The Correlation of Regulatory T (TReg) and Vitamin D3 in Pediatric Nephrotic Syndrome

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ABSTRACT

Nephrotic syndrome (NS) is an autoimmune disease that correlates to the imbalance of regulatory T cells (TReg). This study was aimed to investigate the effect of vitamin D as adjuvant therapy of TReg population in pediatric nephrotic syndrome. This study was designed randomized clinical trial, double blind, with pre- and post-test control groups involving 15 subjects newly diagnosed with NS. Subjects were divided into 2 groups, namely K1 for group treated with prednisone+vitamin D and K2 group for prednisone treatment only. The population of TReg in peripheral blood mononuclear cells (PBMC) was analyzed using flowcytometry. Vitamin D serum level was measured through ELISA method. Results showed that there was a significant elevation of TReg (independent t-test, p = 0.010) in K1 group, which was higher than in K2 group. The Pearson test in the K1 group showed that vitamin D level was positively correlated with TReg (p = 0.039, r = 0.779).

Keywords: Nephrotic syndrome, vitamin D, TReg

INTRODUCTION

Idiopathic nephrotic syndrome is a glomerular disease characterized by several clinical manifestations such as severe proteinuria, hypoalbuminemia, hyperlipidemia, and edema [1, 2]. The prevalence of nephrotic syndrome stands at 12 – 16 cases per 100,000 children, which is mostly found at the age of 2 – 5 years old. In Indonesia, there were 6 cases found in every 100,000 children below 14 years old per year in children, which is dominated by male (male: female ratio = 2 : 1) [3].

Pathogenesis of nephrotic syndrome is based on the immunological aberration, characterized by abundant circulating factor [4] and immuno-regulatory imbalance [5]. Conversely, regulatory T-cells (TReg) is an important tolerogenic T-cell possessing protective effect on podocyte destruction [6, 7]. Vitamin D has been known as immunomodulator that able to induce TReg differentiation as it has pleiotropic effects [8, 9]. Therefore, this study was aimed to investigate the effect of vitamin D as adjuvant therapy to the TReg population in pediatric nephrotic syndrome.

Material and methods

This study was conducted at Biomedical Laboratory, Faculty of Medicine, Brawijaya University. The duration of the study ranged between February until July 2015.

Study Design

This study was designed as a randomized clinical trial (RCT) double blind, with pre-and post-test control group. There were 2 groups namely K1 (prednisone and vitamin D3) and K2 (prednisone only). TReg population and vitamin D levels were measured before and after treatment. Treatment for K1 were prednisone 2 mg/kg body weight/day (maximal dose 80 mg/day) and vitamin D3 oral preparation (D-Vit, PT. Gracia Pharmindo™) 2000 IU/day for 4 weeks. Treatment for K2 was prednisone 2 mg/kg body weight/day (maximal dose 80 mg/day) for 4 weeks according to ISKDC protocol. All the procedures and treatments of this study had been approved by the Ethical Committee Faculty of Medicine.

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**Subjects**

There were 15 subjects included in this study (7 subjects in K1; 8 subjects in K2). Subjects were taken from the Pediatric Nephrology Outpatient Care and Pediatric Ward, Dr. Saiful Anwar General Hospital, Malang during February – July 2015. The inclusion criteria for this study were newly diagnosed nephrotic syndrome patients aged 1 – 14 years old whose parents allowed them to participate in this study (informed consent). Meanwhile, the exclusion criteria for this study were secondary nephrotic syndrome, congenital nephrotic syndrome, relapse nephrotic syndrome, and steroid dependant nephrotic syndrome.

**Isolation of Peripheral Blood Mononuclear Cells (PBMC)**

Blood samples in EDTA vacutainer were homogenized and added with PBS at a ratio of 1 : 1. The blood sample-PBS mixture was transferred slowly into falcon tube walls filled with Ficoll-Hipaque $d = 1.077$ g/dL (1 : 1). This mixture was centrifuged at 1,500 rpm at room temperature for 30 minutes which resulted in the formation of 4 layers namely plasma, PBMC, Ficoll-Hipaque, and erythrocyte. The PBMC ring was slowly transferred into $15mL$ centrifuge bottle. It was washed with $10mL$ PBS and centrifuged at 1200 rpm, at room temperature for 10 minutes. The supernatant was removed, washed using PBS, and centrifuged again at 1,200 rpm at room temperature for 10 minutes. After the second process of washing and centrifugation, PBMC will be formed as pellet at the bottom of centrifuge bottle.

### Measurement of regulatory T-cell population

The population of $T_{reg}$ was measured trough flowcytometry method. Antibodies that were used phycoerythrin (PE) anti-human FOXP3, FITC anti-human CD4, and PE/Cy5 anti-human CD25 (eBioscience, San Diego, CA). PBMC was suspended at certain density (2 × 10^6 cells/mL) in culture medium (RPMI equipped with penicillin 100 U/mL, streptomy-cin 100 µg/mL, glutamine 2 mM, 10% calf fetal serum). The cell suspension was transferred into 24 wells then was stimulated with phorbol myristate acetate (PMA) 50 ng/mL and ionomycin 1 µM for 4 hours in monensin 500 ng/mL (Alexis Biochemical, San Diego, CA). The incubator was set at temperature of 37°C and air pressure of 5% CO₂. After 4 hours, the cell culture was transferred into sterile tubes and centrifuged at 1,500 rpm for 15 minutes.

T-cell lymphocyte was transferred into new tubes, washed with phosphate-buffered saline (PBS), and then incubated with fluorescein isothiocyanate (FITC) anti-human CD4 and PE CD25 at 4°C for 30 minutes. After incubation, specimens were stained with PE anti-human Foxp3. Specimens were transferred into cuvette ready for flowcytometry analysis. The population of $T_{reg}$ was analyzed with BD Cell Quest Pro.

### Measurements of vitamin D level

Vitamin D level was measured through ELISA method as previously described. Briefly 200 µL pre-diluted serum samples were added into each well then it incubated for 2 hours at 25°C. After being washed, 100 µL enzyme conjugate was added into the tubes and incubated for 30 minutes at room temperature. Following this, 100 µL chromogen/substrates solution was added and incubated for 15 minutes at room temperature in dark room. Finally, 100 µL stop solution was added to

### Table 1. Subject Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Combination Prednison+vitamin D (n = 7)</th>
<th>Prednisone only (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 – ≤ 5</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>&gt; 5 - &lt; 10</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>≥ 10 – 14</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Normal</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Vitamin D Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficiency</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Deficiency</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Good</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Undernutrition</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: SSNS (steroid sensitive nephrotic syndrome), SRNS (steroid resistant nephrotic syndrome)

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each well. After 30 minutes, specimens were ready for analysis using ELISA reader at 650 nm.

**Statistical analysis**

Data distribution and homogeneity were statistically analyzed. Moreover, statistical differences of $T_{Reg}$ and vitamin D levels between groups were analyzed by independent t-test. The differences of $T_{Reg}$, Th17, and vitamin D before and after treatment were analyzed by paired t-test. The correlation of $T_{Reg}$ and vitamin D level was analyzed with the Pearson correlation test. Data was analyzed at 95% confidence interval ($\alpha = 0.05$) using SPSS version 17.0 for Windows.

**RESULTS AND DISCUSSION**

**Subject and baseline characteristics**

Subject characteristics such as age, sex, vitamin D status, outcomes (steroid sensitive or resistant), and nutritional status were shown in Table 1. Moreover the clinical outcome of subjects were shown in Table 2. Remission before 4 weeks and remission after 4 weeks were found in both groups that earlier was also found in K1. Most of the subjects were diagnosed with steroid sensitive nephrotic syndrome (SSNS), there was only one patient did not get remission and is classified as steroid resistant nephrotic syndrome (SRNS).

Based on the age factor, subjects were mostly from kids aged under 10 years old. The subjects were dominated by male or 12 boys from 15 subjects. This finding was also in accordance with previous studies and has been considered to be correlated with abnormal T cell clones in male thymus gland [10]. Based on nutritional status, it is revealed that most subjects had good nutritional status. However, it is important to evaluate nutritional status of children with nephrotic syndrome because they are at high risk of suffering from malnourishment.

Vitamin D level status in nephrotic syndrome patients (9 of 15) was low. This result was in accordance with previous study conducted in the General Hospital Dr. Cipto Mangunkusumo that 22 of 26 nephrotic patients had low vitamin D levels (10 insufficiency, 16 deficiency) [11]. Loss of vitamin D-bounded protein through urine had been considered as etiologic factor for low plasma concentration in nephrotic patients [12]. Low vitamin D levels cause hyper-reactivity o dendritic cell, T cell, B cell, $T_{Reg}$ suppression, and pro-inflammatory cytokines elevation [13] that would lead to nephrotic syndrome. Several factors affect 25(OH)D level such as age, race, season, and milk consumption [14].

**Table 2. Clinical outcome**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Combination Prednisone+ vitamin D (n=7)</th>
<th>Prednisone only (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classification</td>
<td>SNSS</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>SNRS</td>
<td>1</td>
</tr>
<tr>
<td>Remission</td>
<td>Early responder</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Late responder</td>
<td>1</td>
</tr>
<tr>
<td>Resistance</td>
<td>Resistance</td>
<td>1</td>
</tr>
</tbody>
</table>

**Figure 1. $T_{Reg}$ percentage before treatment (pre-test) and after treatment (post-test)**

**Figure 2. Vitamin D Level before treatment (pre-test) and after treatment (post-test)**
**Regulatory T cell population**

The results demonstrated that there was no significant difference in the population of T_{Reg} in K1 and K2 (independent t-test, \( p = 0.97 \) pretest) before treatment. However, the differences were found significantly after treatment (independent t-test, \( p = 0.03 \) post test). Furthermore, the elevation of the T_{Reg} population in K1 and K2 (before and after treatment, independent t-test, \( p = 0.01 \)) were significantly different. Figure 1 shows the T_{Reg} percentage before treatment, after treatment, and its enhancement after treatment. Furthermore, the enhancement of T_{Reg} percentage was significantly different in both groups (paired t-test, K1 \( p = 0.00 \), K2 \( p = 0.00 \)).

**Vitamin D level and T_{Reg} population**

The vitamin D level was found higher in K1 than K2 (before and after treatment, independent t-test, \( p = 0.00 \)). Figure 2 shows vitamin D levels before treatment, after treatment, and its elevation after treatment. Furthermore, the elevation of vitamin D level was significantly different in both groups (paired t-test, K1 \( p = 0.00 \), K2 \( p = 0.00 \)).

The elevation of T_{Reg} population in prednisone and vitamin D treated group was higher than in prednisone only treated group. Reduction of T_{Reg} population and its dysfunction in nephrotic syndrome would lead to disability to suppress effector T cells [15] that is associated to proteinuria [16, 17]. T_{Reg} also acts as anti-inflammatory T cells through secretion of several anti-inflammatory cytokines such as IL-10 and TGF-\( \beta \) [18].

Vitamin D administration could induce and stimulate T_{Reg} directly through antigen presenting cells or dendritic cells also indirectly through endocrine or intracrinal conversion of 25(OH)D becoming 1,25(OH)2D3 [18]. Furthermore, vitamin D administration was correlated with elevation of T_{Reg} Foxp3+ population [9, 19]. Several mechanisms focused on how vitamin D affects T_{Reg} have been studied. Administration of 1,25(OH)2D3 could enhance STAT5 phosphorylation in Foxp3+ cells via TGF-\( \beta \) and IL-2 that lead to T_{Reg} differentiation [20, 21]. Conversely, low vitamin D levels would lead to IL-6 upregulation instead of TGF-\( \beta \) downregulation causing Th17 differentiation [21].

Glucocorticoid had been known as one of anti-inflammation drugs that induces T cell apoptosis, T cell energy, and suppress T cell function [22]. Furthermore, glucocorticoid could induce IL-10 upregulation resulted in immature dendritic cells or macrophage thus inducing differentiation of T_{Reg}/suppressor T cells [22]. Adjuvant therapy with vitamin D3 could induce immunosuppressive effects of T_{Reg} through upregulation of Foxp3 and IL-10 [23, 24, 25].

**CONCLUSION**

In conclusion, there was significant elevation of T_{Reg} population in the prednisone and vitamin D treated group than in prednisone only treated group. However, the vitamin D level was positively correlated with T_{Reg} population.

**ACKNOWLEDGMENT**

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Correlation of \(T_{\text{Reg}}\) and Vitamin D


