CTLs are targeted to kill β cells in patients with type 1 diabetes through recognition of a glucose-regulated preproinsulin epitope

Ania Skowera,1,2 Richard J. Ellis,1 Ruben Varela-Calviño,3 Sefina Arif,1 Guo Cai Huang,4 Cassie Van-Krinks,1 Anna Zaremba,1 Chloe Rackham,1 Jennifer S. Allen,1 Timothy I.M. Tree,1 Min Zhao,4 Colin M. Dayan,5 Andrew K. Sewell,6 Wendy Unger,7 Jan W. Drijfhout,7 Ferry Ossendorp,7 Bart O. Roep,7 and Mark Peakman1,2

1Department of Immunobiology, King’s College London, London, United Kingdom. 2National Institute for Health Research (NIHR), Biomedical Research Centre, Guy’s and St. Thomas’ NHS Foundation Trust and King’s College London, London, United Kingdom. 3Department of Biochemistry, Faculty of Pharmacy, University of Santiago de Compostela, Spain. 4Diabetes Research Group, School of Medicine, King’s College London, London, United Kingdom. 5Henry Wellcome Laboratories for Integrative Neuroscience and Endocrinology, University of Bristol, Bristol, United Kingdom. 6Department of Medical Biochemistry and Immunology, Cardiff University School of Medicine, Heath Park, Cardiff, United Kingdom. 7Department of Immunohaematology and Blood Transfusion, Leiden University Medical Centre, Leiden, The Netherlands.

The final pathway of β cell destruction leading to insulin deficiency, hyperglycemia, and clinical type 1 diabetes is unknown. Here we show that circulating CTLs can kill β cells via recognition of a glucose-regulated epitope. First, we identified 2 naturally processed epitopes from the human preproinsulin signal peptide by elution from HLA-A2 (specifically, the protein encoded by the A*0201 allele) molecules. Processing of these was unconventional, requiring neither the proteasome nor transporter associated with processing (TAP). However, both epitopes were major targets for circulating effector CD8+ T cells from HLA-A2* patients with type 1 diabetes. Moreover, cloned preproinsulin signal peptide–specific CD8+ T cells killed human β cells in vitro. Critically, at high glucose concentration, β cell presentation of preproinsulin signal epitope increased, as did CTL killing. This study provides direct evidence that autoreactive CTLs are present in the circulation of patients with type 1 diabetes and that they can kill human β cells. These results also identify a mechanism of self-antigen presentation that is under pathophysiological regulation and could expose insulin-producing β cells to increasing cytoxicity at the later stages of the development of clinical diabetes. Our findings suggest that autoreactive CTLs are important targets for immune-based interventions in type 1 diabetes and argue for early, aggressive insulin therapy to preserve remaining β cells.

Introduction

The final molecular and cellular pathways leading to β cell destruction in the human autoimmune disease type 1 diabetes are not known. Any resolution of this question must address the mechanism through which insulin-producing β cells, but not adjacent, non-β endocrine cells (α, δ, and PP cells secreting the hormones glucagon, somatostatin, and pancreatic polypeptide), are singled out for killing. Two distinct hypotheses have emerged. The first proposes that β cells die as a result of their selective susceptibility to inflammatory mediators, such as cytokines, nitric oxide, and oxygen free radicals (1), released by islet-infiltrating immune cells. The second states that CD8+ CTLs, recognizing β cell–specific peptides presented by HLA class I molecules, have the pivotal role in selective β cell death (2). In support of a CTL mechanism, postmortem studies of patients performed close to diabetes onset show numerical dominance of CD8+ T cells in the characteristic islet mononuclear cell infiltrate (3–5). Genetic susceptibility to disease is linked to inheritance of selected class I HLA molecules, including HLA-A2 (A*0201) (6). In animal models, efficient adoptive transfer of disease typically requires CD8+ T cells (2), and diabetes is prevented by genetic modifications that abrogate MHC class I molecule expression (7). Moreover, transgenic introduction of HLA-A2*0201 into diabetes-prone NOD mice markedly accelerates disease development (8).

Despite these pieces of circumstantial evidence, however, to date there are no published reports demonstrating CTL killing of human β cells. This gap in our knowledge is a result of many constraints on such studies. Most importantly, islet-infiltrating T cells from patients with diabetes are very rarely available for expansion and cloning to examine their CTL potential, while the search for such cells trafficking in the peripheral blood requires prior knowledge of the autoantigens targeted and the epitopes and HLA-presenting molecules involved. To address these requirements, we chose to create surrogate β cells expressing a single autoantigen and HLA class I molecule and investigate their naturally displayed peptide repertoire. This uncovered the signal peptide (SP) as a source of preproinsulin (PPI) epitopes that constitute major targets of CD8+ T cell responses in HLA-A2+ patients with type 1 diabetes. We show that expanded clones of PPI SP–specific CD8+ T cells kill human HLA-A2–expressing β cells in vitro, especially when β cells are exposed to high glucose concentrations. It has long been speculated that β cells, stressed by the need to control blood glucose levels as diabetes develops, could become enhanced targets for the immune system. Our study provides evidence of a mechanism through which this can occur.
Results

Identification of PPI epitopes. We elected to study PPI as a target autoantigen in type 1 diabetes because of its β cell specificity; the fact that we and others have shown its importance as a target of CD4\(^+\) T cell responses in clinical diabetes in humans (9–11); and in view of its prominent involvement in murine diabetes models (12). Since access to sufficient numbers of human β cells to study the peptide repertoire is not feasible, we elected to generate a “surrogate β cell.” The HLA-negative chronic myelogenous leukemia cell line K562 was selected as an appropriate carrier cell and transfected with PPI and HLA-A*0201 genes to derive a surrogate human β cell (termed K562-PPI-A2) that secretes proinsulin and expresses HLA-A2 (Figure 1, A and B). Peptides were acid eluted from the surface HLA-A2 molecules, and using a subtractive approach, we identified peptide species unique to K562-PPI-A2 cells and not present in either the control K562-PPI or K562-A2 single gene–transfected cell lines (Figure 1, C–F). Two prominent peptides were identified by mass spectrometry (MS) and sequenced by MS/MS and collision-induced dissociation, matching to PPI\(_{17-24}\) (WGPDPAA) and PPI\(_{15-24}\) (ALWGP-DPAA) (Figure 2, A and B).

Disease relevance of SP epitopes of PPI. The finding that the major peptide species presented from PPI-expressing cells are located in the SP (Figure 2C) was unexpected and led us to examine their disease relevance. Circulating IFN-γ–producing CD8\(^+\) T cells specific for these epitopes were detected by ELISPOT assay (9) in approximately 50% of patients with new-onset type 1 diabetes who possess the HLA-A*0201 genotype (Figure 3, Table 1, and Supplemental Table 1; supplemental material available online with this article; doi:10.1172/JCI35449DS1). CD8 responsiveness was confirmed by disappearance of ELISPOT reactivity after immunomagnetic depletion of CD8\(^+\) T cells, as described previously (9). In contrast, this reactivity was rare in HLA-A2–negative type 1 diabetes patients (2 of 12 patients [17%] positive to either peptide; \(P < 0.05\) versus HLA-A2\(^+\) patients). Responses to PPI\(_{15-24}\) either or both epitopes were significantly more frequent in HLA-A2\(^+\) patients than in
HLA-matched nondiabetic control subjects (Figure 3). The presence of circulating effector CD8+ T cells recognizing these epitopes is therefore specific for disease and HLA-A2. Indeed, we were able to conclude that SP epitopes constitute major targets of the CD8+ T cell response against PPI in type 1 diabetes, since the frequencies of responses we detected to these epitopes were higher than those to a range of other putative HLA-A2–restricted epitopes from insulin/proinsulin that are currently being investigated in parallel studies in our laboratory (insulin B10–18 [refs. 13, 14], 27% of patients; B18–27 [ref. 15], 27%; C22–30 [ref. 13], 14%; C27–35 [ref. 13], 23%; proinsulin C31–A5 [ref. 13], 9%; and insulin A1–10 [ref. 13], 18%) (data not shown).

Phenotype and target cell killing of PPI15–24–reactive CD8+ T cells. To examine the functional properties of PPI SP-reactive CD8+ T cells, we established short-term CD8+ T cell lines from HLA-A2+ patients with type 1 diabetes who showed appropriate ELISPOT reactivity, focusing on the PPI15–24 epitope because of its relative immunodominance (Figure 3). From these lines, cells staining with PPI15–24–loaded HLA-A2 tetramers (PPI15–24–Tmr) were sorted by flow cytometry and expanded, yielding 5 PPI15–24–Tmr CD8+ T cell clones from a single patient (Figure 4, A and B). Three of these clones (1E6, 3F2, and 1C8) have been characterized in detail at a functional level (see below), and each is known to express TCR β variable chain TRBV12-4 and 2 productively rearranged TCR α chain genes, TRAV12-3 and TRAV13-2. Interestingly, a clone with the same TRBV and TRAV expression, and TRBV3 CDR3 sequence identical to 1E6, was isolated from fresh blood obtained from the same patient 1.5 years after the first sample, in a “honeymoon” phase of the disease, during which insulin treatment was temporarily not required. Thus, while it is difficult to be certain whether the clones we originally obtained are independent or duplicate cloning events, our data show that their ancestral clone is long-lived and likely to be dominant in this patient. Future studies will be required to address whether similar clones are found in other patients and what additional specificities are responsible for their ELISPOT reactivity.

Clones showed HLA-A2–restricted responses to PPI15–24, either when PPI15–24 peptide was presented after pulsing of HLA-A2–autologous antigen-presenting cells (Figure 4, C and D) or when it was presented naturally by K562-PPI-A2 cells (Figure 4E). PPI15–24–specific T cell clones did not recognize PPI17–24. In contrast, using an identical approach, we were unable to isolate PPI15–24–specific CD8+ T cell clones from healthy HLA-A2+ non-diabetic donors (n = 3).

After antigenic stimulation, PPI15–24–specific CD8+ T cell clones predominately produced TNF-α (Figure 4, C and E), in addition to IFN-γ, and expressed the chemokine receptors CXCR3 and CCR4, both of which have been shown to be important in CD8+ T cell participation in autoimmune models of type 1 diabetes (16, 17) (Supplemental Figure 1). Clones also expressed surface markers characteristic of an effector CD8+ T cell phenotype (Supple-
mental Figure 1). The killing potential of PPI$_{15-24}$-specific CD8$^+$ T cell clones was revealed by expression of cytolysins including granzyme B, perforin, and TNF-related apoptosis-inducing ligand (TRAIL; Supplemental Figure 1).

To examine antigen-specific CTL activity of PPI$_{15-24}$-reactive CD8$^+$ T cells, we first used K562-PPI-A2 cells as targets in a conventional cytotoxicity assay. Killing was highly efficient and restricted to K562 cells expressing both PPI and HLA-A2 (Figure 5A).

**Table 1**

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Bgd, background (DMSO) spots; control peptides A2$_{140-149}$ from HLA-A2; CSP$_{334-342}$ from Plasmodium falciparum circumsporozoite; and PDC$_{159-167}$ from the E2 pyruvate dehydrogenase complex. Bold indicates positive response (stimulation index, ≥2.0). CEF, mix of viral peptides as positive control; NCs, nondiabetic control subjects; T1D, type 1 diabetes patients.

**Figure 3**

Circulating effector CD8$^+$ T cells that recognize PPI SP epitopes are present in patients with type 1 diabetes. IFN-γ ELISPOT PBMC reactivity to PPI$_{15-24}$, either PPI$_{17-24}$ or PPI$_{16-24}$, or both peptides was significantly more frequent in patients with type 1 diabetes and HLA-A*0201 (black bars) than in HLA-matched nondiabetic control subjects (white bars). Responses to PPI$_{17-24}$ were not significantly different in this series ($P = 0.08$), but see Supplemental Table 1 showing a similar analysis of an extended, independent series of cases in which the prevalence of responses to PPI$_{17-24}$ is significantly higher in patients with type 1 diabetes than in control subjects ($P = 0.004$). In contrast, the prevalence of responses to the mixture of viral peptides was similar in the 2 groups (see also Supplemental Table 1).
These results indicate that circulating autoreactive CD8+ T cells in patients with type 1 diabetes recognize β cell–specific targets and have cytotoxic capability.

**PPI-specific CD8+ T cells kill human β cells.** We next labeled monodispersed preparations of human islet cells that were HLA-A2+, isolated from pancreatic islets obtained from organ donors, to examine the key question of β cell killing. PPI_{15–24}–specific CD8+ T cells killed human islet cells in an HLA-A2–restricted manner (Figure 5B and Supplemental Figure 2). Killing of human islet cells appeared to require cell-cell contact mechanisms, such as cytolysin release directly onto target cell membranes, since the supernatants from CTLs activated with cognate peptide had no cytotoxic effects on human islet cells or K562-PPI-A2 (data not shown). Moreover, the killing of human islet cells by PPI_{15–24}–specific CD8+ T cell clones was selective for the β cell. Semiquantitative RT-PCR analysis of mRNA for insulin (specific for β cells) and glucagon (specific for α cells, which are not destroyed in type 1 diabetes) in human islet cells after exposure to PPI_{15–24}–specific CTLs revealed a marked reduction in insulin expression (Figure 5, C and D, lane 2) when compared with islet cells cultured alone (lane 1) or with an irrelevant (HLA-A2–restricted
at residue 24 and of appropriate length. Table 2 shows average masses for putative NH₂-terminally extended peptide species with a COOH terminus at residue 24 and length of 8-mer or greater. None of these species was detected after proteasome digestion, although several other fragments of PPI₁₁–₂₄ were found (Figure 6B). Since conventional generation of HLA class I epitopes requires that the correct COOH terminus is generated by the proteasome (since COOH-terminal trimming does not occur), this makes it unlikely that PPI₁₇–₂₄ and PPI₁₅–₂₄ are derived by proteasomal cleavage. The lack of requirement for TAP transport or proteasomal cleavage in the generation and loading of PPI₁₇–₂₄ and PPI₁₅–₂₄ suggests that they are generated within the ER, rather than via retrograde translocation of PPI fragments into the cytoplasm for conventional processing. Indeed, we demonstrate that intact PPI₁₇–₂₄ is generated by soluble ER proteases and that PPI₁₅–₂₄ is likely to require a combination of these and intramembrane proteolysis (see Supplemental Results). Overall, these data indicate an unconventional processing route for PPI₁₇–₂₄ and PPI₁₅–₂₄, which includes signal peptidase activity, soluble ER proteases, and intramembrane-cleaving proteases (I-CLiPs), the nature and specificity of which remain to be established.

**Figure 5**

CD8⁺ T cell clones specific for PPI SP epitope PPI₁₅–₂₄ are cytotoxic and kill human β cells. (A) Percent specific lysis of K562-PPI-A2 cells by 1E6 PPI₁₅–₂₄-specific T cell clone (open squares) but not K562-A2 (triangles) or K562-PPI cells (data not shown). Control CTL 2D9 recognizing A2-presented CMV pp65₉₅₅–₉₆₃ does not kill K562-PPI-A2 cells (open circles). Both clones kill K562-A2 and K562-PPI-A2 cells pulsed with respective cognate peptide (lysis >90% at 25:1 effector/target ratio; data not shown). (B) Lysis of human HLA-A2⁺ (open squares) islet cells by 1E6. A2-negative islet cells (triangles) were not killed, and there was no killing by 2D9 (open circles). A2⁺ (but not HLA-A2⁺) islet cells pulsed with PPI₁₅–₂₄ were killed (lysis >90% at 25:1; data not shown). Representative of 5 assays for K562 and 3 for human islets (including 2 different donors), performed in triplicate (data are presented as mean, with error bars representing SEMs). (C) Representative (from 3 independent experiments) agarose gel resolution of semiquantitative RT-PCR amplification from human islet cell cytotoxicity assays using insulin- and glucagon-specific primers. (D) PCR product density relative to β-actin (IOD, integrated optical density). A greater than 4-fold reduction in insulin mRNA when islet cells were cultured with 1E6 PPI₁₅–₂₄-specific CTLs is seen (lane 2; IOD, 50.0 ± 10.0), compared with no added clone (lane 1; IOD, 202.0 ± 10.0). No reduction in insulin expression is seen in the presence of 2D9 (lane 3). Glucagon expression is similar under all conditions, indicating that killing of human islet cells by 1E6 PPI₁₅–₂₄-specific CTLs is β cell specific.

CMV peptide–specific) CTL clone (lane 3). Under similar conditions, glucagon expression remained unchanged (Figure 5, C and D), indicating that β cells were being targeted selectively for killing in these assays. Importantly, these studies confirm that the PPI SP epitope PPI₁₅–₂₄ is naturally processed and presented by human β cells, as well as their engineered surrogates.

**Processing and presentation of PPI SP epitopes.** HLA class I molecule presentation of SPs is unusual, being most typically observed in the absence of functioning transporter associated with processing (TAP) (18). However, this seemed an unlikely explanation for our observation, since K562 cells are TAP replete. Moreover, processing and presentation of PPI₁₅–₂₄ by K562-PPI-A2 cells is not affected by cotransfection with the gene encoding the varicellovirus-derived TAP inhibitor protein UL49.5 (19) (Figure 6A). In addition, digestion of a PPI₁₁–₃₀ peptide by both constitutive and immunoproteasomes did not identify any products matching to NH₂-terminal extensions of peptides with COOH terminus A and B, and in concert TNF-α production by PPI₁₅–₂₄-specific T cells increased significantly (P < 0.01) and linearly (test for linear trend, P < 0.005; Figure 7C). In contrast, TNF-α production was not influenced by glucose concentration when islet cells were pre-pulsed with PPI₁₅–₂₄ peptide (P = NS; Figure 7D).

This finding prompted us to examine whether increased activation of PPI₁₅–₂₄-specific CTLs by islet cells exposed to high glucose concentration could result in enhanced β cell killing. As shown in Figure 8A, stepwise increases in ambient glucose concentration resulted in significant (P < 0.005) and linear (P < 0.005) increases in killing by the CTL clone 1E6 and other clones (Supplemental Figure 2). β Cell specificity was confirmed by a stepwise decline in levels of insulin mRNA as CTL killing increased (Figure 8, B and C). Moreover, the increased killing was not a result of increased fragility of β cells, since killing of PPI₁₅–₂₄ peptide–pulsed islet cells was not significantly altered by high ambient glucose (P = NS; Figure 8D) and was not β cell specific (Figure 8, E and F). Moreover,
over a 16-hour period in the presence of high glucose (20 mM), islet killing peaked when insulin mRNA transcripts were most abundant, rather than when insulin secretion was at its highest (Figure 9). Taken together, these data show that when β cells are induced to increase PPI synthesis, there is a concomitant increase in PPI SP epitope presentation. In the presence of specific CTLs, such β cells are subjected to a greater β cell killing efficiency. Prolonged exposure to high glucose concentrations was required to see the effect, since killing was not enhanced when islets were exposed to 20 mM glucose for 30 minutes before the cytotoxicity assay (data not shown).

Cross-presentation of PPI SP epitopes. Having established the importance of the PPI15–24 epitope in β cell targeting, we questioned how specific effector CD8+ T cells could be primed to recognize this epitope during the pathogenesis of type 1 diabetes. CTL priming requires cross-presentation, a process in which professional antigen-presenting cells such as DCs take up, process, and present antigens as peptide–HLA class I molecule complexes to naive CD8+ T cells. This process is a necessary component of immunity, for example, against viruses that do not infect antigen-presenting cells, but its involvement in autoimmune disease is relatively unexplored. Moreover, in this particular context, it is clear that intact PPI, from which PPI15–24 is derived, is ER membrane inserted and not directly available for extracellular uptake as a soluble protein. Tang and colleagues have shown that in the NOD mouse model of autoimmune diabetes, whole β cells are ingested by DCs and transported to the pancreatic lymph node (22). We therefore examined whether DCs cultured with soluble PPI or with K562-PPI cells could cross-present PPI15–24 to specific T cell clones. Our results show that DCs are efficient at cross-presentation of PPI15–24 from soluble PPI and also from intact PPI-expressing cells (Figure 10).

Discussion
The novelty of this study is 4-fold. First, it provides evidence that human autoreactive CD8+ T cells can be responsible for the selective β cell destruction that is the hallmark of clinical type 1 diabe-
The debate as to the mechanism of β cell death in type 1 diabetes has simmered for several years but has important clinical implications, since greater understanding in this area has the potential to guide novel immune intervention strategies. At present, none of the therapeutic approaches under evaluation in type 1 diabetes at phase I, II, or III stages is specifically designed to target autoreactive CD8+ T cells (28). Our finding that circulating CTLs capable of killing β cells are present in a sizeable proportion of patients with type 1 diabetes legitimizes the development of CD8+ T cell–specific strategies to halt β cell destruction, although the challenge will be to develop approaches that leave antiviral responses relatively intact. An example might be targeting of the NKG2D/MICA axis. The CTL clones we isolated from type 1 diabetes patients were NKG2D+, and blockade of the equivalent pathway in the NOD mouse prevents islet destruction and development of diabetes (29).

A second approach that might at least slow progression of β cell destruction would be to minimize endogenous insulin production through early and aggressive introduction of insulin therapy. The repeated observation that many patients who are insulin dependent at diagnosis then temporarily cease to require insulin injections in subsequent months (the so-called honeymoon period) is consistent with the hypothesis that the introduction of exogenous...
myelogenous leukemia cell line K562 expressing HLA-A2 (K562-A2) under Geneticin resistance was obtained (32) from C. Britten (Johannes Gutenberg-University of Mainz, Mainz, Germany) and cultured in RPMI-1640 medium supplemented with 10% heat-inactivated FBS and 1% penicillin/streptomycin solution (all Invitrogen) at 37°C, 5% CO₂. Geneticin (Invitrogen) concentration in the medium was maintained at 0.7 mg/ml. HLA-A2 was expressed by greater than 95% of cells. Transfection of the PPI gene was carried out using Effectene (QIAGEN), and K562-PPI-A2 cells were maintained in the same manner as K562-A2 cells with the addition of 10 μg/ml blasticidin. After 2 weeks of culture under selection, proinsulin (DRG International Inc.) and immunoreactive insulin (Diagnostic Systems Laboratories Inc.) were detected in the supernatants by ELISA and RIA, respectively.

Analysis of HLA-A2 peptide repertoire. Peptides were extracted from the surface of cultured cells by citric acid elution (33). Briefly, 4 × 10⁶ cells were washed 3 times in PBS and resuspended in a total volume of 25 ml of pH 3.3 citrate-phosphate buffer (0.131 M citric acid, 0.066 M Na₂HPO₄) for 1 minute at room temperature. Cells were then pelleted and the supernatant citric acid solution (containing previously cell-bound HLA class I peptides) harvested and stored at –80°C prior to fractionation by reverse phase-HPLC (RP-HPLC) on a Symmetry C18 column (Waters) connected to a Waters 2690 Separations Module and 2487 Detector using water/0.05% trifluoroacetic acid (TFA) and acetonitrile/0.05% TFA with collection of 120 fractions. Each fraction was vacuum dried (SpeedVac vacuum concentrator; Thermo Scientific) at room temperature, to approximately 5–10 μl and stored at ~80°C.

For matrix assisted laser desorption/ionization time-of-flight (MALDI-TOF) MS analysis of peptides, 0.5 μl sample was mixed with 0.5 μl freshly prepared 2,5-dihydroxybenzoic acid matrix (MassPREP DHB matrix; Waters) or α-cyano-4-hydroxycinnamic acid matrix (CHCA; Bruker Daltonics) prepared at 10 mg/ml in 1:1 (v/v) acetoniitrite, 0.1% TFA. For internal calibration, a further 1 μl MS calibrant mixture was added, containing 2.5 fmol leu-enkephalin (556.2771 m/z) and 5 fmol substance P (1347.73543 m/z). MS was performed using a Bruker Daltonics MALDI-TOF mass spectrometer. Samples from K562-PPI-A2, K562-A2, and K562-PPI cells were ionized for matrix assisted laser desorption/ionization using a Voyager ABI 4700 (Applied Biosystems) to derive

Methods

Generation of surrogate β cells. PPI cDNA was inserted between the BamHI and EcoRI sites in the pcDNA6/myc-His B vector (Invitrogen) for expression in mammalian cell lines under blasticidin selection. The human chronic insulin therapy allows targeted β cells to reduce their synthetic activity and thus acquire a degree of protection from CTL attack. Indeed, previous studies, albeit on small numbers of subjects, have suggested that preservation of endogenous insulin reserve might benefit from administration of insulin in the prediabetic period (30) or exertion of tight metabolic control soon after diagnosis (31). Our study provides a rational basis for such an approach by identifying a possible mechanism through which it operates. Finally, the novel pathway through which PPI SP epitopes are generated implies the existence of I-CLiPs and ER proteases that are critical for CTL epitope display. Identification of the precise components involved in PPI SP processing could lead to the development of novel therapeutic agents that target these pathways.
partial sequence information under collision-induced dissociation (CID) using atmospheric gas. The MS/MS spectrum for each unique mass was submitted to a Mascot server (35), querying either the NCBI nr (nonredundant) (36) or a local database to identify the precursor sequence.

Subjects. Fresh heparinized and clotted blood samples were obtained from 56 HLA-A*0201 patients of mixed European descent with type 1 diabetes (mean ± SD age, 29 years ± 6.5; median duration of disease 10 weeks, range 3–14 weeks) with acute onset of symptoms requiring insulin from the time of diagnosis and 36 HLA-A*0201 nondiabetic control subjects, also of mixed European descent, without history of first-degree relatives with type 1 diabetes and matched for age (mean ± SD age, 31 ± 5.7 years). All samples were screened initially for HLA-A2 by flow cytometry (using the BB7.2 mAb clone; BD Biosciences — Pharmingen), and HLA-A1*0201 positivity was confirmed by PCR sequence-specific primer (PCR-SSP) genotyping.

Fresh PBMCs were isolated on density gradients (Lymphoprep; Nycomed) and washed in RPMI-1640 (Invitrogen) twice before use. These studies were carried out with the approval of King’s College Hospital Research Ethics Committee, and informed consent was obtained from all participants.

ELISPOT for the detection of CD8+ T cell responses. Fresh PBMCs were precultured in single wells of 48-well plates at a density of 1 x 10^6 in 0.5 ml TC medium (RPMI-1640, antibiotics from Invitrogen, and 10% human AB serum from PAA) containing test peptide to a final concentration of 10 μM and incubated at 37°C, 5% CO₂, tilted by 5°. Peptides were synthesized by standard Fmoc chemistry (Interactiva Biotechnologie GmbH) to at least 90% purity as confirmed using RP-HPLC and MS. Control wells contained TC medium with an equivalent concentration of DMSO or CEF (viral peptide mix, at a final concentration equivalent to 10 μM; Mabtech). After 24 hours incubation, nonadherent cells were resuspended using pre-
warmed TC medium (2% AB serum), washed, and brought to a concentration of 10^6/300 μl, and 100 μl was dispensed in triplicate into wells of 96-well ELISA plates (Nunc MaxiSorp) preblocked with 1% BSA in PBS and precoated with monoclonal anti–IFN-γ (U-CyTech Biosciences). In some assays, harvested cells were depleted of CD8+ T cells using immunomagnetic beads (Miltenyi Biotec). After cytokine capture at 37°C, 5% CO_2 for 15 hours, cells were lysed in ice-cold double-distilled water, plates washed in PBS/Tween-20 (0.05%), and spots developed according to the manufacturer’s instructions. Plates were dried and spots of greater than 60 μm counted in a BioReader 3000 (Bio-Sys). Triplicate values were pooled to provide total spots per 10^6 PBMCs, and values obtained in test wells were compared with the background (DMSO) wells to derive a stimulation index (SI). In preliminary studies using insulin/proinsulin peptides known to elicit responses in patients with type 1 diabetes (14, 15, 24, 37), the optimal operating conditions for the assay were established using a receiver-operator characteristic (ROC) curve as described previously (9), and samples were considered positive when the SI was at least 2. In a subset of patients and control subjects (n = 15 per group), additional non-islet peptides were included as controls for nonspecific reactivity: an immunodominant epitope of the E2 component of pyruvate dehydrogenase complexes, the major mitochondrial antigen in primary biliary cirrhosis residues 159–167: KLSEGDDLA (38); an epitope of the circumsporozoite protein of Plasmodium falciparum variant NF54 residues 334–342: YLNKIQNSL (39); and an HLA-A2-derived peptide eluted from HLA-A2 (B.O. Roep et al., unpublished observations) residues 140–149: YAYDGKDYIA. For the remaining subjects (n = 41 patients and n = 21 controls), the human islet amyloid polypeptide precursor protein 5–13 (IAPP_5-13) (KLQVFLIVL) (40, 41) was used as a control for nonspecific reactivity to SPs. Positive ELISPOT responses to IAPP_5-13 were present in 4 of 41 patients (9.7%) and 4 of 21 control subjects (19%; P = NS).

Generation of CD8+ T cell clones. Monocyte-derived DCs were obtained as described previously (42) and used to generate mature DCs. DCs were pulsed with 10 μg/ml PPI_15-24 peptide for 1 hour at 37°C in IMDM/AB medium (Invitrogen). After extensive washing, monocyte-derived DCs and autologous CD8+ lymphocytes (purified from PBMCs using the CD8 Isolation Kit II; Miltenyi Biotec) were cultured at a 1:5 ratio in 24-well culture plates. Initial culture medium IMDM/AB was supplemented with IL-7 (10 ng/ml; PeproTech). After 2 days, 5% Cellkine (ZeptoMetrix Corp.) and IL-15 (0.1 ng/ml; PeproTech) were added. After 7 days of culture, CTLs were restimulated with mature autologous DCs (pulsed with 10 μg/ml PPI_15-24) at a 1:5 ratio. On day 22, CD3+CD8+ T cells staining with PPI_15-24–Tmr and negative for 7-aminoactinomycin-D (live/dead discriminator) were flow sorted and seeded at 1 cell/well in 96-well plates, each well containing 1 x 10^5 irradiated allogeneic PBMCs, in X-Vivo 15 (BioWhittaker) and 5% Cellkine, IL-7 (10 ng/ml), IL-15 (0.1 ng/ml), and PHA-M (5 μg/ml; Sigma-Aldrich). Growing CD8+ T cell clones were isolated and restimulated every 14 days as described above. Phenotypic analysis of clones was carried out as previously described (43) using the following mAbs for surface and intracellular staining (43): anti-CD3, anti-CD4, anti-CD56, anti-CD16, anti-CD8, anti–IFN-γ, anti-NKG2D, anti-CD28, anti-CD45RA, anti-CD45RO, anti-CXCR3, anti–TNF-α, anti–IFN-γ, anti–granzyme B, anti-perforin, and anti-TRAIL (all from BD and BD Biosciences — Pharmingen); anti-CCR7 and anti-CCR4 (both from R&D Systems); anti-CD62L and anti-CD44 (both from Serotec Ltd).

**Figure 9**
Enhanced islet killing at high glucose concentration is related to translation of insulin mRNA rather than insulin secretion. Analysis of islet cell killing in relation to insulin secretion and insulin mRNA expression. Human A2+ islets were cultured for the specified time periods in the presence of 20 mM glucose, and at the end of that time, islet cells were removed into a cytotoxicity assay with clone 3F2. White bars show insulin secretion over the periods 0–1 hours, 1–8 hours, and 8–16 hours. Gray bars show insulin mRNA expression above baseline (designated 1,000 AU, measured as IOD) in islets harvested at the specified time points. The line graph with open circles shows killing of islets harvested at the specified time points. The results show that β cells exposed to high glucose degranulate rapidly but that this is not related to enhanced killing by PPI_15-24–specific CTLs. The relationship between insulin mRNA levels and killing suggests that PPI_15-24 generation is related to levels of PPI transcription and translation rather than to insulin secretion.

**Figure 10**
PPI SP epitope PPI_15-24 is cross-presented by DCs from intact PPI and PPI-expressing cells. (A) DCs pulsed with soluble PPI and then matured induce TNF-α production by 1E6 PPI_15-24–specific T cells. Cytokine production in the presence of a control protein (the fusion partner of recombinant human PPI) and PPI_15-24 peptide are shown for comparison. (B) DCs pulsed with freeze-thawed K562 cells expressing PPI (K562-PPI) and then matured induce TNF-α production by 1E6 clone cells. Cytokine production in the presence of control cells (nontransfected K562) and PPI_15-24 peptide are shown for comparison. Bars represent means from triplicate experiments, error bars SEMs; data are representative of 3 independent experiments.
Functional analysis of clones was carried out after stimulation with peptide-pulsed DCs, PBMCs, and variously transfected K562 cell lines, using \(^{3}H\)thymidine incorporation, TNF-α secretion (measured by ELISA from ImmunoTools), or intracellular TNF-α and IFN-γ expression (measured by flow cytometry). As a control, we used the same approach to clone CD8\(^{+}\) T cells recognizing the immunodominant HLA-A2-restricted CMV pp65 peptide NLVPVMATV.

**Human islet isolation, culture, and cytotoxicity assays.** Human islet isolations were performed using a method described previously (44). Pancreata were retrieved with the consent of donors' relatives and permission of the Ethical Review Committee of King’s College Hospital. Islet-enriched cell fractions were cultured in CMRL1066 containing 5.6 mM glucose, supplemented with 10% FBS and penicillin (100 U/ml), streptomycin (100 μg/ml), and 1-glutamine (2 mmol/l) (Invitrogen) for 2 weeks, with medium changed every 2 days. Cells were allowed to become monolayer cultures and before cytotoxicity assays were cultured in the presence of cytokines (500 IU/ml IFN-γ; 50 IU/ml IL-1β; 2,500 IU/ml TNF-α [Strathmann Biotec] and 1,000 IU/ml IFN-α [Roche Laboratories]) for 16–24 hours to upregulate HLA class I expression (cytokines and concentrations established in preliminary studies and selected for optimal upregulation).

Cytotoxicity was analyzed by a nonradioactive europium TDA (EuTDA) cytotoxicity assay using DELFIA Technology (PerkinElmer) according to the manufacturer’s instructions (45). Briefly, either human islet cell cultures (1 × 10⁶) or K562-PP1-A2, K562-A2, or K562-PP1-A2-UL49.5 cell lines were incubated for 20 minutes at 37°C in 1 ml of RPMI/10% FBS with 3 μl of fluorescence-enhancing ligand. After extensive washing with PBS (5 times), 50 μl of labeled islet cells (5 × 10⁶) were seeded in triplicate into V-shaped 96-well plates followed by 50 μl of effector cells (CD8\(^{+}\) T cell clone) at varying ratios in X-Vivo 15%/5% AB serum/IL-7 (10 ng/ml), IL-15 (0.1 ng/ml), and 2.5% Cellline. The cultures were incubated for 4 hours at 37°C, and 20 μl of the supernatant transferred to a clear, flat-bottom microtitration plate, followed by addition of 200 μl/well of enhancement solution. After 15 minutes at room temperature with shaking, the europium signal was measured using a VICTOR3 Time-Resolved Fluorescence Reader (PerkinElmer). To determine maximum lysis, islet cells alone (5 × 10⁶ in 100 μl) were treated with 20 μl lysis buffer. Spontaneous release was measured from wells containing only labeled islet cells in 100-μl volume. Specific cytotoxicity was calculated using the following formula: % specific release = (experimental – spontaneous release)/ (experimental – spontaneous release) × 100 (% maximum – spontaneous release). In some experiments, islet cell monolayers were cultured for 14 hours before cytotoxicity assays in the presence of 11 mM or 20 mM glucose.

**Detection of insulin and glucagon mRNA.** Semiquantitative RT-PCR was performed using total RNA isolated using an RNA Minirep Kit (Promega) and quantified using a spectrophotometer (GeneQuant II; Pharmacia Biotech) at 260-nm wavelength as described previously (44, 46, 47). Briefly, 100 ng of total RNA was converted into first-strand cDNA using RT (Invitrogen) in a volume of 20 μl. The hot-start (Qiagen) RT-PCR was used with the following parameters: 95°C for 15 minutes for 1 cycle; then various amplification cycles for individual genes. Human β-actin gene was amplified in parallel as an internal control. The PCR primers used were: human insulin–forward (5′-CATCAAGCAGCATTGTC-3′) and reverse (5′-CTGGTTCAGGGCTT-TATCC-3′); human glucagon–forward (5′-GCATTACCTTTTGCTGGATGTC3′) and reverse (5′-AGTATTTTGGGTCTGAA-3′); human β-actin–forward (5′-CCCAGATCATGTTTGGACCC-3′) and reverse (5′-CCAAGAGGTACCTGGGCTCAG-3′). DNA relative quantity was analyzed using a gel program (version 3.0 computer analyzer of Media Cybernetics) and expressed relative to the density of the β-actin gene PCR product. For analyzing small quantities of RNA following cytotoxicity assays, RNA derived from 106 HEK 293 cells was added to each assay sample before cDNA synthesis (HEK 293 cells do not express insulin or glucagon).

**Analysis of processing of PPI SP epitopes.** In vitro protease-mediated digests were carried out as described previously (14). In brief, 205 proteasomes were purified from an Epstein-Barr virus (immunoproteasome) and a HeLa cell line (constitutive proteasome) as described (48). Low-molecular-mass polypeptide 2 (LMP2) and LMP7 contents were confirmed by 2D immunoblotting. To assess kinetics, digestions were performed during different incubation periods. The PPI, α synthetic peptide (20 μg) was incubated with 1 μg of purified proteasome at 37°C for 2 and 20 hours in 300 μl of proteasome digestion buffer (49). TFA (1%; 30 μl) was added to halt the digestion, and samples were stored at -20°C until MS analysis.

**Cross-presentation of PPI SP epitopes.** To examine cross-presentation of PPI SP epitopes by DCs, FastDC were generated from a HLA-A2+ donor based on a method previously described (50) and pulsed with soluble antigen (PPI generated in E. coli as described [ref. 9]) or purification tag alone as control, both at 20 μg/ml or heat-killed PPI-expressing cells (K562-PP1 and K562 as control; 1:1 equivalent ratio with DCs) for 6 hours prior to addition of maturation factors (1,000 IU/ml TNF-α and 10 ng/ml IL-1β, both from Strathmann Biotec; and 1 μM PGE\(_{2}\), from Sigma-Aldrich). After overnight culture, DCs were harvested, washed twice, and cultured with PPI\(_{1-24}\)-specific T cell clone at a 5:1 ratio (T/DC) for 24 hours, after which supernatants were removed and TNF-α measured by ELISA.

**Statistics.** Differences in frequencies of responses in study groups were compared using Fisher’s exact test. ROC plots were generated as described previously (9). The effects of glucose concentration were analyzed by 1-way ANOVA with repeated-measures test and test for linear trend. Comparisons were carried out using GraphPad Prism software and considered significant when P was less than 0.05.

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Address correspondence to: Mark Peakman, Department of Immunobiology, King’s College London, School of Medicine, 2nd Floor, Borough Wing, Guy’s Hospital, London SE1 9RT, United Kingdom. Phone: 44-207-188-0148; Fax: 44-207-188-3385; E-mail: mark.peakman@kcl.ac.uk.

Ania Skowera and Richard J. Ellis contributed equally to this work.


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