Fibroblast mitogenic activity of lung lavage fluid from infants with chronic lung disease of prematurity

A E Currie, M Kelly, J R Vyas, H Pandya, D Field, S Kotecha

Background: Lung fibrosis is thought to be important in chronic lung disease of prematurity (CLD).

Methods: Fibroblast proliferative activity was assessed in 207 bronchoalveolar lavage fluid (BALF) samples from 43 infants. Sixteen developed CLD (birth weight 765 g [630–1230], gestation 26.5 weeks [23–29]), 18 developed respiratory distress syndrome (RDS) (birth weight 1415 g [430–4160], gestation 31 weeks [23–39]), and nine control infants (birth weight 2110 g [900–3720], gestation 32 weeks [26–41]) received mechanical ventilation for non-pulmonary reasons.

Results: The fibroblast proliferative activity relative to 10% fetal calf serum was 64–75% in infants with CLD, 55–86% in the RDS group, and 42–68% in control infants during the first 5 weeks of life. Only at day 3 was there a difference between the groups (CLD 72% v control 42%, p < 0.01; RDS 63% v control 42%, p < 0.05). With the use of neutralising antibodies, platelet derived growth factor BB (PDGF-BB) and epidermal growth factor were undetectable, and insulin-like growth factor I (IGF-I) accounted for 14% (p < 0.05) and 11% (p < 0.005) of BALF mitogenic activity from the RDS and CLD groups respectively.

Conclusions: The mitogenic activity of BALF was similar in the three groups studied and was only partially accounted for by IGF-I. Growth factors other than PDGF-BB and IGF-I contribute significantly to this process.

Although the risk factors for chronic lung disease of prematurity (CLD) have been accurately described, the underlying pathogenesis is less clear.1 2 Oxygen toxicity and barotrauma are important risk factors, and a more recently described addition is pulmonary inflammation.3 Histologically, in infants who die from CLD, lung fibrosis is a characteristic feature of the disease.4 The hyaline membranes, which are present early in the development of neonatal respiratory distress syndrome (RDS), are replaced during the second week by interstitial and perivascular fibrosis.5 The septal walls are thickened, and myofibroblast proliferation is seen by electron microscopy.6 Using immunohistochemistry, we have shown that newly synthesised collagen, namely procollagen type I, is deposited early in infants who die from respiratory failure compared with those who die from non-respiratory causes.7 Components of the extracellular matrix, including N-termini of collagen molecules and fibronectin, are also increased in tracheal fluid obtained from infants who develop CLD.8 9 Thus pulmonary fibrosis appears to be a hallmark of CLD.

Development of pulmonary fibrosis is dependent on the proliferation of fibroblasts together with synthesis and deposition of the extracellular matrix by these cells.9 Proliferation of fibroblasts and the subsequent synthesis of the extracellular matrix is thought to be mediated by growth factors. Transforming growth factor β (TGF-β) is a potent profibrotic agent promoting the synthesis and deposition of the extracellular matrix.10 We have previously shown that it is considerably increased early in bronchoalveolar lavage fluid (BALF) obtained from infants who developed CLD compared with those infants who did not.11 The growth factors platelet derived growth factor B (PDGF-BB) and insulin-like growth factor (IGF-I) are potent mitogens for fibroblasts.12 13 IGF-I consists of B and A chains, with the mature 70 amino acid molecule being highly conserved in vertebrates, showing 40% homology with insulin and 60% with IGF-II.14 IGF-I is expressed in fetal tissues by mesenchymal cells, and its ablation in mice results in decreased prenatal growth and lethality immediately after birth.15 Postnatally, IGF-I has multiple functions, including acting as a progression factor for fibroblasts, thus inducing their proliferation. IGF-I has been shown to be increased in systemic sclerosis and in idiopathic pulmonary fibrosis.16 17 PDGF is a 30 kDa protein of either homodimer (PDGF-AA or PDGF-BB) or a heterodimer (PDGF-AB).18 Dimers with at least one B chain will bind to the receptor PDGFR-β. PDGF-BB is more relevant to respiratory biology as it is a potent mitogen for lung fibroblasts and has been shown to be increased in respiratory diseases such as idiopathic lung fibrosis and acute lung injury.19 Sources within the lung include alveolar macrophages, which are increased in many respiratory diseases including CLD.20

As both IGF-I and PDGF-BB are potent mitogens for lung fibroblasts, and as lung fibrosis is a hallmark of CLD, we postulated that BALF obtained from infants who developed CLD would have greater fibroblast mitogenicity than similar fluid obtained from infants who required mechanical ventilation for neonatal RDS and for non-pulmonary reasons. In addition, by using antibody neutralising experiments, we determined whether PDGF-BB or IGF-I contributed to the fibroblast proliferative activity of BALF.

METHODS

Patient groups

Three groups of mechanically ventilated infants were studied: (a) CLD group: infants who developed RDS followed by CLD—that is, who were oxygen dependent at 28 days of age and had an abnormal chest radiograph; (b) RDS group:...
Infants who developed RDS but were nursed in air and had a normal chest radiograph by day 28 of age; (c) control group: infants who received mechanical ventilation for non-pulmonary reasons and had an oxygen requirement of ≤28% throughout the study period.

Infants of mothers who had infection or prolonged rupture of membranes (of >48 hours) were excluded, as were infants with documented or strongly suspected sepsis—that is, with positive blood or endotracheal tube secretion cultures or raised white cell count or C reactive protein concentration (>0.5 mg/l).

**Bronchoalveolar lavage (BAL)**

BAL was performed at the time of clinically indicated tracheal suctioning as previously described.21–22 Briefly, the infant was placed in the supine position with the head turned to the left to direct the catheter into the right lower lobe. An FG 5 catheter was gently inserted in a segmental bronchus until resistance was felt, and two aliquots of 1 ml/kg saline was instilled. With the catheter in situ, after two or three ventilator breaths, the instilled fluid was aspirated back with a suction pressure of 5–7 kPa. The procedure was performed at the time of clinically indicated routine suctioning. The first BAL was performed within 24 hours of birth. Thereafter the infants underwent BAL twice a week until 35 days of age or extubation, whichever occurred earlier. The local research ethics committee had approved the lavage procedure, and informed parental consent was obtained before the procedure was started. The collected BALF was placed on ice and centrifuged at 500 g for 10 minutes of collection. The supernatant was stored at room temperature for 10 minutes within 10 hours. Thereafter, cells were incubated under the following experimental conditions: controls of 0.5%, 10% FCS, 20 ng/ml IGF-I or PDGF-BB; or BALF with or without growth factor and/or antibody (recombinant PDGF-BB, epidermal growth factor (EGF), and IGF-I and respective antibodies; R&D Systems Europe, Abingdon, Oxon, UK). All experiments were performed in triplicate.

Preliminary experiments showed that 48 hours of incubation was optimal to show fibroblast proliferation. Additional experiments showed that 1:10 to 1:20 dilution of BALF was optimal to show fibroblast proliferation (see below and fig 3). Thus, a 1:10 dilution was used for fibroblast proliferation assays in triplicate, and, because of limited volumes of BALF obtained from preterm infants, a 1:20 dilution was used in triplicate for antibody neutralising experiments.

**Methylene blue assay**

The proliferation of Swiss 3T3 cells was determined by a modified assay described by Oliver et al.23 After removal of the culture medium, the cells were fixed with 10% formaldehyde in phosphate buffered saline for one hour, and 100 µl of fresh methylene blue in 0.1 M borate buffer (pH 8.5) was added. After elution of the dye from the cells with 1:1 (v/v) ethanol and 0.1 M HCl, the absorbance was measured at 650 nm with a microplate photometer (Dynatech Labs). Initial experiments validated the methylene blue assay with both cell counting and incorporation of [3H]thymidine. The results of the methylene blue assay were within 10% of the results obtained by cell counting and [3H]thymidine incorporation.

**Antibody blocking experiments**

Initial experiments using a dose range of 0–100 ng/ml recombinant growth factor (PDGF-BB and IGF-I) and the fibroblast proliferation assay described above showed that 20 ng/ml growth factor (both PDGF-BB and IGF-I) resulted in near maximum fibroblast proliferation. Additional experiments showed that 10× manufacturer’s specified neutralising dose50 of the respective antibody completely abolished the mitogenic activity of both growth factors, each used at 100 ng/ml. For experiments using BALF, the lavage fluid was incubated for two hours on ice with the antibody before addition to the fibroblasts. The experiments were terminated after 48 hours of incubation as described above by the addition of 10% formaldehyde in phosphate buffered saline. Cell proliferation was determined by using the methylene blue assay described above.

**Data analysis**

Results are given as median (range) for patient characteristics such as birth weight and gestation, and median (interquartile range) for the fibroblast proliferation assays. All experiments with the fibroblast proliferation assay were performed in triplicate. The mean of the triplicates is given for single experiments. When multiple plates were compared, the Aso

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**Table 1 Patient characteristics**

<table>
<thead>
<tr>
<th></th>
<th>CLD</th>
<th>RDS</th>
<th>Control</th>
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<tbody>
<tr>
<td><strong>Number</strong></td>
<td>16</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td><strong>Male female</strong></td>
<td>9.7</td>
<td>11.7</td>
<td>6.3</td>
</tr>
<tr>
<td><strong>Birth weight (g)</strong></td>
<td>765 (630–1230)</td>
<td>1415 (430–4160)</td>
<td>2110 (900–3720)</td>
</tr>
<tr>
<td><strong>Gestational age (weeks)</strong></td>
<td>26.5 (23–29)</td>
<td>31 (23–39)</td>
<td>32 (26–41)</td>
</tr>
<tr>
<td><strong>Antenatal dexamethasone</strong></td>
<td>15 (94%)</td>
<td>8 (44%)</td>
<td>3 (33%)</td>
</tr>
<tr>
<td><strong>Sulfactant administration</strong></td>
<td>15 (94%)</td>
<td>15 (83%)</td>
<td>1 (11%)</td>
</tr>
<tr>
<td><strong>Day 1 maximum peak inspiratory pressure (cm H2O)</strong></td>
<td>7.5 (5–21)</td>
<td>9.5 (4.4–29)</td>
<td>5.3 (4–7)</td>
</tr>
<tr>
<td><strong>Day 1 maximum airway pressure (cm H2O)</strong></td>
<td>5.3 (2.1–30.5)</td>
<td>5.9 (0.9–94.3)</td>
<td>1.8 (1.3–3.0)</td>
</tr>
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*Except where indicated otherwise, median values (range) are shown.*

CLD, Chronic lung disease of prematurity; RDS, Respiratory distress syndrome.
Relative fibroblast proliferation (%) value for each well was calculated relative to the value for 10% fetal calf serum for each 96 well plate. *p < 0.01 for CLD v control and p < 0.05 for RDS v control.

Figure 1 Relative fibroblast proliferation induced by bronchoalveolar lavage fluid obtained from infants who progressed to chronic lung disease of prematurity (CLD), who developed and recovered from neonatal respiratory disease (RDS), and control infants receiving mechanical ventilation for non-respiratory reasons. The proliferative activity is relative to the A<sub>650</sub> value obtained for 10% fetal calf serum for each 96 well plate. *p < 0.01 for CLD v control and p < 0.05 for RDS v control.

Table 1 shows patient characteristics including use of surfactant and antenatal corticosteroids. In particular, 15/16 (94%) in the CLD group, 15/18 (83%) in the RDS group, and 1/9 (11%) in the control group were treated with exogenous surfactant. Significant differences in gestation and birth weight were noted between infants in the CLD and RDS groups (p < 0.0005) and those in the CLD and control groups (p < 0.0001), but not between those in the RDS and control groups (birth weight, p = 0.13; gestation, p = 0.073). Significant differences were also found between the CLD and control groups for inspired oxygen (p < 0.001) and oxygenation index (p < 0.005), but not for peak inspiratory pressure in the first 24 hours of age, and between the RDS and control groups for inspired oxygen (p < 0.01) and oxygenation index (p < 0.01). The difference for peak inspiratory pressure in the first 24 hours of age between the RDS and control groups approached significance (p = 0.06).

Figure 2 Neutralising antibodies were used against platelet derived growth factor (PDGF-BB) and epidermal growth factor (EGF) to show whether bronchoalveolar lavage fluid (BALF) fibroblast activity was dependent on these two growth factors. Parallel experiments showed that BALF spiked with PDGF-BB did increase fibroblast proliferation, but this was decreased to baseline levels by prior addition of a neutralising antibody (ab) to PDGF-BB. Further experiments used neutralising antibodies to IGF-I, which prevented any fibroblast proliferative activity in native BALF at 1:10 and 1:50 dilutions.

Fibroblast mitogenic activity of BALF

Figure 3 shows the results. In the CLD group, the A<sub>650</sub> relative to 10% FCS was 64–75% during the five week study period. In the infants with RDS, the relative fibroblast proliferation was 55–63%, except for an increase to 86% on day 7. In the control group, the values were between 42% and 68%. Significant differences were only found between the groups at day 3 of age (CLD v controls: 72% v 42%, p < 0.01; RDS v controls: 63% v 42%, p < 0.05), but not between the CLD and RDS groups at any time. Gestation, birth weight, and use of antenatal corticosteroids or exogenous surfactant did not influence the day 1 results for fibroblast proliferation in the different groups studied. (Only day 1 results were compared for gestation, birth weight, and use of antenatal corticosteroids and surfactant because later samples are likely to be influenced by postnatal factors such as oxygen and ventilation).

Detection of fibroblast mitogenic growth factors in BALF

Using neutralising antibodies to PDGF-BB and EGF, we were unable to contribute any fibroblast proliferative activity in BALF to these two growth factors (fig 2). Parallel experiments “spiking” BALF with growth factor showed that the increased proliferation of fibroblasts with 20 ng/ml PDGF-BB was prevented by the prior addition of neutralising antibody to PDGF-BB. As expected, spiking with EGF did not increase fibroblast proliferation (data not shown).

Further experiments used neutralising antibodies to IGF-I to show whether this growth factor contributed to the mitogenic activity observed in BALF from ventilated infants. Fibroblast proliferative activity was shown in BALF by using dilutions of 1:10 to 1:50 (one individual experiment shown in fig 3). Spiking each diluted BALF with IGF-I increased the proliferation and that it was prevented by the prior addition of a neutralising antibody (ab) to IGF-I. Furthermore, this antibody also decreased the fibroblast activity of native BALF at 1:10 and 1:50 dilutions.
We have found that fibroblast proliferative activity of BALF from infants who progressed to CLD and those who developed RDS was remarkably similar in all infants studied, suggesting that lung growth in infants with CLD is disordered, resulting in decreased alveolisation, increased mean linear diameter of alveoli, and decreased lung surface area. They also reported disordered deposition of elastin in dense focal areas, which would be expected to affect lung mechanics, including compliance. These observations suggest that normal lung growth is disordered in CLD and that regulation of lung growth, including deposition of components of the extracellular matrix, may be abnormal rather than an increase in numbers of fibroblasts. TGF-β1, which we have previously reported to be increased in CLD,\(^{10}\) is a known inhibitor of alveolisation\(^{20}\) and may be part of a cascade leading to disordered lung growth in CLD. In this study, we did not see the production of increased components of the extracellular matrix, which may be of greater importance than increased proliferation of fibroblasts.

As rapid lung growth\(^ {12} \) is probably regulated by the growth factors we have studied, any additional growth factor activity resulting from repair/remodelling processes after acute lung injury may be difficult to identify. Another explanation for the discrepancy between the increased fibroblast numbers observed at autopsy of infants who have died from CLD when compared with control infants and our data showing minimal increased mitogenicity for fibroblasts may be the removal of fibroblasts from the lung by the process of apoptosis.\(^ {31} \) Most studies have concentrated on the proliferation of fibroblasts, and yet few have studied the removal of this cell type from the lung. Clearly the balance between fibroblast proliferation and removal of these cells will affect whether or not lung fibrosis occurs.

Growth factors such as IGF-I and PDGF-BB are known mitogens for lung fibroblasts,\(^ {32} \)\(^ {33} \) but in BALF from those infants who died and did not develop CLD, we were unable to show any contribution by PDGF-BB, and only 10–15% activity was attributable to IGF-I. This is unlikely to be due to methodological problems because the increased proliferation caused by spiking the lavage fluid was prevented by the prior addition of the relevant neutralising antibody. The existence of inhibitory autoantibodies to PDGF-BB in BALF has been postulated. We would like to speculate that the lack of fibroblast proliferation caused by PDGF-BB was not due to the presence of inhibitors because the spiking of BALF resulted in fibroblast proliferation, as the presence of inhibitors would have prevented such an effect. Factors other than the growth factors that we have studied are known to promote proliferation of fibroblasts. Particular attention has recently focused on components of the clotting cascades. Thrombin has been shown to be a potent mitogen for fibroblasts and has been shown to be increased in respiratory diseases in adults.\(^ {32} \)

We have used methylene blue to assess the proliferation of fibroblasts with BALF, FCS, and growth factors. It is a simple technique which gives repeatable results. We validated the technique using \(^{[3}H\)thymidine incorporation and found a good correlation between the two methods, as previously reported by Laurent's group.\(^ {31} \) However, we are aware that the staining is proportional to both cell volume and cell numbers, but the correlation between this method and incorporation of \(^{[3}H\)thymidine is reassuring. The antibody neutralising experiments were performed with spiking of the BALF with IGF-I and PDGF-BB as well as EGF (as a control).\(^ {28} \) We found that addition of IGF-I and PDGF-BB increased fibroblast proliferation, but the simultaneous addition of neutralising antibody abrogated this increase thus validating the method.

In summary, we are not aware of any other study showing the fibroblast proliferative activity of BALF obtained from infants who develop CLD. Fibroblast proliferation was remarkably similar in all infants studied, suggesting that fibroblast proliferation is not prominent in the development of CLD. In addition, we have only been able to account for 10–15% of the mitogenic activity for fibroblasts in lung lavage fluid from newborn infants. Factors other than IGF-I and
PDGF-BB are responsible for promoting fibroblast division in the newborn lung.

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This publication is dedicated to the memory of Martin Kelly.

REFERENCES