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Elevated serum IL-8 levels are associated with disease activity in idiopathic intermediate uveitis

Anne-Marie Klok, Leny Luyendijk, Michel J W Zaal, Aniki Rothova, C Erik Hack, Aize Kijlstra

Aim—To find a laboratory indicator for systemic involvement in intermediate uveitis.

Methods—Interleukin 8 (IL-8) and C reactive protein (CRP) serum levels were measured in patients with idiopathic intermediate uveitis (n=61), uveitis controls (n=143), and normal controls (n=29). The records of those with intermediate uveitis were reviewed with the emphasis on disease activity and severity as characterised by the presence of cystoid macular oedema, vitreous exudates or snowbank formation, papillitis, and periphlebitis.

Results—Increased serum IL-8 (>20 pg/ml) was found in 27 out of 61 patients with intermediate uveitis (p<0.01), 12 of 27 patients with sarcoid uveitis (p<0.05), in 19 of 30 patients with HLA-B27 associated acute anterior uveitis (p<0.05), and in five of 29 healthy controls. Raised IL-8 levels in intermediate uveitis were significantly associated with active disease (p<0.001) and the presence of vitreous exudates (p<0.001), papillitis, and periphlebitis (p<0.01). Elevated CRP levels were found in 12 of the 143 uveitis controls but in none of the intermediate uveitis patients or normal controls. During follow up an associated systemic disease was more frequently noticed in patients with an elevated serum IL-8 at entry into the study.

Conclusions—Elevated IL-8 serum levels were found in patients with active intermediate uveitis of unknown origin. An elevated IL-8 level seems to predispose the patient to a later development of associated systemic disease.

Intermediate uveitis is an inflammation in the region of the posterior ciliary body, anterior retina, anterior choroid, and vitreous. It is characterised by cells and debris in the vitreous, snowbank formation along the pars plana, varying degrees of periphlebitis, and a relatively quiet anterior chamber. It generally occurs bilaterally and usually affects young patients although it can also be seen later in life. The course of intermediate uveitis is variable, ranging from a self limited process to chronic disease with remissions and exacerbations. It can result in severe complications including cystoid macular oedema (C MO), epiretinal membrane formation, cataract, neovascularisation, vitreous haemorrhage, and retinal detachment.

It is not clear how many disease entities are included in the category of intermediate uveitis. The aetiology of intermediate uveitis is still unknown although some patients are subsequently found to have other underlying systemic disease responsible for the ocular process. The main systemic diseases associated with intermediate uveitis are sarcoidosis and multiple sclerosis. To establish these latter associations a number of well defined clinical and laboratory variables are currently available. When the patient presents with eye disease the outcome of these tests may however not yet be evident. Furthermore, it is possible that other as yet unknown systemic disorders may also be involved in intermediate uveitis. One way to find an indication for systemic involvement is to assess acute phase reactants.

In this study we therefore measured the serum concentration of C reactive protein (CRP): its level in the serum increases rapidly from a normal level of 0.8 mg/l to as much as several hundred milligrams per litre in response to most forms of tissue injury, inflammation, or infection.

Elevated serum IL-8 levels are also found in the serum of patients with eye diseases which are related to a systemic disease including proliferative diabetic retinopathy and HLA-B27 associated anterior uveitis (S Sprenkels, personal communication). In an earlier study we reported raised serum IL-8 levels in 11 of 20 samples from patients with intermediate uveitis. In this study we measured serum IL-8 in a larger group of intermediate uveitis patients and extended our earlier findings by investigating a possible relation with disease activity.

Patients and methods

We studied 61 patients with intermediate uveitis who visited the ophthalmology department of the Academic Hospital of the Free University of Amsterdam and the Academic Hospital of Utrecht in the period between 1981 and 1996. For the uveitis screening, at the first visit to one of our clinics blood samples were obtained by venepuncture, allowed to clot, and
Serum samples of 143 uveitis controls with active disease (27 patients with sarcoidosis, 30 HLA-B27 acute anterior uveitis, 31 toxoplasma chorioretinitis, 25 Behcet uveitis, and 30 Fuchs’ heterochromic cyclitis) and 29 healthy controls were obtained and processed as described above. These sera were collected in the same time as the intermediate uveitis group and stored under similar conditions. A diagnosis of uveitis was made according to the criteria of the International Uveitis Study Group.4

Serum levels of CRP were assessed by using an immunodiffusion assay according to the manufacturer’s recommendations (LC-Partigen; Behring, Marburg, Germany). CRP levels of <10 mg/l were considered normal.17

IL-8 was measured with an enzyme linked immunoassay (ELISA) in which a monoclonal anti-human IL-8 antibody and a polyclonal anti-human IL-8 antibody were used (Central Laboratory of the Netherlands Red Cross Blood Transfusion Service (CLB), Amsterdam). The preparation of these antibodies and the development of the IL-8 ELISA have been described elsewhere.16 ELISA plates were coated overnight with a monoclonal antibody against IL-8. After washing, 100 µl of the sample dilutions (1:5 in a high performance ELISA buffer, CLB) were added in each well and incubated for 1 hour. After washing, the plates were incubated with 100 µl biotinylated polyclonal sheep anti-IL-8 antibody (CLB) for 1 hour. Then the plates were developed with streptavidin-horseradish peroxidase followed by tetramethylbenzidine as a substrate. Purified human recombinant IL-8 (rIL-8) obtained by transfecting Escherichia coli DH5 with the plasmid pMBL11 (British Biotechnology Ltd, Oxford) was used as a standard and results were expressed in picograms per millilitre.18 The concentration of IL-8 in samples was calculated by comparing the absorption of samples with that of serial dilutions of human rIL-8. The detection limit of the assay was 20 pg/ml.

Statistical analysis of the data was performed using Mann–Whitney U test and $\chi^2$ analysis.

Results

CRP levels were within normal limits in all patients with intermediate uveitis. Elevated CRP levels were found in 12 of the 143 uveitis controls (in two of 27 sarcoidosis patients, in four of 30 HLA-B27 acute anterior uveitis, in four of 25 patients with Behcet’s syndrome, and in two of 30 patients with Fuchs’ heterochromic cyclitis) and in none of the normal controls.

IL-8 was detectable in the serum of 27 of the 61 patients with intermediate uveitis (Table 1, Fig 1). Circulating IL-8 was also found in five of the 29 normal controls and in 31 of the 143 uveitis controls. IL-8 in the serum of intermediate uveitis patients was significantly higher than in the normal controls (p<0.01). The uveitis controls were subdivided in specific entities. Elevated IL-8 levels were found in 12 of 27 serum samples of sarcoidosis patients, in 19 of 30 with HLA-B27 acute anterior uveitis, in five of 31 with toxoplasmosis, in five of 25

### Table 1 Elevated IL-8 levels (>20 pg/ml) in serum of uveitis patients

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No/total</th>
<th>Median* (pg/ml)</th>
<th>Range (pg/ml)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate uveitis</td>
<td>27/61</td>
<td>700</td>
<td>20–5823</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Sarcoidosis</td>
<td>12/27</td>
<td>1600</td>
<td>26–6197</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>HLA-B27 AAU</td>
<td>19/30</td>
<td>2914</td>
<td>22–6051</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Toxoplasmosis</td>
<td>5/15</td>
<td>1152</td>
<td>40–3040</td>
<td></td>
</tr>
<tr>
<td>Behcet’s syndrome</td>
<td>5/25</td>
<td>188</td>
<td>30–715</td>
<td></td>
</tr>
<tr>
<td>Fuchs’ cyclitis</td>
<td>9/30</td>
<td>1933</td>
<td>83–5483</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>5/29</td>
<td>213</td>
<td>24–833</td>
<td></td>
</tr>
</tbody>
</table>

AAU=associated anterior uveitis.

*Median levels of serum containing IL-8 levels above 20 pg/ml.

Statistical analysis was performed using the Mann–Whitney U test whereby uveitis groups were compared with controls.
Elevated serum IL-8 in intermediate uveitis

Statistical analysis was performed using the \( \chi^2 \) test.

Table 3  IL-8 and disease activity in intermediate uveitis

<table>
<thead>
<tr>
<th>IL-8 pos* (27)</th>
<th>IL-8 neg (34)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMO</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Vitreous exudates</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>Papillitis</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Periphlebitis</td>
<td>11</td>
<td>3</td>
</tr>
</tbody>
</table>

*IL-8 level above 20 pg/ml.

Statistical analysis was performed using the \( \chi^2 \) test.

Discussion

In this report we show that patients with active intermediate uveitis of unknown origin have elevated serum IL-8 levels. The presence of circulating IL-8 in active intermediate uveitis may suggest a systemic involvement in this type of inflammatory eye disease or at least suggest an immune pathogenesis of this disease. Whether this increased IL-8 merely reflects an acute phase reaction in these patients, was investigated by measuring circulating CRP. CRP is an acute phase protein that is produced and secreted by hepatocytes in response to a wide variety of infections, inflammatory conditions, and tissue damage. Normally, the acute phase response lasts only a few days; however, in cases of chronic or recurring inflammation CRP can be elevated for prolonged periods. In this study we did not detect raised CRP levels in the patients with intermediate uveitis whether they had active or smoldering disease, which indicates that the increased IL-8 is not associated with an acute phase reaction.

IL-8 is a cytokine which attracts neutrophil granulocytes and T lymphocytes and is also involved in angiogenesis. 11, 12 IL-8 is produced by leukocytes such as monocytes and macrophages but also by a variety of other cells such as fibroblasts, endothelial cells, and within the eye by retinal pigment epithelial cells and is triggered by bacterial endotoxins, tumour necrosis factor, and IL-1. 13, 14 High levels of circulating IL-8 have been detected in various systemic diseases such as sarcoidosis 15 and ulcerative colitis. 14 Raised IL-8 serum levels were found in 81% of patients with chronic sarcoidosis. The serum IL-8 concentration was found to be higher in patients with active sarcoidosis than in patients with inactive sarcoidosis and all patients with active sarcoidosis had a serum IL-8 concentration greater than the normal range. 15 The occurrence of eye disease was not reported in the latter study. Raised IL-8 levels were also reported in the serum of patients with eye diseases which are related to a systemic disease including proliferative diabetic retinopathy and HLA-B27 associated anterior uveitis. 11

The source of circulating IL-8 in active intermediate uveitis is not clear. It seems unlikely that cells in the inflamed peripheral retina and vitreous would produce such large...
amounts of IL-8 that would lead to detectable levels in the blood compartment. In other uveitis entities we only observed significantly elevated IL-8 levels when systemic underlying disease was present (HLA-B27 acute anterior uveitis or sarcoidosis). This strongly suggests that another source than the eye is responsible for raised IL-8 in active intermediate uveitis. Further evidence for systemic involvement in intermediate uveitis comes from studies in which increased levels of other immune markers such as soluble ICAM-1 were reported. More recently, Bora and colleagues found elevated serum levels of a 36 kDa protein (nup36) in patients with active pars planitis. 5

In HLA-DR15 positive intermediate uveitis patients about 50% had systemic findings of another HLA-DR15 related disorder (multiple sclerosis, optic neuritis, or narcolepsy). We have not yet performed HLA typing in the group of intermediate uveitis patients and can therefore not confirm these observations. In our study we excluded patients with a known systemic disease at entry. During follow up, however, four patients had developed multiple sclerosis, three patients were suspected for having multiple sclerosis, one patient developed sarcoidosis, and five had a presumed diagnosis of sarcoidosis. Since intermediate uveitis tends to be a disease of young adulthood, it is possible that at the time of diagnosis of the ocular condition, clinical and laboratory variables for these latter associated diseases may not yet be evident. In this study in 37% of the IL-8 positive intermediate uveitis patients an associated systemic disease was found 1–10 years later.

Larger numbers and longer follow up may provide definitive evidence as to whether a high IL-8 level is a marker of an increased likelihood of developing systemic disease in patients with intermediate uveitis.