced asthma model that infiltrating antigen-specific CD4<sup>+</sup> T cells can be localized within the smooth muscle cells (our unpublished data).

The particular importance of CX<sub>3</sub>CR1 in the development of AD, compared to a "pure" Th2 pathology such as allergic asthma, probably results from its combined action on both Th1 and Th2 arms of the disease. Such a major effect could be evidenced in a model of mild-

inflammation induced by epicutaneous sensitization in the absence of adjuvant and might not have been found by using models of highly polarized Th2 inflammation obtained upon immunization with adjuvant.

CX<sub>3</sub>CR1 does not appear involved in every skin disease as CX<sub>3</sub>CR1-deficient and -proficient mice displayed similar epidermal thickening and inflammation in a well established experimental model mimicking human psoriasis by repeated applications of Imiquimod (a TLR7/8 agonist) (van der Fits et al., 2009) (not shown). Likewise, earlier studies had demonstrated that CX<sub>3</sub>CR1-deficient and -proficient mice also exhibited similar responses in a model of contact hypersensitivity/DTH to oxazolone (Jung et al., 2000). This reinforces the high potential of CX<sub>3</sub>CR1 and CX<sub>3</sub>CL1 as therapeutic targets in allergic diseases.

In conclusion, the identification of a new mode of action for a chemokine and the full inhibition of AD by a CX<sub>3</sub>CR1 antagonist further demonstrates that the CX<sub>3</sub>CR1/CX<sub>3</sub>CL1 axis represents a new promising therapeutic target in allergic inflammatory diseases like allergic asthma and atopic dermatitis.



## **MATERIALS AND METHODS**

### **Animals**

Littermate CX<sub>3</sub>CR1<sup>gfp/gfp</sup>, CX<sub>3</sub>CR1<sup>+gfp</sup>, CX<sub>3</sub>CR1<sup>gfp/gfp</sup> and CX<sub>3</sub>CR1<sup>+gfp</sup> Thy1.1<sup>+/-</sup> WT15 TCR transgenic mice were generated in a Balb/c ByJ background (12 backcrosses) as previously described (Mionnet et al., 2010). Eight- to 12-week-old female mice were used for all experiments. Animals were housed within the specific pathogen-free facility from the Institut Pasteur de Lille or from the Institut de Pharmacologie Moléculaire et Cellulaire in Sophia-Antipolis. Experiments were performed after approval by the Ethics Committee for Animal Experimentation from Lille and Nice.

### **Experimental atopic dermatitis**

As previously described, AD was induced by epicutaneous sensitization (Staumont-Salle et al., 2008) with LACK antigen. Briefly, patches soaked with 25 µL of 0.2% LACK solution in PBS or with vehicle were applied on abdominal skin 24 hours after shaving and were left on for three 1-week periods (with patch renewal at midweek), with a 2-week interval between applications. At the time of the last patch removal (day 49), animals were challenged for 20 minutes by means of aerosol nebulization with LACK (0.2% in PBS) by using an ultrasonic nebulizer (System, Villeneuve sur Lot, France) and serum was collected. On the next day, airway hyperresponsiveness (AHR) to increasing concentrations of methacholine was measured by means of invasive plethysmography using a FlexiVent and expressed by dynamic lung resistance (SCIREQ) (Kanda et al., 2009). Animals were sacrificed by cervical dislocation. Bronchoalveolar lavage fluid (BALF) was collected and analyzed on cytospin preparations after RAL 555 staining. Skin and inguinal lymph nodes were collected for histological analyses and real-time PCR after RNA extraction. LACK was produced and

detoxified using Endotrap columns (Profos). Endotoxin levels assessed by LAL assay (Pierce) were below 5 ng/mg of protein.

### **Treatment with a CX3CL1 antagonist (CX3-AT) in a model of AD**

CX3-AT blocking reagent was prepared as described (Mionnet et al., 2010) and administered by weekly intraperitoneal injections (50 µg/mouse) either during the 3 sensitization periods (prophylactic protocol) or only during the last week of sensitization (therapeutic protocol) and animals were analyzed as described above. Alternatively, CX<sub>3</sub>-AT was applied topically (50 µg/mouse) by patch together with the antigen during the last 3 days of a single round of sensitization or during the third and last week-long round of sensitization.

### **Histology and immunohistochemistry**

Tissue biopsy specimens were processed as previously described (Staumont-Salle et al., 2008). Briefly, samples were fixed in ImmunoHistoFix (Interstiles, Brussels, Belgium) and embedded in ImmunoHistoWax (Interstiles) at 37°C. Five µm sections were stained with May Grünwald Giemsa for measurement of epidermal thickness and eosinophil and mast cells counts (Staumont-Salle et al., 2008) by using a microscope with Arcturus XT software. Epidermal thickness was determined at 250-fold magnification; an average of 10 measures was calculated for each sample. Eosinophils and mast cells were enumerated by examining 20 random fields at 400-fold magnification; cell frequency was converted to cells per square millimeter and results were expressed as mean ± SD. For immunohistochemical analysis, sections embedded in ImmunoHistoWax were immunostained with anti-I-A<sup>d</sup>/I-E<sup>d</sup> (MHC II) mAb (clone M5/114, rat IgG2b, BD Biosciences) and cryopreserved sections were stained with anti-CD4 mAb (clone RM4-5, rat IgG2a, BD Biosciences) as previously described (Angeli et al., 2004). For each section, 10 random fields were examined at x400.

### **Immunoglobulin concentrations**

Immunoglobulin (IgE, IgG<sub>1</sub> and IgG<sub>2a</sub>) concentrations in serum were measured as previously described by ELISA (Staumont-Salle et al., 2008). Two-fold serial dilutions were prepared for each serum (starting dilution 1:25 for IgE, 1:5000 for IgG<sub>1</sub>, 1:1000 for IgG<sub>2a</sub>). Antibody titers were calculated as the dilution corresponding to twice the mean absorbance value obtained for non-sensitized mouse sera.

### **Murine cell purification and *in vivo* assays**

For the antigen-presenting capacity assay, splenic CD4<sup>+</sup> T cells were purified from CX3CR1<sup>+/+</sup> WT15 Thy1.1<sup>+/+</sup> Rag-2<sup>-/-</sup> TCR transgenic mice, encoding a LACK specific TCR, by positive selection using anti-CD4 beads (MACS, Miltenyi) (purity >95%), stained with CFSE (Sigma) and further injected (2 X 10<sup>6</sup> cells) via the lateral tail vein into CX3CR1<sup>gfp/gfp</sup> and CX3CR1<sup>+gfp</sup> recipient mice, 1 day before epicutaneous LACK sensitization. Proliferation of donor cells in the inguinal LN was assessed by flow cytometry 5 days later.

For analysis of CX<sub>3</sub>CR1<sup>+/+</sup> and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> T cell proliferation, splenic CD4<sup>+</sup> T cells were purified from CX<sub>3</sub>CR1<sup>gfp/gfp</sup> Thy1.1<sup>+/+</sup> and CX<sub>3</sub>CR1<sup>+gfp</sup> Thy1.1<sup>+/-</sup> WT15 donor mice, stained with CFSE, and co-injected (2 X 10<sup>6</sup> of each population) into Thy1.1<sup>-/-</sup> CX<sub>3</sub>CR1<sup>+/+</sup> wild-type mice, one day before epicutaneous LACK sensitization. Proliferation was assessed in the inguinal LN 4 days later by flow cytometry.

For preparation of Th1 and Th2 cells, CD4<sup>+</sup> T cells from TCR transgenic mice were purified by negative selection and 1.5 X 10<sup>6</sup> cells were incubated for 3 days with 0.75 X 10<sup>6</sup> T cell-depleted splenocytes in complete RPMI with 50 nM LACK<sub>156-173</sub> peptide and (i) 10 ng/ml r-IL-4 and 10 µg/ml antibody to IFNγ (R4-6A2) for Th2 cells or (ii) 10 ng/ml r-IL-12 and 10 µg/ml antibody to IL-4 (11B11) for Th1 cells. In some experiments, Thy1.1<sup>-/-</sup> Thy1.2<sup>+/+</sup> WT

mice received either CX<sub>3</sub>CR1<sup>gfp/gfp</sup> or CX<sub>3</sub>CR1<sup>+gfp</sup> LACK-specific Th1 or Th2 cells (2 X 10<sup>6</sup> cells per mouse) by intravenous injection and then underwent one single round of LACK epicutaneous sensitization. Animals were sacrificed at day 7 and skin samples were collected for histological analysis of AD characteristics as previously described. In other experiments, the same number of both CX<sub>3</sub>CR1<sup>gfp/gfp</sup> and CX<sub>3</sub>CR1<sup>+gfp</sup> LACK-specific Th1 or CX<sub>3</sub>CR1<sup>gfp/gfp</sup> and CX<sub>3</sub>CR1<sup>+gfp</sup> LACK-specific Th2 cells were co-injected in Thy1.1<sup>-/-</sup> Thy1.2<sup>+/+</sup> WT mice (1.5 X 10<sup>6</sup> of each genotype per mouse), one day before LACK epicutaneous sensitization. When indicated, recipient mice treated as described above, were injected i.p. with BrdU (BD Biosciences) (200 µg) for the last 18 hrs. BrdU incorporation of CX<sub>3</sub>CR1 - proficient and -deficient Th1 and Th2 donor cells was studied by flow cytometry in inguinal LN. Survival of Th1 and Th2 donor cells was analyzed by annexin-V and 7-aminoactinomycin D (7-AAD) staining in both skin and inguinal LN.

In reconstitution experiments, 5 X 10<sup>6</sup> naïve CX<sub>3</sub>CR1<sup>gfp/gfp</sup> or CX<sub>3</sub>CR1<sup>+gfp</sup> CD4<sup>+</sup> T cells were adoptively transferred into CX<sub>3</sub>CR1<sup>gfp/gfp</sup> mice 24h prior to induction of AD.

### **Human T cells**

PBMC and skin samples were obtained from patients with AD from the Department of Dermatology or from healthy donors from the Department of Plastic Surgery. This study was approved by the Ethical Committee from the University Hospital of Lille. All subjects provided written informed consent. Patients with AD were selected according to the Hanifin and Rajka criteria (Hanifin and Rajka, 1980). PBMC were obtained after elimination of granulocytes on a Ficoll gradient. Punch skin biopsies (diameter 5 mm) were cultured in complete RPMI 1640 supplemented with 100 U/ml penicillin, 100 µg/ml streptomycin (all Invitrogen), 5% human serum (Sigma) and 20U IL-2/ml (Novartis). After 10-13 days, emigrating cells were collected and characterized by surface and intracellular staining by flow

cytometry. Surface and intracellular cytokine staining was performed using the Cytotfix/Cytoperm kit (BD Biosciences) according to the manufacturer's instructions. The following fluorochrome-conjugated antibodies were used: anti-IFN- $\gamma$ -V450 (B27), anti-TNF-Alexa fluoer 700 (Mab11), anti-IL-4-PerCP-Cy5.5 (8D4-8), anti-IL17A-PE (N49-653), anti-IL-5-APC (TRFK5), anti-IL-9 PerCP-Cy5.5 (MH9A3), anti-CD4-APC-Cy7 (RPA-T4), anti-IL-13-Horizon-V450 (JES10-5A2) (all BD Bioscience), anti-IL4-PE (3010.211), (BD FastImmune), anti-IL22-APC (142928) (R&D), CX3CR1-FITC (2A9-1) Biolegend.

### **Retroviral transduction**

The human Bcl2 cDNA was cloned into the mouse bi-cistronic retroviral expression vector MIGR. Th2 differentiated cells were incubated with viral supernatant containing 5  $\mu$ g/ml Polybrene (Sigma) and spun at 32°C for 8 h as described (Mionnet et al., 2010). Viral supernatant was replaced with fresh medium. GFP-expressing T cells were sorted 3 d later.

### **Statistical analysis**

Statistical significance was determined by Student T test, except for plethysmographic data, for which ANOVA for repeated measures was used. Graphpad and STATview softwares were used, respectively. Results were expressed as means  $\pm$  SEM. A *P* value <0.05 was considered significant.

## **Acknowledgement**

The authors wish to thank Drs S. Eyrich (ZAUM and Technische Universität, München, Germany) and L. Cifuentes (Department of Dermatology, Technische Universität, München, Germany) for their help.

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## FIGURE LEGENDS

**Figure 1. Absence of atopic dermatitis and attenuation of associated humoral and lung inflammatory response in CX<sub>3</sub>CR1-deficient mice.** AD was induced on abdominal skin in CX<sub>3</sub>CR1<sup>+/+</sup> and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> mice by epicutaneous LACK sensitization for three 1-week periods, with a 2-week interval between applications. At day 49, sera were collected and animals were challenged by LACK nebulization. At day 50, AHR to increasing concentrations of methacholine was measured by invasive plethysmography. Then, mice were sacrificed and BAL fluid was collected and analyzed on cytospin preparations. Skin samples were collected at the site of sensitization. **A.** May Grünwald Giemsa staining of skin sections (original magnification X10 for the main panels and X63 for the inset). Black arrows indicate mast cells and, in the inset, eosinophils. **B.** Epidermal thickness. **C.** Eosinophil, mast cell, MHC II<sup>+</sup> and CD4<sup>+</sup> T cell numbers in dermis. **D.** Immunoglobulin concentrations in serum. Total IgE (upper left panel), -LACK-specific IgG<sub>1</sub> (bottom left panel) and LACK-specific IgG<sub>2a</sub> (bottom right panel) concentrations. **E.** Airway hyperreactivity to increasing methacholine concentrations. Resistance was evaluated by invasive plethysmography. **F.** Lung inflammatory response: total number of cells, macrophages, neutrophils, lymphocytes and eosinophils in BAL fluid. Data are expressed as mean ± SEM (*n*=6-10 animals per group). One out of two independent experiments is shown for each panel. \* *P* < 0.05; \*\* *p* < 0.01.

**Figure 2. Abrogation of AD features in wild-type mice treated with CX3-AT.** **A.** Timeline of CX3-AT administration during AD induction. **B.** Epidermal thickness. **C.** Eosinophil, mast cell, MHC II<sup>+</sup> and CD4<sup>+</sup> T cell numbers in dermis. **D.** Airway hyperreactivity to increasing methacholine concentrations. Resistance was evaluated by invasive plethysmography. **E.**

Lung inflammatory response: total number of cells, macrophages, neutrophils, lymphocytes and eosinophils in BAL fluid. Data are expressed as mean  $\pm$  SEM ( $n=6-10$  animals per group). One out of 2 independent experiments is shown for each panel. Statistically different from PBS-treated mice \*  $P < 0.05$  and \*\*  $p < 0.01$ ; \$ statistically different from vehicle-treated mice ( $P < 0.05$ ).

**Figure 3. CX<sub>3</sub>CR1 expression regulates both Th1- and Th2- induced skin inflammation.**

**A.** CFSE-labeled CX<sub>3</sub>CR1<sup>+/+</sup> WT15 Thy1.1<sup>+/+</sup> CD4<sup>+</sup> T cells were injected i.v. into CX<sub>3</sub>CR1<sup>gfp/gfp</sup> or CX<sub>3</sub>CR1<sup>+/gfp</sup> mice one day before epicutaneous sensitization with LACK. Donor cells were analyzed by flow cytometry 5 days later in inguinal LN after gating onto CD4<sup>+</sup> Thy1.1<sup>+</sup> cells. Data show one representative flow cytometry profile of CFSE staining with numbers indicating frequencies of dividing donor cells  $\pm$  SEM ( $n=6$ ). **B.** CFSE-labeled CX<sub>3</sub>CR1<sup>+/gfp</sup> Thy1.1<sup>+/-</sup> and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> Thy1.1<sup>+/+</sup> WT15 CD4<sup>+</sup> T cells were co-injected i.v. into WT Thy1.1<sup>-/-</sup> Thy1.2<sup>+/+</sup> mice one day before LACK or PBS epicutaneous sensitization. Donor cells were analyzed by flow cytometry 4 days later in inguinal LN after gating CD4<sup>+</sup> Thy1.1<sup>+</sup> cells. Data show a representative flow cytometry profile of CFSE staining with numbers indicating dividing CX<sub>3</sub>CR1<sup>+/+</sup> and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> donor cells ( $n=5$  mice in each group). Wild-type mice were injected at day -1 with LACK-specific CX<sub>3</sub>CR1<sup>gfp/gfp</sup> or CX<sub>3</sub>CR1<sup>+/gfp</sup> Th1 or Th2 cells, sensitized for one single week with LACK or PBS at day 0 and further analyzed at day 7. **C.** Epidermal thickness. **D.** Eosinophil and mast cell numbers in dermis at the site of sensitization. Data are expressed as mean  $\pm$  SEM ( $n=6-10$  animals per group). One out of 2 independent experiments is shown for each panel. \*  $P < 0.05$ .

**Figure 4. CX<sub>3</sub>CR1 provides a selective advantage to effector CD4<sup>+</sup> T cells.** Equal numbers of LACK-specific CX<sub>3</sub>CR1<sup>gfp/gfp</sup> (black histograms or symbols) and CX<sub>3</sub>CR1<sup>+/gfp</sup> (white

histograms or symbols) Th2 or Th1 cells were co-injected into WT mice at day 0. Recipients were sensitized with LACK or PBS at day 1 and day 4 and analyzed at day 3 (A,C,D) or day 7 (B,D). **A.** Donor cells were analyzed in skin by flow cytometry. Data show representative flow cytometry profiles (upper panels). Data show mean frequencies  $\pm$  SEM of donor Th1 (bottom left panel) or Th2 (bottom right panel) cells among the CD4<sup>+</sup> T cell population. One representative experiment out of two is shown. ( $n=6$  mice per group). **B.** Donor cells were analyzed in skin by flow cytometry (upper panels). Data show donor cell frequency of Th1 (bottom left panel) or Th2 (bottom right panel) in individual mice with bars indicating the mean from three experiments ( $n=16$  mice per group). \*  $P < 0.05$ . **C.** 18 h before sacrifice, recipient mice were injected with BrdU, and donor cells were analyzed by flow cytometry after staining with anti-BrdU, anti-Thy1.1, -Thy1.2, -CD4, and -CD45 antibodies. Data show cell frequency of donor Th1 or Th2 cells in individual mice with bars indicating the mean in LACK-sensitized ( $n=4$  mice) and PBS-sensitized mice ( $n=2-3$  mice). (One representative experiment out of two). **D.** Donor cells were analyzed in draining LN and skin by flow cytometry for GFP expression at days 3 (white bars) and 7 (grey bars). Data show representative flow cytometry profiles after aggregating files from individual mice (upper panels) ( $n=6$  mice per group). One experiment out of three is shown. Histograms show mean frequencies  $\pm$  SEM of GFP<sup>+</sup> cells among Th1 (left panels) or Th2 (right panels) donor cells ( $n=12$  mice per group at day 3 and  $n=18$  mice at day 7).

**Figure 5. CX3CR1 is required for T cell retention in chronically inflamed skin.**

**A.** Equal numbers of LACK-specific CX<sub>3</sub>CR1<sup>gfp/gfp</sup> (black histograms) and CX<sub>3</sub>CR1<sup>+ /gfp</sup> (white histograms) Th2 or Th1 cells were co-injected into WT recipient mice at day 0. Recipients were sensitized with LACK at day 1 and day 4 and analyzed at day 3 and day 7. Donor cells were analyzed by flow cytometry 3 days later in inguinal draining LN after

staining with antibodies against CD45, CD4, Thy1.1, Thy1.2, and annexin-V and 7-AAD. Data show mean frequencies of annexin-V<sup>+</sup> cells among donor cells  $\pm$  SEM. **B.** CX<sub>3</sub>CR1<sup>+gfp</sup> (white histograms) and CX<sub>3</sub>CR1<sup>gfp/gfp</sup> (black histograms) Th2 cells were infected with a Bcl2 or an empty retroviral vector. Equal numbers of transduced cells were co-injected into recipients that were further sensitized with one round of LACK sensitization. Data show the mean of donor cell frequency in skin (left panel) and inguinal draining LN (right panel) of individual mice in one representative experiment out of two (*n*=5 mice per group). **C.** AD was induced in WT mice as described in the legend of Fig.1 and equal numbers of LACK-specific CX<sub>3</sub>CR1<sup>gfp/gfp</sup> (green population) and CX<sub>3</sub>CR1<sup>+gfp</sup> (pink population) Th1 (upper panels) or Th2 (lower panels) cells were co-injected at day 41. Donor cells were analyzed in skin, draining LN and spleen by flow cytometry. Data show representative flow cytometry profiles. Numbers indicate frequencies  $\pm$  SEM of donor Th1 (upper panels) or Th2 (bottom panels) cells among the CD4<sup>+</sup> T cell population. One representative experiment out of two is shown (*n*=12 mice per group). 18 h before sacrifice, recipient mice were injected with BrdU and donor cells were analyzed by flow cytometry after staining with anti-BrdU, -Thy1.1, -Thy1.2, -CD4 or -CD45 antibodies. Data show representative cytometry profiles and numbers indicate the mean (*n*=12 mice) (One representative experiment out of two). **D.** Equal numbers of LACK-specific CX<sub>3</sub>CR1<sup>gfp/gfp</sup> (black histograms) and CX<sub>3</sub>CR1<sup>+gfp</sup> (white histograms) effector cells were co-injected into WT recipient mice at day 0. Recipients were sensitized with LACK at day 1 and day 4. At day 4, some recipient mice topically received LACK together with CX3-AT. Three days later, the frequencies of donor cells were analyzed in skin and draining LN by flow cytometry. Data show mean of donor cell frequency of individual mice in one representative experiment out of two (*n*=5 mice per group). \* *P* < 0.05). **E-G.** AD was induced as described in the legend of Fig.1. During the last round of sensitization, some mice also received CX3-AT (50  $\mu$ g/mouse) through the patch together with LACK as indicated on

the figure. **E.** May Grünwald Giemsa staining of skin sections (original magnification X10). **F.** Epidermal thickness. **G.** Mast cell and eosinophil numbers. Data for panels E-G show mean of cell numbers in one representative experiment out of two ( $n=6$  mice per group). \*  $P < 0.05$ . **H-J**  $CX_3CR1^{gfp/gfp}$  mice were injected with polyclonal naïve WT or  $CX_3CR1^{gfp/gfp}$  (KO)  $CD4^+$  T cells 24h prior to AD induction. During the last round of sensitization, mice also received CX3-AT (50  $\mu$ g/mouse) through the patch together with LACK as indicated on the figure. **H.** Epidermal thickness. **I-J.** Mast cell and eosinophil numbers. Data for panels H-J show mean of cell numbers in one representative experiment ( $n=5$  mice per group). \*  $P < 0.05$ ; n.s. Not significant.

**Figure 6: CX3CR1 is expressed by skin-infiltrating  $CD4^+$  T cells in AD patients.**

A. CX3CR1 expression by circulating  $CD4^+$  T cells. PBMC were from patients with AD or from healthy donors were analyzed by flow cytometry for CX3CR1 expression. Data show frequency of  $CX3CR1^+$  cells among  $CD4^+$  T cells in individual donor. n.s. Not significant. B. Cells from skin biopsies were characterized by surface and intracellular staining by flow cytometry. Left panel show a representative FACS profile. Numbers indicate the mean  $\pm$  SEM of the frequency of  $CX3CR1^+$  among  $CD4^+$  T cells from  $n=6$  patients. Right panels show frequencies of cytokine-secreting  $CX3CR1^+$  and  $CX3CR1^-$   $CD4^+$  T cells for each patient.