Thyroid hormone stimulates basal and interleukin (IL)-1-induced IL-6 production in human bone marrow stromal cells: a possible mediator of thyroid hormone-induced bone loss

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Abstract

It is well known that excessive thyroid hormone in the body is associated with bone loss. However, the mechanism by which thyroid hormone affects bone turnover remains unclear. It has been shown that it stimulates osteoclastic bone resorption indirectly via unknown mediators secreted by osteoblasts. To determine if interleukin-6 (IL-6) or interleukin-11 (IL-11) could be the mediator(s) of thyroid hormone-induced bone loss, we studied the effects of 3,5,3′-tri-iodothyronine (T$_3$) on basal and interleukin-1 (IL-1)-stimulated IL-6/IL-11 production in primary cultured human bone marrow stromal cells. T$_3$ at 10$^{-12}$–10$^{-8}$ M concentration significantly increased basal IL-6 production in a dose-dependent manner. It also had an additive effect on IL-1-stimulated IL-6 production, but failed to elicit a detectable effect on basal or IL-1-stimulated IL-11 production. Treatment with 17β-estradiol (10$^{-8}$ M) did not affect the action of T$_3$ on IL-6/IL-11 production. These results suggest that thyroid hormone may stimulate bone resorption by increasing basal and IL-1-induced IL-6 production from osteoblast-lineage cells, and these effects are independent of estrogen status.


Introduction

It has been established that excessive thyroid hormone in the body is associated with bone loss. Bone mass is reduced in patients with hyperthyroidism or receiving long-term thyroid hormone suppression therapy (Toh et al. 1985, Diamond et al. 1991, Allain & McGregor 1992), and individuals with a history of thyrotoxicosis have an increased risk of fracture (Cummings et al. 1995). Studies on biochemical markers (Lee et al. 1990, Harvey et al. 1991), and bone histomorphometry (Bordier et al. 1967, Mundy et al. 1976, Mosekilde & Melsen 1978) showed increased bone turnover in thyrotoxic patients, suggesting that predominantly osteoclastic activity is responsible for the bone loss in thyrotoxicosis. However, the exact mechanism by which thyroid hormone stimulates bone resorption remains unclear.

It has been shown that thyroid hormone directly stimulates bone resorption in organ culture of neonatal mouse calvaria (Klaushof et al. 1989) and fetal rat limb bones (Mundy et al. 1976, Hoffmann et al. 1986). Thyroid hormone receptors have been demonstrated in osteoblastic cell lines such as ROS 17/2-8 (Rizzoli et al. 1986), UMR-106 (LeBron et al. 1989) and MC3T3-E1 (Kasono et al. 1988), and direct effects of tri-iodothyronine (T$_3$) on proliferation and differentiation of human osteoblast-like cells have also been documented (Kassem et al. 1993). In contrast, there has been a paucity of data on the direct functional effects of thyroid hormone on osteoclasts, despite a report that human osteoclastoma cells express T$_3$ receptors (Allain et al. 1996). Previous studies suggested that the action of T$_3$ on bone is mediated by osteoblasts. Allain et al. (1992) and Britto et al. (1994) showed that T$_3$ stimulated osteoclastic bone resorption in the presence of osteoblasts, but not in their absence. Furthermore, stimulation of resorption also occurred if osteoclasts were pretreated with T$_3$ and then osteoblast–osteoclast coculture was carried out in the absence of T$_3$. These findings imply that thyroid hormone indirectly stimulates osteoclasts via a mediator produced by osteoblasts. However, the mediator responsible for the activation of osteoclasts by thyroid hormone has yet to be elucidated.

Osteoblasts and bone marrow stromal cells produce bone-active cytokines such as interleukin-6 (IL-6) and interleukin-11 (IL-11) which are critical for osteoclast formation and bone resorption (Manolagas 1995, Girasole et al. 1992, 1994). These cytokines have been suggested to mediate the effects of many stimulators of bone resorption such as parathyroid hormone, interleukin-1, and tumor necrosis factor-α. On the basis of these studies, it can be...
Thyroid hormone and osteoblastic IL-6 production

Materials and Methods

Materials

3,3′,5′-Tri-iodothyronine (T₃), 3,3′,5′-tri-iodothyronine (reverse T₃, rT₃), recombinant human IL-1α and α-modified minimum essential medium (α-MEM) were purchased from Sigma Chemical Co. (St Louis, MO, USA). IL-6 ELISA kits were obtained from Genzyme (Cambridge, MA, USA), and IL-11 ELISA kits from R&D Systems (Minneapolis, MN, USA). The detection limits of IL-6 and IL-11 assays were 18 and 8 pg/ml, and coefficients of variation were 9.5 and 8.9% respectively.

hBMSC culture

hBMSCs were isolated from ribs discarded at the time of open thoracotomy as described previously (Kim et al. 1996, 1997b). None of the patients from whom the ribs were obtained had metabolic bone disease, thyroid disease, or were taking thyroid hormone. Briefly, the ribs were excised aseptically, cleaned of soft tissues, and opened longitudinally. The exposed bone marrow was flushed out using several washes of serum-free α-MEM. The medium with flushed bone marrow was centrifuged at 1400 r.p.m. for 10 min. Cell pellets were resuspended in culture medium, and enriched bone marrow stromal cells were obtained by Ficoll/Hypaque (specific gravity 1.077) gradient centrifugation. The cells were seeded into a 75 cm² plastic culture flask at a density of 4 × 10⁵ cells/cm² and cultured in α-MEM containing 10% fetal bovine serum, penicillin and streptomycin (100 U/ml and 100 µg/ml respectively). The medium was changed twice weekly from the second week, and when the cells were grown to 80% confluence, they were then subcultured using 0.01% trypsin and 0.05% EDTA. The second-passage cells were used for the experiments.

Effect of T₃ on basal IL-6 and IL-11 production by hBMSCs

T₃ and rT₃ were dissolved in ethanol and the initial 10⁻⁸ M stock solution was serially diluted to concentrations of between 10⁻⁸ M and 10⁻¹² M. The vehicle was added to control cultures, and the final concentration of ethanol in the culture medium did not exceed 0.1%.

The cells (3 × 10⁴/well) were subcultured in a 48-well plate containing α-MEM and 5% charcoal-stripped serum for 2 days. Subsequently, the medium was replaced with fresh medium containing various doses of T₃ (10⁻¹²–10⁻⁸ M) or rT₃ (10⁻⁸ M), and then cultured for an additional 72 h. After 72 h, the conditioned medium was collected, centrifuged free of cell debris, and stored at −20°C until IL-6 and IL-11 assay. The concentration of IL-6 and IL-11 in the medium was measured by ELISA using commercial kits. The number of cells in each well was determined by quadruplicate hemocytometer counts of trypsin–EDTA-released cells at the end of the culture.

Influence of 17β-estradiol on the effect of thyroid hormone

To examine the possible influence of estrogen on the effect of thyroid hormone on basal and IL-1-stimulated IL-6/IL-11 production, the cells were treated with 17β-estradiol (10⁻⁸ M) for 24 h before the addition of T₃ and/or IL-1. The results were compared with those from groups not treated with estrogen in the same set of experiments.

Statistics

All experiments were repeated at least three times using different hBMSC preparations, and representative data are shown in the figures. The significance of the differences between treatment groups was assessed using the Mann–Whitney U-test or ANOVA and post-hoc analysis with Duncan’s multiple range test as appropriate. Dose–response relationships were examined by Spearman’s rank correlation analysis.

Results

Effect of T₃ on basal IL-6 and IL-11 production by hBMSCs

Treatment with T₃, over the concentration range 10⁻¹²–10⁻⁸ M, significantly increased hBMSC IL-6 production in a dose-dependent manner (Fig. 1A). rT₃, an inactive analog of T₃, did not elicit a response at a dose of 10⁻⁸ M (data not shown).
In contrast, T₃ had no detectable effect on IL-11 production (Fig. 1B).

**Effect of T₃ on IL-1-stimulated IL-6 and IL-11 production by hBMSCs**

As previously reported (Kim et al. 1997b), IL-1 (10–1000 U/ml) dose-dependently stimulated both IL-6 and IL-11 production in hBMSCs. T₃ (10⁻⁸ M) additively increased the IL-1-induced IL-6 production at various concentrations of IL-1 (Fig. 2A). However, IL-1-induced IL-11 production was not affected by T₃ treatment (Fig. 2B).

**Influence of 17β-estradiol on the effect of thyroid hormone**

Treatment with 17β-estradiol (10⁻⁸ M) inhibited IL-1-induced IL-6 production, but not T₃-stimulated IL-6 production (Fig. 3A). IL-6 production co-stimulated by T₃ and IL-1 was partially inhibited by 17β-estradiol, but it was still greater than that stimulated by T₃ or IL-1 alone.

There was no significant difference in IL-11 production in the presence or absence of 17β-estradiol (Fig. 3B).

**Discussion**

In the present study, T₃ significantly increased basal and IL-1-stimulated IL-6 production in hBMSCs. These results support the possibility that increased IL-6 production by osteoblast-lineage cells plays an important role in thyroid hormone-induced bone loss. In line with this possibility, Lakatos et al. (1997) reported that serum IL-6 concentrations are elevated in patients with hyperthyroidism, and blood mononuclear cells derived from hyperthyroid patients secrete more IL-6 than those taken from healthy subjects. They also showed that bone turnover is increased and radius bone mineral content is reduced in patients with hyperthyroidism. Our results are also consistent with the report of Siddiqi et al. (1998) demonstrating that T₃ increased both secretion and mRNA expression of IL-6 and IL-8 by hBMSCs and MG63 osteoblast-like cell lines.
IL-1, 10

Figure 3 Effects of 17β-estradiol (E2) on T3 and/or IL-1-stimulated IL-6 (A) and IL-11 (B) production in hBMSCs. The cells were treated with 17β-estradiol (10−8 M) for 24 h before the addition of T3 (10−8 M) and/or IL-1 (1000 U/ml). The amounts of IL-6/IL-11 produced during 72 h were compared with those in groups not treated with estrogen. Values are means ± s.d. (n=6).

Tarjan & Stern (1994, 1995) reported that T3 potentiated the stimulatory effect of IL-1 on IL-6 production in neonatal mouse calvarial osteoblasts and fetal rat limb bone cultures, which is in agreement with our results with hBMSCs. However, our results show that T3 alone significantly increased basal IL-6 production. Tarjan & Stern (1995) failed to observe the stimulatory effect in fetal rat limb bone culture of T3 on basal IL-6 secretion over a 10−11−10−6 M concentration range. They observed that T3 alone increased 45Ca release significantly only at a fairly high concentration (10−6 M), but in the presence of IL-1, 10−8 M T3 significantly potentiated the IL-1 effect on 45Ca release. Treatment with IL-1 receptor antagonist blocked the potentiating effects of T3. They therefore speculated that the enhancement of IL-1-induced IL-6 production might be a biologically relevant mechanism of thyroid hormone-induced bone loss. On the other hand, our data showed that T3, in the absence of IL-1, also directly stimulated IL-6 production. The reason for this discrepancy is not clear, but may be related to the difference in species of cell origin or stage of osteoblast phenotype expression (Williams et al. 1994). It has also been suggested that the presence/absence or relative levels of various forms of thyroid hormone receptor (α, β1, β2) in osteoblastic cells may explain the variability of the response to thyroid hormone (Suwanwalaikorn et al. 1997). Alternatively, we cannot exclude the possibility that endogenous IL-1 production is higher in human than rat bone cell cultures. However, it was reported that human bone marrow stromal cells did not constitutively produce significant amounts of IL-1β, although low levels of expression of IL-1β mRNA were detected (Aman et al. 1994).

Our results show that the effect of thyroid hormone on IL-6 production was not affected by estrogen. Consistent with this, Lakatos et al. (1997) observed that there was no difference in pre- and post-menopausal IL-6 levels in hyperthyroid patients. Taken together, the results suggest that thyroid hormone and estrogen act via different mechanisms in regulating IL-6 production. A recent meta-analysis report showed that suppressive doses of thyroid hormone therapy had a detrimental effect on all skeletal sites in postmenopausal women, whereas it had little effect in premenopausal women (Uzzan et al. 1996). Our experimental data and those of others (Tarjan & Stern 1994, 1995) showing the synergistic effect of thyroid hormone and IL-1, which is increased in the estrogen-deficient state, on IL-6 secretion may explain this phenomenon. However, further studies are needed to clarify this controversial issue.

IL-11 is a fairly recently discovered cytokine which has a role in osteoclast development (Girasole et al. 1994). The effects of thyroid hormone on IL-11 secretion have not yet been studied. We observed in this study that neither basal nor IL-1-induced IL-11 production is affected by thyroid hormone. However, we cannot exclude the possibility that thyroid hormone affects IL-11 production synergistically with other systemic or local cofactors (Manolagas 1995, Kim et al. 1997b) that exist in vivo.

In this study, T3 had a detectable effect on IL-6 secretion at concentrations much lower than those found in human plasma (about 10−9 M). Under the experimental conditions used, free hormone concentrations in the medium may be higher than those found in vivo, as culture medium containing 5% serum would contain less T3-binding protein than in vivo. At present, however, the physiological implication of this finding is difficult to clarify even if we measure the free T3 concentrations in the culture medium, because the local thyroid hormone concentration to which bone cells are exposed in vivo may be different from the circulating concentration. Further studies are needed.

It should be pointed out that the hBMSCs used in this study are not mature osteoblasts. However, previous studies have shown that, when cultured to confluence in the presence of serum, these cells possess many of the phenotypic characteristics of differentiated osteoblasts, including deposition of mineralized matrix (Kassem et al. 1991, Cheng et al. 1994). They produce type I procollagen.
and osteocalcin in response to 1,25-dihydroxyvitamin D₃ (Kassem et al. 1991) and also increase cAMP in response to parathyroid hormone (Cheng et al. 1994). We also confirmed that these cells deposit calcium in the extracellular matrix, and express mRNA characteristic of osteoblastic cells, such as alkaline phosphatase, α1(I)collagen, osteopontin, and decorin (Kim et al. 1997a). Another possible limitation of using these cells is that they may exhibit heterogeneity between samples because of different proportions of preosteogenic, preadipogenic and prechondrogenic cell precursors. However, this should not be a significant problem because we cultured the cells under the same standardized conditions and we repeated the experiments at least three times using different hMSC preparations to confirm the consistency of the results.

In conclusion, these results suggest that thyroid hormone may increase bone resorption by stimulating osteoclast formation and activity by increasing basal and IL-1-induced IL-6 production by osteoblastic cells.

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References


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