Prostaglandin E$_2$ receptor 3 signaling is induced in placentas with unexplained recurrent pregnancy losses

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Abstract

Although an inflammatory microenvironment is required for successful implantation, an inflammatory overreaction is one of the causes of unexplained recurrent pregnancy losses (uRPL). Prostaglandin E$_2$ (PGE$_2$) plays a pivotal role in regulating immune balance during early pregnancy, and it can stimulate inflammatory reactions via prostaglandin E$_2$ receptor 3 (EP3). However, the role of PGE$_2$ receptor signaling in the uRPL remains unknown. We aimed to investigate whether EP3 signaling is involved in the mechanism of uRPL. Via immunohistochemistry we could show that the expression of cyclooxygenase-2, EP3 and G protein alpha inhibitor 1 ($G_i_1$) was enhanced in the decidua of the uRPL group in comparison to the control group in first-trimester placentas.

In vitro, we demonstrated that sulprostone (an EP1/EP3 agonist) inhibited the secretion of beta-hCG and progesterone in JEG-3 cells and the secretion of beta-hCG in HTR-8/SVneo cells while it induced the expression of plasminogen activator inhibitor type 1 in JEG-3 cells. In addition, PGE$_2$/sulprostone was able to stimulate the expression of $G_i_1$, phosphorylated-extracellular signal-regulated kinases 1/2 (p-ERK1/2) and p53. L-798,106 (an EP3-specific antagonist) suppressed the expression of EP3 and p-ERK1/2 without affecting the secretion of beta-hCG. Elevated activation of EP3 signaling in first-trimester placentas plays an important role in regulating the inflammatory microenvironment, the hormone secretion of extravillous trophoblasts and the remodeling of extracellular matrix in the fetal-maternal interface. L-798,106 might be a ‘potential therapeutic candidate’ for the treatment of uRPL.

Introduction

Recurrent pregnancy losses (RPL) are defined as two or more consecutive failed pregnancies before the 20th week of pregnancy according to the Practice Committee of the American Society for Reproductive Medicine (1). RPL affects 1% of all women worldwide (2), and only a minority can be explained by particular causative factors, including genetic abnormalities, structural abnormalities, infection, endocrine abnormalities, immune dysfunction and thrombophilic disorders (1). Up to 50% of RPL cases are classified as unexplained RPL (uRPL). Abnormal inflammation in the fetal-maternal interface and unbalanced extracellular matrix (ECM) remodeling are considered as key factors contributing to uRPL (3).
Prostaglandin E₂ (PGE₂) has long been known as a potentiator of inflammation (4) and is the major fraction of prostaglandins produced by the placenta (5). PGE₂ can regulate the balance between Th1 and Th2 cell responses (6), modulate chemokine production (6) and suppress lymphocyte alloreactivity of decidual cells during early gestation (7). Th1/Th2 cell ratios are higher in women with uRPL compared to controls with healthy pregnancies (8). The prostaglandin E₁ analog (Misoprostol) and the PGE₂ analog (Sulprostone) have been proven to be effective drugs for pregnancy termination (9, 10). PGE₂ has been demonstrated to be upregulated in cervical ovulatory mucus (11) and the endometrium (12, 13) of women with uRPL compared to controls with healthy pregnancies during implantation. Therefore, increased expression of PGE₂ might be a disadvantage for implantation, placentation and maintenance of pregnancy.

Arachidonic acid is metabolized by cyclooxygenase-1 and cyclooxygenase-2 (COX-2) into prostaglandin H₂ (PGH₂), which is converted into multiple prostaglandins including PGE₂ (14). As a rate-limiting enzyme that catalyzes the synthesis of PGE₂, COX-2 is localized in the endometrium throughout the menstrual cycle and during early pregnancy (15). However, results of COX-2 expression in uRPL patients are contradictory.

PGE₂ can combine with both nuclear receptors and membrane receptors. Previous studies of our group analyzed the expression of nuclear receptors in the placenta of spontaneous miscarried and RPL patients (16, 17, 18, 19, 20, 21). However, little is known about the expression of membrane receptors of PGE₂ in the placenta of women with uRPL. The effects of PGE₂ are mainly facilitated by specific membrane-bound G protein-coupled EP receptors (EP1–EP4) with various signaling pathways: EP1 is coupled to the G protein alpha q (Gₐq) to mobilize intracellular Ca²⁺, EP2 and EP4 are coupled to the G protein alpha stimulator (Gₛ) to stimulate adenylyl cyclase, and EP3 is mainly coupled to the G protein alpha inhibitor (Gᵢ) to inhibit adenylyl cyclase (22). All four membrane receptors of PGE₂ are expressed by the placenta and fetal membranes, and only EP3 is intensely localized in the membrane of syncytiotrophoblast in the placenta of women in labor (23). This indicates that EP3 may have an influence on trophoblast invasion and placentation. The expression of COX-2 and EP3 has been proven to be elevated in the placenta of a rat model for ischemia-reperfusion injury (24). PGE₂ triggers mast cell activation via an EP3-Gₛα-Ca²⁺ influx/phosphatidyl-3-kinase signaling pathway, which contributes to vascular permeability and consequent edema formation in mice (4). However, no previous studies exist about the expression of EP3 in the placenta of uRPL patients, as well as the possible signal processes of EP3 in normal pregnancy and uRPL during the first trimester of pregnancy.

In addition, PGE₂ binding with EP1/EP3 receptor can induce the production of plasminogen activator inhibitor type 1 (PAI-1) in cardiac fibroblasts (25). PAI-1 levels in the plasma are increased in RPL patients in comparison to women with healthy pregnancies (26). Among all the thrombophilic genes, PAI-1-675 4G/5G polymorphism is one of the most frequently analyzed PAI-1 genetic variants, although the contribution of PAI-1-675 4G/5G to uRPL is conflicting (27).

We hypothesized that EP3 signaling may be an essential pathway in the mechanism of uRPL. Our study group aimed to analyze the main proteins’ expression of EP3 signaling in the placentas of first-trimester pregnancies with uRPL immunohistochemically. Additionally, we studied the effects of PGE₂, an EP1/EP3 agonist (sulprostone) and an EP3 antagonist (L-798,106) on the function of trophoblast cells by using the choriocarcinoma cell line Jeg-3 and the human trophoblast-derived cells HTR-8/SVneo in vitro.

Materials and methods

Placental tissue methods

The study was approved by the ethical committee of the Medical Faculty, Ludwig-Maximilian-University of Munich (Number of approval: 337-06) and informed consent was obtained from each patient in written form. Samples and clinical information were anonymized and encoded for statistical workup.

We analyzed placental tissues of 19 patients with a history of more than two consecutive pregnancy losses of unknown causes (uRPL group) and of 19 healthy controls with legal pregnancy termination (control group) from a private practice in Munich, Germany. Exclusion criteria for the uRPL group, described thoroughly in our previous studies (28), include infectious diseases, uterine anomalies, endocrinological dysfunctions, hyperprolactinemia, hyperandrogenemia, thyroidal dysfunctions, autoimmunologic disorders, deficiencies in coagulation factors, as well as fetal and parental chromosomal disorders. All placentas were obtained within the first 24 h after diagnosis without any prior hormonal pretreatment. Samples were obtained by dilatation and evacuation without any prior pharmaceutical induction. These samples were fixed immediately in 4% buffered
formalin for 20–24 h and embedded in paraffin for further immunohistochemical and double immunofluorescence analysis (29).

**Immunohistochemistry**

Paraffin-embedded slides were dewaxed in xylol and washed in 100% ethanol. For inhibition of the endogenous peroxidases, tissue samples were incubated in methanol with 3% H2O2 and rehydrated in a descending alcohol series. Slides were heated in a pressure cooker using sodium citrate buffer (pH=6.0), containing 0.1 M citric acid and 0.1 M sodium citrate in distilled water. After cooling and washing in PBS, all slides were incubated with blocking solution (Reagent 1, Zytocem-Plus HRP-Polymer-Kit (mouse/rabbit)) for 20 min to avoid non-specific binding of the primary antibodies. The primary antibodies used for the experiment were anti-COX rabbit IgG polyclonal antibody (Sigma, SAB4502491, 1:400 dilution), anti-EP3 rabbit IgG polyclonal antibody (Abcam, ab189131, 1:300 dilution) and anti-G1 rabbit IgG polyclonal antibody (Novus Biologicals, Littleton, CO, USA; NBP2-16558, 1:1000 dilution). The slides were incubated with different primary antibodies for 16 h at 4°C. After washing, the secondary antibodies/complexes of the ABC detection kits (Vector Laboratories) were applied following the manufacturer's protocols to detect reactivity. Immunostaining was visualized with the substrate and the chromogen-3, 3′-diaminobenzidine (DAB; Dako) for 1 min in case of COX-2, 2.5 min for EP3 and 45 sec for G1.

Third-trimester placenta was used as a positive control for the immunohistochemical staining of COX-2 and G1 to test antibody function and to determine an appropriate dilution of the antibody for staining. Colon was used as a positive control for EP3. Positive cells showed a brownish color and the negative control, as well as unstained cells, appeared blue (30). Negative controls were used with the same control tissues and were performed by replacement of a pre-immune serum at the same concentration as the primary antibody (negative control for super sensitive rabbit antibodies, BioGenex, California, USA).

All slides were analyzed under the microscope by two independent observers using a Leitz photomicroscope. For the light microscopy analysis, a semi-quantitative IRS score was used (31), which is calculated via the multiplication of optical staining intensity (grades: 0=no, 1=weak, 2=moderate and 3=strong staining) and the percentage range of positive stained cells (0=no staining, 1=≤10% of the cells; 2=11–50% of the cells; 3=51–80% of the cells and 4=≥81% of the cells were stained for the antibody, respectively).

**Double immunofluorescence staining**

For the characterization of COX-2, EP3 and G1-expressing cells in the decidua, we applied the same paraffin-embedded slides with double immunofluorescence staining. The same experimental steps were carried out as for immunohistochemistry until the step of blocking. Slides were blocked with a blocking solution (Ultra V Block, Lab Vision, Fremont, CA, USA) to avoid non-specific staining and then incubated with various primary antibodies overnight at 4°C. Prolactin was used as a specific marker for stromal cells and human leukocyte antigen-G (HLA-G) was used as a specific marker for trophoblast cells. Different primary antibodies were diluted with a diluting medium (Dako) according to the following ratios: 1:400 for rabbit anti-COX-2 polyclonal IgG (Sigma, SAB4502491) and 1:500 for mouse anti-Prolactin polyclonal IgG (Serotec, Kidlington, Oxfordshire, UK; MCA712), 1:300 for rabbit anti-EP3 polyclonal IgG (Abcam, ab189131), 1:300 for rabbit anti-G1 polyclonal IgG (Novus Biologicals, NBP2-16558), 1:50 for mouse anti-HLA-G polyclonal IgG (Serotec, MCA2044). After washing, slides were incubated with Cy2-/Cy3-labeled antibodies (Jackson Dianova, Hamburg, Germany) as fluorescent secondary antibodies for 30 min at room temperature in darkness to avoid fluorescence quenching. Cy2-labeled secondary antibodies were at a dilution of 1:100 and Cy3-labeled antibodies were at a dilution of 1:500. Finally, the slides were embedded in mounting buffer containing 4′,6-diamino-2-phenylindole (DAPI, Vectastain, Vector Laboratories) for blue staining of the nucleus after washing and drying. Digital images were obtained with a digital camera system (Axiocam; Zeiss CF20DXC; KAPPA Messtechnik, Gleichen, Germany) and digitally saved.

**Cell culture and cell stimulation**

JEG-3 cells (ATCC HTB-36) and HTR-8/SVneo cells (ATCC CRL-3271) were used as trophoblast models. Both cell lines were cultured in RPMI 1640 medium + Gluta MAX (Gibco) supplemented by 10% fetal bovine serum (FCS, Gibco). Cells were seeded into 24-well plates for the determination of beta-hCG, progesterone and PAI-1 and 6-well plates for Western blotting. After 6–8 h, cell culture medium was replaced with fresh RPMI1640 with stimulation chemicals for the remaining 48 h, which included dimethyl sulfoxide (DMSO, 0.5%) as vehicle control, PGE2 (TOCRIS, Bristol,
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UK), sulprostone (TOCRIS) and L-798,106 (TOCRIS). Both JEG-3 (50,000 cells/well) and HTR-8/SVneo cells (60,000 cells/well) were incubated with PGE2, sulprostone and L-798,106 at different concentrations of 0.1, 1, 10, 100, 1000nM and 10μM in 24-well plates.

Cell viability assay

JEG-3 cells were seeded at the density of 1.5 × 10⁴ cells/well in 96-well plates and were incubated with different concentration of PGE2 and L-798,106 for 48h. To each well, 20μg MTT (Sigma) were added for 1.5 h at 37°C. After removing MTT, 200μL DMSO were added to each well and mixed thoroughly on the shaker for 5 min at room temperature. The optical density was examined at 595 nm using Elx800 universal Microplate Reader.

ADVIA Centaur assay

Supernatants of JEG-3 and HTR-8/SVneo cells in 24-well plates were collected and centrifuged (13,200 g, 10 min) to remove debris. The concentration of beta-hCG and progesterone in the supernatant was determined according to the manufacturer’s instructions on an ADVIA Centaur XP autoanalyzer (Siemens Medical Solution Diagnostics) as described in our previous publications (32, 33). The concentration of total beta-hCG was measured in two-site sandwich immunoassay (ADVIA Centaur Total hCG Test; Siemens Medical Solutions Diagnostics). The detectable concentration of total beta-hCG ranges from 2.0IU/mL to 1000IU/mL. The concentration of progesterone in supernatants was measured by an automated quantitative immunoassay (ADVIA Centaur Progesterone Test; Siemens Medical Solutions Diagnostics) with a sensitivity of 0.2ng/mL. Intraobserver and interobserver coefficients of variation were 9.8 and 5.8%, respectively.

PAI-1 ELISA

PAI-1 levels in the supernatants of JEG-3 and HTR-8/SVneo were measured utilizing commercially available ELISA kit (R&D system, DSE100). A standard curve was obtained in parallel to each assay and results converted into ng/mL. The intra- and inter-assay variability was respectively 4.6 and 8.7%.

Western blotting

Cell lysates were extracted from JEG-3 and HTR-8/SVneo cells with radioimmunoprecipitation assay buffer (RIPA, Sigma-Aldrich, R0278-50ML). For Western blotting, 20μg of cell lysates were first separated in 10% sodium dodecyl sulfate-polyacrylamide gel electrophoresis and then transferred to a polyvinylidene fluoride membrane (Bio-Rad). The membrane was blocked in 4% skim milk powder and then incubated with the primary antibodies for 16h at room temperature. Different primary antibodies were used as the following: rabbit polyclonal anti-EP3 antibody (Abcam, ab94496, 1:500), rabbit polyclonal anti-Gr1 antibody (Novus Biologicals, NB2-16558, 1:500), rabbit polyclonal anti-phosphorylated extracellular signal-regulated kinases (p-ERK1/2) antibody (Abcam, ab47339, 1:500), mouse monoclonal anti-p53 antibody (Abcam, ab26, 1:200). Beta-actin was used as a housekeeping gene and mouse monoclonal anti-beta-actin antibody was diluted 1:1000 in 4% milk powder (Sigma, A5441). Afterward, the membrane was incubated with the goat-anti-rabbit/mouse secondary antibody conjugated with alkaline phosphatase (1:1000 dilution, Jackson Immuno Research), and detected with 5-bromo-4-chloro-3-indolyolphosphate/nitro-blue tetrazolium (BCIP/NBT)-chromogen substrate solution (Promega). Western blots were scanned and quantified using the GelScan V6.0 1D Analysis Software (SERVA, Electrophoresis GmbH, Heidelberg, Germany). Band intensities of EP3, Gβ1, p-ERK1/2 and p53 were normalized with band intensities of beta-actin. The blots were repeated three times.

Statistical analysis

All data were analyzed with SPSS Statistics 23 software (IBM Corporation, Armonk, NY, USA) and are expressed as the mean ± S.D. Independent t-test was used to compare the clinical data of uRPL and control group. Mann–Whitney-U test was applied for evaluating IRS scores of EP3, COX-2 and G1 expression in placentas of two groups. Spearman’s rank correlation analysis was adopted to evaluate the correlation between two monotonic, nonlinear variables. Wilcoxon test was used for the evaluation of beta-hCG, progesterone and PAI-1 expression levels between vehicle and stimulation groups. Wilcoxon test was also used for analyzing the band intensities of EP3, Gβ1, p-ERK1/2 and p53. P-values <0.05 were regarded statistically significant.

Results

Clinical data of the uRPL group and control group

The mean age of the women in the uRPL group was 37.76±4.88 years and of the control group...
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35.78±5.88 years (P=0.41). Mean gestational age of the uRPL group was 9.09±2.17 weeks and of the control group 9.71±1.88 weeks (P=0.66). The gravidity times were decreased in patients with uRPL (3.11±1.08) compared to healthy controls (3.42±1.90, P=0.002), while the parity times of two groups showed no significant differences (0.94±0.94 vs 1.63±1.12, P=0.35). Demographic and clinical data are illustrated in Table 1.

Expressions of COX-2, EP3 and G_{11} were all increased in the decidua of patients with uRPL compared to healthy controls, implying that a correlation could exist between them. We further analyzed the correlation of each two of these three components in the decidua. Unfortunately, there was no statistically significant correlation between COX-2 and EP3 expression (r=-0.059; P=0.788), neither for EP3 and G_{11} (r=0.251; P=0.261) nor for COX-2 and G_{11} (r=0.158, P=0.450) in the decidua.

Localization of COX-2, EP3 and G_{11} in the decidua of first-trimester placentas

As the decidua consists of maternal decidua stroma cells and extravillous trophoblasts, double immunofluorescence was used to identify COX-2, EP3 and G_{11}-expressing cells. Prolactin was used as a marker for stromal cells and HLA-G as a maker for trophoblasts, respectively. COX-2 was co-expressed with prolactin predominantly in the cytoplasm of stromal cells (Fig. 2A, B and C). Both EP3 (Fig. 2D, E and F) and G_{11} (Fig. 2H, I and G) were co-expressed with HLA-G in the cytoplasm of extravillous trophoblasts. G_{11} was expressed especially beneath the cell membrane of extravillous trophoblasts (Fig. 2G). Since co-expression of COX-2, EP3 and G_{11} was similar in both the uRPL and control group, we only showed pictures of the uRPL group.

Influence of PGE_{2}, sulprostone and L-798,106 on the expression of EP3 signaling in JEG-3 cells in vitro

In order to investigate the mechanism of the EP3 signaling in extravillous trophoblasts of uRPL in vitro, JEG-3 and HTR-8/SVneo cells were used and stimulated with different concentrations of PGE_{2}, EP1/EP3 agonist (sulprostone) and EP3 antagonist (L-798,106) for 48 h.

Firstly, the MTT assay was used to assess the viability of JEG-3 cells after 48 h of treatment with 0.1, 1, 10, 100, 1000 nM and 10 µM PGE_{2}, L-798,106 or the vehicle control (DMSO, 0.1%). 10 nM PGE_{2}, L-798,106 or the vehicle (DMSO, 0.1%) was used to identify COX-2, EP3 and G_{11}-expressing cells.

COX-2 was co-expressed with prolactin predominantly in the cytoplasm of stromal cells (Fig. 2A, B and C). Both EP3 (Fig. 2D, E and F) and G_{11} (Fig. 2H, I and G) were co-expressed with HLA-G in the cytoplasm of extravillous trophoblasts. G_{11} was expressed especially beneath the cell membrane of extravillous trophoblasts (Fig. 2G). Since co-expression of COX-2, EP3 and G_{11} was similar in both the uRPL and control group, we only showed pictures of the uRPL group.

Table 1 Demographic and clinical characteristics of the study population.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Normal pregnancy (n=19)</th>
<th>uRPL (n=19)</th>
<th>P-value (t-test)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal age (years)</td>
<td>35.78±5.88 (25–46)</td>
<td>37.76±4.88 (30–44)</td>
<td>0.41</td>
</tr>
<tr>
<td>Gestational age (weeks)</td>
<td>9.71±1.88 (6–13)</td>
<td>9.09±2.17 (4–12)</td>
<td>0.66</td>
</tr>
<tr>
<td>Gravidity</td>
<td>3.42±1.90 (1–7)</td>
<td>3.11±1.08 (2–5)</td>
<td>0.002</td>
</tr>
<tr>
<td>Parity</td>
<td>1.63±1.12 (0–4)</td>
<td>0.94±0.94 (0–3)</td>
<td>0.35</td>
</tr>
</tbody>
</table>

Values are represented as mean±s.d.; the range is shown in parentheses.

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Figure 1
Immunohistological analyses of COX-2, EP3 and G<sub>i1</sub> expression in placentas of uRPL patients (B, D, J, N and P) and healthy controls (A, C, G, I, M and O) from the first trimester were measured via IRS score. In the syncytiun, the stainings of COX-2 (A and B), EP3 (G and H) and G<sub>i1</sub> (M and N) are compared between the uRPL patients and controls, which are represented as box-plots (E, K and Q). In the decidua, the expressions of COX-2 (C and D), EP3 (I and J) and G<sub>i1</sub> (O and P) are increased in uRPL patients compared to controls, which are represented as box-plots (F, L and R). The range between the 25th and 75th percentiles is represented by the boxes with a horizontal line at the median. The bars show the 5th and 95th percentiles. Dots indicate values more than 1.5 box lengths from the 75th percentile. Magnification ×10 lens, scale bar = 200 µm. uRPL = unexplained recurrent pregnancy losses. COX-2, cyclooxygenase-2; EP3, prostaglandin E<sub>2</sub> receptor 3; G<sub>i1</sub>, G protein alpha inhibitor 1; uRPL, unexplained recurrent pregnancy losses.

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significantly increased viability of JEG-3 cells compared to control group \( (P<0.05, \text{ data not shown}). \)

For JEG-3 cells, the production of beta-hCG was suppressed from 16.33±3.30 IU/mL in the vehicle to 12.20±1.76 IU/mL by 10 nM PGE\(_2\) \( (P=0.046)\), while its concentration was not significantly influenced by 0.1 nM and 1 nM PGE\(_2\) (Fig. 3A). Additionally, beta-hCG expression was inhibited from 16.33±3.30 IU/mL in the vehicle to 10.19±1.79 IU/mL and 10.99±1.15 IU/mL when sulprostone concentration was 1 nM and 10 nM \( (P=0.028, P=0.028, \text{ respectively, Fig. 3A}). \) However, beta-hCG levels were not altered by L-798,106 independent of the concentration of 0.1, 1 or 10 nM (Fig. 3A).

Progesterone expression of JEG-3 cells was downregulated by PGE\(_2\), sulprostone and L-798,106, independent of different concentrations (0.1, 1 and 10 nM) in comparison to the vehicle after 48 h \( (P=0.028, \text{ each}) \) (Fig. 3B).

PAI-1 levels were significantly altered 34% higher through 10 nM sulprostone than the vehicle, while no significant changes of PAI-1 expression were detected through 10 nM PGE\(_2\) and 10 nM L-798,106 (Fig. 3C).

Western blotting was utilized to access the expression of EP3, G\(_i\), and p-ERK1/2 in JEG-3 cells stimulated by PGE\(_2\) and L-798,106, 10 nM each (Fig. 3D). The molecular weight of EP3 is 37 kDa and of G\(_i\) it is 40 kDa. EP3 expression was decreased by 31.8% after treatment with 10 nM L-798,106 compared to the vehicle group \( (P=0.008, \text{ Fig. 3D}). \) G\(_i\) expression was increased by 12.4% through 10 nM PGE\(_2\) \( (P=0.012, \text{ Fig. 3E}). \) The molecular weights of p-ERK1/2 are 44 and 42 kDa.

Figure 2

Localization of COX-2, EP3 and G\(_i\) is shown in the decidua of patients with uRPL. COX-2 is co-expressed with prolactin, which is a specific marker for stromal cells (A, B and C). EP3 is co-expressed with HLA-G, which is a specific marker for extravillous trophoblasts (D, E and F). G\(_i\) is co-expressed with HLA-G in extravillous trophoblasts (G, H and I). Co-expression of COX-2, EP3 and G\(_i\), is shown with →. Magnification x63, scale bar=20 \( \mu \)m. COX-2, cyclooxygenase-2; EP3, prostaglandin E\(_2\) receptor 3; G\(_i\), G protein alpha inhibitor 1; uRPL, unexplained recurrent pregnancy losses.
JEG-3 cells were incubated with 0.5% DMSO for 1, 2, 6, 12, 24, 48 h and the results showed there was the strongest expression of p-ERK1/2 after 1 h incubation (Supplementary Fig. 2A). After 1 h incubation, the expression of p-ERK1/2 was stimulated by 18.3% through 10 nM sulprostone compared to the vehicle ($P=0.035$), while no significant change was detected in the group treated with 10 nM PGE$_2$ or L-798,106 (Fig. 3F).

Influence of PGE$_2$, sulprostone and L-798,106 on the expression of EP3 signaling in HTR-8/SVneo cells in vitro

HTR-8/SVneo cells were incubated with PGE$_2$, sulprostone and L-798,106 at a concentration of 10 nM and 100 nM, respectively. Beta-hCG levels of HTR-8/SVneo cells were downregulated through PGE$_2$, sulprostone and L-798,106 for all concentrations after 48 h ($P<0.05$, each) (Fig. 4A). Progesterone levels could not be detected in the supernatants of HTR-8/SVneo cells. PAI-1 levels were reduced 3.7% through 10 nM L-798,106 than the vehicle, while no significant changes of PAI-1 expression were detected through 10 nM sulprostone (Fig. 4B).

In Western blotting, EP3 expression was increased by 11.6% through 10 nM PGE$_2$ ($P=0.011$, Fig. 4C) and decreased by 25.9% through 10 nM L-798,106 compared to the vehicle ($P=0.008$, Fig. 4C). Gi$_1$ expression was increased by 22.5% through 10 nM sulprostone ($P=0.046$, Fig. 4D), while no significant changes were observed through 10 nM PGE$_2$. The expression of p-ERK1/2 decreased when the incubation time with 0.5% DMSO is increased from 1 to 48 h and the strongest expression of p-ERK1/2 was after 1 h incubation (Supplementary Fig. 2A). The expression of p-ERK1/2 was inhibited by 21.8% after treatment with 10 nM L-798,106 for 1 h compared to the vehicle group ($P=0.011$, Fig. 4E). The molecular weight of p53 is 53 kDa, and its expression was stimulated by 17.0% through 10 nM PGE$_2$ ($P=0.028$, Fig. 4F) and by 24.5% through 10 nM sulprostone ($P=0.028$, Fig. 4F).
Discussion

An increased inflammatory reaction is one of the main causes of uRPL (8). PGE₂ plays a pivotal role in regulating immune balance and angiogenesis during early pregnancy (8), and it is able to stimulate inflammatory reactions via EP3 (4). The role of EP3 receptor signaling in the mechanism of uRPL still remains unknown. Our group is the first to investigate EP3 signaling pathway in placentas of patients with uRPL.

As the rate-limiting enzyme for PGE₂ synthesis, COX-2 is expressed by human endometrial stromal cells (34), and it is involved in the implantation of blastocysts in the early pregnancy phase (35). So far, a small number of publications exist about COX-2 expression levels in uRPL, but the results are conflicting. One research group reported that lower expression levels of COX-2 have been found in the chorionic villi of women with uRPL (35), and another group showed the similar result in the embryo of mice with autoimmune-type recurrent miscarriages (36). Our result is in accordance with a further study group who found that the expression levels of COX-2 are increased in the endometrium of uRPL women in comparison to healthy controls (13). In this study, expression of PGE₂ and pro-inflammatory cytokines is also induced in the endometrium of women with uRPL, such as interleukin 1beta, tumor necrosis factor alpha (TNF-alpha), interferon gamma (IFN-gamma) and transforming growth factor beta1 (TGF-beta1) (37). IL-1, TNF-alpha and IFN-gamma belong to Th1 cytokines, and this Th1 predominance has been known to be one of the immunological reasons for uRPL (37). In addition, TNF-alpha can induce COX-2 gene expression in first-trimester trophoblasts (38).

Ryantova et al. (2008) observed that PGE₂ levels in the cervical ovulatory mucus are increased in patients with uRPL (11), which is mainly caused by increased levels of COX-2. However, the effects of PGE₂ on trophoblast cells in vitro are contradictory. Biondi et al. (2006) proved that PGE₂ inhibits proliferation and migration of HTR-8/SVneo cells by enhancing cAMP (39), while Horita et al. (2007) suggested that PGE₂ promotes migration of HTR-8/SVneo cells by leukemia inhibitory factor (40). We investigated that PGE₂ inhibited the production of beta-hCG and progesterone in JEG-3 cells and the production of beta-hCG in HTR-8/SVneo cells. Low expression levels of beta-hCG and progesterone in the serum have been used to diagnose early pregnancy losses (41, 42). Intravaginal PGE₂ can decrease the excretion of hCG in the urine and...
progesterone in the plasma (43), which is in line with our study that high expression levels of PGE₂ in the placenta are detrimental to pregnancy maintenance.

Prostaglandin E₂ receptors (EP1–4) are G protein-coupled receptors that both bind and are activated by PGE₂. Yamazaki et al. (2006) indicated that mRNA and protein expression of COX-2 and EP3 are increased in the placenta of rats after ischemia-reperfusion, which is associated with intrauterine growth restriction (24). In our study we could demonstrate that EP3 expression was mainly expressed in the extravillous trophoblasts and increased in extravillous trophoblast cells of uRPL patients compared to normal pregnancies in the first trimester of pregnancy. The EP3 gene formed nine distinct mRNAs encoding at least eight EP3 isoforms (44), and the anti-EP3 antibody we used could detect the protein region within the internal sequence amino acids 360–409. It might partly explain different band signals of EP3 in JEG-3 and HTR-8/SVneo cells for in vitro studies. We furthermore investigated that sulprostone (an EP1/EP3 agonist) inhibited the secretion of beta-hCG and progesterone in JEG-3 cells and beta-hCG expression in HTR-8/SVneo cells. Sulprostone, as a PGE₂ analog, can be used for medical termination of early pregnancy (10). Sulprostone coupling with EP1 or EP3 receptor may result in a reduced production of beta-hCG and progesterone in extravillous trophoblasts. Both are detrimental to blastocyst growth and pregnancy maintenance (45). However, Biondi et al. (2006) reported that PGE₂ inhibited proliferation and migration of HTR-8/SVneo cells via EP2 and EP4 receptors instead of EP3 (39). In order to investigate the exhaustive mechanisms of membrane receptors of PGE₂ in the placenta of uRPL, the remaining membrane receptors of PGE₂ (EP1, EP2 and EP4) still need to be explored, among which the EP1 receptor represents an important receptor we will focus on in future investigations (46).

The activation of G protein-coupled receptors stimulates the activity of adenylate cyclase (AC), increases intracellular levels of cAMP and activates protein kinase A (PKA), and this cAMP/PKA signaling cascade is a key second messenger pathway for steroid biosynthesis (47). Gₛ inhibits AC, resulting in decreased levels of cAMP and therefore inhibiting activity of PKA (48). We found that the expression of Gₛıldı was mainly expressed in extravillous trophoblasts and upregulated in the decidua of women with uRPL. It suggests that the cAMP/PKA signaling pathway may be suppressed in the extravillous trophoblasts of uRPL. cAMP stimulates the transcription of the alpha-hCG gene expression in villous trophoblasts by interacting with the CREB (49). PKA can stimulate progesterone synthesis in the human placenta by phosphorylation of enzymes (50). We investigated that both PGE₂ and sulprostone stimulated the expression of Gₛıldı and suppressed the production of beta-hCG and progesterone, which can be explained by the activated EP3/Gₛıldı and inhibited cAMP/PKA signaling.

Interestingly, we investigated that only sulprostone was able to upregulate the expression of PAI-1 in JEG-3 cells, which is known as the main inhibitor of fibrinolysis (51). High plasma levels of PAI-1 and high PAI activities are present in women suffering from uRPL in comparison to healthy controls (26). PGE₂ utilizes EP1/EP3 to increase PAI-1 levels in cardiac fibroblasts, contributing to elevated fibrin deposition in aortic stenosis (25). TGF-beta1 can induce PAI-1 gene expression by phosphorylation of extracellular signal-regulated kinases (ERK1/2) and p53 (52). The expression of p53 is increased in chorionic villi of RPL patients compared to healthy controls (53). We found that sulprostone stimulated the expression of phosphorylated-ERK1/2 (p-ERK1/2) in JEG-3 cells and the expression of p53 in HTR-8/SV neo cells. Additionally, the expression of p-ERK1/2 was inhibited by L-798,106 in HTR-8/SV neo cells. The activation of EP3 signaling induces increased expression of p-ERK1/2 and p53 in extravillous trophoblasts, which results in increased PAI-1 gene expression and an imbalance of ECM degradation during first-trimester pregnancies. Both the in vivo study of Yamazaki et al. (24) and also our study suggest that under pathological circumstances large differences in EP3 expression in the placenta can be observed. In contrast, only small magnitude changes of EP3 and PAI-1 were detected in our cell culture studies. It implies that trophoblast cells in vitro can mimic parts of the in vivo environment, however it still cannot replace the complex physical milieu of the placenta. Therefore, in vivo investigations of EP3 regulation in animal models or observational studies in humans should be the focus in future.

In conclusion, we suggest that the reason for increased PGE₂ expression in the placenta in women with uRPL might due to enhanced levels of COX-2 in stromal cells of the placenta. PGE₂ in combination with EP3 receptor of extravillous trophoblasts induces Gₛıldı and inhibits AC activity, contributing to reduced levels of cAMP and inhibited activity of PKA (Fig. 5). The decreased cAMP/PKA signaling could suppress the production of beta-hCG and progesterone. At the same time, the activated EP3/Gₛıldı can stimulate p-ERK1/2 and p53, enhancing PAI-1 gene expression (Fig. 5). Upregulation of PAI-1 can inhibit ECM degradation, contributing to interstitial fibrin deposition.
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Supplementary data
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Declaration of interest
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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Figure 5
EP3 signaling is induced in the extravillous trophoblasts of uRPL patients. Arachidonic acid is metabolized by COX-2 into PGH₂, which is converted into multiple prostaglandins, such as PGE₂. PGE₂ acts through different membrane receptors (EP1–4) (22). In the placenta of uRPL patients, enhanced levels of COX-2 might be the reason for increased PGE₂ expression. PGE₂ coupling with EP3 induces Gi, and reduces cAMP, which can eventually lead to a downregulation of beta-hCG and progesterone and an upregulation of PAI-1. The decreased cAMP/PKA signaling inhibits the secretion of progesterone via PKA (50) and the transcription of beta-hCG via CREB (49). The activated EP3/Gi, can stimulate p-ERK1/2 and p53, which eventually enhance PAI-1 gene transcription (52). These changes could prevent trophoblast implantation and placentation, finally causing recurrent pregnancy losses. COX-2, cyclooxygenase-2; Gi, G protein alpha inhibitor 1; Gα, G protein alpha q; Gs, G protein alpha stimulator; PAI-1, plasminogen activator inhibitor type 1; p-ERK1/2, phosphorylated extracellular signal-regulated kinases 1/2; PGE₂, prostaglandin E₂; PGH₂, prostaglandin H₂; PKA, protein kinase A; uRPL, unexplained recurrent pregnancy losses.

deposition in the maternal-fetal interface. These changes could prevent trophoblast implantation and placentation, causing failed pregnancy maintenance. It is still unclear whether the observed findings are reflective of the uRPL or causative of it. We explored that the EP3 antagonist (L-798,106) led to a downregulation of EP3 expression without influencing the beta-hCG expression in JEG-3 cells. This suggests that L-798,106 might be a ‘potential therapeutic candidate’ for the treatment of uRPL. To further investigate the mechanism of uRPL, future studies are necessary to understand the role of the additional membrane receptors of PGE₂ (EP1, 2 and 4) and other members of Gi family (G₁₂ and G₁₃) in the placenta.

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Author contribution statement
Udo Jeschke and Viktoria von Schönfeldt conceived and designed the experiments; Yao Ye, Christina Kuhn and Martina Rahmeh performed the experiments; Myriam Ripphahn and Roland Immler cultured HTR-8/SVneo cells; Yao Ye and Aurelia Vattai analyzed the data and wrote the manuscript; Markus Spencerio and Udo Jeschke revised the manuscript. Sven Mahner, Nina Ditsch and all other authors read and approved the manuscript.

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