Mucosal Damage and Neutropenia Are Required for Candida albicans Dissemination

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Candida albicans fungemia in cancer patients is thought to develop from initial gastrointestinal (GI) colonization with subsequent translocation into the bloodstream after administration of chemotherapy. It is unclear what components of the innate immune system are necessary for preventing C. albicans dissemination from the GI tract, but we have hypothesized that both neutropenia and GI mucosal damage are critical for allowing widespread invasive C. albicans disease. We investigated these parameters in a mouse model of C. albicans GI colonization that led to systemic spread after administration of immunosuppression and mucosal damage. After depleting resident GI intestinal flora with antibiotic treatment and achieving stable GI colonization levels of C. albicans, it was determined that systemic chemotherapy with cyclophosphamide led to 100% mortality, whereas selective neutrophil depletion, macrophage depletion, lymphopenia or GI mucosal disruption alone resulted in no mortality. Selective neutrophil depletion combined with GI mucosal disruption led to disseminated fungal infection and 100% mortality ensued. GI translocation and dissemination by C. albicans was also dependent on the organism’s ability to transform from the yeast to the hyphal form. This mouse model of GI colonization and fungemia is useful for studying factors of innate host immunity needed to prevent invasive C. albicans disease as well as identifying virulence factors that are necessary for fungal GI colonization and dissemination. The model may also prove valuable for evaluating therapies to control C. albicans infections.

Introduction

Candida albicans is a ubiquitous commensal organism that can cause serious disseminated infections in cancer patients [1,2]. Candida spp. are the fourth leading cause of nosocomial bloodstream infections in the United States, with treatment costs estimated to be more than $2–$4 billion annually [3] and with attributable mortality rates estimated to be between 38% to 49% [4]. Among the various invasive fungal infections reported in cancer patients, candidiasis is the most common infection (58%–69%) [5–7], and over the past decade, the incidence of invasive fungal infections in this population has increased significantly [8].

The presumed mechanism for all invasive C. albicans disease involves initial mucosal surface colonization followed by invasion into the adjacent tissues and organs. In cancer patients, C. albicans usually colonizes the gastrointestinal (GI) tract with subsequent translocation into extraintestinal organs (i.e., mesenteric lymph nodes, blood stream, liver, and spleen) in the setting of chemotherapy-induced neutropenia and GI mucosal damage [9]. The three primary mechanisms that promote pathogenic microbial (bacterial and fungal) translocation in animal models are: 1) disruption of the normal GI microbiologic equilibrium allowing intestinal overgrowth of pathogens, 2) increased permeability of the intestinal mucosal barrier, and 3) deficiencies in the host immune defenses [10,11]. Not surprisingly, common risk factors for developing candidemia in human patients include neutropenia, mucositis, use of broad spectrum antibiotics, and invasive medical procedures [6,12]. The majority of murine models of disseminated candidiasis have employed the administration of a chemotherapeutic agent (e.g., cyclophosphamide) followed by the subsequent intravenous injection of C. albicans [13,14] or simply the intravenous injection of high inocula of C. albicans [15,16]. Therefore, a murine model that first establishes GI colonization followed by translocation and dissemination via disruptions of select components of the innate host defense would afford valuable opportunities for studying the details of C. albicans pathogenesis, as well as delineating the relative roles of the major immune compartments or the actual immune mechanisms responsible for killing and/or controlling translocating C. albicans [10].

To evaluate normal host factors that must be disrupted to allow for GI colonization, fungal dissemination and significant morbidity or mortality due to candidemia, we have developed a reproducible mouse model wherein C. albicans GI colonization is first established and subsequent fungal dissemination is achieved following induction of immunosuppression and disruption of mucosal integrity. Both neutropenia and GI mucosal damage appear to be necessary

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for fungal dissemination in this murine model. Finally, we evaluated \( \text{C. albicans} \) mutants that had varying abilities to switch between the yeast and the hyphal growth form of \( \text{C. albicans} \) and found changes in virulence associated with an inability to switch to the hyphal phase, indicating the utility of this animal model for studying different aspects of the pathogenic process of \( \text{C. albicans} \) in the setting of GI colonization and dissemination.

Results

GI Colonization by \( \text{C. albicans} \)

Wild-type \( \text{C. albicans} \) strains SC5314 (a strain that has been frequently used in various \( \text{C. albicans} \) murine models [17–20]) and CAF2–1 consistently colonized the mouse GI tract at comparable levels: SC5314 (median = 2.24 \( \times \) 10^7 cfu/g stool, first quartile = 1.07 \( \times \) 10^7, third quartile = 3.75 \( \times \) 10^7) and CAF2–1 (median = 2.60 \( \times \) 10^7 cfu/g stool, first quartile = 2.28 \( \times \) 10^7, third quartile = 3.19 \( \times \) 10^7; Figure 1). When tested up to 21 d later, there was no significant change in fungal colonization levels of the stool.

Dissemination by \( \text{C. albicans} \)

Mice that were colonized with \( \text{C. albicans} \) strains SC5314 and CAF2–1, as well as non-\( \text{Candida} \) colonized control mice that were only decontaminated with antibiotics, were separated into 17 groups (8 mice/group, with the exception of 4 mice/group in \( \text{RAG}^\text{1–1} \) mice), treated with immunosuppressive regimens (Table 1), and the effect on dissemination of the different methods of immunosuppression determined (Table 2). Mice that were only decontaminated with antibiotics all survived after administration of immunosuppressive regimens—with the exception of 1 death in the group given mAb RB6-8C5 plus methotrexate (MTX) (Group 7). All groups that were colonized with \( \text{C. albicans} \) strains SC5314 and CAF2–1 then given immunosuppression showed levels of GI colonization comparable to those of mice not given immunosuppression (results shown in Figure 1; data for immunosuppressed mice not shown). Mice that were only given antibiotic decontamination and no immunosuppression after colonization with \( \text{C. albicans} \) (Group 1) also all survived.

Chemotherapy. When either Cy alone (Group 2), Cy plus MTX (Group 3) or mAb RB6-8C5 plus MTX (Group 5) were administered, fungal dissemination occurred in all mice associated with a high level of mortality. Interestingly, when MTX alone (Group 4) was given, 3 of 8 mice in the group colonized with strain SC5314 and 4 of 8 mice in the group colonized with strain CAF2–1 died from disseminated disease. In contrast, when MTX was given concurrently with mAb RB6-8C5 (Group 5), all mice died following fungal dissemination.

Neutrophil depletion. Mice that were made neutropenic after a single injection of 200 \( \mu \)g of anti-neutrophil mAb RB6-8C5 (mAb \( \times \) 1) survived (Group 6). Even when given two additional doses of mAb RB6-8C5 (mAb \( \times \) 3; Group 7) and thus made neutropenic for 15 d, there was no evidence of \( \text{C. albicans} \) dissemination in these mice. The four mice that died in this group only showed evidence of bacterial (e.g., \textit{Enterobacter} spp.), not fungal, dissemination.

Macrophage depletion. By immunohistochemical analysis, macrophages in both the liver and spleen were reduced after liposomal clodronate administration (Figure S1). By FACS analysis, F4/80 and CD11b double-stained macrophages were reduced in the spleen and bone marrow after liposomal clodronate administration from 26% to 16% (Figure S2). Mice given liposomal clodronate (Group 8), clodronate plus mAb RB6-8C5 (Group 9), or clodronate plus DSS (Group 10) all survived.

Lack of functional lymphocytes. \( \text{RAG}^\text{1–1} \) mice colonized with strains SC5314 or CAF2–1 showed no evidence of dissemination (Group 11)—not even when mAb RB6-8C5 (Group 12), DSS (Group 13), or liposomal clodronate (Group 14) were subsequently administered to different groups of \( \text{RAG}^\text{1–1} \) mice.

GI mucosal disruption. There was no histologic evidence of any GI mucosal injury or damage in the ceca of mice given mAb RB6-8C5 or DSS for 3 d; in contrast, mice given DSS for...
7 d had ulcerations and focal areas of inflammation noted in the cecum (Figure 2). The cecums of the mice that had received DSS for 7 d and one dose of mAb RB6-8C5 showed diffuse autolysis and sloughing. Mice given DSS alone showed no evidence of \textit{C. albicans} dissemination (Group 15); however, when both DSS (2.5%) and mAb RB6-8C5 were given, disseminated disease and mortality was achieved (50% to 87.5% mortality). Increasing the DSS concentration from 2.5% (Group 16) to 5% (Group 17) while still giving a single 200 µg/mouse dose of mAb RB6-8C5 achieved 100% mortality associated with fungal dissemination to the liver.

When mice were found moribund or died, the levels of \textit{C. albicans} in the livers were comparable among animals given the different treatment regimens when both neutropenia and mucosal damage were induced (Figure 3). With the exception of the four mice noted previously in Group 7 (mAb × 3), there was no evidence of concurrent bacterial infection.

### Translocation Studies
We analyzed the effects of immunosuppression and/or mucosal damage treatments on translocation of \textit{C. albicans} from the GI tract. All mice in these studies were colonized with \textit{C. albicans} SC5314 and had levels of GI colonization comparable to that shown in Figure 1 (data not shown). Mice given no immunosuppression (Group A) all survived, and none appeared moribund and none grew \textit{C. albicans} from the blood, spleen or MLN. Of note, fungi were found at very low levels in the livers of 4 (out of 20) healthy-appearing mice (9, 42, 208, and 369 cfug). The mice given mAb RB6-8C5 treatment only (Group B) all survived, and none appeared moribund. Similar to Group A, \textit{C. albicans} was not found in the blood, spleen or MLN of mice only given the neutropenia-inducing mAb, but fungi were occasionally found in the liver (5 out of 20; median 9.88 × 10^5 cfug, first quartile = 4.09 × 10^7, third quartile = 2.68 × 10^9); these are clearly higher levels than those found in the livers of mice in Group A which did not receive any immunosuppression. In contrast, 3 of the 4 mice from the group given neutropenia-inducing mAb RB6-8C5 plus MTX (Group C) died by day 4 post-immunosuppression, and 4 of 4 of these mice had died by day 5. All of these mice showed significant levels of \textit{C. albicans} in the liver (median 8.77 × 10^3 cfug, first quartile = 3.45 × 10^3, third quartile = 2.51 × 10^5). Finally, the mice given Cy only (Group D) all had \textit{C. albicans} in the liver by days 4 and 5; (median 7.71 × 10^3 cfug, first quartile = 3.87 × 10^3, third quartile = 1.13 × 10^6)

### \textit{C. albicans} Morphogenesis as a Virulence Determinant
In order to assess the role of fungal morphogenesis as a virulence determinant in our murine model, we tested three \textit{C. albicans} strains for their ability to colonize and disseminate following immunosuppression: strain CAF2-1 is a wild-type organism that was chosen because it, like the additional mutants we tested, only has one copy of the \textit{URA3} gene [21]; strain HLC54 (cph1/cph1 efg1/efg1) exhibits decreased filamentation, hereafter referred as \textit{efg1/cph1} [22]; and strain BCa-210 (\textit{tup1/tup1}), hereafter referred to as \textit{Δtup1}) exhibits constitutive filamentous growth [23]. As shown in Figure 4, both CAF2-1 (median = 2.99 × 10^7 cfug, first quartile = 2.38 × 10^7, third quartile = 3.30 × 10^7) and strain \textit{efg1/cph1} (median = 5.32 × 10^7 cfug, first quartile = 4.69 × 10^7, third quartile = 1.03 × 10^8) were able to colonize the GI mucosa at comparable levels, while the \textit{Δtup1} strain colonized at a level 2-logs lower (median = 7.71 × 10^4 cfug, first quartile = 5.0 × 10^3, third quartile 1.66 × 10^6, \textit{p} = 0.0003 by Mann Whitney test compared with other two strains). This discrepancy is explained by the fact that the maximum concentration achievable of \textit{Δtup1} in water was approximately 2-logs lower than the levels for the wild-type and \textit{efg1/cph1} strains—a difference which was consistent throughout the experiment. Interestingly, strain \textit{efg1/cph1} caused less mortality compared to wild-type \textit{C. albicans} (8 of 16 mice given \textit{efg1/cph1} died versus 14 of 16 mice infected with wild-type, \textit{p} = 0.02, Fisher’s exact test), whereas in spite of the 2-log lower levels of strain \textit{Δtup1} in feces it caused mortality comparable to that of wild-type (7 of 8 mice died; Figure 5). In preliminary experiments with wild-type \textit{C. albicans} strains SC5314 and CAF2-1, if we administered immunosuppression (e.g., mAb RB6-8C5 plus MTX) before final levels of GI colonization (between 10^7 and 10^8 cfug) had been established, dissemination was not induced, and all mice survived (data not shown). All of these surviving mice continued to be colonized with their respective strains of \textit{C. albicans} at levels comparable to that achieved before administration of mAb and MTX.

Eight additional mice were administered higher concentrations of \textit{Δtup1} (5.5 × 10^5 cfug/ml) in the drinking water, and GI colonization levels achieved with this higher dose were comparable to those of the wild-type \textit{C. albicans} strain (median = 1.48 × 10^7 cfug, first quartile = 5.20 × 10^6, third quartile = 4.08 × 10^7), indicating that the level of GI colonization can be increased for this strain. To determine if this constitutively filamentous strain could by itself induce mucosal damage sufficient to achieve dissemination, we
administered the mice 200 μg of mAb RB6-8C5 only. No enhanced mucosal disruption sufficient to allow fungal dissemination in most mice was achieved by constitutive hyphal expression, as 7 of 8 colonized mice made only neutropenic still survived.

Discussion

In this study, we attempted to devise a mouse model to study *C. albicans* pathogenesis and host factors leading to susceptibility to disseminated infection that emulate the pathophysiology that takes place in a human host, wherein receipt of broad-spectrum antibiotics, extensive hospitalization, or administration of immunosuppressive agents makes patients more vulnerable to invasive disease, often associated with intercurrent mucosal disruption owing to surgery, tumor invasion, or chemotherapy [24,25]. In neutropenic patients, the role of the gut as a source for disseminated candidiasis has been supported from autopsy studies [26].

Several murine models of GI-derived *C. albicans* fungemia and sepsis have been reported previously [27–32]. The levels of GI colonization we obtained were substantially higher than those achieved by prior investigators (1 to 3 log-fold higher) [31,33] and were maintained at least up to 21 d (our latest verification date). This higher colonization level is most likely due to the addition of penicillin to the drinking water. Penicillin most likely led to reductions of endogenous anaerobic bacterial flora, promoting subsequent intestinal overgrowth by *C. albicans* [34]. One other model did achieve comparable colonization levels by also administering adjunctive oral antibiotics [32]. The need for reduction of indigenous flora, particularly gram-negative bacteria, is critical given that bacteria are just as likely as the *C. albicans* to translocate and disseminate when immunosuppression is administered [35].

We were able to show this model recapitulates important aspects of human susceptibility to candidiasis, although there are some limitations to consider. The model was developed using adolescent/young adult 6- to 8-wk-old female C3H/HeN mice, and its applicability to other mouse strains or mice of other ages is not fully known. It would be difficult to use neonatal or infant mice in this model as others have done with acute *C. albicans* infections [28–30] due to the need for the animals to be able to drink both antibiotic water and fungi in the water and then give the immunosuppressive/mucosal disrupting agents, which would not be feasible with mice prior to weaning. C3H/HeN mice were used because of experience in a previous model of *P. aeruginosa* GI colonization and neutropenia-induced dissemination [35], and the fact that this strain has no major underlying immune deficit and is highly susceptible to DSS-induced colitis [36]. While we have not extensively studied other mouse strains, initial studies using Swiss Webster and C57BL mice showed that comparable levels of GI colonization, mortality, and liver dissemination can be achieved when using Cy as the immunosuppressive/mucosal damaging agent (AVK and GBP, unpublished data). *C. albicans* administration via drinking water limits the ability to control the infecting dose as might be achieved by administering fungal cells by gavage. However, administering *C. albicans* in the drinking water for 5 d led to a reproducible and consistent GI colonization level (Figure 1) associated with dissemination following the disruption of specific host defenses. Additionally, we did not confirm the entire spectrum of bacterial decontamination achieved by the antibiotics, as we did not utilize anaerobic culture conditions or media specific for all types of aerobic and anaerobic flora. Therefore, we cannot be absolutely sure that we truly eradicated all indigenous aerobic and anaerobic flora. In any case, whatever residual aerobic or anaerobic flora that remained after antibiotic decontamination does not appear to have any pathogenic significance, as evidenced by the fact that mice given only antibiotic contamination and subsequent immunosuppression all appeared healthy and exhibited 0% mortality.

We also chose to measure fungal levels in livers as an indicator of dissemination. In other murine models of intravenous *C. albicans* infection fungal levels in the kidneys were used to confirm systemic infection was achieved. In preliminary experiments, we found that in mice that were colonized with *C. albicans*, given subsequent immunosuppression (cyclophosphamide or RB6-8C5 + MTX), and had no other detectable infectious cause of death (e.g. bacterial dissemination) that the liver (presence of *C. albicans* in 100% of livers from deceased mice) was a more reliable organ for confirmation of dissemination compared to the kidneys.

**Table 2. Survival of Mice after Administration of Immunosuppressive Regimens**

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<th>Strain</th>
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<th>Cy + MTX</th>
<th>MTX</th>
<th>mAb + MTX</th>
<th>mAb × 1</th>
<th>mAb × 3</th>
<th>Liposomal Clodronate</th>
<th>Clodronate + mAb</th>
<th>Clodronate + DSS</th>
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Abbreviations: mAb, RBC-8C5 monoclonal antibody; Cy, cyclophosphamide; MTX, methotrexate; DSS, dextran sulfate sodium; RAG–/–, recombinase activating gene deficient mice.

Mice were observed for a total of 7 days after the administration of immunosuppression, with the exception of Group 5, which was observed for periods of 5 days after each RB6-8C5 mAb dose for a total of 15 days.

*p-value by Fisher’s exact test compared to untreated group.

* Bacterial (Enterobacter spp.) dissemination only.

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(presence of *C. albicans* in 50%–80% of kidneys in deceased mice; AYK and GBP, unpublished data). One other model using *C. albicans* GI colonization and chemotherapy-induced dissemination also noted 100% recovery from the livers but significantly less recovery from the kidneys [32]. Finally, for practical purposes we had to use organs for CFU enumeration from moribund then euthanized mice or mice that died between observations whose carcasses were frozen as close to the time of death as feasible. However, in limited studies we did compare the *C. albicans* yields from organs resected after freezing and storage with yields from organs resected from freshly euthanized mice and found the differences in CFU were not statistically different (AYK and GBP, unpublished data). Nonetheless, because there could be effects from post-mortem fungal growth or losses upon storage at −20°C one must be cautious in using levels of *C. albicans* in the organs as a measure of virulence.

We also attempted to determine how *C. albicans* might spread from the GI lumen to internal organs. Given the sporadic and low levels of hepatic dissemination in mice

### Table 2. Extended.

<table>
<thead>
<tr>
<th>RAG^{−/−}</th>
<th>RAG^{−/−}</th>
<th>RAG^{−/−}</th>
<th>RAG^{−/−}</th>
<th>DSS (2.5%, 5%)</th>
<th>2.5% DSS</th>
<th>5% DSS</th>
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<tr>
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<td>+ mAb</td>
<td>+ Clodronate</td>
<td>(&lt;8 days)</td>
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<td>Group 14</td>
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<td>(p = 0.0007)*</td>
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**Figure 2.** DSS-Induced Murine Gastrointestinal Mucosal Damage  
Histological sections of cecums from mice colonized with *C. albicans* strain SC5314 with continuation of penicillin, streptomycin, and gentamicin in the drinking water then given water with 2.5% DSS for various periods with or without induction of neutropenia.  
(A) No DSS, 200 μg of RB6-8CS IP once.  
(B) DSS for 3 d.  
(C) DSS for 7 d.  
(D) DSS for 7 d and after the third day of DSS mice were given 200 μg of RB6-8CS IP once and observed for 96 h after the RB6-8CS dose. Magnification: Objective 10×.  
Sections in (A) and (B) have normal histologic appearance, whereas in panels (C) and (D) disruption of the epithelial barrier integrity was clearly seen. doi:10.1371/journal.ppat.0040035.g002
Figure 3. Viable Counts of C. albicans Strains SC5314 or CAF2–1 in the Livers of Deceased C3H/HeN Mice that Were Previously Colonized in the GI Tract with C. albicans and Subsequently Given Various Forms of Immunosuppression

Cy, cyclophosphamide; MTX, methotrexate; RB6, RB6-8c5 mAb; DSS, dextran sulfate sodium. Points represent results from individual animals. Horizontal lines with bars represent median with interquartile range when \( n > 3 \), otherwise only the median is shown. doi:10.1371/journal.ppat.0040035.g003

Colonized with C. albicans but not receiving any immunosuppression, it is conceivable that C. albicans is able to translocate to the liver via the portal circulation or via the biliary tree in the absence of immunosuppression, but does not cause widespread disease because of a competent immune system that is able to prevent significant dissemination of the fungi. In our study, mice colonized with C. albicans and given only RB6-8C5 mAb also showed sporadic levels of hepatic dissemination, albeit at higher levels than in mice that did not receive immunosuppression. The higher fungal burden is most likely secondary to the lack of neutrophils and thus the subsequent diminished ability of the immunosuppressed animal to clear the C. albicans from the liver. But even in the absence of neutrophils, the fungal burden was not enough to cause frequent morbidity or death. Not surprisingly, when we administered systemic chemotherapeutic agents such as cyclophosphamide (resulting in both neutropenia and GI mucosal disruption without neutropenia did not result in widespread dissemination with C. albicans).

In the final analysis we found both neutropenia and disruption of the integrity of the GI mucosa were needed for fungal dissemination. In several intravenous murine models of C. albicans systemic infection, neutrophil depletion notably increases fungal burden and mortality [37,38]. In this murine model, however, neutropenia alone is not sufficient for extra-intestinal dissemination most likely due to the fact that C. albicans is still unable to breach the intact GI epithelium.

Although one prior study implicated the importance of CD4+ lymphocytes in protective immunity to systemic C. albicans infection [39], several studies in SCID mice have shown that a defect in the TH1 CD4+ T-cell response to C. albicans results in mucosal or esophageal candidiasis but not in systemic dissemination. Even in C5 deficient DBA/2 mice [38] and a recent murine HIV model [40], T cell depletion also does not result in disseminated C. albicans disease. Although the RB6-8C5 mAb at the dose used also induces some depletion of lymphocytes [35], we found that both C3H/HeN and RAG-1 mice that lack mature lymphocytes were not susceptible to fungal disease following GI colonization and neutropenia alone. Thus, our murine model correlates with these previous studies: lymphopenia alone or in combination with macrophage depletion, neutrophil depletion, or GI mucosal disruption without neutropenia did not result in fungal dissemination or death of the colonized mouse.

Similarly, depleting macrophages only did not lead to any susceptibility to systemic fungal infection. Although murine peritoneal macrophages [41,42], pulmonary alveolar macrophages [43], Kupffer’s cells [44] and human peripheral blood monocytes [45] have the ability to phagocytose and kill C. albicans in vitro, in vivo studies on disseminated candidiasis have generated evidence both supporting [42,46–48] and refuting the importance [49–51] of macrophages. Of the two studies utilizing selective macrophage depletion [48,50], only one administered liposomal clodronate followed by intravenous fungal injection to produce a disseminated candidiasis. Spleens from the mice treated with clodronate lost their ability to trap yeast [48]. Furthermore, when macrophage-depleted mice were systemically challenged with C. albicans, not only was clearance of yeast decreased in blood, but kidneys had higher fungal burdens and overall mouse survival was decreased. Although we used the same dose of clodronate, we also utilized FACS analysis to quantify the macrophage depletion (37% depletion) rather than measuring peripheral blood monocyte counts (30%–85% depletion). Ultimately, our lack of finding a significant role for macrophages in host resistance to C. albicans may be related to the use of different models. In an intravenous model with direct
inoculation, this degree of macrophage depletion may be enough of a deficit to lead to more severe disseminated disease. In our murine model, it may be that macrophages do play a role, but more substantial macrophage depletion may be necessary to see this effect.

Finally, while DSS has been used for experimental murine models of human inflammatory bowel disease [52,53], the histopathologic damage induced by DSS has some similarities to chemotherapy-induced mucositis in that both result in denudation and ulceration. Interestingly, when we maintained the same degree of neutropenia but increased the GI mucosal damage (by changing DSS from 2.5% to 5%), we notably increased the mortality to 100%, and this is most likely secondary to the increased mucosal damage caused by the higher concentration of DSS. These studies further support our hypothesis that it is a combination of neutropenia and GI mucosal damage that are critical for \textit{C. albicans} dissemination in our murine model.

In the host, \textit{C. albicans} grows as all known morphologic forms (budding yeast, pseudohyphal filaments, and true hyphae), and it has been postulated that the ability to induce hyphal formation is a critical virulence determinant [22]. Mutant strains of \textit{C. albicans} that are incapable of hyphal formation have been found to be avirulent in murine models of disseminated candidiasis [54-56]. Whether it is simply that hyphae formation leads to an increased ability to invade host epithelial cells, or induces greater cytotoxicity, or whether the advantage of filamentous growth is in providing greater resistance to phagocytosis [22], the definitive mechanistic explanation linking hyphal formation to virulence is lacking. When testing the morphogenesis mutants, $\Delta \text{efg1/cph1}$, which exhibit decreased filament formation [22], and $\Delta \text{tup1}$, which exhibits constitutive filamentous growth [23], we noted a nearly 2-log lower GI colonization level of the $\Delta \text{tup1}$ mutant compared to the wild-type strain, CAF2-1. As noted earlier, this discrepancy in colonization level was most likely due to the difficulty of suspending $\Delta \text{tup1}$ in drinking water and achieving higher concentrations. All of the mice colonized with strain $\Delta \text{tup1}$ had colonization levels lower than the $10^7$ to $10^8$ cfug achieved with \textit{C. albicans} strains SC5314 and CAF2-1, yet 7 of the 8 mice colonized with the $\Delta \text{tup1}$ strain died following immunosuppression and GI mucosal damage. Since it is difficult to titrate inocula in our murine model, this finding of dissemination and mortality in the setting of significantly lower GI colonization levels may suggest that the $\Delta \text{tup1}$ mutant is more virulent in this setting. The appropriate quantification of filamentous strains, however, is confounded by the fact that cells may not be properly separated, and thus CFUs are underestimated. In addition, filamentous growth of the $\Delta \text{tup1}$ mutant alone is not sufficient to disrupt the GI mucosa and allow for fungal dissemination even in the setting of neutropenia.

Our findings with CAF2-1 and $\Delta \text{efg1/cph1}$ were consistent with previous investigators that utilized an intravenous model of \textit{C. albicans} dissemination [22,57,58]. However, in a model of hypoxic-induced GI translocation [59] and another study using oral inoculation followed by intraperitoneal (IP) injections of dexamethasone for immunosuppression [57], $\Delta \text{efg1/cph1}$ was found to be more invasive compared to the wild-type CAF2-1. Whereas both of these studies used the presence of \textit{C. albicans} in extraintestinal organs to define invasiveness or virulence, we used death attributable to \textit{C. albicans} dissemination. Furthermore, we utilized a different means of immunosuppression and attempted to verify that bacterial translocation was not a confounding factor. Therefore, our findings with $\Delta \text{efg1/cph1}$ support the hypothesis that the ability to form filaments is important for translocation and dissemination with \textit{C. albicans}.

In conclusion, we have developed a murine model of \textit{C. albicans} GI colonization following anti-microbial agent reductions in the indigenous flora and systemic spread during neutropenia that additionally requires GI mucosal damage. Neutropenia alone is not sufficient to produce disseminated \textit{C. albicans} disease in this murine model. Being able to control these host factors should allow for a more detailed study of host and fungal factors needed to achieve GI colonization and systemic dissemination. These factors should thus be useful for evaluating pathogenesis as well as therapies to control \textit{C. albicans} invasive infections.

Materials and Methods

\textbf{Fungal strains and growth.} The strains of \textit{C. albicans} used are listed in Table 3. \textit{C. albicans} strains were grown overnight at 37°C in yeast extract-peptone-dextrose (YPD) broth, harvested by centrifugation, washed with PBS, and resuspended in PBS. \textit{C. albicans} concentration was determined by use of a hemocytometer.

\textbf{Murine model of antibiotic-induced GI tract colonization by \textit{C. albicans} and immunosuppressive-induced fungemia.} Six- to 8-wk-old female C3H/HeN mice (Harlan, [http://www.harlan.com/models/c3h.asp]) were housed as groups of 4 in sterilized cages equipped with filter hoods. In some experiments, 6-wk-old female recombinase activating gene deficient mice (Rag1–, [http://jaxmice.jax.org/strain/002216.html]) were used. Mice were supplied with sterile bedding, sterile water and sterile mouse chow and maintained under specific pathogen-free conditions at the ARCMC-MCP animal facility at Harvard Medical School in compliance with the Harvard Medical Area Institutional Animal Care and Use Committee guidelines. To deplete the indigenous GI bacterial and fungal flora, mice were fed sterile water with 2 mg streptomycin/ml (Research Product International, Mt. Prospect, IL), 1500 U penicillin G/ml (Sigma-Aldrich, St. Louis, MO), and 0.250 mg fluconazole/ml (Roxanne Laboratories, Columbus, OH) for 3 d, then switched to the same concentrations of streptomycin and penicillin G in their drinking water for one more day.
day. Stool was collected from individual mice (0.030–0.050 g per stool pellet), homogenized in 1 ml 1% protease peptone, and 100 μl of the homogenate was spread and plated on yeast extract-peptone-dextrose (YPD), tryptase soy (TSA), or MacConkey agar plates. C. albicans strains (grown as described above) were added to sterile water with 2 mg streptomycin/ml, and 1,500 U penicillin G/ml at approximately 10^7 cfu/ml, and then C. albicans was administered via the drinking water to mice for 5 d. Candidal levels were constant in the drinking water and therefore water bottles were not changed during this time. After 5 d of exposure to Candida, stool was again collected, homogenized in 1 ml 1% protease peptone, serially diluted and plated on YPD agar with 0.010 mg vancomycin/ml and 0.100 mg gentamicin/ml to measure levels of GI colonization by C. albicans. We then induced immunosuppression by treating the mice with the immunosuppressive agents listed in Table 1. After administration of immunosuppressive agents, mice were fed sterile water with 2 mg streptomycin/ml, 1,500 U penicillin G/ml, and 0.2 mg gentamicin/ml for the remainder of the experiment and monitored for morbidity for 7 d. Mortality was euthanized and along with mice found dead between observation periods, the carcasses were frozen at minus 20°C, later thawed, livers resected, homogenized in 1 ml 1% protease peptone, serially diluted and 100 μl of the homogenate was spread-plated on YPD with 0.100 mg gentamicin/ml (Research Product International, Mt. Prospect, IL) and 0.010 mg vancomycin/ml (Sigma-Aldrich), and additional 100 μl amounts plated onto TSA and MacConkey agar plates. Growth media were incubated at 37°C overnight under aerobic conditions. The presence of a homogeneous population of creamy-white colonies on YPD with gentamicin and vancomycin was used for confirmation of C. albicans systemic dissemination (Figure 6).

Production or RB6-SC5 monoclonal antibody and induction of neutropenia. The RB6-SC5 monoclonal antibody (mAb) specific for the Lyb antigen highly expressed by polymorphonuclear neutrophils (PMN) was produced by growth of hybridoma cells in culture (Dulbecco’s modified Eagle’s medium with 10% fetal calf serum (FCS)) followed by purification of antibody by affinity chromatography, as previously described [35]. A single dose of 200 μg of RB6-SC5 was administered to C3H/HeN mice to produce a severe neutropenia (absolute neutrophil count < 1000/mm^3) for 5 d [35].

In vivo macrophage depletion. CL2MBP (clodronate) was a gift from Roche Diagnostics (Mannheim, Germany). Preparation of liposomes containing CL2MBP was done as described previously [60]. For assessment of macrophage depletion, three uninfected mice per group were inoculated IP with 200 μl of PBS liposomes or with CL2MBP liposomes (2 mg) [61]. At 2 d later, macrophages were quantified in the bone marrow and spleens using FACS analysis. Bone marrow and spleens were harvested from euthanized mice. To prepare single cell suspensions, spleens were sliced into small pieces with a scalpel, and the pieces placed at the ends of autoclaved frosted-glass microscope slides (Fisher Scientific, Pittsburgh, PA), previously immersed in Hank’s balanced salt solution (HBSS; Gibco/Invitrogen, Carlsbad, CA) with 10% FCS. Splenic fragments were disrupted by opposing the slide ends and applying gentle pressure in round circular movements. The resulting splenic cell suspension was collected in a Petri dish and finally run over a 70 μm nylon cell strainer (BD Biosciences, San Diego, CA). For bone marrow cells, single cell suspensions were prepared by running bone marrow cells resuspended in HBSS with 10% FCS over a 70 μm nylon cell strainer. Cells from the three mice were pooled. Erythrocytes were eliminated using lysing solution (BD Biosciences, San Diego, CA). The remaining hematopoietic cells were washed and resuspended in PBS supplemented with 2% FCS, 1% bovine serum albumin, and 0.1% NaN_3 (FACS buffer). Cells were blocked with Mouse Fc Block (BD Biosciences, San Diego, CA) at 1 μg per 10^6 cells for 5 minutes at 4°C. Alexa-488-conjugated antibody to the mouse macrophage cell surface glycoprotein F4/80 (mAb BMS, Caltag/Invitrogen, Carlsbad, CA) and/or phycoerythrin-conjugated antibody to mouse CD11b (BD Biosciences, San Diego, CA) at 10 μg/ml were added to 1 × 10^6 cells in 100 μl of FACS buffer then incubated at 4°C for 30 min followed by washing with FACS buffer. To determine background levels of fluorescence, non-antigen-specific isotype controls (Alexa-488-conjugated-IgG2a, or phycoerythrin-conjugated-IgG2a antibodies) were used as primary antibodies. After staining, cells were fixed with 1% paraformaldehyde. Fluorescence was detected on a Dako MoFlo High Performance Cell Sorter (Dako, Fort Collins, CO), and data analysis was performed using Summit Software v 4.3 (Dako, Fort Collins, CO). Gates were set to include CD11b and F4/80 double positive cells.

Livers and spleens from mice inoculated IP with 200 μl of PBS liposomes or CL2MBP liposomes (2 mg) 48 h prior to sacrifice were resected, fixed in Bouin’s solution, and paraffin-embedded sections cut and mounted on slides. 5 μm sections of hepatic and splenic tissue were deparaffinized in xylene and rehydrated in a series of reverse ethanol washes (100%, 95%, and 80% ethanol sequentially). The samples were then blocked by incubation in histology blocking buffer (PBS containing 1% bovine serum albumin and 2% normal rat serum [Sigma-Aldrich]) for 15 min at 37°C. Samples were then incubated with 1 μg Alexa-488-conjugated antibody to the macrophage F4/80 antigen for 90 min at 37°C. To detect background fluorescence, an appropriate isotype control antibody (1 μg rat IgG2a/ml) was used. The samples were then washed and sections visualized with the 10× alpha-plan lens on a Zeiss Axioplan 2 microscope, fitted with filter sets for GFP fluorescence, and a cooled CCD Hamamatsu Orca camera. Images were acquired and processed using MetaMorph (Molecular Devices Corporation, Sunnyvale, CA) and Adobe Photoshop software [62].

In vivo gastrointestinal mucosal disruption. To verify we had induced GI mucosal damage/disruption with dextran sodium sulfate (DSS), C57HeN mice (6- to 8-wk-old females) colonized with C. albicans strain SC5314 and maintained on sterile water with streptomycin, penicillin, and gentamicin to prevent bacterial recontamination were divided into four groups and sacrificed for cecal histology after the following specific treatments: Group A was given RB6-SC5 monoclonal antibody on day 0; Group B was given 5% DSS for 5 d; Group C was given 5% DSS for 7 d; and Group D was given 5% DSS water for 7 d, and after the third day of DSS water, mice were given mAb RB6-SC5 once, and observed for 96 h after the RB6-SC5 dose. Cecal were resected and immediately fixed in Bouin’s solution. Sections were stained with hematoxylin and eosin and reviewed by a veterinary pathologist.

Translocation studies. To determine if the C. albicans colonizing the GI tract was translocating to extra-gastrointestinal sites, mice were colonized with C. albicans strain SC5314 using the protocol described above then organized into the following four groups containing 24...
mice per group: Group A, no immunosuppression; Group B, neutropenia induced by IP injection of 200 µg RB6-SC5 mAb once; Group C, neutropenia and G1 mucosal disruption induced by one IP injection of 200 µg RB6-SC5 mAb and a contemporary, single IP injection of 150 mg/kg MTX; and Group D, neutropenia and mucosal damage induced by three IP injections of 150 mg/kg Cy given every other day (Table 4). Four mice from each group were sacrificed on days 0, 1, 2, 3, 4, and 5 after immunosuppression was initiated. Blood (100 µl) was drawn from an ethanol-cleaned tail vein and spread-plated onto YPD agar with vancomycin and gentamicin, TSA, and MacConkey agar plates. Mice were then sacrificed. Mesenteric lymph nodes (MLN), spleens, and livers were immediately resected; organs were homogenized in 1 ml of 1% protease peptone; and 100 µl of homogenate was spread-plated on YPD agar with vancomycin and gentamicin, TSA, and MacConkey agar plates. The presence of a homogenous population of creamy-white colonies on YPD with gentamicin and vancomycin were used for confirmation of the presence of *C. albicans*. Serial dilutions and plating for fungal enumeration were also done to obtain quantitative data (CFU per gram tissue and CFU per ml blood).

**Statistical analyses.** Survival data were analyzed by Fisher’s exact test and the survival curve was analyzed by the Kaplan-Meier log rank test using the GraphPad Prism software (San Diego, CA). Two-way comparisons of GI colonization levels were carried out using the Mann-Whitney tests and Prism software, and when multiple comparisons or more than two groups were analyzed, Bonferroni’s correction to the significance level α was invoked.

**Supporting Information**

**Figure S1.** Immunohistochemical Staining with Alexa-488 Anti-Mouse F4/80 of Murine Spleens and Liver after Liposomal Clodronate Administration

(A) Isotype control (Alexa-488 rat IgG2a) staining of normal murine spleen. (B) Alexa-488 rat anti-mouse F4/80 staining of normal murine spleen. (C) Isotype control (Alexa-488 rat IgG2a) staining of normal murine spleen 48 h after IP clodronate. (D) Alexa-488 rat anti-mouse F4/80 staining of murine spleen 48 h after IP clodronate. (E) Isotype control (Alexa-488 rat IgG2a) staining of normal murine liver.

**Figure S2.** Expression of F4/80 and CD11b on Murine (C3H/HeN) Bone Marrow and Spleen Cells

Alexa-488–conjugated antibody to the mouse macrophage cell surface glycoprotein F4/80 and/or phycocerythrin-conjugated antibody to mouse CD11b were used. Cells from three mice were pooled for each analysis. (A) Bone marrow from normal mice. (B) Bone marrow from mice treated with liposomal clodronate 200 µl (2 mg) 48 h prior to analysis. (C) Splenocytes from normal mice. (D) Splenocytes from mice treated with liposomal clodronate 200 µl (2 mg) 48 h prior.

**Figure S3.** Bone marrow and spleen cells from normal (C3H/HeN) and neutropenic (C3H/HeN) mice with liposomal clodronate

(A) Bone marrow from normal mice. (B) Bone marrow from mice treated with liposomal clodronate 200 µl (2 mg) 48 h prior to analysis. (C) Splenocytes from normal mice. (D) Splenocytes from mice treated with liposomal clodronate 200 µl (2 mg) 48 h prior.


**Table 4. Translocation Study**

<table>
<thead>
<tr>
<th>Group</th>
<th>C. albicans Strain</th>
<th>Immunosuppression</th>
<th>Route</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
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<tr>
<td>A</td>
<td>SC5314</td>
<td>None</td>
<td>IP</td>
<td>200 µg</td>
<td>—</td>
</tr>
<tr>
<td>B</td>
<td>SC5314</td>
<td>RB6-SC5 monoclonal antibody (mAb)</td>
<td>IP, IP</td>
<td>200 µg, 150 mg/kg/dose</td>
<td>Once, once</td>
</tr>
<tr>
<td>C</td>
<td>SC5314</td>
<td>RB6-SC5 mAb, methotrexate (MTX)</td>
<td>IP</td>
<td>150 mg/kg/dose</td>
<td>Three times every other day</td>
</tr>
</tbody>
</table>

**References**

15. Barnes JL, Osgood RW, Lee JC, King RD, Stein JH (1983) Host-parasite interaction...

**Immune Deficits Needed for C. albicans Disease**