

FDA-approved immunosuppressants targeting staphylococcal superantigens: mechanisms and insights

Teresa Krakauer

Department of Immunology,
Molecular Translational Sciences
Division, United States Army Medical
Research Institute of Infectious
Diseases, Fort Detrick, Frederick,
MD, USA

Abstract: Immunostimulating staphylococcal enterotoxin B (SEB) and related superantigenic toxins cause diseases in human beings and laboratory animals by hyperactivating cells of the immune system. These protein toxins bind to the major histocompatibility complex class II (MHC II) molecules and specific V β regions of T-cell receptors (TCRs), resulting in the stimulation of both monocytes/macrophages and T lymphocytes. The bridging of TCR with MHC II molecules by superantigens triggers intracellular signaling cascades, resulting in excessive release of proinflammatory mediators and massive polyclonal T-cell proliferation. The early induction of tumor necrosis factor α , interleukin 1 (IL-1), interleukin 2 (IL-2), interferon gamma (IFN γ), and macrophage chemoattractant protein 1 promotes fever, inflammation, and multiple organ injury. The signal transduction pathways for staphylococcal superantigen-induced toxicity downstream from TCR/major histocompatibility complex (MHC) ligation and interaction of cell surface co-stimulatory molecules include the mitogen-activated protein kinase cascades and cytokine receptor signaling, activating nuclear factor κ B (NF κ B) and the phosphoinositide 3-kinase/mammalian target of rapamycin pathways. Knowledge of host regulation within these activated pathways and molecules initiated by SEB and other superantigens enables the selection of US Food and Drug Administration (FDA)-approved drugs to interrupt and prevent superantigen-induced shock in animal models. This review focuses on the use of FDA-approved immunosuppressants in targeting the signaling pathways induced by staphylococcal superantigens.

Keywords: immunosuppressant, superantigen, toxic shock, NF κ B, mTORC1

Introduction

Staphylococcal enterotoxin B (SEB) and the distantly related toxic shock syndrome toxin 1 (TSST-1) are common etiological agents that cause toxic shock syndrome.^{1,2} The disease is characterized by fever, hypotension, desquamation of skin, and multiple organ system failure.¹⁻³ These virulence proteins produced by *Staphylococcus aureus* are commonly called superantigens as they potently stimulate T-cells, resulting in polyclonal T-cell activation.⁴⁻⁶ Staphylococcal superantigens hyperactivate cells of the innate immune system and adaptive T-cells concomitantly by binding to the major histocompatibility complex class II (MHC II) molecules on antigen-presenting cells (APCs) and specific V β regions of T-cell receptors (TCRs).⁶⁻¹² However, their mode of interaction differs from conventional antigens in that they bind on the outside of the peptide-binding groove of MHC II and exert their biological effects as an intact molecule without being “processed” by APCs. In addition, recognition of a superantigen:MHC II complex by the TCR is not restricted by the major histocompatibility complex (MHC) and depends upon the variable region within a TCR β

Correspondence: Teresa Krakauer
Department of Immunology, Molecular
Translational Sciences Division, United
States Army Medical Research Institute
of Infectious Diseases, 1425 Porter
Street, Fort Detrick, Frederick, MD
21702-5011, USA
Tel +1 301 619 4733
Fax +1 301 619 2348
Email Teresa.Krakauer.civ@mail.mil

chain (V β). Structural properties of many superantigens are well characterized, and most residues involved in their binding to cell surface receptors on immune cells have been identified.^{12,13} Various modes of interaction with MHC II and TCRV β are used by superantigens to promote immunological synapse of interacting cells and cell activation.^{14,15} Activated cells produce cytokines, chemokines, tissue factors, lytic enzymes, and reactive oxygen species (ROS), activating both inflammation and coagulation.^{16–18} These cytokines include tumor necrosis factor α (TNF α), interferon gamma (IFN γ), and interleukin 1 (IL-1), proinflammatory mediators with potent immunoenhancing effects, known to be pathogenic at high levels *in vivo*.^{18–23}

Staphylococcal superantigens are stable, single-chain globular proteins of 22–30 kD that are highly resistant to proteases and heat denaturation. Despite differences in sequence homology among the staphylococcal enterotoxins (SEs) and TSST-1, they have similarities in their secondary and tertiary structures.^{6,24} Crystallographic studies of staphylococcal superantigens reveal two conserved, tightly packed domains with a β -barrel domain at the N-terminal and a β -grasp motif at the C-terminal. The relatively conserved TCR-binding site is located in the shallow groove between these two domains. Superantigens bind to common, conserved elements outside the peptide-binding groove on MHC II molecules with a relatively high affinity.^{6,24} There are at least two distinct binding sites on MHC II molecules for superantigens:¹⁰ a common, low-affinity binding site involving the invariant α -chain of MHC II and a high-affinity, zinc-dependent binding site on the polymorphic β -chain.^{24–26} The bridging of superantigens to MHC II and TCR allows cooperative interactions between receptors, hyperactivating the host immune system. Two decades of elegant structural and molecular studies defined binding motifs of bacterial superantigens with MHC II and TCRV β .^{6,24} Many excellent reviews are available on this topic so they will not be discussed further.^{5,6,12,24–29}

Three signals of T-cell activation and signal transduction

Similar to conventional antigen, the binding of superantigen/MHC II to TCR transmits the classical first signal for T-cell activation.³⁰ Upon superantigen binding, engagement of co-stimulatory molecules CD80 and CD86 on APCs with CD28 on T-cells delivers the second signal that optimizes T-cell activation through the formation of stable cell conjugates.^{31,32} Other cell adhesion molecules and receptors such as intercellular adhesion molecule 1 (ICAM1) on APCs and leukocyte function-associated antigen 1 (LFA-1)

on T-cells also participate in cell activation by superantigens.³³ Co-stimulatory signaling increases the stability of mRNA of IL-2, IFN γ , TNF α , granulocyte-macrophage colony-stimulating factor (GM-CSF), and the expression of anti-apoptotic protein Bcl-xL to promote T-cell survival.^{34–36} TCR and co-stimulatory receptors activate protein tyrosine kinases (PTKs), LCK, and ZAP-70, resulting in phospholipase C gamma (PLC γ) activation, release of intracellular second messengers, and increase in intracellular Ca⁺⁺.^{37,38} The increase in intracellular calcium concentration activates calcineurin phosphatase, which dephosphorylates nuclear factor of activated T-cells (NFAT), allowing for its translocation into the nucleus where it activates the expression of IL-2 and other T-cell cytokines for T-cell differentiation into T helper 1 (TH1) cells and other T-cell subsets.³⁰ Additionally, PTKs also activate protein kinase C (PKC) and Ras GTPase, both of which are also triggered by cell stress and growth factors.³⁰ The activation of PTK, PLC γ , and PKC initiates three important downstream signaling pathways: 1) Ca⁺⁺/calcineurin pathway; 2) mitogen-activated protein kinase (MAPK) cascade; and 3) nuclear factor κ B (NF κ B) pathway, resulting in the activation of transcriptional factors NFAT, activating protein 1 (AP1), and NF κ B.^{30,38–40} NF κ B binds to the promoter region of many proinflammatory mediators, including IL-1 and TNF α , resulting in proinflammatory cytokine expression.⁴⁰ The third signal to fully activate T-cells consists of inflammatory cytokines and T-cell growth and differentiation factors, some of which can be induced by signals 1 and 2.⁴¹ The signal transduction pathways of superantigen-activated T-cells are presented in Figure 1.

TCR and co-stimulatory receptor stimulation also activate the lipid kinase phosphoinositide 3 kinase (PI3K).^{42,43} Additionally, IL-2 receptor (IL-2R), IFN γ receptor (IFN γ R), growth factor receptors, and G-protein-coupled receptor (GPCR) also transduce activation signals via the PI3K pathway upon binding to their respective ligands. PI3K activation generates several inositol phospholipids and activates the protein kinase Akt and mammalian target of rapamycin complex 1 (mTORC1) downstream.^{42–45} Activation of mTORC1 leads to phosphorylation of the ribosomal 40S protein p70S6 kinase (p70S6K) and the eukaryotic initiation factor 4E-binding protein 1 (4EBP1).^{44,45} Phosphorylated p70S6K promotes mRNA translation, protein biosynthesis, and cell growth, whereas phosphorylation of 4EBP1 enhances protein synthesis by inhibiting its binding to the initiation factor eukaryotic translation initiation factor 4E-binding protein (eIF4E). Activation of mTORC1

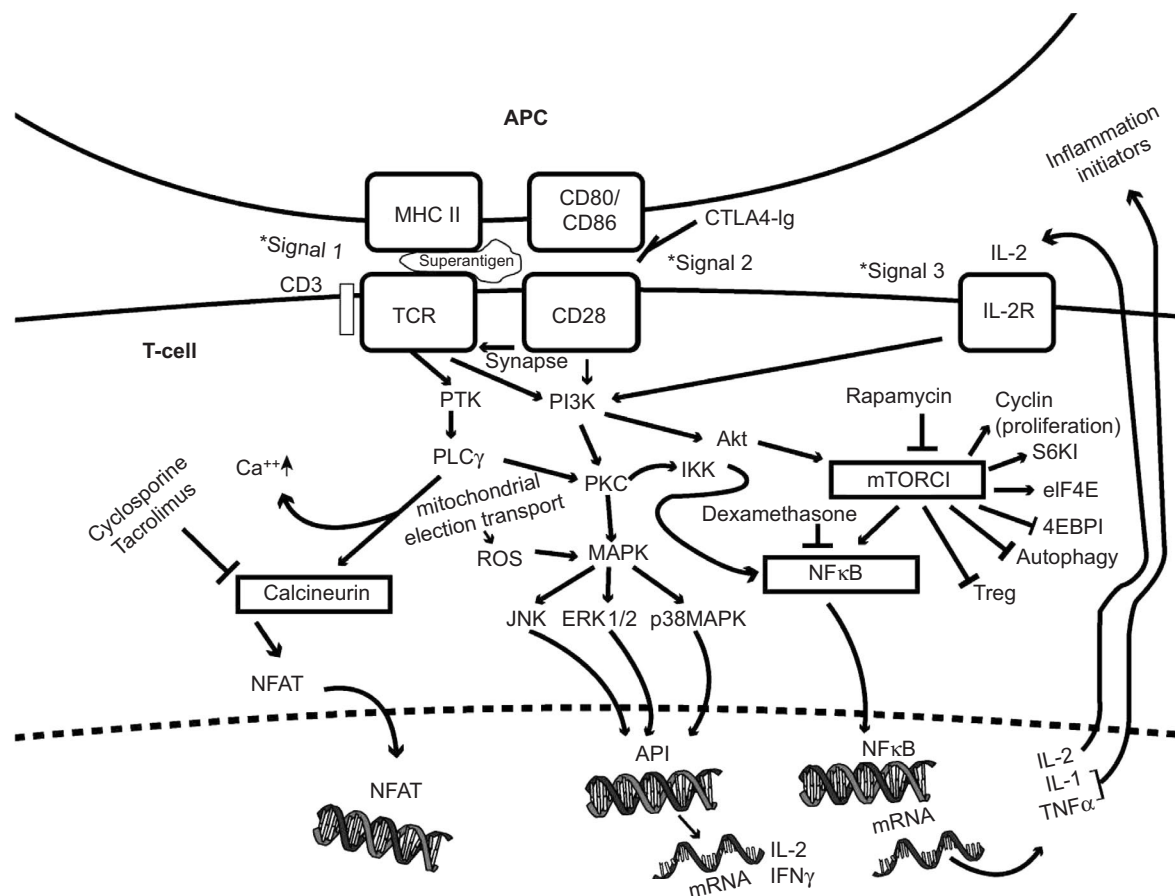


Figure 1 Superantigen-activated T-cell signaling pathways and sites of action of FDA-approved immunosuppressants.

Abbreviations: APC, antigen-presenting cell; CTLA4-Ig, cytotoxic T lymphocyte antigen-4 immunoglobulin; ERK1/2, extracellular signal-regulated kinase 1 and 2; FDA, US Food and Drug Administration; IKK, I κ B kinase; IL-1, interleukin 1; IL-2, interleukin 2; IL-2R, interleukin 2 receptor; JNK, jun-N-terminal kinase; MHC II, major histocompatibility complex class II; mTORC1, mammalian target of rapamycin complex 1; NFAT, nuclear factor of activated T-cells; NF κ B, nuclear factor kappa B; PI3K, phosphoinositide 3 kinase; PLC γ , phospholipase C γ ; ROS, reactive oxygen species; TCR, T-cell receptor; TNF α , tumor necrosis factor α ; Treg, regulatory T-cell.

resulting from all three signals of T-cell activation is essential for G1 to S phase transition as it controls cell proliferation and protein translation.^{44,45} Additionally, mTORC1 also functions to integrate diverse signals of nutrient sufficiency and cellular energy via an upstream negative regulator, the adenosine monophosphate (AMP)-activated protein kinase (AMPK).⁴⁶

Cellular response to superantigens

Human peripheral blood mononuclear cells (PBMC) are often used to study immune cell activation and the subsequent cellular changes by superantigens as these cells are responsive to picomolar concentrations of SEs and TSST-1.^{7,47,48} The cytokines IL-1, TNF α , IFN γ , IL-2, interleukin 6 (IL-6), and chemokines, specifically macrophage chemoattractant protein 1 (MCP-1), are induced early by superantigens in human PBMC. There is also a good correlation of the induction of these cytokines with lethal superantigen-induced shock in murine models.^{19,21,23,49–52} IL-1 and TNF α

also activate other cells, including fibroblasts, epithelial, and endothelial cells, to perpetuate inflammation by inducing cell adhesion molecules and additional mediators from these cells.⁵³ Matrix metalloproteases (MMPs) and tissue factor induced by IL-1 and TNF α contribute to the damaging effects on the immune and cardiovascular systems, resulting in multi-organ dysfunction and lethal shock. Superantigen-activated T-cells induce the prototypic TH1 cytokine IFN γ , which augments immunological responses by increasing MHC class II and intercellular adhesion molecule (ICAM) on APCs, epithelial cells, and endothelial cells.^{21,33} IFN γ also upregulates TNF α receptor and IL-1 receptor (IL-1R), thus synergizing with TNF α and IL-1 to promote tissue injury.⁵³ The T-cell growth factor IL-2 is induced by superantigen-activated T-cells and promotes T-cell proliferation and differentiation.^{31,32} The receptors and signaling pathways for these mediators are diverse, accounting for the different immunoregulatory activities of cytokines. The intracellular signaling pathways and molecular components of cytokine

receptor signaling have been studied extensively as they serve as targets of therapeutic interventions.^{53–57}

Cytokines as mediators of inflammation activating NF κ B and mTORC1

IL-1 interacts with IL-1 receptor 1 (IL-1R1) and an accessory protein to activate NF κ B via signaling adaptors myeloid differentiation factor 88 (MyD88), IL-1R-associated protein kinase (IRAK), and TNF receptor-associated factor 6 (TRAF6).^{53,54} This activation pathway is highly conserved, and its signaling components are also triggered by the binding of pathogen-associated molecular patterns (PAMPs) to toll-like receptors (TLRs).^{58,59} PAMPs such as lipoprotein, lipopolysaccharide (LPS), flagellin, dsRNA, and viral RNA bind to specific TLR to activate innate host response. A central component of IL-1R/TLR signaling is the activation of I κ B kinases (IKKs), resulting in nuclear translocation and activation of NF κ B. The MyD88/IRAK/TRAF6 pathway also activates the stress kinase c-Jun-N-terminal kinase (JNK) via the signaling molecule TRAF6.⁶⁰ SEB upregulates the expression of toll-like receptor 2 (TLR2) and toll-like receptor 4 (TLR4), thereby synergizing with other microbial products to activate innate immune response.^{61,62}

TNF α activates NF κ B by binding to TNF receptor 1 (TNFR1) or TNF receptor 2 (TNFR2). The cytotoxic functions of TNF α are mostly mediated by its binding to TNFR1 via cytoplasmic death domains.^{63,64} The death domain adaptors Fas-associated death domain (FADD) and TNF receptor (TNFR)-associated death domain (TRADD) form a complex with the kinase receptor-interacting protein kinase 1 (RIP1), which then binds TRAF2 to activate the MAPK cascade and NF κ B. In addition, the deubiquitylation of RIP1 enables RIP1 to interact with RIP3 to promote necrosis. Activation of death domains by TNF α binding also activates caspase 8 and triggers apoptosis via the extrinsic cell death pathway commonly used by the TNFR superfamily. SEB upregulates the expression of CD95 (Fas), a receptor of the TNFR superfamily, and induces apoptosis via caspase 8 activation.⁶⁵ The TNFR superfamily members activate the caspase 8 cascade, JNK, and NF κ B, accounting for the pleiotropic effects of TNF α , including cell activation, apoptosis, coagulation, inflammation, and host defense.^{63,64}

IFN γ (type II IFN) is produced by NK cells, CD8 T-cells, and TH1 subset of CD4 T-cells. IFN γ binds to IFN γ R and signals via Janus kinase 1 (JAK1), Janus kinase 2 (JAK2), and signal transducer and activator of transcription 1 (STAT1).^{66,67} Both type I (IFN α and IFN β) and type II IFNs signal via

PI3K/mTORC1 after binding to two different types of IFN receptors. Although the main function of type I IFN is antiviral, IFN α and IFN β have overlapping activities with IFN γ as they induce many common interferon-stimulated genes (ISGs).^{67,68} IFNs induce apoptosis, and many ISGs have antiviral, anti-angiogenic, and ubiquitylating activities. The immunomodulatory effects of IFNs are mediated by immunity-related GTPases (IRGs) and guanylate-binding proteins (GBPs). In addition to antimicrobial defense functions, IFN γ also induces immunoproteasomes and the expression of MHC class II molecules to enhance antigen processing. Similar to IL-1 and TNF α , IFN γ activates PKC leading to MAPK activation. Both types of IFNs induce and activate death receptors such as CD95, which then activates FADD, subsequently activating caspase 8. Activated caspase 8 can cleave proapoptotic molecule Bid to a truncated form, allowing for its interaction with two mitochondrial proapoptotic molecules, Bak and Bax.⁶⁹ The oligomerization of Bak/Bax results in mitochondrial outer membrane permeabilization and the release of cytochrome c to the cytosol. Cytochrome c binds cytosolic protein apoptotic protease-activating factor 1 (APAF1), leading to the formation of an apoptosome, a multi-protein complex of APAF1 and caspase 9. Activation of the initiator caspases, caspase 8 for the extrinsic apoptosis pathway or caspase 9 for the intrinsic apoptosis pathway, leads to the induction of caspase 3, caspase 6, and caspase 7 and subsequent apoptotic cell death. Damage to mitochondria also releases mitochondrial DNA (mtDNA), which has similar motifs to bacterial DNA and activates intracellular DNA sensors.^{70–72} TNF α and IFN γ act synergistically on epithelial cells to increase ion transport and disrupt epithelial barrier function.^{73,74} IFN γ also synergizes with IL-1 and TNF α to promote leukocyte recruitment, inflammation, and coagulation.⁵³

IL-2 is a T-cell growth factor and activates T-cell by binding to a high-affinity IL-2 receptor. It signals through JAK1 and Janus kinase 3 (JAK3), activating PI3K/mTORC1 and Ras to promote cell growth, differentiation, and proliferation.⁷⁵ Ras activates the MAPK cascade, leading to activation of AP1 and NFAT. IL-2 from SEB-activated T-cells has potent vascular effects and induces vasodilation, vascular leak, and edema.^{50,76,77} TNF α synergizes with IL-2 to promote vascular leak as seen in acute lung injury induced by superantigens or pathogens.^{50,78}

The chemokines, IL-8, MCP-1, macrophage inflammatory protein (MIP)-1 α , and MIP-1 β , are induced directly by SEB or TSST-1.^{21,79} Chemokines orchestrate leukocyte migration and activate leukocytes to promote inflammation and

tissue injury.^{53,80,81} Chemokine binds to seven-transmembrane GPCR, induces early calcium flux, activates PLC, and signals via the PI3K/mTORC1 pathway.⁵³ Recruited and activated neutrophils produce ROS and MMPs, contributing to organ damage.⁸⁰ Either systemic or intranasal exposure to SEB can cause acute lung injury, characterized by increased expression of adhesion molecules ICAM-1 and vascular cell adhesion molecule (VCAM), increased neutrophils and mononuclear cell infiltrates, endothelial cell injury, and increased vascular permeability.^{50,76,77}

Oxidative stress and ROS damage mitochondria

Superantigens induce massive proliferation in resting T-cells, which requires increased protein synthesis and metabolism. Enhanced glycolysis and fatty acid oxidation not only support protein biosynthesis but also generate oxidative stress and ROS.⁸² Increased protein synthesis, ROS, and activated PKC from cell activation are upstream activators of endoplasmic reticulum (ER) stress.⁸³ SEB induces the expression of ubiquitin ligases, proteasome peptidases, and immunoproteasomes in multiple organs.⁸⁴ These ER stress response genes are likely a result of Ca⁺⁺ flux, misfolded proteins, and activated PKC. Prolonged ER stress activates the unfolded protein response and apoptosis via the induction of caspases.^{85,86} Increased activity of the mitochondrial electron transport chain following superantigen-activated proliferation also promotes oxidative stress and the generation of ROS, ultimately activating mTORC1 (Figure 1).

Increased T-cell proliferation also switches cell metabolism from oxidative phosphorylation to glycolysis and deactivates AMPK, a critical sensor of nutrient and cellular energy, leading to mTORC1 activation.^{44,45} AMPK is a conserved cellular energy sensor activated by decreasing cellular ATP and increasing AMP and ADP. A deleterious consequence of mTORC1 activation is the suppression of autophagy, a homeostatic, catabolic process for the lysosomal degradation of damaged organelles, protein aggregates, and intracellular pathogens.⁸⁷ Enhanced mitochondrial respiration and ROS damage mitochondria, activate caspase 9, and promote apoptosis.^{69,87} Mitophagy, a special form of autophagy, normally removes damaged mitochondria resulting from damage and cell stress signals. However, hyperactivation of mTORC1 in superantigen-activated cells disrupts normal host mitophagy. Damaged mitochondria release cytochrome c and mtDNA to the cytosol, in addition to activating apoptosis via the intrinsic cell death pathway.^{71,72} mtDNA binds endosomal toll-like

receptor 9 (TLR9), activating the transcriptional factors NFκB and interferon regulatory factor 7 (IRF7). The leakage of mtDNA by damaged mitochondria exacerbates inflammation as mtDNA acts as a potent “damage-associated molecular pattern” (DAMP) to activate cytosolic pattern recognition receptors (PRRs).

DAMPs bind Nod-like receptors (NLRs) activating inflammatory cytokines and pyroptosis

Cytosolic DAMPs such as ROS and mtDNA are upstream activators of inflammasome, an intracellular multi-protein signaling complex that promotes the proteolytic activation of caspase 1.⁸⁷⁻⁹¹ DAMPs bind to intracellular NLRs (nucleotide-binding oligomerization domain [Nod] and leucine-rich repeat-containing receptors), leading to recruitment of the adaptor apoptosis-associated speck-like protein, which consists of a pyrin domain and a caspase recruitment domain (CARD). The CARD domain recruits pro-caspase-1 into the inflammasome complex, and auto-proteolytic activation of caspase 1 leads to proteolytic processing and activation of proinflammatory cytokines IL-1β and interleukin 18 (IL-18). Inflammasome activation also induces pyroptosis, a specialized form of cell death that eliminates cells harboring intracellular pathogens.⁹¹ ER stress, viral entry, and replication can destabilize lysosomes and activate inflammasome.⁹² Other inflammasome activators include potassium efflux and phagocytosis of bacteria or particulates.⁹⁰ Thus, bacteria, bacterial-secreted products, viruses, viral DNA, and viral RNA are potent activators of inflammasome as they bind cytosolic NLRs and induce inflammatory cytokines IL-1 and IL-18 and pyroptotic cell death.⁸⁹⁻⁹¹ Apoptosis plays a critical role in downregulating immune responses but simultaneously has devastating effects when apoptotic cell death is unrestrained. Autophagy acts to counteract apoptosis and maintain cellular homeostasis.^{87,93,94} A recent study indicates that blocking autophagy augments T-cell activation.⁹⁵ In superantigen-activated cells, autophagy likely contravenes apoptosis as it removes DAMPs and downregulates inflammation.

DAMPs and inflammatory cytokines induce multiorgan injury

IL-1 from inflammasome activation has pleiotropic effects initiating inflammation, NFκB, and pyroptosis. TNFα signaling has an established role that initiates cell death, MAPK cascade, and NFκB activation. The TNFR superfamily members, including TNFR1 and CD95, induce apoptosis by activating caspases, and damaged mitochondria also contributes to apop-

otic cell death. IFN γ triggers innate host defense responses, antiviral genes, apoptotic programs, and immunoproteasomes and has many immunomodulatory functions. The cell death pathway triggered *in vitro* and *in vivo* by superantigens includes genes associated with apoptosis, such as FADD, death receptor ligand TRAIL (TNFSF10), caspases, CARD, and phospholipid scramblase 1 (PLSCR1).^{84,96,97} These genes are observed in superantigen-activated PBMC and major organs from the “double-hit” SEB model. Cellular injury is also apparent from the expression of MMPs, cathepsins, and other cell matrix breakdown products such as versican and fibronectin in superantigen-activated cells.^{84,97} DNA damage repair enzymes, poly(ADP-ribose) polymerases, are induced in PBMC and multiple organs of the “double-hit SEB” mouse model, indicating DNA damage and repair.⁸⁴

Potential drug targets of intervention

There is currently no effective therapeutic treatment for superantigen-induced shock except for the use of intravenous immunoglobulins.^{98,99} Various humanized monoclonal antibodies are developed to neutralize SEs and TSST-1 by targeting specific epitopes on SEs and TSST-1.^{100–103} However, targeting and neutralizing a superantigen directly is effective only at early stages of exposure before cell activation and initiation of the proinflammatory cytokine cascade.

There are at least three important host-directed targets based on superantigen interaction with host cells: 1) TCR and/or MHC class II interactions with toxins; 2) co-stimulatory receptor interactions; and 3) signaling pathways and molecules induced by activated T-cells and macrophages. Inhibition of all or one of the abovementioned three targets/pathways has been reported both *in vitro* and *in vivo*, thus representing viable means of blocking the toxic effects of these bacterial superantigens.¹⁰⁴ The targeting of toxin–receptor interaction has been reviewed recently.¹⁰⁴ The disadvantage of this strategy is that to be effective, drugs inhibiting toxin–receptor interaction have to be administered early upon toxin exposure, which is not always possible. Blockade of superantigen-activated signal transduction molecules/pathways represents the most amenable mode of intervention as these molecules/pathways occur postexposure and will likely inhibit other superantigens. NF κ B and mTORC1 are prime targets in this regard as the three initial signals provided by TCR, co-stimulatory receptors and cytokines converge on these two hubs of signal transduction (Figure 1). Interruption of these concurrent cascades to tissue injury after exposure of superantigens provides an effective strategy in

preventing superantigen-induced lethal shock. Many of the superantigen-induced pathways and cell injury are similar to the pathological pathways activated in organ transplantation.

Mouse models of superantigen-induced shock

An obvious component of *in vivo* testing of therapeutics against superantigen-induced shock is finding a relevant animal model that mimics human disease. Mice are often used as models for obtaining a basic understanding of immunological mechanisms involved in superantigen-mediated shock as reagents such as antibodies against cell surface molecules and mediators are commercially available. However, mice are naturally less susceptible to SEs and TSST-1, compared to human beings, because of an inherent lower affinity of these exotoxins for murine MHC class II.¹⁰⁵ Potentiating agents such as D-galactosamine, actinomycin D, and LPS are used to amplify the toxic effects of superantigens.^{19,49–52,106–108} These superantigen-induced shock models using potentiating agents have major drawbacks for therapeutic studies as the sensitizing agents themselves often induce the same mediators as SEs or TSST-1 by activating similar cells and signaling pathways. Both actinomycin D and D-galactosamine are hepatotoxic, and mouse models using these potentiating agents produce unrealistically high levels of TNF α and liver damage.¹⁰⁹ Drugs designed to inhibit TNF α have a higher therapeutic impact in models using these two potentiating agents. In the SEB plus LPS mouse model, the synergistic action of SEB and LPS promotes early TNF α release and prolongs the release of IFN γ , IL-2, IL-6, and MCP-1.⁵² The higher and prolonged levels of these mediators lead to acute mortality with mice succumbing to toxic shock within 48 hours when LPS is used together with SEB.^{49,51,52} Importantly, the lethal end point of these murine models is different from human and nonhuman primates exposed to SEB.¹⁸

Two newer, simplified murine models have been developed to study SEB-induced shock without potentiating agents. Transgenic mice expressing human MHC class II respond to lower doses of SEB without synergistic agents due to the higher affinity binding of SEB to human MHC class II molecules.^{10,18} Transgenic mice with HLA-DR3 or -DQ8 lethally respond to SEs without potentiation, and the serum levels of mediators correlate with lethal shock.^{110–112} Pathological lesions in lungs of transgenic mice, temperature fluctuations, delayed lethal end point later at 96 hour are similar to those in nonhuman primates (NHPs) exposed to lethal doses of SEB.^{18,111} Low-dose continuous administration of SEB to HLA-DQ8 transgenic mice induces a lupus-like

syndrome with multiple organ injury.²³ An alternative murine model deploys a “double-hit” strategy with two low doses of SEB using C3H/HeJ mice, an LPS-resistant mouse strain.⁷⁶ This “SEB-only” toxic shock model relies on the intranasal administration of SEB and the enhanced action of another dose of SEB later to induce pulmonary inflammation and lethal shock. Importantly, pathological lesions, cytokine response, multiple organ injury, and time to lethality in this “SEB-only” model resemble findings in NHPs and clinical staphylococcal toxic shock syndrome.^{84,99} Gene profiling study in this mouse model with SEB reveals many damage response and IFN-induced genes in multiple organs, including 1) innate response; 2) pro- and anti-apoptotic molecules; 3) ER and oxidative stress; 4) intracellular DNA/RNA sensors; 5) immunoproteasome components and E3 ligases; and 6) antiviral ISGs. Upregulation of these damage response genes contributes to irreversible multi-organ damage seen in animal models of toxic shock and human toxic shock syndrome.

Other animal models used to study the *in vivo* biological effects of bacterial superantigens include NHPs, piglets, and rabbits.^{18,20,22,107,113–122} The SEs readily induce an emetic response in primates when ingested in low microgram quantities.¹¹³ Inhalation of sublethal nanogram doses of aerosolized SEB causes severe incapacitation in NHPs.¹¹⁵ Classic primate studies for SEs have been performed by various groups and are considered the “gold standard” as NHP models mimic different aspects of human disease induced by these superantigens.^{18,20,113–115} However, the high cost and animal welfare concerns associated with NHPs limit their use for routine therapeutic efficacy testing. Piglets were used to study TSST-1-induced effects and more recently for testing SEB vaccines.^{116,117} Toxic shock models with rabbits using subcutaneous or continuous infusion of superantigen also mimic human disease closely, but lack of biological reagents hampers their use for immunological studies.¹¹⁹ Other toxic shock rabbit models have been developed recently to study infective endocarditis, acute kidney injury, and sepsis using *S. aureus* producing various superantigens.^{121,122} These rabbit models are invaluable in providing *in vivo* information for the development of sepsis and septic complications of bacterial infections.

Repurposing of US Food and Drug Administration (FDA)-approved immunosuppressants

Traditional drug discovery against pathogens and toxins produced by pathogens is a costly and lengthy process with

low level of success to FDA approval for human use.¹²³ The intense investigations to define molecular mechanisms of superantigen activation of the immune system present multiple “drugable” targets and pathways. Based on these signaling pathways, an alternative low-cost yet faster approach to target superantigens is drug repurposing. This strategy of drug discovery takes advantage of the known mechanisms of FDA-approved drugs and their safety profile. A dominant signaling hub in superantigen-activated cells is mTORC1 as TCR, CD28, IL-2R, IFN γ R, and chemokine receptors all signal through the PI3K/mTORC1 pathway (Figure 1). Another key signaling hub is NF κ B as TCR and CD28 via PKC also activate NF κ B signaling. In addition, proinflammatory cytokines, IL-1 and TNF α , each independently activates NF κ B via MyD88/TRAF6/IRAK and FADD/TRADD/RIP, respectively. Activation of NF κ B leads to the induction of inflammatory genes, as well as antiviral, anti-apoptotic, and proapoptotic molecules seen in the “SEB-only” murine model.⁸⁴ Thus, the three initial signals provided by TCR, co-stimulatory receptors and cytokines converge on NF κ B and mTORC1 (Figure 1). There are many similarities between the pathways leading to the adverse events in transplant rejection and superantigen-induced shock as similar cells and receptors are involved in both types of diseases.³⁹ Out of the many approaches used against superantigen-induced shock, immunosuppressive agents used to prevent graft loss by suppressing T-cell activation have proven to be the most effective when tested in mouse models of superantigen-induced shock.^{19,124,125} Major classes of FDA-approved immunosuppressants include: 1) co-stimulation blockers; 2) NF κ B inhibitors; 3) calcineurin inhibitors; and 4) mTORC1 inhibitors. The use of FDA-approved immunosuppressants against staphylococcal superantigens and their mechanisms of action are presented in Figure 1 and Table 1.

Co-stimulation blockade

The CD28 co-stimulatory receptor binds CD80 or CD86 on APCs and generates signal 2 for T-cell activation. A transmembrane molecule homologous to CD28, cytotoxic T lymphocyte antigen-4 (CTLA4), is upregulated during T-cell activation and acts as a negative regulator to control T-cell responses.³¹ The higher affinity of CTLA4 for CD80 and CD86 enables it to compete with CD28 for the binding to these co-stimulatory molecules and block co-stimulation. A synthetic fusion protein, CTLA4 immunoglobulin (CTLA4-Ig), inhibits CD28 signaling and prevents lethal TSS by inhibiting co-stimulation in a D-galactosamine-sensitized mouse model.¹²⁴ Blockade of the CD28 by CTLA4-Ig

Table 1 FDA-approved immunosuppressants tested for efficacy in animal models of superantigen-induced toxic shock

Pharmacologic agent	Mechanism of action	Biological effects against SEB
CTLA4-Ig	Blocks co-stimulatory receptor CD28	Blocked binding of CD28 to CD80/86 and attenuated TSST-I-induced TNF α and IFN γ . ¹²⁴ Protected 75% of mice from TSST-I-induced toxic shock ¹²⁴
Dexamethasone	Inhibits NF κ B	Inhibited TSST-I-induced proinflammatory cytokines and chemokines in human PBMC ⁴⁸ Reduced serum levels of cytokines, attenuated hypothermia due to SEB, and protected mice 100% in both SEB-induced and SEB plus LPS-induced shock models ^{108,132}
Cyclosporine A	Binds cyclophilin and inhibits calcineurin phosphatase and T-cell activation	Blocked SEB-induced cytokines and proliferation Protected mice from shock in SEB plus galactosamine model ¹⁹ Blocked cytokines and T-cell proliferation but had no effect on lethality in nonhuman primates ¹³⁵
Tacrolimus (FK506)	Binds FKBP12 and inhibits calcineurin phosphatase and T-cell activation	Suppressed serum cytokines but provided no protection against SEB-induced shock in HLA-DR3 transgenic mice ¹³⁶
Rapamycin (sirolimus)	Binds FKBP12, inhibits mTORC1, and induces autophagy	Blocked SEB-induced cytokines, chemokines, and T-cell proliferation Protected mice 100% from lethality even when administered 24 hours after SEB ^{125,140}

Abbreviations: CTLA4-Ig, cytotoxic T lymphocyte antigen-4 immunoglobulin; FDA, US Food and Drug Administration; FKBP12 HLA, human leukocyte antigen; IFN γ , interferon gamma; LPS, lipopolysaccharide; mTORC1, mammalian target of rapamycin complex 1; NF κ B, nuclear factor kappa B; PBMC, peripheral blood mononuclear cells; SEB, staphylococcal enterotoxin B; TNF α , tumor necrosis factor α ; TSST-I, toxic shock syndrome toxin 1.

effectively inhibits TSST-1- induced T-cell proliferation and TNF α and IFN γ production in vitro and in vivo.¹²⁴ A recent study shows that CTLA4-Ig promotes regulatory T-cell (Treg) development and function in a TGF β -dependent manner.¹²⁶ Thus, blockade of the CD28–CD80/86 co-stimulatory pathway not only blocks co-stimulation and immunological synapse formation but might also enhance immunosuppression by increasing Treg activity.¹²⁷ Two versions of CTLA4-Ig, abatacept and belatacept, are FDA-approved biologics for rheumatoid arthritis and prevention of renal transplant rejection, respectively, but have not been tested against superantigen in animal models.^{128,129}

NF κ B inhibitors

Dexamethasone is a potent immunosuppressant and NF κ B inhibitor used to treat many types of inflammatory diseases and septic shock.^{130,131} Dexamethasone is effective in preventing SEB-induced shock in the “SEB-only” model and the LPS plus SEB model of toxic shock.^{108,132} However, inhibition of NF κ B is protective in these mouse models only if blockade by dexamethasone is applied early after superantigen exposure and for a long duration. Interestingly, the combined effect of early dexamethasone treatment followed by the anti-oxidant *N*-acetyl cysteine later is also efficacious in the “SEB-only” murine model of toxic shock.¹³³ Although the NF κ B pathway is an obvious target, other inhibitors of NF κ B have only been partially successful in vivo¹³⁴ as the NF κ B cascade is a major signal transduction pathway for many other cellular receptors, including PRRs and cytokine receptors. NF κ B is a central regulator of apoptosis and inflammation and is essential for

host defense. Inhibition of NF κ B would likely compromise innate immune function.

Calcineurin inhibitors

Cyclosporine A (CsA) and tacrolimus (FK506) are two well-known FDA-approved calcineurin inhibitors used clinically to prevent kidney graft rejection.³⁹ Both drugs form molecular complexes with their cellular receptors, cyclophilin and FK506-binding protein 12 (FKBP12), respectively, to inhibit the calcium-dependent phosphatase function of calcineurin. Although CsA inhibits SEB-induced T-cell proliferation in vitro, reduces serum cytokines, and attenuates pulmonary inflammation, it has no effect on lethality in non-human primates.¹³⁵ In contrast, CsA effectively prevents SEB-induced shock in a D-galactosamine-sensitized murine model of toxic shock.¹⁹ Tacrolimus suppresses superantigen-induced T-cell activation in vitro but does not reduce lethality in transgenic mice.¹³⁶

mTORC1 inhibitors

Rapamycin is a well-known mTORC1 inhibitor as it binds to the immunophilin FKBP12, forming a complex that then blocks mTORC1 activation. Rapamycin (also known as sirolimus) is used clinically to prevent graft rejection in organ (kidney, liver, heart) transplantation.³⁹ Adverse effects of rapamycin include dose-dependent increase in serum cholesterol and myelosuppression with long-term use.¹³⁷ mTORC1 is a central integrator of environmental cues, including immune, nutrient, and energy signals arising from TCR, co-stimulatory receptors, growth factors,

ATP, glucose, and amino acids.^{44–46} As described earlier, superantigen induces mTORC1 downstream of PI3K/Akt via the three signals of T-cell activation. More recent studies indicate that mTORC1 regulates T-cell differentiation and Treg function.^{138,139} Rapamycin inhibits cytokine release and T-cell proliferation by blocking mTORC1 signaling induced by SEB.^{125,140} Rapamycin protects mice from SEB-induced shock even when administered 1 day after SEB administration, providing an effective drug postexposure.¹⁴⁰ Inhibition of mTORC1 by rapamycin likely prevents organ damage by inducing autophagy and increasing the numbers of Treg cells and their suppressive functions simultaneously.^{138,139}

Although studies using rapamycin to block SEB-induced shock in the “SEB-only” mouse model show that rapamycin is efficacious, the immunological mechanisms have not been fully elucidated. A subsequent study of gene profiling in the same model sheds light on the effects of “pure” SEB without potentiating agents in vivo by revealing damage response, DNA sensors, and ISG upregulation upon SEB exposure.⁸⁴ Furthermore, the same damage response activators are present in all organs (lung, spleen, liver, kidney, and heart) and mouse PBMC in the presence of SEB without confounding synergistic agents. Rapamycin is a potent autophagy inducer in addition to its ability to block mTORC1.¹⁴¹ Recent studies show that mTORC1 regulates T-cell differentiation and its activation blocks FoxP3, a key transcription factor for Treg.^{139,142} Thus, rapamycin blockade of mTORC1 likely induces a variety of regulatory pathways in SEB-stimulated cells, including autophagic removal of damaged mitochondria, induction of functional Treg, downregulation of apoptosis, inflammatory cytokines, and T-cell proliferation. The success of delayed administration of rapamycin in preventing the toxic effects of SEB indicates that the tissue damage from cytokine storm and resolution of inflammation in organs is critical in preventing shock.

Conclusion

The host response to superantigen initiated by cellular activation of monocyte/macrophages and T-cells leads to the early release of IFNs, inflammatory cytokines, and chemokines. The damage response induced by superantigens starts with effects from inflammatory cytokines and apoptotic programs activated by IFNs and TNF α . DAMPs such as mitochondrial ROS and mtDNA trigger additional apoptosis, activate inflammasomes, and induce transcription factors for ISGs. Inflammation, apoptosis, and cellular damage from superantigen activation lead to tissue injury and organ dysfunction. The induction of PI3K/mTORC1 in superantigen-activated

cells blocks autophagy and also promotes damage in multiple organs. FDA-approved immunosuppressants directed at inhibiting mediator release and the downstream cell-destructive events provide proof of concept that these drugs can be transitioned to clinical use against superantigens.

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Disclosure

Opinions, interpretations, conclusions, and recommendations are those of the author and are not necessarily endorsed by the US Army. The author reports no conflicts of interest in this work.

References

1. Kotzin BL, Leung DYM, Kappler J, Marrack PA. Superantigens and their potential role in human disease. *Adv Immunol.* 1993;54:99–166.
2. Uchiyama T, Imanishi K, Miyoshi-Akiyama T, Kata H. Staphylococcal superantigens and the diseases they cause. In: Alouf JE, Popoff MR, editors. *The Comprehensive Sourcebook of Bacterial Protein Toxins.* 3rd ed. London: Academic Press; 2006:830–843.
3. DeVries AS, Leshner L, Schlievert PM, et al. Staphylococcal toxic shock syndrome 2000–2006: epidemiology, clinical features, and molecular characteristics. *PLoS One.* 2011;6(8):e22997.
4. Choi Y, Kotzin BL, Hernon L, Callahan J, Marrack PA, Kappler J. Interaction of *Staphylococcus aureus* toxin “superantigens” with human T-cells. *Proc Natl Acad Sci U S A.* 1989;86(22):8941–8945.
5. Alouf JE, Muller-Alouf H. What are superantigens? In: Alouf JE, Popoff MR, editors. *The Comprehensive Sourcebook of Bacterial Protein Toxins.* 3rd ed. London: Academic Press; 2006:821–829.
6. Fraser JD, Proft T. The bacterial superantigen and superantigen-like proteins. *Immunol Rev.* 2008;225:226–243.
7. Carlsson R, Fischer H, Sjogren HO. Binding of staphylococcal enterotoxin A to accessory cells is a requirement for its ability to activate human T-cells. *J Immunol.* 1988;140(8):2484–2488.
8. Fleischer B, Schrezenmeier H. T-cell stimulation by staphylococcal enterotoxins. Clonally variable response and requirement for major histocompatibility complex class II molecules on accessory or target-cells. *J Exp Med.* 1988;167(5):1697–1707.
9. Jardetzky TS, Brown JH, Gorga JC, et al. Three-dimensional structure of a human class II histocompatibility molecule complexed with superantigen. *Nature.* 1994;368(6473):711–718.
10. Abrahmsén L, Dohlsten M, Segrén S, Björk P, Jonsson E, Kalland T. Characterization of two distinct MHC class II binding sites in the superantigen staphylococcal enterotoxin A. *EMBO J.* 1995;14(13):2978–2988.
11. Leder L, Llera A, Lavoie PM, et al. A mutational analysis of the binding of staphylococcal enterotoxins B and C3 to the T-cell receptor beta chain and major histocompatibility complex class II. *J Exp Med.* 1998;187(6):823–833.
12. Li H, Llera A, Mariuzza RA. Structure-function studies of T-cell receptor-superantigen interactions. *Immunol Rev.* 1998;163:177–186.
13. Papageorgiou AC, Tranter HS, Acharya KR. Crystal structure of microbial superantigen staphylococcal enterotoxin B at 1.5 angstrom resolution: implications for superantigen recognition by MHC class II molecules and T-cell receptors. *J Mol Biol.* 1998;277:61–79.

14. Cemerski S, Shaw A. Immune synapses in T-cell activation. *Curr Opin Immunol.* 2006;18(3):298–304.
15. Cartwright NG, Kashyap AK, Schaefer BC. An active kinase domain is required for retention of PKC θ at the immunological synapse. *Mol Biol Cell.* 2011;22(18):3491–3497.
16. Scholl PR, Trede N, Chatila TA, Geha RS. Role of protein tyrosine phosphorylation in monokine induction by the staphylococcal superantigen toxic shock syndrome toxin-1. *J Immunol.* 1992;148(7):2237–2241.
17. Mattsson E, Herwald H, Egsten A. Superantigen from *Staphylococcus aureus* induce procoagulant activity and monocyte tissue factor expression in whole blood and mononuclear cells via IL-1 β . *J Thromb Haemost.* 2003;1(12):2569–2575.
18. Ulrich RG, Wilhelmsen CL, Krakauer T. Staphylococcal enterotoxin B and related toxins. In: Dembek Z, editor. *Textbook of Military Medicine: Medical Aspects of Biological Warfare.* Washington, DC: US Department of Army, Borden Institute; 2007:311–322.
19. Miethke T, Wahl C, Heeg K, Echtenacher B, Krammer PH, Wagner H. T-cell-mediated lethal shock triggered in mice by the superantigen staphylococcal enterotoxin B: critical role of tumor necrosis factor. *J Exp Med.* 1992;175(1):91–98.
20. Mattix ME, Hunt RE, Wilhelmsen CL, Johnson AJ, Baze WB. Aerosolized staphylococcal enterotoxin B-induced pulmonary lesions in rhesus monkeys (*Macaca mulatta*). *Toxicol Pathol.* 1995;23(3):262–268.
21. Tessier PA, Naccache PH, Diener KR, et al. Induction of acute inflammation *in vivo* by staphylococcal superantigens. II. Critical role for chemokines, ICAM-1, and TNF-alpha. *J Immunol.* 1998;161(3):1204–1211.
22. Strandberg KL, Rotschafer JH, Vetter SM, Buonpane RA, Kranz DM, Schlievert PM. Staphylococcal superantigens cause lethal pulmonary diseases in rabbits. *J Infect Dis.* 2010;202(11):1690–1697.
23. Chowdhary VR, Tilahun AY, Clark CR, Grande JP, Rajagopalan G. Chronic exposure to staphylococcal superantigen elicits a systemic inflammatory disease mimicking lupus. *J Immunol.* 2012;189(4):2054–2062.
24. Baker MD, Acharya KR. Superantigens: structure, function, and diversity. In: Kotb M, Fraser JD, editors. *Superantigens, Molecular Basis for Their Role in Human Diseases.* Baltimore: ASM Press; 2007:121–135.
25. Ulrich RG, Bavari B, Olson MA. Staphylococcal enterotoxins A and B share a common structural motif for binding class II major histocompatibility complex molecules. *Nat Struct Biol.* 1995;2(7):554–560.
26. Hudson KR, Tiedemann RE, Urban RG, Lowe SC, Strominger JL, Fraser JD. Staphylococcal enterotoxin A has two cooperative binding sites on major histocompatibility complex class II. *J Exp Med.* 1995;182(3):711–720.
27. McCormick JK, Yarwood JM, Schlievert PM. Toxic shock syndrome and bacterial superantigens: an update. *Ann Rev Microbiol.* 2001;55:77–104.
28. Sundberg EJ, Li Y, Mariuzza RA. So many ways of getting in the way: diversity in the molecular architecture of superantigen-dependent T-cell signaling complexes. *Curr Opin Immunol.* 2002;14(1):36–44.
29. Baker MD, Acharya KR. Superantigens: structure-function relationships. *Int J Med Microbiol.* 2004;293(7–8):529–537.
30. Smith-Garvin JE, Koretzky GA, Jordan MS. T-cell activation. *Ann Rev Immunol.* 2009;27:591–619.
31. Linsley PS, Ledbetter JA. The role of the CD28 receptor during T-cell responses to antigen. *Ann Rev Immunol.* 1993;11:191–212.
32. Isakov N, Altman A. PKC-theta-mediated signal delivery from the TCR/CD28 surface receptors. *Front Immunol.* 2012;3:273–284.
33. Krakauer T. Co-stimulatory receptors for the superantigen staphylococcal enterotoxin B on human vascular endothelial cells and T-cells. *J Leukoc Biol.* 1994;56(4):458–463.
34. Lindstein T, June CH, Ledbetter JA, Stella G, Thompson CB. Regulation of lymphokine messenger RNA stability by a surface-mediated T-cell activation pathway. *Science.* 1989;244(4902):339–343.
35. Fraser J, Newton M, Weiss A. CD28 and T-cell antigen receptor signal transduction coordinately regulates interleukin 2 gene expression in response to superantigen stimulation. *J Exp Med.* 1992;175:1131–1134.
36. Boise LH, Minn AJ, Noel PJ, et al. CD28 costimulation can promote T-cell survival by enhancing the expression of Bcl-x1. *Immunity.* 1995;3(1):87–98.
37. Chatila T, Wood N, Parsonnet J, Geha RS. Toxic shock syndrome toxin-1 induces inositol phospholipid turnover, protein kinase C translocation, and calcium mobilization in human T-cells. *J Immunol.* 1988;140(4):1250–1255.
38. Weiss A. T lymphocyte activation. In: Paul W, editor. *Fundamental Immunology.* 4th ed. Philadelphia: Lippincott-Raven; 1998:411–447.
39. Halloran PF. Immunosuppressive drugs for kidney transplantation. *N Engl J Med.* 2004;351(26):2715–2729.
40. DiDonato JA, Mercurio F, Karin M. NF κ B and the link between inflammation and cancer. *Immunol Rev.* 2012;246(1):379–400.
41. Curtsinger JN, Schmidt CS, Mondino A, et al. Inflammatory cytokines provide a third signal for activation of naive CD4+ and CD8+ T-cells. *J Immunol.* 1999;162(6):3256–3262.
42. Deane JA, Fruman DA. Phosphoinositide 3-kinase: diverse roles in immune cell activation. *Ann Rev Immunol.* 2004;22:563–598.
43. Memmott RM, Dennis PA. Akt-dependent and independent mechanisms of mTOR regulation in cancer. *Cell Signal.* 2009;21(5):656–664.
44. Thomson AW, Turnquist HR, Raimondi G. Immunoregulatory functions of mTOR inhibition. *Nat Rev Immunol.* 2009;9(5):324–337.
45. Laplante M, Sabatini DM. mTOR signaling at a glance. *J Cell Sci.* 2009;122(pt 20):3389–3394.
46. Carling D, Thornton C, Woods A, Sanders MJ. AMP-activated protein kinase: new regulation, new roles? *Biochem J.* 2012;445(1):11–27.
47. Parsonnet J, Hickman RK, Eardley DD, Pier GB. Induction of human interleukin-1 by toxic shock syndrome toxin-1. *J Infect Dis.* 1985;151(3):514–522.
48. Krakauer T. Inhibition of toxic shock syndrome toxin-induced cytokine production and T-cell activation by interleukin 10, interleukin 4, and dexamethasone. *J Infect Dis.* 1994;172(4):988–992.
49. Stiles BG, Bavari S, Krakauer T, Ulrich RG. Toxicity of staphylococcal enterotoxins potentiated by lipopolysaccharide: major histocompatibility complex class II molecule dependency and cytokine release. *Infect Immun.* 1993;61(12):5333–5338.
50. Neumann B, Engelhardt B, Wagner H, Holzmann B. Induction of acute inflammatory lung injury by staphylococcal enterotoxin B. *J Immunol.* 1997;158(4):1862–1871.
51. Beno DW, Uhing MR, Jiyamapa-Serna VA, et al. Differential induction of hepatic dysfunction after intraportal and intravenous challenge with endotoxin and staphylococcal enterotoxin B. *Shock.* 2003;19(4):352–357.
52. Krakauer T, Buckley M, Fisher D. Proinflammatory mediators of toxic shock and their correlation to lethality. *Mediators Inflamm.* 2010;2010:517594.
53. Krakauer T, Vilcek J, Oppenheim JJ. Proinflammatory cytokines: TNF and IL-1 families, chemokines, TGF β and others. In: Paul W, editor. *Fundamental Immunology.* 4th ed. Philadelphia: Lippincott-Raven; 1998:775–811.
54. Sims JE, Smith DE. The IL-1 family: regulators of immunity. *Nat Rev Immunol.* 2010;10(2):89–102.
55. Theofilopoulos AN, Baccala R, Beutler B, Kono DH. Type I interferons (α/β) in immunity and autoimmunity. *Annu Rev Immunol.* 2005;23:307–336.
56. Romagnani P. From basic science to clinical practice: use of cytokines and chemokines as therapeutic targets in renal diseases. *J Nephrol.* 2005;18(3):229–233.
57. Ghoreschi K, Laurence A, O’Shea JJ. Selectivity and therapeutic inhibition of kinases: to be or not to be? *Nat Immunol.* 2009;10(4):356–360.
58. Takeuchi O, Akira S. Pattern recognition receptors and inflammation. *Cell.* 2010;140(6):805–820.

59. Kawai T, Akira S. Toll-like receptors and their crosstalk with other innate receptors in infection and immunity. *Immunity*. 2011;34(5):637–650.
60. Vallabhapurapu S, Karin M. Regulation and function of NFκB transcription factors in the immune system. *Ann Rev Immunol*. 2009;27:693–733.
61. Hopkins PA, Fraser JD, Pridmore AC, Russell HH, Read RC, Srisukandana S. Superantigen recognition by HLA class II on monocytes up-regulates toll-like receptor 4 and enhances proinflammatory responses to endotoxin. *Blood*. 2005;105(9):3655–3662.
62. Hopkins PA, Pridmore AC, Ellmerich S, et al. Increased surface toll-like receptor 2 expression in superantigen shock. *Crit Care Med*. 2008;36(4):1267–1276.
63. Van Herreweghe F, Festjens N, Declercq W, Vandenabeele P. Tumor necrosis factor-mediated cell death: to break or to burst, that's the question. *Cell Mol Life Sci*. 2010;67(10):1567–1579.
64. Keystone EC, Ware CF. Tumor necrosis factor and anti-tumor necrosis factor therapies. *J Rheumatol*. 2010;85:27–39.
65. Klintman D, Li X, Sato T, Wang Y, Jeppsson B, Thorlacius H. Staphylococcal enterotoxin A-induced hepatotoxicity is predominantly mediated by Fas ligand (CD95L). *Ann Surg*. 2004;240(6):1065–1072.
66. Stark GR, Darnell JE Jr. The JAK-STAT pathway at twenty. *Immunity*. 2012;36(4):503–514.
67. MacMicking JD. Interferon-inducible effector mechanisms in cell-autonomous immunity. *Nat Rev Immunol*. 2012;12(5):367–382.
68. McNab F, Mayer-Barber K, Sher A, Wack A, O'Garra A. Type 1 interferons in infectious disease. *Nat Rev Immunol*. 2015;15(2):87–103.
69. Czabotar PE, Lessene G, Strasser A, Adams JM. Control of apoptosis by the BCL-2 protein family: implications for physiology and therapy. *Nat Rev Mol Cell Biol*. 2014;15(1):49–63.
70. Takaoka K, Wang Z, Choi MK, et al. DAI (DLM-1/ZBP1) is a cytosolic DNA sensor and an activator of innate immune response. *Nature*. 2007;448(7152):501–506.
71. Muruve DA, Petrilli V, Zaiss AK, et al. The inflammasome recognizes cytosolic microbial and host DNA and triggers an innate immune response. *Nature*. 2008;452(7183):103–107.
72. Zhang Q, Raouf M, Chen Y, et al. Circulating mitochondrial DAMPs cause inflammatory responses to injury. *Nature*. 2010;464(7285):104–107.
73. Lu J, Philpott DJ, Saunders PR, Perdue MH, Yang PC, McKay DM. Epithelial ion transport and barrier abnormalities evoked by superantigen-activated immune cells are inhibited by interleukin-10 but not interleukin-4. *J Pharmacol Exp Ther*. 1998;287(1):128–136.
74. Lu J, Wang A, Ansari S, Hershberg RM, McKay DM. Colonic bacterial superantigens can evoke an inflammatory response and exacerbate disease in mice recovering from colitis. *Gastroenterology*. 2003;125(6):1785–1795.
75. Malek TR, Castro I. Interleukin-2 receptor signaling: at the interface between tolerance and immunity. *Immunity*. 2010;33(2):153–165.
76. Huzella LM, Buckley MJ, Alves DA, Stiles BG, Krakauer T. Central roles for IL-2 and MCP-1 following intranasal exposure to SEB: a new mouse model. *Res Vet Sci*. 2009;86(2):241–247.
77. Liu D, Zienkiewicz J, DiGiandomenico A, Hawiger J. Suppression of acute lung inflammation by intracellular peptide delivery of a nuclear import inhibitor. *Mol Ther*. 2009;17(5):796–802.
78. Dubinett SM, Huang M, Lichtenstein A, et al. Tumor necrosis factor-α plays a central role in interleukin-2 induced pulmonary vascular leak and lymphocyte accumulation. *Cell Immunol*. 1994;157(1):170–180.
79. Krakauer T. Induction of CC chemokines in human peripheral blood mononuclear cells by staphylococcal exotoxins and its prevention by pentoxifylline. *J Leukoc Biol*. 1999;66(1):158–164.
80. Sadik CD, Kim ND, Luster AD. Neutrophils cascading their way to inflammation. *Trends Immunol*. 2011;32(10):452–460.
81. Zlotnik A, Yoshie D. The chemokine superfamily revisited. *Immunity*. 2012;36(5):705–716.
82. Santos CX, Tanaka LY, Wosniak J, Laurindo FR. Mechanisms and implications of reactive oxygen species generation during the unfolded protein response: roles of endoplasmic reticulum oxidoreductases, mitochondrial electron transport, and NADPH oxidase. *Antioxid Redox Signal*. 2009;11(10):2409–2427.
83. Solinas G, Karin M. JNK1 and IKKβ: molecular links between obesity and metabolic dysfunction. *FASEB J*. 2010;24(8):2596–2611.
84. Ferreyra GA, Elinoff JM, Demirkale CY, et al. Late multiple organ surge in interferon-regulated target genes characterizes staphylococcal enterotoxin B lethality. *PLoS One*. 2014;9(2):e88756.
85. Yoneda T, Imaizumi K, Oono K, et al. Activation of caspase-12, an endoplasmic reticulum (ER) resident caspase, through tumor necrosis factor receptor-associated factor 2-dependent mechanism in response to the ER stress. *J Biol Chem*. 2001;276(17):13935–13940.
86. Jimbo A, Fujita E, Kouroku Y, et al. ER stress induces caspase-8 activation, stimulating cytochrome c release and caspase-9 activation. *Exp Cell Res*. 2003;283(2):156–166.
87. Martins JD, Liberal J, Silva A, Ferreira I, Neves BM, Cruz MT. Autophagy and inflammasome interplay. *DNA Cell Biol*. 2015;34(4):274–281.
88. Shimada K, Crother TR, Karlin J, et al. Oxidized mitochondrial DNA activates the NLRP3 inflammasome during apoptosis. *Immunity*. 2012;36(3):401–414.
89. De Nardo D, Latz E. NLRP3 inflammasomes link inflammation and metabolic disease. *Trends Immunol*. 2011;32(8):373–379.
90. Gross O, Thomas CJ, Guarda G, Tschopp J. The inflammasome: an integrated view. *Immunol Rev*. 2011;243(1):136–151.
91. Miao EA, Rajan JV, Aderem A. Caspase-1-induced pyroptotic cell death. *Immunol Rev*. 2011;243(1):206–214.
92. Bronner DN, Abuaita BH, Chen X, et al. Endoplasmic reticulum stress activates the inflammasome via NLRP3- and caspase-2-driven mitochondrial damage. *Immunity*. 2015;43(3):451.
93. Nakahira K, Haspel JA, Rathinam VA, et al. Autophagy proteins regulate innate immune responses by inhibiting the release of mitochondrial DNA mediated by the NALP3 inflammasome. *Nat Immunol*. 2011;12(3):222–230.
94. Yorimitsu T, Nair U, Yang Z, Klionsky DJ. Endoplasmic reticulum stress triggers autophagy. *J Biol Chem*. 2006;281(40):30299–30304.
95. Paul S, Schaefer BC. Selective autophagy regulates T-cell activation. *Autophagy*. 2012;8(11):1690–1692.
96. Mendis C, Das R, Hammamieh R, et al. Transcriptional response signature of human lymphoid cells to staphylococcal enterotoxin B. *Genes Immun*. 2005;6(2):84–94.
97. Dauwalder O, Pachot A, Cazalis MA, et al. Early kinetics of the transcriptional response of human leukocytes to staphylococcal superantigenic enterotoxins A and G. *Microb Pathog*. 2009;47(3):171–176.
98. Darenberg J, Soderquist B, Normark BH, Norrby-Teglund A. Differences in potency of intravenous polyspecific immunoglobulin G against streptococcal and staphylococcal superantigens: implication for therapy of toxic shock syndrome. *Clin Infect Dis*. 2004;38(6):836–842.
99. Lappin E, Ferguson AJ. Gram-positive toxic shock syndromes. *Lancet Infect Dis*. 2009;9(5):281–290.
100. Larkin EA, Stiles BG, Ulrich RG. Inhibition of toxic shock by human monoclonal antibodies against staphylococcal enterotoxin B. *PLoS One*. 2010;5(10):e13253.
101. Tilahun ME, Rajagopalan G, Shah-Mahoney N, et al. Potent neutralization of staphylococcal enterotoxin B by synergistic action of chimeric antibodies. *Infect Immun*. 2010;78(6):2801–2811.
102. Varshney AK, Wang X, Cook E, et al. Generation, characterization, and epitope mapping of neutralizing and protective monoclonal antibodies against staphylococcal enterotoxin B-induced lethal shock. *J Biol Chem*. 2011;286(11):9737–9747.
103. Karauzum H, Chen G, Abaandou L, et al. Synthetic human monoclonal antibodies toward staphylococcal enterotoxin B (SEB) protective against toxic shock syndrome. *J Biol Chem*. 2012;287(30):25203–25215.

104. Krakauer T. Update on staphylococcal superantigen-induced signaling pathways and therapeutic interventions. *Toxins*. 2013;5(9):1629–1654.
105. Scholl P, Sekaly R, Diez A, Glimcher L, Geha R. Binding of toxic shock syndrome toxin-1 to murine major histocompatibility complex class II molecules. *Eur J Immunol*. 1990;20(9):1911–1916.
106. Chen JY, Qiao Y, Komisar JL, Baze WB, Hsu IC, Tseng J. Increased susceptibility to staphylococcal enterotoxin B intoxication in mice primed with actinomycin D. *Infect Immun*. 1994;62(10):4626–4631.
107. Dinges MM, Schlievert PM. Comparative analysis of lipopolysaccharide-induced tumor necrosis factor alpha activity in serum and lethality in mice and rabbits pretreated with the staphylococcal superantigen toxic shock syndrome toxin 1. *Infect Immun*. 2001;69(11):7169–7172.
108. Krakauer T, Buckley M. Dexamethasone attenuates staphylococcal enterotoxin B-induced hypothermic response and protects mice from superantigen-induced toxic shock. *Antimicrob Agents Chemother*. 2006;50(1):391–395.
109. Silverstein R. D-galactosamine lethality model: scope and limitations. *J Endotoxin Res*. 2004;10(3):147–162.
110. Yeung RS, Penninger JM, Kundig T, et al. Human CD4 and human major histocompatibility complex class II (DQ6) transgenic mice: supersensitivity to superantigen-induced septic shock. *Eur J Immunol*. 1996;26(5):1074–1082.
111. Roy CJ, Warfield KL, Welcher BC, et al. Human leukocyte antigen-DQ8 transgenic mice: a model to examine the toxicity of aerosolized staphylococcal enterotoxin B. *Infect Immun*. 2005;73(4):2452–2460.
112. Rajagopalan G, Sen MM, Singh M, et al. Intranasal exposure to staphylococcal enterotoxin B elicits an acute systemic inflammatory response. *Shock*. 2006;25(6):647–656.
113. Bergdoll MS. Monkey feeding test for staphylococcal enterotoxin. *Meth Enzymol*. 1998;165:324–333.
114. Hodoval LF, Morris EL, Crawley GJ, Beisel WR. Pathogenesis of lethal shock after intravenous staphylococcal enterotoxin B in monkeys. *Appl Microbiol*. 1968;16(2):187–192.
115. Krakauer T, Pitt L, Hunt RE. Detection of interleukin-6 and interleukin-2 in serum of rhesus monkeys exposed to a nonlethal dose of staphylococcal enterotoxin B. *Mil Med*. 1997;162(9):612–615.
116. Bulanda M, Zaleska M, Mandel L, et al. Toxicity of staphylococcal toxic shock syndrome toxin 1 for germ-free and conventional piglets. *Rev Infect Dis*. 1989;11(suppl 1):S248–S253.
117. Inskeep TK, Stahl C, Odle J, et al. Oral vaccine formulations stimulate mucosal and systemic antibody responses against staphylococcal enterotoxin B in a piglet model. *Clin Vaccine Immunol*. 2010;17(8):1163–1169.
118. Schlievert PM. Enhancement of host susceptibility to lethal endotoxin shock by staphylococcal pyrogenic exotoxin type C. *Infect Immun*. 1982;36(1):123–128.
119. Parsonnet J, Gillis ZA, Richter AG, Pier GB. A rabbit model of toxic shock syndrome that uses a constant, subcutaneous infusion of toxic shock syndrome toxin 1. *Infect Immun*. 1987;55(5):1070–1076.
120. Huang WT, Wang JJ, Lin MT. Antipyretic effect of acetaminophen by inhibition of glutamate release after staphylococcal enterotoxin A fever in rabbits. *Neurosci Lett*. 2004;355(1–2):33–36.
121. Spaulding AR, Salgado-Pabon W, Kohler PL, Horswill AR, Leung DYM, Schlievert PM. Staphylococcal and streptococcal superantigen exotoxins. *Clin Microbiol Rev*. 2013;26(3):422–447.
122. Kulhankova K, King J, Salgado-Pabon W. Staphylococcal toxic shock syndrome: superantigen-mediated enhancement of endotoxin shock and adaptive immune suppression. *Immunol Res*. 2014;59(1–3):182–187.
123. Paul SM, Arrowsmith J. Trial watch: phase III and submission failures; 2007–2010. *Nat Rev Drug Discov*. 2011;10(2):87–92.
124. Saha B, Jaklic B, Harlan DM, Gray GS, June CH, Abe R. Toxic shock syndrome toxin-1-induced death is prevented by CTLA4Ig. *J Immunol*. 1996;157(9):3869–3875.
125. Krakauer T, Buckley M, Issaq HJ, Fox SD. Rapamycin protects mice from staphylococcal enterotoxin B-induced toxic shock and blocks cytokine release in vitro and in vivo. *Antimicrob Agents Chemother*. 2010;54(3):1125–1131.
126. Deppong CM, Bricker TL, Rannals BD, VanRooijen N, Hsieh CS, Green IM. CTLA4Ig inhibits effector T-cells through regulatory T-cells and TGF- β . *J Immunol*. 2013;191(6):3082–3089.
127. Thauland TJ, Koguchi Y, Dustin ML, Parker DC. CD28-CD80 interactions control regulatory T-cell motility and immunological synapse formation. *J Immunol*. 2014;193(12):5894–5903.
128. Genovese MC, Becker JC, Schiff M, et al. Abatacept for rheumatoid arthritis refractory to tumor necrosis factor α inhibition. *N Engl J Med*. 2005;353(11):1114–1125.
129. Vincenti F, Larsen C, Durrbach A, et al. Costimulation blockade with belatacept in renal transplantation. *N Engl J Med*. 2005;353(8):770–781.
130. Sprung CL, Goodman S, Weiss YG. Steroid therapy of septic shock. *Crit Care Nurs Clin North Am*. 2011;23(1):171–180.
131. Ramamoorthy S, Cidlowski JA. Corticosteroids: mechanisms of action in health and disease. *Rheum Dis Clin North Am*. 2016;42(1):15–31.
132. Krakauer T, Buckley M, Huzella LM, Alves D. Critical timing, location and duration of glucocorticoid administration rescues mice from superantigen-induced shock and attenuates lung injury. *Int Immunopharmacol*. 2009;9:1168–1174.
133. Krakauer T, Buckley M. Efficacy of two FDA-approved drug combination in a mouse model of staphylococcal enterotoxin B-induced shock. *Mil Med*. 2013;178(9):1024–1028.
134. Tilahun AY, Theuer JE, Patel R, David CS, Rajagopalan G. Detrimental effect of the proteasome inhibitor, bortezomib in bacterial superantigen- and lipopolysaccharide-induced systemic inflammation. *Mol Ther*. 2010;18(6):1143–1154.
135. Komisar JL, Weng CF, Oyejide A, Hunt RE, Briscoe C, Tseng J. Cellular and cytokine responses in the circulation and tissue reactions in the lung of rhesus monkeys (*Macaca mulatta*) pretreated with cyclosporine A and challenged with staphylococcal enterotoxin B. *Toxicol Pathol*. 2001;29(3):369–378.
136. Tilahun AY, Darau MJ, Clar CR, Patel R, Rajagopalan G. The impact of tacrolimus on the immunopathogenesis of with staphylococcal enterotoxin-induced systemic inflammatory response syndrome and pneumonia. *Microbes Infect*. 2012;14(6):528–536.
137. Murgia MG, Jordan S, Kahan BD. The side effect profile of sirolimus: a phase I study in quiescent cyclosporine-prednisone-treated renal transplant patients. *Kidney Int*. 1996;49:209–216.
138. Zeng H, Yang K, Cloer C, Neale G, Vogel P, Chi H. mTORC1 couples immune signals and metabolic programming to establish T_{reg} cell function. *Nature*. 2013;499(7459):485–490.
139. Battaglia M, Stabilini A, Roncarolo MG. Rapamycin selectively expands CD4+CD25+FoxP3+ regulatory T-cells. *Blood*. 2005;105(12):4743–4748.
140. Krakauer T, Buckley M. Intranasal rapamycin rescues mice from staphylococcal enterotoxin B-induced shock. *Toxins*. 2012;4(9):718–728.
141. Levine B, Packer M, Codogno P. Development of autophagy inducers in clinical medicine. *J Clin Invest*. 2015;125(1):14–24.
142. Huijts CM, Santegoets SJ, Quiles Del Rey M, et al. Differential effects of inhibitors of the PI3K/mTOR pathway on the expansion and functionality of regulatory T-cells. *Clin Immunol*. 2016;168:47–54.

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