Increased Frequency and Suppression by Regulatory T Cells in Patients with Acute Myelogenous Leukemia

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Abstract

Purpose: Regulatory CD4+CD25\textsuperscript{high}Foxp3+ T cells (Treg) control peripheral immune tolerance. Patients with cancer, including those with hematologic malignancies, have elevated numbers of Treg in the peripheral circulation and in tumor tissues. However, mechanisms of suppression and clinical significance of Treg, especially in patients with acute myelogenous leukemia (AML), has not been well defined.

Experimental Design: We prospectively evaluated the phenotype, function, and mechanisms of suppression used by Treg in newly diagnosed untreated AML patients. The relationship between the frequency of circulating Treg and the disease status as well as treatment outcome was also evaluated.

Results: The percentage of circulating Treg was higher ($P < 0.0001$) and their phenotype was distinct in AML patients relative to normal controls. Suppression mediated by Treg co-cultivated with proliferating autologous responder cells was also higher ($P < 0.001$) in AML than that mediated by control Treg. Using Transwell inserts, we showed that interleukin-10 and transforming growth factor-$\beta$ production as well as cell-to-cell contact were necessary for Treg-mediated suppression. Also, the pretreatment Treg frequency predicted response to chemotherapy. Unexpectedly, patients who achieved complete remission still had elevated frequency of Treg, which mediated high levels of suppressor activity.

Conclusions: Treg accumulating in the peripheral circulation of AML patients mediate vigorous suppression via contact-dependent and contact-independent mechanisms. Patients with lower Treg frequency at diagnosis have a better response to induction chemotherapy. During the post-induction period, the Treg frequency and suppressive activity remain elevated in complete remission, suggesting that Treg are resistant to conventional chemotherapy.

Numerous studies show that tumors exert suppressive effects on the host immune system and that tumor progression is linked to functional impairments of immune cells (1, 2). Regulatory T cells (Treg) are a functionally heterogeneous subpopulation of T lymphocytes, which play a key role in maintaining tolerance (3). Treg are CD4$^+$ lymphocytes characterized by constitutive expression of high levels of the interleukin (IL)-2 receptor $\alpha$ chain (CD25). A majority of CD4$^+$CD25$^{\text{high}}$ Treg also express a forkhead family transcription factor (Foxp3) up to now considered to be essential for the development and function of Treg (4, 5). However, Foxp3 expression and high levels of Foxp3 mRNA expression have recently been shown in several cell lines derived from non-T-cell lineage cells, in tumor cells, and in activated effector T cells (6–8). Another transcription factor important for Treg function, the nuclear factor of activated T (NFAT) cells, forms a complex with Foxp3 and regulates the transcription of several genes including the IL-2 gene (9, 10). Treg also express CTL-associated antigen-4 (CTLA-4), CD45RO, CD39, CD73, and glucocorticoid-induced tumor necrosis factor (GITR), although the percentages of Treg expressing these markers are variable in patients with cancers (11, 12). Because most of these markers can be induced by activation of conventional CD4$^+$ T cells, they cannot discriminate between Treg and effector T cells (13). To date, no definitive biomarker has been found for human Treg, and a “functional” definition remains their most reliable characteristic.
A growing body of evidence suggests that Treg play an important role in human cancer progression. Treg-mediated immunosuppression has emerged as a crucial mechanism of tumor evasion, which may contribute to the observed lack of responses to immunotherapy in cancer patients (2, 14). Selective elimination of CD4+CD25+ T cells in mice results in tumor growth inhibition or, in some instances, tumor regression. In contrast, adoptive transfer of CD4+CD25+ T cells is associated with suppression of antitumor immunity and tumor progression (15–17).

Mechanisms involved in Treg-mediated suppression of antitumor immunity are under investigation and recent studies have identified several distinct mechanisms Treg use for elimination of responder T cells, including activation of perforin-dependent or granzyme B-dependent pathways, production by Treg of IL-10 and transforming growth factor-β1 (TGF-β1), or up-regulation by Treg of indoleamine-2,3-dioxygenase expression in antigen-presenting cells (18, 19). ATP hydrolysis has recently emerged as another Treg-mediated mechanism of suppression. CD39 and CD73 expressed by Treg are enzymes belonging to the ectonucleoside triphosphate diphosphohydrolase family. Both enzymes work in sequence to generate the nucleoside, adenosine, with potent immunosuppressive effects on effector T cells (20, 21).

More recently, we and others have reported that the percentages of Treg are increased in the circulation of patients with solid tumors and hematologic malignancies relative to those in healthy controls (11, 12, 18, 22). Treg frequencies have been determined in these studies based on Foxp3 expression. More recently, the expression of CD25high has been used for definition of the human Treg subset-based clonal and functional analyses (11, 12). The accumulation of Treg and their increased suppressor function in cancer patients with advanced disease suggest that immune suppression is linked to tumor progression. Indeed, the increased proportion of Treg in the peripheral blood or at the tumor site has been reported to correlate with a poor disease outcome (23, 24).

Acute myelogenous leukemia (AML) is a disease with considerable phenotypic and genotypic heterogeneity, characterized by acquisition of somatic mutations in hematopoietic progenitors, which acquire a proliferative and/or survival advantage, impair hematopoietic differentiation, and confer properties of limitless self-renewal. Several studies have described the presence of abnormalities in the immune system of patients with AML, including defective function of natural killer cells and dendritic cells (25, 26). In comparison with solid malignancies, relatively little information is available about functional characteristics of Treg or their clinical significance in patients with acute leukemia. In the present study, we investigate the phenotype, function, and mechanisms of suppression used by Treg in newly diagnosed untreated AML patients and evaluate the relationship between the frequency of circulating Treg and the disease status as well as treatment outcome.

Materials and Methods

AML patients and healthy volunteers. Samples of venous blood (20–50 mL) were obtained from 31 newly diagnosed AML patients (18 females and 13 males) before any treatment and 25 age-matched healthy volunteers. All subjects signed an informed consent approved by the Institutional Review Board of the University of Pittsburgh. The blood was drawn into heparinized tubes, hand-carried to the laboratory, and immediately processed using Ficoll-Hyphaque gradients. Peripheral blood mononuclear cells (PBMC) were recovered, washed in AIM-V medium (Invitrogen), counted in a trypan blue dye, and immediately used for experiments.

Immunophenotypic analysis of cells and tissues. The following anti-human monoclonal antibodies (mAb) were used for flow cytometry: anti-CD3-ECI (R&D Systems), anti-CD4-PC5, anti-CD69-FITC, anti-CD3D2L-FITC, anti-CD25-PE, anti-CD122-PE, anti-CD152-PE (CTLA-4), and anti-CD132-PE (IL-2R). Intracytoplasmic expression of TGF-β1 and IL-10 was assessed before and after stimulation of PBMC with 5 ng/mL IL-2 and 20 ng/mL anti-CD3. Intracellular staining for Foxp3 and TGF-β1 and IL-10 was assessed before and after stimulation of PBMC with 5 ng/mL IL-2 and 20 ng/mL anti-CD3. Intracellular staining for Foxp3 and TGF-β1 and IL-10 was assessed before and after stimulation of PBMC with 5 ng/mL IL-2 and 20 ng/mL anti-CD3.

Intracellular staining for Foxp3, CD152 (CTLA-4), and GITR was done as described previously (27). Intracytoplasmic expression of TGF-β1 and IL-10 was assessed before and after stimulation of PBMC with 5 ng/mL IL-2 and 20 ng/mL anti-CD3. Intracellular staining for Foxp3 and TGF-β1 and IL-10 was assessed before and after stimulation of PBMC with 5 ng/mL IL-2 and 20 ng/mL anti-CD3. Intracellular staining for Foxp3 and TGF-β1 and IL-10 was assessed before and after stimulation of PBMC with 5 ng/mL IL-2 and 20 ng/mL anti-CD3.
saponin, resuspended in fluorescence-activated cell sorting flow solution, and immediately analyzed by flow cytometry. Appropriate isotype controls were included for each sample.

**Flow cytometry.** A Beckman Coulter flow cytometer equipped with Expo32 software was used to acquire at least $2 \times 10^5$ lymphocytes in each sample. The acquisition and analysis gates were set on lymphocytes based on forward scatter and side scatter properties of the cells. Forward and side scatter were set in a linear scale. For more extensive analysis, gates were set on CD3+CD4+ and CD4+CD25high T-cell subsets as appropriate. CD4+ T cells with mean fluorescence intensity of CD25 expression $>120$ were classified as CD25high based on the data previously reported by us (27).

**Suppressor activity.** For use in suppression assays, CD4+CD25high T cells were single-cell sorted from the populations of CD4+CD25+ T cells obtained by positive selection of PBMC using the Regulatory T Cell Separation Kit and AutoMACS (Miltenyi Biotech). CD4+CD25high T cells were tested for regulatory function in coculture assays as described previously (11). Briefly, CD4+CD25+ responder cells were labeled with 1.5 μmol/L carboxyfluorescein diacetate succinimidyl ester (Molecular Probes/Invitrogen) and cocultured with autologous Treg at the suppressor to responder cell ratios of 1:1, 1:5, and 1:10 for 5 days. Bead-bound OKT3 (1 μg/mL; American Type Culture Collection) and soluble anti-CD28 mAb (1 μg/mL) (Miltenyi Biotec) were used for T-cell stimulation in the presence of 150 IU IL-2/mL. T-cell populations were classified as suppressive if they inhibited proliferation of the CD4+CD25+ responder cells in the coculture assay and if decreasing the number of CD4+CD25high cells relative to the number of CD4+CD25+ responder cells in coculture restored proliferation. All carboxyfluorescein diacetate succinimidyl ester data were analyzed using the ModFit software provided by Verity Software House. The percentage of suppression was calculated based on the proliferation index of responder cells alone compared with the proliferation index of cultures containing responder cells and Treg. The program determines the percent of cells within each peak, and the sum of all peaks in the control culture is taken as 100% of proliferation or 0% of suppression.

**Fig. 1.** Increased frequency of CD4+CD25high T cells in the peripheral blood of patients with AML before treatment. 

A, gating strategy used to identify the CD4+CD25high T reg. CD4+ T cells with mean fluorescence intensity of CD25 expression $>120$ were classified as CD25high as reported previously (26). Only CD4+CD25high T cells with this or higher mean fluorescence intensity in PBMC have suppressor activity. B, percentages of CD4+CD25+ (left) and CD4+CD25high (right) T cells in the peripheral blood of NC and AML patients. The percentage of Treg was increased in AML patients relative to that of NC $P < 0.001$. C, multicolor confocal microscopy shows the presence of CD4+CD25+Foxp3+ and CD4+CD25+Nfat1+ in the peripheral blood of a representative AML patient. Green, CD4+ cells (1 and 4); red, CD25+ cells (2 and 5); blue, Foxp3+ cells (2); blue, Nfat1+ cells (5). Merged pictures show CD4+CD25+Foxp3+ (3) and CD4+CD25+Nfat1+ (6). Bar, 10 μm.
Transwell assays. To assess whether cell-to-cell contact was necessary for Treg to mediate suppression, polycarbonate 24-well Transwell inserts (0.4 μm; Corning Costar) were used to separate responder cells from suppressor cells. At least 5 × 10^4 carboxyfluorescein diacetate succinimidylester-labeled CD4+CD25+ T cells were stimulated with OKT3 and anti-CD28 mAb (each at 1 μg/mL) in the presence of 150 IU IL-2/mL in lower chambers. The same number of autologous Treg (4.2 ± 0.3%) than is NC (1.4 ± 0.1%). The majority of CD4+CD25high Treg (>95%) in both AML and NC expressed intracellular Foxp3 and were negative for CD127. CD4+CD25high Foxp3+ cells were CD4+CD25+NFAT1+ in the peripheral blood of AML patients (Fig. 1C).

Phenotypic analysis of the CD4+CD25high Treg subset. On staining for intracellular and cell surface markers in CD4+CD25high T cells, considerable phenotypic differences were observed between AML patients and NC (Fig. 2A and B). Surface expression of GITR and CTLA-4 was increased in Treg of AML patients (P < 0.001 for both) relative to NC. This was also noted for GITR and CTLA-4 expression within the CD4+ Foxp3+ subset (data not shown) and the intracellular expression of perforin and granzyme B (P < 0.01 for both). In contrast, HLA-DR, CD62L, and CD95 expression was reduced in Treg of the AML patients compared with NC (P < 0.001 for all). Cell surface expression of CD45RO and chemokine receptors CCR7 and CCR4 or intracellular expression of Foxp3 was not significantly different.

Suppressor function of circulating CD4+CD25high T cells in AML patients. To evaluate the suppressor cell function mediated by CD4+CD25high T cells (S), suppression assays were done. At the suppressor to responder cell ratio of 1:1, the mean ± SD suppression of responder cell proliferation was 63 ± 7% in NC. However, when CD4+CD25high T cells isolated from AML patients were cocultured with autologous CD4+CD25+ responder cells, the mean suppression was significantly higher at 82 ± 8% (P < 0.001; Fig. 3A and B).

Having established that Treg from AML patients have higher suppressive activity, we evaluated the intracellular expression of TGF-β1 and IL-10, cytokines that have been shown to play a role in Treg-mediated suppression (11). Compared with NC, the levels of expression of TGF-β1 and IL-10 were higher in Treg obtained from AML patients (P < 0.001 for both). This was also not significant for IL-12 and IFN-γ, while TNF-α expression was higher in Treg of the AML patients compared with NC (P < 0.05 for all). Cell surface expression of CD45RO and chemokine receptors CCR7 and CCR4 or intracellular expression of Foxp3 was not significantly different.

Confocal microscopy. To detect CD4+CD25+Foxp3+ and CD4+CD25+NEAT1+ Treg in the peripheral blood of AML patients, PBMC (1 × 10^4) were cytocentrifuged onto glass slides, air dried, and fixed in acetone and ethanol 1:1 for 8 min. Smears were blocked with 10% donkey serum in PBS for 45 min. Cells were incubated with primary antibodies for 1 h at room temperature in a moist chamber, washed in PBS, and then incubated with the secondary antibodies under the same conditions and in the dark. Controls were treated with isotype control IgG in place of primary antibodies. Cells were examined using an inverted Olympus Fluoview 1000 laser scanning confocal microscope under an oil immersion objective. For digital image analysis, the software Adobe Photoshop 7.0 version was used.

Results

Treg frequency in the peripheral blood of AML patients. The percentages of circulating CD4+CD25+ T cells were similar in the AML patients and NC (mean ± SD, 12.8 ± 1.8% versus 12.1 ± 0.7%). However, the percentage of circulating CD4+CD25high Treg was higher (P < 0.0001) in the AML patients (4.5 ± 0.2%; range, 1.7-8.2%) compared with NC (1.5 ± 0.08%; range, 0.9-3.1%; Fig. 1A and B). Similarly, the frequency of CD4+Foxp3+ Treg was higher in the AML patients (4.2 ± 0.3%) than is NC (1.4 ± 0.1%). The majority of CD4+CD25high Treg (>95%) in both AML and NC expressed intracellular Foxp3 and were negative for CD127. CD4+CD25high Foxp3+ cells were CD4+CD25+NFAT1+ in the peripheral blood of AML patients (Fig. 1C).

Phenotypic characteristic of CD4+CD25high Treg obtained from PBMC of AML patients and NC. A, gating strategy used to identify the CD4+CD25high Treg and coexpression of Foxp3 in CD4+CD25high cells. B, percentage of cells positive for various markers within the CD4+CD25high T cell subsets in NC and AML patients. * P < 0.05.
of cytokines produced by Treg in suppression of responder cell proliferation, the cocultured cells were separated by a Transwell membrane. Suppression mediated by CD4+CD25high T cells (S) isolated from AML patients in the presence of Transwell membranes was significantly inhibited (Fig. 4). The addition of neutralizing antibodies to IL-10 and/or TGF-β1 in the absence of the Transwell inserts resulted in reduction of the Treg-mediated suppression, with the greatest inhibition observed when the combination of these antibodies was used (P < 0.001). The addition to cocultures of neutralizing antibodies to IL-10 and TGF-β1 in the presence of Transwell inserts resulted in the greatest reduction of the Treg-mediated suppression (P < 0.00001; Fig. 4B). In aggregate, these data suggest that both cell-to-cell contact and cytokine production contribute to suppression mediated by Treg obtained from AML patients.

**CD4+CD25high Treg isolated from AML patients hydrolyzed ATP.** Adenosine generation catalyzed by ectoenzymes CD39 and CD73 has been shown to contribute to Treg-mediated suppression (20, 21). Both CD39 and CD73 were expressed in CD4+CD25high Treg from AML patients (Fig. 5A and B). Compared with Treg of NC, those obtained from AML patients more efficiently hydrolyzed ATP to adenosine (Fig. 5C).

**Frequency and suppressor function of circulating CD4+CD25high T cells and clinical outcome in AML patients.** Cytogenetic analysis was done in all newly diagnosed AML patients, and cytogenetic abnormalities were grouped according to the published criteria (28). We have not detected any significant difference in the percentage of circulating Treg between the patients who have an unfavorable karyotype and those with favorable and intermediate karyotypes at presentation. The mean percentage of circulating CD4+CD25high Treg at diagnosis in patients who had achieved complete remission (CR) was lower than that in the peripheral circulation of patients who had persistent leukemia after induction chemotherapy (4.1 ± 0.3% versus 5.6 ± 0.6%; P < 0.04; Fig. 6A). Similarly, the CD4+Foxp3+ population was lower (3.8 ± 0.4% versus 5.2 ± 0.6%) in these AML patients.

We also evaluated the frequency, phenotype, and suppressor activity of Treg in 7 AML patients who achieved CR. The percentages of their CD4+CD25high T cells as well as CD4+Foxp3+ T cells increased (P < 0.001) relative to the pretreatment values (6.1 ± 0.7% versus 3.3 ± 0.4%). Expression of various surface and intracellular Treg markers that were evaluated at diagnosis did not significantly change once patients achieved CR. Compared with NC, the mean percent suppression was significantly higher in Treg of CR patients, and these post-treatment suppression levels were similar to those determined before chemotherapy (Fig. 6B and C). The data suggest that, in AML patients who achieve CR after induction therapy, the frequency of Treg remains elevated, as does the suppressor activity these cells mediate.

**Discussion**

In this study, we evaluated the frequency, phenotype, and functional characteristics of Treg obtained from the peripheral circulation of patients with AML at diagnosis and in a subset of these patients who achieved CR after induction chemotherapy. The subset of Treg was defined as CD4+CD25high clones based on the emerging evidence that Foxp3 is not a selective marker for human Treg (8) and strong suppressive activity of CD4+CD25high clones (12).

In comparison with NC, the newly diagnosed AML patients had an increased frequency of Treg in the peripheral blood.

![Fig. 3.](http://www.aacrjournals.org) Suppression of proliferation by CD4+CD25high Treg. A, CD4+CD25 responder T cells (R) isolated from PBMC of a representative NC and an AML patient before any treatment. R cells were labeled with carboxyfluorescein diacetate succinimidyl ester and stimulated with OKT3, anti-CD28 antibody, and IL-2 in the absence of Treg (R alone). The addition of CD4+CD25high Treg (S) from PBMC of NC or AML patient at different suppressor to responder cell ratios inhibited R cell proliferation, with the highest inhibition observed at the 1:1 suppressor to responder cell ratio. B, suppression of proliferation by CD4+CD25high Treg in the newly diagnosed AML patients was significantly higher compared with NC. C, intracellular expression of TGF-β1 and IL-10 in NC and AML patients. Although the levels of expression were low, the expression was significantly different. The intracellular expression of TGF-β1 and IL-10 after stimulation with phorbol 12-myristate 13-acetate and ionomycin was significantly higher in the AML patients compared with NC. Asterisks, significant differences between NC and AML patients at P < 0.001.
Further, these cells had a phenotypic profile that was distinct from that of Treg in the blood of NC and mediated significantly higher suppression. An elevated frequency of Treg in the peripheral blood has been previously reported in various solid cancers and hematologic malignancies (18). Wang et al. have shown an increased frequency of Treg in the peripheral blood of AML patients and a concomitant increase in their frequency in the bone marrow (29). Surprisingly, AML patients had a higher percentage of apoptotic cells in the CD4+CD25<sup>high</sup> T-cell subset relative to NC and a higher proliferative rate, suggesting a rapid turnover of Treg, which compensated for the higher apoptotic loss (29).

Increases of Treg at the tumor site or in the peripheral circulation of cancer patients have been previously associated with poor treatment outcomes in some cancer patients and with more advanced disease stages (23, 24). To gain further insights into the role Treg play in acute leukemia, we also evaluated the frequency of Treg after induction chemotherapy. We found that patients who achieved CR after induction chemotherapy had a significantly lower Treg frequency at diagnosis compared with patients who did not respond and had persistent leukemia. Counterintuitively, the Treg frequency remained elevated in patients who achieved CR after induction therapy. Furthermore, Treg suppressor activity remained persistently high in these CR patients. These data suggest that Treg are resistant to induction chemotherapy and that this therapy may have enhancing effects on the frequency and/or function of Treg. The high frequency of Treg post-therapy could represent a secondary response to inflammation caused by induction chemotherapy and to cytokine secretion promoting the expansion and proliferation of peripheral Treg. Whether the observed high suppressor activity levels of Treg in patients with CR are related to higher relapse rates will need to be further evaluated in a larger cohort of AML patients.

Not only was the frequency of circulating CD4<sup>+</sup>CD25<sup>high</sup> T cells increased in AML patients in our study, but these Treg mediated high suppression levels, inhibiting proliferation of autologous effector cells. As Treg can use different mechanisms of suppression, initially we used the Transwell system to show that Treg of AML patients mediated suppression via cell-to-cell contact. Indeed, in the presence of a Transwell membrane, suppression was reduced by ~50%, confirming that the cell-to-cell contact is important. In addition, neutralizing antibodies to IL-10 and TGF-β1 further inhibited Treg-mediated suppression in the Transwell experiments, indicating that these cytokines also contribute to Treg-mediated suppression. Another mechanism of Treg-mediated suppression that we investigated was enzymatic hydrolysis of ATP to adenosine (20, 21). Our data showed for the first time that Treg in AML patients express endonucleotidases, CD39 and CD73, and consequently can hydrolyze ATP more efficiently than their counterparts in NC.

Treg suppressor function is controlled by the constitutive expression of several receptors. Compared with NC, expression levels of these biomarkers on Treg, including CTLA-4 and GITR, were elevated in AML patients. Studies in mouse models and in cancer patients have shown that blocking of Treg receptors results in a decrease of Treg suppressor function, improves antitumor immunity, and induces tumor regression (30–33). These data suggest that the distinct receptor repertoire of Treg in AML patients could be related to suppressor activity mediated by these T cells and that blocking of these receptors on Treg could restore antitumor immunity.

In summary, our data provide insights into the regulatory mechanisms used by Treg in patients with AML. The increased frequency of Treg with high suppressor activity in AML patients at diagnosis indicates that these cells likely play a role in host antitumor immune responses. However, following induction chemotherapy, the frequency and suppression mediated by Treg remain elevated even in AML patients who achieve a CR. These data suggest that chemotherapy does not reduce the frequency or function of Treg and that their persistence could influence leukemia recurrence. Although further studies are required to confirm this hypothesis, it might be possible to suggest that immunotherapies that down-regulate functional activity of Treg should be considered for patients with AML.

**Disclosure of Potential Conflicts of Interest**

No potential conflicts of interest were disclosed.
Fig. 5. Constitutive expression of CD39 and CD73 by Treg and adenosine generation. A, expression levels of CD39 and CD73 proteins on CD4+CD25^{high} T cells in AML patients and NC. B, percentages of CD4+CD25^{high} T cells coexpressing CD39 and CD73 in the circulation of AML patients and NC. Mean ± SD (A and B). C, ATP hydrolysis by CD4+CD25^{high} or CD4+CD25^{low} cells isolated from a representative AML patient or a NC. Note that CD4+CD25^{high} T cells from AML hydrolyzed more exogenous ATP than CD4+CD25^{low} from NC or CD4+CD25^{low} T cells. In the presence of an inhibitor of ectonucleotidases, ARL67165, the ability of CD4+CD25^{high} cells to hydrolyze ATP was reduced. Representative of five experiments done. Asterisks, significant differences between triplicate samples tested at \( P < 0.001 \).

Fig. 6. Frequency and suppressor function of Treg in AML patients at diagnosis and after achieving CR. A, frequency of Treg was evaluated in all patients at diagnosis. Patients who achieved CR after induction chemotherapy had lower Treg levels compared with patients that had persistent leukemia. B, frequency of Treg after induction chemotherapy was evaluated in 7 patients who had achieved CR and was found to be significantly higher at the time of CR relative to that determined before treatment. C, compared with NC, the suppressor activity of CD4+CD25^{high} Treg remained elevated in AML patients who achieved CR. Elevated suppression levels were similar to those determined before treatment levels but were significantly higher relative to suppression mediated by Treg from NC. Mean ± SD. Asterisks, significant differences in suppression mediated by Treg of AML patients or NC at \( P < 0.001 \).
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