I5-epi-lipoxin A4 reduces the mortality of prematurely born pups in a mouse model of infection-induced preterm birth

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ABSTRACT: Preterm birth remains the leading cause of neonatal mortality and morbidity worldwide. There are currently few effective therapies and therefore an urgent need for novel treatments. Although there is much focus on trying to alter gestation of delivery, the primary aim of preterm birth prevention therapies should be to reduce prematurity related mortality and morbidity. Given the link between intrauterine infection and inflammation and preterm labour (PTL), we hypothesized that administration of lipoxins, key anti-inflammatory and pro-resolution mediators, could be a useful novel treatment for PTL. Using a mouse model of infection-induced PTL, we investigated whether 15-epi-lipoxin A4 could delay lipopolysaccharide (LPS)-induced PTL and reduce pup mortality. On Day 17 of gestation mice (n = 9–12) were pretreated with vehicle or 15-epi-lipoxin A4 prior to intraperitoneal administration of LPS or PBS. Although pretreatment with 15-epi-lipoxin A4 did not delay LPS-induced PTL, there was a significant reduction in the mortality amongst prematurely delivered pups (defined as delivery within 36 h of surgery) in mice treated with 15-epi-lipoxin A4 prior to LPS treatment, compared with those receiving LPS alone (P < 0.05). Quantitative real-time (QRT)-PCR analysis of utero-placental tissues harvested 6 h post-treatment demonstrated that 15-epi-lipoxin A4 treatment increased Ptgs2 expression in the uterus, placenta and fetal membranes (P < 0.05) and decreased 15-Hpgd expression (P < 0.05) in the placenta and uterus, suggesting that 15-epi-lipoxin A4 may regulate the local production and activity of prostaglandins. These data suggest that augmenting lipoxin levels could be a useful novel therapeutic option in the treatment of PTL, protecting the fetus from the adverse effects of infection-induced preterm birth.

Key words: anti-inflammatory / lipoxin / parturition / preterm birth / resolution

Introduction

Preterm labour (PTL), defined as labour before 37 weeks gestation, remains a major obstetric problem estimated to affect between 5 and 18% of pregnancies worldwide, with ~15 million babies born prematurely each year (March of Dimes, 2012). Despite advances in the medical care of preterm infants, there are currently few effective treatment options and premature birth remains the leading cause of neonatal mortality. Indeed, preterm birth is estimated to account for up to 75% of neonatal deaths (Goldenberg et al., 2008). Additionally, preterm birth is associated with an increased risk of a range of short-term morbidity and long-term disabilities, including cerebral palsy, bronchopulmonary dysplasia (BPD), retinopathy of prematurity and learning difficulties (Saigal and Doyle, 2008).

Spontaneous labour at term is now considered to be an inflammatory event that is associated with an immune cell infiltration into the cervix, myometrium and fetal membranes and increased production of pro-inflammatory mediators in the utero-placental tissues (Denison et al., 1998; Thomson et al., 1999; Sennstrom et al., 2000; Young et al., 2002; Osman et al., 2003). Although the causes of PTL are often unclear, many cases are associated with the presence of occult or overt intrauterine infection (Goldenberg et al., 2000) and the premature activation of these inflammatory pathways is likely responsible for PTL in this scenario. Animal models have confirmed a causal link between intrauterine infection and inflammation and PTL, given that injection of bacterial components, such as LPS or pro-inflammatory cytokines, such as tumour necrosis factor-α (TNF-α) or interleukin (IL)-1β reliably induce PTL (Romero et al., 1991; Elovitz et al., 2003; Sadowsky et al., 2006). Our own in vitro studies have shown that LPS directly induces contractions of isolated human myometrial cells (Hutchinson et al., 2013). Influx of immune cells likely also contributes to the process, although further work is required to define their precise roles (Timmons and...
Materials and Methods

Mouse model of infection-induced PTL

All animal studies were conducted under a UK Home Office licence to JEN (60/4241) and were approved by the University’s ethical board and the UK Home Office. Timed-pregnant CD-1 mice were obtained from Charles River Laboratories (Margate, UK) on D9-11 of gestation (the day vaginal plug was found was designated D1 of gestation). Mice were acclimatized for a minimum of 6 days prior to surgery. On D17 of gestation, a mini-laparotomy procedure was performed to expose the uterine horns, as previously described (Rinaldi et al., 2014). The number of viable pups in each horn was recorded prior to injection. In LPS dose–response experiments, the horn with the greater number of fetuses was injected with either LPS (5–20 μg; from Escherichia coli 0111:B4; Sigma-Aldrich, Poole, UK) or sterile PBS (Gibco, Life Technologies Ltd, Paisley, UK) each in a 25 μl volume using a 33-gauge Hamilton syringe. Injections were performed directly into the uterine cavity between the first and second anterior fetuses. Care was taken not to enter any amniotic sacs. The wound was then closed and mice received a subcutaneous injection of Vetegegas analgesia (Alstoe Ltd, York, UK) at a dose of 0.03 mg/ml in 60 μl.

Mice were kept at 30°C while they recovered from surgery, before being transferred to individual cages for continuous monitoring using individual CCTV cameras and a digital video recorder. The time to delivery was recorded and defined as the number of hours from the time of intrauterine injection, to delivery of the first pup. Preterm delivery was defined as delivery of the first pup within 36 h of intrauterine injection. Term delivery in CD1 mice occurs on D19-21 of gestation, and we previously reported that mean (±SEM) time to delivery in a ‘no surgery’ control group of CD1 mice was 1.34 ± 1.13 h (n = 8), with all these mice delivering on D19 of gestation (Rinaldi et al., 2014). Based on these data, delivery within 36 h of injection was chosen as preterm in our model. Within 12–24 h of delivery, the number of live/dead pups was recorded and the mortality rate per dam was calculated by dividing the number of dead pups by the number of viable pups counted in utero at the time of intrauterine injection.

In experiments to determine whether lipoxin administration could modulate LPS-induced preterm delivery and pup mortality, mice were pretreated with 15-epi-lipoxin A₄ prior to intrauterine PBS or LPS administration. The 15-epi-lipoxin A₄ analogue was chosen as several studies have reported that it is more stable, has a longer half-life and mice received a subcutaneous injection of Vetegegas analgesia (Alstoe Ltd, York, UK) at a dose of 0.03 mg/ml in 60 μl.

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A4 used in this study were chosen based on published literature, which shows that lipoxins can be tolerated and have strong anti-inflammatory and pro-resolution effects over a wide range of doses in vivo (Levy et al., 2002; El Kebir et al., 2009; Kure et al., 2009; Conte et al., 2010; Borgeson et al., 2011; Zhou et al., 2011). Mice were culled by lethal exposure to CO2 and all pups were removed from the uterine horns and decapitated. Uterine tissue was sampled from three fixed sites within the uterus; fetal membranes were dissected free from the placenta, and these tissues were collected from three separate gestational sacs. Tissues were stored in RNAloter® (Sigma-Aldrich) at −80°C until processing.

Quantitative real-time PCR

Total RNA was extracted from uterus, fetal membranes and placental tissue collected 6 h post-surgery using the RNeasy mini kit (Qiagen, Crawley, UK) as per the manufacturer’s guidelines. Total RNA (300 ng) was reverse transcribed using the High Capacity cDNA Reverse Transcription kit (Applied biosystems, Life Technologies Ltd, Paisely, UK). Quantitative real-time PCR (qRT-PCR) was carried out to quantify the mRNA expression of specific genes of interest. Predesigned gene expression assays from Applied Biosystems were used to examine the expression of 15-hydroxy prostaglandin dehydrogenase (15-Hpgd) (Mm00515121_ml), Il-1β (Mm00436451_g1), Tnf-α (Mm00999906_ml), Cxcl1 (Mm04207460_ml), Cxcl2 (Mm00436450_ml) and Cxcl5 (Mm00436451_g1). Primer and probe sequences for β-actin, Ptg2 and Il-6 were designed using Primer Express software (version 3.0). Details of designed β-actin, Ptg2 and Il-6 primer and probe sequences are given in Table I. Target gene expression was normalized for RNA loading using β-actin and the expression in each sample was calculated relative to a calibrator sample (untreated D18 uterus), which was included in all reactions, using the 2−ΔΔCT method of analysis. All qRT-PCR analysis was performed on an Applied Biosystems 7900HT instrument.

Statistical analysis

Data are presented as mean ± SEM. Where data were not normally distributed they were transformed prior to analysis to achieve normal distribution. Time to delivery was log-transformed before analysis; and the proportion of dead pups was arc-sin transformed prior to analysis. Data were analysed by one-way analysis of variance to compare treatment groups, followed by either Dunnett’s or Newman–Keuls multiple comparison tests between treatment groups to identify significant differences. All statistical analyses were performed using GraphPad Prism 5.0 software (Graph Pad, San Diego, CA, USA). P < 0.05 was considered to indicate statistical significance.

Table I  Primer and probe sequences designed using Primer Express software.

<table>
<thead>
<tr>
<th>Gene</th>
<th>Primer/Probe</th>
<th>Sequence</th>
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<tr>
<td>β-actin</td>
<td>Forward</td>
<td>5′-GCCCTTTTGACGCTCCTCGT-3′</td>
</tr>
<tr>
<td></td>
<td>Reverse</td>
<td>5′-GGCCAGGATATCCTCTAC-3′</td>
</tr>
<tr>
<td></td>
<td>Probe</td>
<td>5′-CACCCGGCCACGGTGGCGAT-3′</td>
</tr>
<tr>
<td>Ptg2</td>
<td>Forward</td>
<td>5′-GCCCTGGGGCAACACAG-3′</td>
</tr>
<tr>
<td></td>
<td>Reverse</td>
<td>5′-TGTTTGGAAATTGCGTC-3′</td>
</tr>
<tr>
<td></td>
<td>Probe</td>
<td>5′-TGTTGGCACTACTAAAGCA-3′</td>
</tr>
<tr>
<td>Il-6</td>
<td>Forward</td>
<td>5′-CCACGGCCTCCCTCTAC-3′</td>
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<tr>
<td></td>
<td>Reverse</td>
<td>5′-TCAGAACGGAGGGGGGGGCA-3′</td>
</tr>
<tr>
<td></td>
<td>Probe</td>
<td>5′-TCACAGAGGATACCCTCCCAA CAGACCGT-3′</td>
</tr>
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Results

Intrauterine LPS administration dose-dependently increases pup mortality

As we have previously reported, intrauterine LPS administration dose-dependently induces PTL in a mouse model (Rinaldi et al., 2014). To assess the effects of intrauterine LPS treatment on pup mortality mice were treated with increasing doses of LPS and the pup mortality rate was calculated following delivery. Pup mortality was increased in response to administration of increasing doses of intrauterine LPS, with a significantly higher proportion of dead pups born to mice treated with 20 μg LPS, compared with the PBS control group (mean ± SEM proportion of dead pups 0.75 ± 0.05 versus 0.40 ± 0.06, respectively, P < 0.01; Fig. 1A). To further investigate whether this observed increase in pup mortality in the 20 μg LPS group was simply due to a higher proportion of preterm deliveries in this group, rather than a direct effect of the LPS treatment, pup mortality was also assessed only in mice delivering preterm (defined as delivery within 36 h of surgery). Even amongst mice delivering preterm, fetal mortality was still significantly greater in mice treated with 20 μg LPS group compared with PBS (mean ± SEM proportion of dead pups 0.85 ± 0.04 versus 0.49 ± 0.11, respectively, P < 0.01; Fig. 1B). Subsequent experiments were performed with 20 μg LPS as this dose has been shown to induce preterm delivery reliably in our model with the least variation (Rinaldi et al., 2014).

Pretreatment with 15-epi-lipoxin A4 reduces pup mortality without delaying LPS-induced preterm delivery

To investigate the therapeutic potential of lipoxin to delay preterm delivery and reduce prematurity induced fetal mortality, mice were pretreated with 15-epi-lipoxin A4 1–2 h prior to intrauterine LPS (20 μg) or PBS administration. Control mice were pretreated with vehicle prior to intrauterine LPS or PBS administration. Pretreatment with 125 ng 15-epi-lipoxin A4 prior to intrauterine PBS had no effect on time to delivery compared with the vehicle control group (Fig. 2A). As expected mice receiving intrauterine LPS delivered significantly earlier than the vehicle control group (LPS mean time to delivery: 27.54 h ± SEM 6.33; versus vehicle mean time to delivery: 55.40 h ± SEM 6.40; P < 0.001; Fig. 2A). Pretreatment with either 12.5 or 125 ng 15-epi-lipoxin A4 prior to intrauterine LPS administration did not delay LPS-induced PTL. Mice in these groups still delivered significantly earlier than the vehicle control group (mean ± SEM time to delivery 12.5 ng 15-epi-lipoxin A4 + LPS: 27.02 ± 4.57 h; mean time delivery in 125 ng 15-epi-lipoxin A4 + LPS: 26.82 ± 2.61; P < 0.01 versus vehicle).

Again as expected, mice treated with LPS alone had significantly increased pup mortality compared with the vehicle group (mean ± SEM proportion of dead pups: 0.84 ± 0.09; P < 0.01; Fig. 2B). Interestingly, pretreatment with 125 ng 15-epi-lipoxin A4 prior to intrauterine PBS significantly reduced pup mortality, compared with the vehicle control group (mean ± SEM proportion of dead pups 0.13 ± 0.05 versus 0.42 ± 0.1, respectively, P < 0.05; Fig. 2B). Within the subgroup of mice delivering preterm (within 36 h of surgery), pretreatment with 125 ng 15-epi-lipoxin A4 prior to intrauterine LPS significantly reduced pup mortality, compared with mice receiving LPS alone (mean proportion ± SEM of dead pups 0.55 ± 0.12 versus 0.97 ± 0.02, respectively; P < 0.05; Fig. 2C).
Conversely, uterine mice treated with 2.5 μg 15-epi-lipoxin A₄, we administered higher doses (0.25 and 2.5 μg) of 15-epi-lipoxin A₄ 1–2 h prior to LPS or vehicle to try to maximize the anti-inflammatory effects in these 6 h experiments. As stated earlier, all doses of 15-epi-lipoxin A₄ used were within the range of effective doses used in vivo in previously published studies.

In the uterus, Ptgs2 expression was significantly elevated in response to 2.5 μg 15-epi-lipoxin A₄ alone (P < 0.01), LPS alone (P < 0.01), and 0.25 μg and 2.5 μg 15-epi-lipoxin A₄ + LPS (P < 0.001; Fig. 3A), compared with the vehicle control group. Co-treatment with 2.5 μg 15-epi-lipoxin A₄ and LPS also significantly increased uterine Ptgs2 expression compared with treatment with LPS alone (P < 0.05; Fig. 3A). Conversely, uterine 15-Hpgd expression was significantly reduced in mice treated with 2.5 μg 15-epi-lipoxin A₄ prior to intrauterine PBS, compared with vehicle (P < 0.01) and LPS alone (P < 0.05). LPS alone did not significantly alter 15-Hpgd expression; however, mice treated with 0.25 μg 15-epi-lipoxin A₄ + LPS and 2.5 μg 15-epi-lipoxin A₄ + LPS had significantly reduced uterine 15-Hpgd expression, compared with the vehicle group (P < 0.001). Additionally pretreatment with 0.25 μg 15-epi-lipoxin A₄ and 2.5 μg 15-epi-lipoxin A₄ prior to intrauterine LPS, significantly reduced uterine expression of 15-Hpgd, compared with LPS alone (P < 0.001; Fig. 3A).

Placental Ptgs2 expression was significantly elevated in mice treated with 2.5 μg 15-epi-lipoxin A₄ prior to intrauterine PBS, compared with vehicle (P < 0.05; Fig. 3B) and LPS alone (P < 0.05). Ptgs2 expression in the placenta was unaffected by LPS alone, but pretreatment with 15-epi-lipoxin A₄ at both 0.25 and 2.5 μg prior to intrauterine LPS administration significantly increased Ptgs2 expression compared with both the vehicle control group (P < 0.01 and P < 0.001, respectively; Fig. 3B) and compared with LPS treatment alone (P < 0.001; Fig. 3B). Placental 15-Hpgd expression was significantly down-regulated in response to 2.5 μg 15-epi-lipoxin A₄ alone (P < 0.001), LPS alone (P < 0.05), 0.25 μg 15-epi-lipoxin A₄ + LPS (P < 0.01) and 2.5 μg 15-epi-lipoxin A₄ + LPS (P < 0.05; Fig. 3B), compared with the vehicle control group.

In the fetal membranes, intrauterine LPS treatment alone did not significantly alter Ptgs2 expression; however, mice treated with 0.25 μg 15-epi-lipoxin A₄ + LPS had significantly elevated Ptgs2 expression compared with the vehicle control group (P < 0.05; Fig. 3C); and mice treated with 2.5 μg 15-epi-lipoxin A₄ + LPS had significantly elevated Cox-2 expression, compared with both the vehicle control group and LPS alone (P < 0.05; Fig. 3C). Expression of 15-Hpgd in the fetal membranes was significantly reduced in response to LPS treatment alone (P < 0.01), 0.25 μg 15-epi-lipoxin A₄ + LPS (P < 0.01) and 2.5 μg 15-epi-lipoxin A₄ + LPS (P < 0.001; Fig. 3B).

In contrast to the effects on Ptgs2 and 15-Hpgd, pretreatment with 15-epi-lipoxin A₄ at either 0.25 or 2.5 μg prior to intrauterine LPS did not attenuate or amplify the LPS-induced expression of the classical inflammatory markers Tnf-α and Il-1β in the uterus (Fig. 4A), placenta (Fig. 4B) and fetal membranes (Fig. 4C). Similarly, pretreatment with 15-epi-lipoxin A₄ did not alter the LPS-induced expression of the other inflammatory mediators examined, Il-6, Cxcl1, Cxcl2 and Cxcl5 (data not shown).

Pretreatment with 15-epi-lipoxin A₄ does not further up-regulate the LPS-induced expression of Il-10 in the utero-placental tissues

Previous studies have reported that one mechanism by which lipoxins exert anti-inflammatory actions is by up-regulating the expression of...
the anti-inflammatory cytokine, IL-10 (Baker et al., 2009; Borgeson et al., 2011). Therefore, we investigated the mRNA expression of Il-10 in the utero-placental tissues 6 h post-surgery using qRT-PCR. Treatment with LPS alone resulted in significantly elevated expression of Il-10 in the uterus ($P < 0.05$; Fig. 5A), placenta ($P < 0.01$; Fig. 5B) and fetal membranes ($P < 0.001$; Fig. 5C). However, pretreatment with 15-epi-lipoxin A$_4$, at either 0.25 or 2.5 µg, prior to intrauterine LPS treatment did not result in a further increase in Il-10 expression, compared with LPS alone.

**Discussion**

We have previously shown the anti-inflammatory effects of the dual-acting anti-inflammatory and pro-resolution lipid mediators, lipoxins, in human gestational tissues in vitro (Maldonado-Perez et al., 2010). Here, we tested the efficacy of 15-epi-lipoxin A$_4$ as a novel therapeutic agent in an in vivo mouse model of infection-induced PTL. Contrary to our original hypothesis, we did not observe a reduction in preterm delivery or reduced pro-inflammatory signalling in mice treated with 15-epi-lipoxin A$_4$. We did, however, show that 15-epi-lipoxin A$_4$ treatment reduced the mortality of prematurely delivered pups and altered basal and LPS-induced Ptgs2 and 15-Hpgd expression in the utero-placental tissues.

We believe that the finding that 15-epi-lipoxin A$_4$ treatment resulted in a greater proportion of prematurely delivered pups being born alive is a novel and important discovery. Current treatment options for preterm birth are largely limited to tocolytic therapies that aim to block myometrial contractions and prolong gestation. However, there is little convincing evidence that these treatments actually result in improved neonatal outcome in the long-term. Given that preterm birth remains the single

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**Figure 2** Effect of pretreatment with 15-epi-lipoxin A$_4$ on time to delivery and pup mortality. Time to delivery and the proportion of dead pups was determined in mice pretreated with vehicle ($n = 12$) or 125 ng 15-epi-lipoxin A$_4$ ($n = 9$), prior to intrauterine PBS; and in mice pretreated with vehicle ($n = 12$), 12.5 ng 15-epi-lipoxin A$_4$ ($n = 11$) or 125 ng 15-epi-lipoxin A$_4$ ($n = 11$), prior to intrauterine LPS (20 µg) administration. (A) Time to delivery. (B) Proportion of dead pups in all litters. (C) Proportion of dead pups in premature litters (delivered within 36 h of surgery); [Vehicle ($n = 3$), 125 ng 15-epi-lipoxin A$_4$ ($n = 2$), LPS ($n = 10$), 12.5 ng 15-epi-lipoxin A$_4$ ($n = 7$) or 125 ng 15-epi-lipoxin A$_4$ ($n = 10$)]. The 15-epi-lipoxin A$_4$ group was excluded from statistical analysis of the proportion of prematurely delivered dead pups due to $n < 3$. Data presented as mean ± SEM (error bars); $^*P < 0.05$, $^{**}P < 0.01$, $^{***}P < 0.001$, compared with vehicle; $^#P < 0.05$ compared with LPS.
biggest cause of neonatal mortality and morbidity worldwide, there is an urgent requirement for novel therapeutic options which are capable of achieving the ultimate goal of preterm prevention therapies—reduced perinatal mortality and morbidity. Interestingly, a recent paper has highlighted the potential of lipoxin treatment to treat preterm-related lung disease, BPD (Martin et al., 2014). Using a mouse model of hyperoxia-induced lung injury Martin et al. (2014) reported that lipoxin A₄ treatment given (post-natally) to neonatal pups reduced the...
morphologic and cellular characteristics of lung injury and improved pup growth; therefore, supporting the hypothesis that pre- and post-natal lipoxins could be useful novel therapeutic agents to improve neonatal outcome.

The pup mortality observed in our model is likely to be a result of the immaturity of the prematurely delivered pups, which if delivered on Day 17 or 18 of gestation are unlikely to be developmentally competent to survive, and also the LPS treatment given to the mice. Owing to the invasive nature of the model, which we have previously shown results in a local inflammatory response, even in mice treated with PBS (Rinaldi et al., 2014), some of the control mice do deliver prematurely, and therefore do experience some pup mortality. We are currently exploring other, less invasive methods, to reduce this preterm delivery in our control group. Importantly, however, we did observe a significant reduction in pup mortality in mice treated with intrauterine PBS if they were pretreated with 15-epi-lipoxin A₄, suggesting that treatment with 15-epi-lipoxin A₄ may be able to protect the fetus from the negative effects of the local inflammatory response induced by the surgery.

The mechanism by which 15-epi-lipoxin A₄ reduces perinatal mortality in our model is currently unclear, although our data implicate prostanooid regulation via increased PtgS2 and decreased 15-Hpgd expression in the uterus and placenta. This increased expression of PtgS2 could

Figure 5 Effect of pretreatment with 15-epi-lipoxin A₄ on mRNA expression of Il-10 in the utero-placental tissues. Uterus, placenta and fetal membranes were collected 6 h post-surgery from mice pretreated with vehicle (n = 3) or 2.5 μg 15-epi-lipoxin A₄ (n = 4), prior to intrauterine PBS; and in mice pretreated with vehicle (n = 5), 0.25 μg 15-epi-lipoxin A₄ (n = 5) or 2.5 μg 15-epi-lipoxin A₄ (n = 5), prior to intrauterine LPS administration. The mRNA expression of Il-10 was quantified by quantitative real-time PCR. (A) Uterine expression. (B) Placental expression. (C) Expression in the fetal membranes. Data presented as mean fold change ± SEM (error bars); *P < 0.05, **P < 0.01, ***P < 0.001, compared with vehicle.
result in increased production of prostaglandins with anti-inflammatory effects, such as PGE2, PGD2 and 15d-PGJ2, as has been described in other studies (Gilroy et al., 1999; Hodges et al., 2004; Fukunaga et al., 2005; Bonnans et al., 2006; Zheng et al., 2011; Font-Nieves et al., 2012). These prostaglandins may act to resolve the inflammatory environment surrounding the fetus, thus leading to the reduced pup mortality rate observed in mice treated with 15-epi-lipoxin A4. Support for this hypothesis comes from a study that reported that administration of 15d-PGJ2 increased pup survival in a mouse model of LPS-induced PTL (Pirianov et al., 2009).

Another potential mechanism by which 15-epi-lipoxin A4 could be acting to reduce pup mortality may be by promoting fetal lung maturation. PGE2 has been implicated in regulating fetal pulmonary surfactant production both in vitro (Acarregui et al., 1990) and in vivo in a sheep model of intra-amniotic infection (Westover et al., 2012); suggesting that the 15-epi-lipoxin A4-induced increase in utero-placental Ptgs2 expression may promote fetal lung maturation via increased local PGE2 production. Additionally, a recent study reported that administration of a synthetic analogue of 15-epi-lipoxin A4 restored expression of surfactant protein C in lung tissue in a model of bleomycin-induced pulmonary fibrosis (Guilherme et al., 2013); supporting the hypothesis that lipoxin administration can regulate lung surfactant production. Further work examining the inflammatory response at several time points is required to elucidate the relationship between Ptgs2 and 15-epi-lipoxin A4 in our model, and to identify whether alterations in prostanoid production are involved in the reduced pup mortality observed in this study.

Interestingly, the administration of low-dose aspirin to women during pregnancy has been associated with reduced perinatal death and other adverse perinatal outcomes (Bujold et al., 2010; Robarge et al., 2013). As 15-epi-lipoxins are produced in the presence of aspirin, it is possible that 15-epi-lipoxin A4 is involved in mediating any beneficial effects of aspirin treatment. Other studies have shown that low-dose aspirin administration to healthy volunteers leads to significantly elevated plasma levels of 15-epi-lipoxin A4 (Chiang et al., 2004); therefore, it would be interesting to assess whether similar mechanisms are acting during pregnancy.

Another important observation from our work which is worthy of further investigation is the finding that elevated levels of Ptgs2 were also observed in uterus and placental tissue obtained from mice treated with 15-epi-lipoxin A4 alone, even though mice in this treatment group did not go into PTL. Previous studies have demonstrated a central role for elevated Ptgs2 expression, and subsequent production of prostaglandins such as PGF2α and PGE2 in the onset of parturition in mice (Sugimoto et al., 1997; Gross et al., 1998, 2000; Tsuboi et al., 2003). However, mice in the 15-epi-lipoxin A4 group delivered at term, despite having elevated Ptgs2 expression, again suggesting that treatment with 15-epi-lipoxin A4 may be triggering an alternative prostanoid pathway, as has been reported in other systems (Zheng et al., 2011).

Interestingly, 15-epi-lipoxin A4 was unable to attenuate LPS-induced pro-inflammatory signalling in our model, which is in contrast to our previous work showing that lipoxin treatment in vitro attenuated IL-6 and IL-8 expression in human myometrial explant culture (Maldonado-Perez et al., 2010). The reasons for these differences are unclear, but may be a result of differences in the type and dose of lipoxin used in the two studies, and also the time-point at which tissues were collected from our in vivo model. Perhaps if tissues had been collected at a different time-point, we may have observed alterations in inflammatory signalling. Whilst it is often difficult to extrapolate between animal models and the clinical scenario in humans, importantly, our in vitro data suggests that lipoxin treatment may have a more profound impact on inflammatory signalling in human tissues.

This study demonstrates for the first time that 15-epi-lipoxin A4 reduces pup mortality in a mouse model of LPS-induced PTL. Although the mechanisms by which 15-epi-lipoxin A4 may be acting to protect the prematurely delivered pups from mortality are not currently clear, we propose that 15-epi-lipoxin A4 may be stimulating the resolution of the LPS-induced inflammatory and/or promoting fetal maturation via increased Ptgs2 expression and decreased 15-HpGd2 expression in the utero-placental tissues. Collectively, these data suggest that lipoxins warrant further investigation as potential novel therapeutic options in the treatment of PTL, which may be useful in protecting the fetus from the adverse effects of infection-induced preterm birth.

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Authors’ roles
S.F.R., R.D.C. and J.W. performed the experiments. S.F.R. wrote the manuscript. S.F.R., R.D.C., J.W., A.G.R. and J.E.N. contributed to the design of the study, analysis and interpretation of the data, drafting of the article and final approval of the version to be published.

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Conflict of interest
No authors declare any financial or other relationships that might lead to a conflict of interest.

References


