B cell depletion in immune thrombocytopenia reveals splenic long-lived plasma cells.
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Primary immune thrombocytopenia (ITP) is a disorder caused by autoantibody-mediated platelet destruction and decreased platelet production. Rituximab, a B cell–depleting agent, has become the first-line treatment for ITP; however, patients with refractory disease usually require splenectomy. We identified antibody-secreting cells as the major splenic B cell population that is resistant to rituximab. The phenotype, antibody specificity, and gene expression profile of these cells were characterized and compared to those of antibody-secreting cells from untreated ITP spleens and from healthy tissues. Antiplatelet-specific plasma cells (PC) were detected in the spleens of patients with ITP up to 6 months after rituximab treatment, and the PC population displayed a long-lived program similar to the one of bone marrow PC, thus explaining for most of these patients the absence of response to rituximab and the response to splenectomy. When analyzed by multiplex PCR at the single-cell level, normal splenic PC showed a markedly different gene expression profile, with an intermediate signature, including genes characteristic of both long-lived PC and proliferating plasmablasts. Surprisingly, long-lived PC were not detected in untreated ITP spleens. These results suggest that the milieu generated by B cell depletion promotes the differentiation and settlement of long-lived PC in the spleen.

Introduction

T cell–dependent immune responses induce the generation of plasmablasts (PB) that migrate to the bone marrow, in which some of them reside for decades as Ig-secreting plasma cells (PC) (1–3). PC have also been described in normal human spleen. In the latter, they display a phenotype similar to that of bone marrow PC, with specific surface marker differences, but their precise life span has not been assessed (4). In addition to bone marrow and spleen, chronically inflamed tissues may also provide a surviving niche for long-lived PC, as shown in the lupus-prone NZBxNZW mouse model (5). The precise phenotype of PC in these different contexts is not established and neither are the signals that drive these cells to reside in one particular niche and to acquire a long-lived program (6).

Primary immune thrombocytopenia (ITP) is an acquired bleeding disorder mediated by pathogenic autoantibodies that enhance platelet destruction and limit their production (7, 8). The major target of these autoantibodies is the platelet membrane glycoprotein IIb-IIIa (GpIIbIIIa), but other glycoproteins may be involved (8). The spleen is not only the major site of platelet destruction but is also considered the main site of autoantibody production, thus seemingly containing all the players required to perpetuate the autoimmune reaction (9, 10). Accordingly, splenectomy has represented for decades the reference second-line treatment of severe chronic ITP, resulting in a durable platelet response in two-thirds of patients (11, 12).

More recently, anti-CD20–induced B cell depletion, which is used in several autoimmune diseases, has been increasingly used in persistent or chronic ITP prior to splenectomy. Around 40% of patients with ITP have an initial significant response to the anti-CD20 (rituximab) treatment (13) and 20% have a long-lasting (5 years and more) response (14). Among the remaining patients, who do not respond or have a transient response to rituximab, 60%–70% are cured by splenectomy (13–15). While reports agree on the efficient peripheral B cell depletion achieved by rituximab treatment, much less is known about B cell depletion in lymphoid tissues and the nature of the resistant pathogenic cells. Moreover, incomplete B cell elimination has been reported in the mouse, either through anti-mouse CD20 treatment (16, 17) or in a transgenic human CD20 mouse model treated with rituximab, thus questioning the extent of B cell depletion achieved in human lymphoid organs (18, 19). Possible immunomodulatory roles of rituximab through non–B cell compartments or through antibody-independent mechanisms have also been proposed (20, 21).

In this study, we have taken advantage of the different therapeutic strategies and outcomes in patients with ITP to analyze the residual B cell populations present in rituximab-treated spleen and have identified a potentially pathogenic long-lived PC population not targeted by rituximab. Transcriptomic analysis at the population and at the single-cell level, performed on splenic anti-
body-secreting cells (ASCs) from HDs and from patients treated or not with rituximab, revealed striking differences between these different entities and challenged the accepted views of the environmental conditions that permit the differentiation and residence of long-lived PC.

**Results**

**Patients with ITP.** Characteristics of 15 splenectomized patients with ITP, treated or not with rituximab, are presented in Supplemental Table 1 (supplemental material available online with this article; doi:10.1172/JCI65689DS1). Ten patients, with a median age of 40 years (range, 26–74 years), received 4 weekly infusions of 375 mg/m² rituximab. All were nonresponsive to rituximab, with platelet counts below 30 × 10⁹/1 or lower than the double of the baseline count in the month preceding splenectomy. They were splenectomized in the 3 to 6 months following the last rituximab infusion. Four of them received intravenous Igs (IvIg) in the 1–3 weeks preceding the splenectomy. Seven out of ten presented with a complete response, with a follow-up of 7 to 24 months. Two of them received IvIg 2 weeks before splenectomy. All were responsive to the splenectomy, with a follow-up of 18 to 30 months. The term “ITP” will be used hereafter for patients not treated with rituximab unless otherwise stated.

The spleen in ITP is the site of an active B cell response. We first investigated the presence of ASCs and germinal center (GC) B cells as hallmarks of an active immune response in the spleens of patients with ITP not treated with rituximab (Figure 1A and Supplemental Table 2). The major part of the ASC population in these patients expressed the Ki67 cell cycle marker and were HLA-DR⁺, i.e., displayed a PB phenotype. Overall, PB were markedly increased in the spleens of these patients (Figure 1B). PC were slightly but not significantly increased compared with healthy donors (HDs) (Figure 1C). Similarly, the GC B cell population was also significantly expanded in these ITP spleens (Figure 1D). By confocal microscopy analysis, we found numerous GC structures within secondary follicles in all ITP spleens examined (n = 3) (Figure 1E), whereas mainly primary follicles were observed in splenic samples from HDs (n = 3) (Figure 1F). PB were found in these ITP spleens (Figure 1, G and H) but were rarely detectable in HDs, with a wide distribution from the GC area to the red pulp. Numerous proliferating T cells were also observed in the patient with ITP and not in the HD (Figure 1, I and J). Altogether, our data indicate that the spleen is the site of an unusually active B cell response in patients with ITP.

Presence of anti-GpIIbIIIa IgG-producing cells in ITP spleens. We next investigated the ability of ASCs to produce autoantibodies in vitro. We used the previously described anti-GpIIbIIIa ELISPOT assay in order to quantify the fraction of autoreactive ASCs (9). In all but one spleen, we observed GpIIbIIIa-specific spots, ranging from 0.5% to 1.2% of total IgG-secreting cells (Figure 1K and Supplemental Table 2). No anti-GpIIbIIIa IgG-secreting cells were observed in HDs (Figure 1L). After a 5-day culture of ITP spleens without stimulation, anti-GpIIbIIIa IgG-secreting cells were still observed with an increase of the size and the intensity of the spots (data not shown), reflecting the robustness of the response. All patients responded to the splenectomy, including the one showing a negative anti-GpIIbIIIa IgG ELISPOT.

Splenic residual B cells in patients with primary failure of rituximab are mainly PC and some of them are autoreactive. In order to study the residual B cells that survived the rituximab-suppressive action, we focused on rituximab-treated patients who did not respond and had been subsequently splenectomized within the 3–6 months after the last rituximab infusion, i.e. before the reemergence of newly formed B cells.

As extensively described, B cells were scarcely detectable in peripheral blood (<0.1% of CD45⁺ cells) (Table 1). We did not observe any dividing Ki67⁺ cells; all cells expressed the CD27 marker, and more than 50% expressed IgA isotypes as previously described (data not shown) (22). By contrast, analysis of the 10 spleens from rituximab-treated patients revealed that 0.5% of CD45⁺ mononuclear cells were B cells (Table 1). Further analysis showed that these rituximab-resistant B lineage cells could be separated in two populations: memory B cells and PC (Figure 2A). No dividing Ki67⁺ cells were observed. In all but one rituximab-treated patient, PC were the main residual population (Figure 2B). As described for normal splenic samples (4), splenic PC from rituximab-treated patients (RTX-PC) did not express CD138 in contrast with bone marrow PC and did not downregulate CD19, as 92%–98% of CD27⁺CD38⁻ cells were CD19⁺. RTX-PC were characterized as CD38⁻CD20⁻Ki67⁻HLA-DR⁺CD9⁺ (Figure 2A) and expressed splenic PC surface markers, such as CD86 and CD11a (ref. 4 and Supplemental Figure 1A). Patients who responded to splenectomy (7 out of 10) tended to have a higher number of PC in the spleen, as compared with nonresponders (Figure 2C), although this difference failed to reach significance due to the small number of patients in each category (P = 0.066).

We used the ELISPOT assay to determine whether some residual PC were autoreactive (Figure 2C). Residual PC expressed IgM, IgG, and IgA isotypes (Supplemental Figure 1B). We observed anti-GpIIbIIIa IgG-secreting cells in 7 out of 10 patients, with a frequency ranging from 0.25% to 4%, but we failed to identify anti-GpIIbIIIa IgM- or IgA-secreting cells (Table 1). Six out of seven patients presenting GpIIbIIIa-specific PC responded to the splenectomy, while specific spots were detectable in a patient who failed to respond (Figure 2, D and E).

Overall, these findings suggested that the failure of rituximab treatment could be explained in the majority of the patients by the presence of residual autoreactive anti-GpIIbIIIa PC in the spleen. Residual PC in patients with primary failure of rituximab display a long-lived genetic program. In patients with a primary failure of rituximab, the persisting splenic B cells are nondoning and contain minimal numbers of memory B cells, thus suggesting that the residual PC observed have been generated before the rituximab-induced depletion and were thus long lived. To test this hypothesis, we performed a transcriptome analysis to compare the gene expression profiles of the various splenic ASC subsets from patients and controls. We sorted PC and PB from 3 HDs and 3 patients with ITP, using HLA-DR expression to discriminate between them (gating strategy: Supplemental Figure 2), as well as PC from 4 rituximab-treated patients. We first focused on the 2 major subsets from patients, i.e., PB from patients with ITP (ITP-PB) and RTX-PC, which could be sorted to high purity due to their predominance in each category of patients. We performed a supervised analysis and identified 609 differentially expressed genes (P < 0.05, > 4-fold change).

The genes overexpressed in RTX-PC compared with those in ITP-PB were antipapoptotic genes (BCL2, CFLAR, TNFAIP3, BIRC3); negative regulators of the cell cycle and notably several members of the family of Kruppel-like factors (KLF2, KLF6, KLF9, KLF15); transcription factors (FOS, JUN, JUNB, RORA); genes related to the...
Figure 1
Spleen in ITP is the site of an active B cell response producing anti-GpIIbIIIa–specific ASCs. (A) Flow cytometry analysis of splenic mononuclear cells labeled with antibodies to CD19, CD38, CD20, CD24, HLA-DR, and Ki67. After gating on CD19+ cells, ASCs were identified as CD20−, CD24−, CD38hi (blue); PB were identified as CD20−, CD24−, CD38hi, HLA-DR+, Ki67+ (red); and GC B cells were identified as CD20+, CD24−, CD38+, Ki67+ (green). (B–D) Numbers of splenic (B) PB, (C) PCs (identified as CD19+CD20−CD24−CD27+CD38hiKi67−), and (D) GC B cells in patients with ITP (n = 5) compared with HD (n = 8). (E–J) Analysis by confocal microscopy of spleen sections from a patient with ITP (ITP1) and a HD (17 years old) using anti-CD3, anti-CD20, anti-Ki67, and anti-lgλ (anti-κ/λ light chains) antibodies. (E) Secondary follicles with proliferating GC B cells, (G, box enlarged in H) PB (CD20−, Ig κ/λ+, Ki67+), and (I, box enlarged in J) T cells (CD3−/Ki67+) in patient with ITP and (F) primary follicles in HD. Scale bars: 100 μm (E–G and I); 5 μm (H and J). Data are representative of 3 ITP and HD samples. (K) ELISPOT quantification of anti-GpIIbIIIa IgG-secreting cells in 3 ITP (top) and 1 HD (top left) among total IgG-secreting cells (bottom middle), with KLH as antigen control (bottom right). (L) Frequency of anti-GPlllBIIIa IgG-secreting cells in patients with ITP (n = 5) compared with HD (n = 4). Two-tailed Mann-Whitney tests (**P < 0.001; *P = 0.044). Symbols indicate individual samples; horizontal bars represent mean values (± SEM).
unfolded protein response (Dnaj, HSPB1, MAFF, ATF3); and genes encoding adhesion molecules or surface receptors (ICAM1, CD9, IL5R, IL6ST). On the other hand, RTX-PC underexpressed, as compared with ITP-PB, genes implicated in positive regulation of the cell cycle (BIRC5, CENPF, MKI67, CDC6, MCM4, MCM6); genes encoding adhesion molecules (SIPRI, CD58); and activating molecules like TLRs (TRL10, TLR7) (Figure 3). Thus, RTX-PC expressed a specific genetic program consistent with a quiescent, long-lived phenotype.

The gene expression profile of PC from HDs differs from the one of RTX-PC. PB from patients with ITP and PC from rituximab-treated patients represent two opposites of the ASCs differentiation pathway. To position PC from HDs along this maturation scale, we compared the gene expression profile of PC from HDs to that of both ITP-PB and RTX-PC for the 609 discriminating genes described previously (Figure 3). For 267 of these genes, the expression was similar between RTX-PC and HD-PC, while for 99 of them, HD-PC expression was similar to that of ITP-PB (<2-fold change). Among the genes shared by HD- and RTX-PC were upregulated HD-PC expression was similar to that of ITP-PB (<2-fold change).

For 267 of these genes, the expression profile revealed that RTX-PC and ITP-PB segregated in 2 distinct populations, either normalized or not with the B2M housekeeping gene (Figure 4A and Supplemental Figure 3). The major fraction of HD-PC showed an intermediate profile that differed from that of RTX-PC and ITP-PB. A few cells clustered with the RTX-PC or ITP-PB population. We then selected 8 genes for further analysis: 4 cell cycle genes (BUB1, MKI67, ZWINT, CENPF, highly expressed in ITP-PB and at background level in RTX-PC) and 4 cell cycle regulators/antiapoptosis genes (KLF6, KLF9, TNFAIP3, ATF3, highly expressed in RTX-PC and expressed at a lower level in ITP-PB). Similar results were obtained for the PCA using this set of genes (Figure 4B). Based on their qualitative expression, we further classified each single cell with a “PB signature” (>1 cell cycle gene and ≤1 upregulated PC genes) or a “PC signature” (no cell cycle gene and >1 upregulated PC genes) or as “unclassified.” These differential criteria were selected to match the transcriptional characteristics of the genes in the 2 categories: an on/off expression for cell cycle genes and a low/high expression for PC-specific genes in ITP-PB vs. RTX-PC. According to these criteria, 84% of RTX-PC showed a “PC signature” and 75% of ITP-PB showed a “PB signature.” In contrast, 75% of individual HD-PC were “unclassified,” with a “PC signature” identified for less than 15% of them (Figure 4C). Thus, RTX-PC are a unique long-lived population from which the major part of HD-PC differ. ITP-PC analyzed at the single-cell level do not display a long-lived program. To ask whether the presence of long-lived PC in rituximab-treated spleens could be contributed to by the autoimmune inflammatory environment, we analyzed PC from patients with ITP (not treated with rituximab) using the same single-cell multiplex PCR approach. PCA based on the expression profile of the 15 genes described previously indicated that, as for HD-PC, the PC present in patients with ITP showed an intermediate phenotype between long-lived PC and proliferating PB (Figure 4D). It seems therefore that the generation of the long-lived PC in spleens of rituximab-treated patients does not result from a previous inflammatory state.

Spleenic ASC from patients with ITP display a specific genetic signature characterized by downregulation of SOCS3. To identify disease-spe-
specific genes, we extracted 158 probes that discriminated all patient subsets (ITP-PC [n = 3], ITP-PB [n = 3], and RTX-PC [n = 4]) from control subsets (HD-PC [n = 3] and PB [n = 2]) (>2-fold change, P < 0.01). The 12 most striking genes are shown in Figure 5A. ASC in HDs overexpressed SOCS3 as well as PTP4A3 (also known as PRL-3; involved in CXCL12-mediated migration of multiple myelomas, and, together with SOCS3, defining a multiple myeloma subtype) (23), in contrast with ASC from patients with ITP that expressed both genes minimally (a 50-fold difference). RT-PCR confirmed that low expression of SOCS3 is a hallmark of ITP ASC (Figure 5B). Contradictory data have been reported concerning the impact of SOCS3 on cell migration. Two groups described a negative feedback control of SOCS3 on the CXCR4 signaling function (24, 25); on the other hand, Tarlinton and colleagues, while reporting a prolonged STAT3 signaling induced by IL-6 stimulation of SOCS3-deficient PC, observed no impact.

Figure 2
Autoreactive PC in patients with primary failure of rituximab. (A) Flow cytometry analysis of splenic mononuclear cells, labeled with anti-CD19, CD38, CD20, CD24, CD27, CD9, HLA-DR, and Ki67 antibodies. All residual splenic B cells were CD19+CD27+ and included memory B cells (CD24−CD38−) and PC (CD24−CD38hi) (blue gate), further identified as CD20+HLA-DR+Ki67−CD9+. (B) Percentage of PC per CD19 cells for each patient (mean, 74.9% [range, 33–98%]). (C) Absolute numbers of spleen PC in rituximab-treated patients, segregated as responders and nonresponders to the splenectomy. Two-tailed Mann-Whitney test (P = 0.066). (D) Frequency of anti-GpIIbIIIa IgG-secreting cells in responders or nonresponders to the splenectomy. Two-tailed Mann-Whitney test (P = 0.64). (E) ELISPOT quantification of anti-GpIIbIIIa IgG-secreting cells in 2 rituximab-treated patients among total IgG-secreting cells, with KLH as antigen control, estimated from 1 × 10⁶ total spleen cells (RTX1 and RTX2) or 2 × 10⁴ cell-sorted PC (RTX2, sorting of CD19+CD27−CD38hi cells). The dilution factor is indicated for IgG-positive spot detection. Symbols indicate individual samples; horizontal bars represent mean values (± SEM).
Interestingly, a higher expression of the CXCR4 gene was observed in ASC from patients with ITP compared with those from HD (Figure 5A), but cell surface expression of CXCR4 was similar between them (data not shown).

**RTX-PC are nonmigratory cells that display a resident phenotype.** In order to find out whether the overexpression of CXCR4 and downregulation of SOCS3 and PRL-3 may have an impact on PC or PB migration toward CXCL12, we studied ASC migration by culturing total spleen cells with or without CXCL12. We observed that 30% of ASC migrated toward CXCL12 in ITP samples and 20% of ASC migrated toward CXCL12 in control samples, with a fraction of cells migrating without cytokines, as previously described (ref. 27 and Figure 5C). The migratory population expressed high levels of HLA-DR at the surface, suggesting that it had a PB phenotype (data not shown).

By contrast, RTX-PC were non migratory toward CXCL12, whatever the duration of cell culture (6, 12, 24 hours). RTX-PC did not express CXCR3, CD62L, or CCR10 (data not shown) but expressed CCR2, the receptor for CCL2 (see below), and the adhesion molecules CD44, CD11a, and CD9 (Supplemental Figure 1A). RTX-PC are thus nonmigratory and display a resident phenotype.

**ASC survival in ITP is increased, suggesting a role for the proinflammatory environment.** We next wanted to assess whether the genetic signature observed could be correlated to the inflammatory ITP microenvironment. Both ASC from rituximab-treated patients and patients with ITP showed an increased survival compared with that of ASC from HD upon in vitro culture (P < 0.01) (Figure 6A). If the better persistence of ASC from rituximab-treated spleens is likely to reflect their intrinsic survival capacity in vitro, it might rather correspond, for ITP-PB, to a maintenance contributed by proliferation. We next investigated whether specific cytokines could be involved and released in the culture medium. In a panel of 27 cytokines, we did not observe a bias for TH1 or TH2 cytokines, either in ITP or rituximab-treated patients (data not shown). By contrast, BAFF secretion was increased 2 fold in rituximab spleen supernatants compared with that in ITP spleens (P < 0.05) (Figure 6B); IL-6 was increased in 3 out of 4 ITP spleens compared with controls but not in rituximab samples (P < 0.05) (data not shown). There was no difference in APRIL secretion in rituximab and/or ITP spleen supernatants compared with those from HD (data not shown). CCL2 (also known as MCP-1) was significantly increased in both ITP and rituximab spleen cultures compared with that in HD cultures (Figure 6C), and its receptor, CCR2, was expressed at the RTX-PC surface. CCL2 has been shown to recruit monocytes, neutrophils, or basophils at inflammation sites. Accordingly, among other cell types tested, basophil numbers were increased in rituximab (P < 0.01) and in ITP (P < 0.05).
spleens (Figure 6D). Nevertheless, addition of CCL2 to the in vitro culture did not modify ASC survival (data not shown). By contrast, addition of BAFF to the culture of total spleen cells from HDs increased the ASC survival by an average of 8 fold ($P < 0.01$) (Figure 6E). We concluded that a proinflammatory environment, capable of increasing the ASC survival, may be driven by CCL2 and that BAFF contributes to ASC survival. The higher concentration of BAFF observed for rituximab spleen (Figure 6E), as well as the increased ASC survival by an average of 8 fold, underscores the importance of BAFF in the long-term survival of ASC in rituximab-treated spleens.

**Discussion**

Splenectomy performed in patients with ITP represents a unique opportunity to study the different partners involved in an autoimmune process. Here, we explored the short- and long-lived ASC involved in different pathogenic settings as well as in normal conditions.

We found that, while normal adult spleen displays scarcely any GCs, patients with ITP showed an ongoing immune response with numerous active GCs (28), giving rise to some antiplatelet-specific ASC. This intense B cell response and considerable expansion of short-lived PB in spleen is thus a hallmark of the disease. Rituximab-induced B cell depletion therapy is widely used in autoimmune diseases, and, accordingly, around 40% of patients with ITP respond to this therapy after 1 year (13) and 20% of them have a long-lasting response (14, 15). This rate of response underlines the efficacy of the rituximab treatment, being able to totally block the ongoing production of ASC by proliferating GCs and memory B cells within lymphoid tissues (20).

We further analyzed the spleens of patients with ITP with a primary failure of rituximab treatment at a stage at which B lymphopoiesis had not restarted yet. In a configuration in which B cell depletion in the blood is almost complete, approximately 0.2%–1% of CD19+ B cells were shown to have resisted the rituximab-mediated depletion in the spleen. We identified, among the residual lymphoid cells, a majority of PC that had survived in the total absence of GC B cells, dividing memory B cells, and PB. A small percentage of these PC, which were mainly of the IgG isotype, secreted antiplatelet antibodies, thus providing an explanation for the failure of rituximab therapy. Accordingly, 7 out of 10 patients responded to splenectomy, suggesting that such autoantibodies occurred frequently restricted to the spleen.

We inferred that the PC observed in rituximab-treated spleens were made previous to the treatment, i.e., at least 3 to 6 months before splenectomy, and postulated that they could be long lived. The surface analysis of these splenic PC showed that they shared several markers with PC from normal bone marrow (HLA-DRlo CD9+Ki-67–). They differed from their bone marrow counterparts by expressing CD11a and CD86 and being negative for CD138. The surface analysis of these splenic PC showed that they shared several markers with PC from normal bone marrow (HLA-DRlo CD9+Ki-67–). They differed from their bone marrow counterparts by expressing CD11a and CD86 and being negative for CD138. These splenic PC were compared at the transcriptomic level with PC isolated from normal spleens and also with PB and PC extracted from the spleens of patients with ITP not treated with rituximab, the situation appeared more complex.

Transcriptomic analyses have so far focused mainly on bone marrow PC or on in vitro generated PB and PC in humans (29–31). By analyzing the short-lived PB in patients with ITP and the long-
Figure 5
Splenic ASC from patients with ITP display a specific genetic signature characterized by downregulation of SOCS3. (A) Selected genes showing significant difference in expression between ASC from disease samples (ITP-PC, RTX-PC, ITP-PB) compared with ASC from HDs (HD-PB and HD-PC) (n = 158; fold change, >2 or <0.5; P < 0.01). Gene expression profiling was performed using Affymetrix U133 Plus 2.0 microarrays after cDNA preamplification. (B) Enhanced expression of suppressor of cytokine signaling 3 (SOCS3) in HD compared with samples of patients with ITP. SOCS3 expression was determined by real-time quantitative RT-PCR, with values normalized for B2M expression. Mann-Whitney test (\(P < 0.05\)). (C) Migration of ASC toward CXCL12 in a transwell migration assay. 1 × 10^6 cells from ITP (n = 2), HD (n = 2), and rituximab (n = 2) splenic samples were cultured overnight in triplicates. The ASC populations were gated as CD3–CD19+CD27+CD38hi cells, and the proportion of migrating ASC was estimated compared with the total number of cells. Mean ± SEM.
main differences in cytokine secretion concerned IL-6 and BAFF, whose secretion was increased in ITP and rituximab-treated spleen supernatants, respectively. The increase in BAFF secretion could be a direct consequence of B cell depletion (44, 45) and might constitute a key factor, allowing, together with other players, for the settlement of long-lived PC in the rituximab-treated spleen.

Many questions remain unanswered in antibody-mediated autoimmune diseases such as ITP. What drives the intense GC reaction target organs of human autoimmune diseases, since only a small percentage of the PC produced seem to secrete autoantibodies? As recently highlighted, inflammatory B cells producing cytokines such as IL-6 may promote this local B cell activation, but the mechanism of tolerance breakdown remains unknown (46). Finally, a straightforward proposition coming out of these results is that ITP may be caused either by autoimmune CD20+ memory B cells and the short-lived PB and PC they produce (response to rituximab) or by long-lived CD20+ pathogenic PC present in the spleen (response to splenectomy after rituximab failure) or in other lymphoid niches (47) (failure of both treatments). One future therapeutic goal in ITP could be, according to our results, to modulate the splenic microenvironment, such as with an anti-BAFF therapy associated with rituximab, in order to prevent the generation of splenic long-lived PC.

**Figure 6**

ASC in ITP display a prolonged in vitro survival within a specific cytokinetic and cellular microenvironment. (A) ASC survival after 5-day culture. Survival was estimated by the fraction of input ASC detectable after 5-day culture of $5 \times 10^4$ spleen cells in triplicate, estimated by an anti-Ig ELISPOT (mean survival, RTX: 26.4% ± 3.7%; ITP: 32% ± 9.5%; HD: 9.3% ± 1.6%). (B) BAFF concentration in spleen supernatants after 5-day culture. BAFF concentration was estimated by ELISA in culture medium of $10^4$ spleen cells cultured in triplicates for 5 days (mean BAFF secretion, RTX: $33.6 ± 6.2$ pg/ml; ITP: $7.2 ± 1.2$ pg/ml; HD: $20.2 ± 1$ pg/ml). (C) CCL2 concentration in spleen supernatants after 5-day culture. CCL2 concentration was estimated as part of a multiplex 27-cytokine assay in spleen supernatants of $10^4$ cells cultured in triplicate for 5 days (mean CCL2 secretion, RTX: $11,410 ± 228$ pg/ml; ITP: $11,410 ± 1,236$ pg/ml; HD: $3,233 ± 1,927$ pg/ml). (D) Number of basophils in ITP and rituximab spleens. Spleen basophils were estimated by flow cytometry as numbers of HLA-DR-CD123-FcεRI+ cells per $10^4$ cells (mean basophil numbers, RTX: $1,162 ± 79.8$; ITP: $1,162 ± 79.8$; HD: $9.3% ± 1.6%$). Survival was estimated as in A. The values obtained with or without BAFF for each sample are connected by a straight line (median fold increased survival with BAFF: 8.3 [3.2–23]). Significant differences estimated by Mann-Whitney and paired t test (**P < 0.01, *P < 0.05). Symbols indicate individual samples; horizontal bars represent mean values (± SEM).
fix/Cytoperm solution. Stained populations were analyzed on a FACS-CantoII apparatus with the DIVA or FlowJo software. Cell sorting was performed with a FACSaria cell sorter (Becton Dickinson), and gates were set to collect the CD19^+CD20^-CD27^-CD38^-HLA-DR^+ (PC) and HLA-DR^+ (PB) fractions in HDs and patients with ITP and CD3 CD19^+CD27^-CD38^- cell fractions in patients treated with anti-CD20. The cell purity after sorting was greater than 99%. 

**ELISPOT assays**

Anti-GpIIbIIIa IgG PC detection. Multiscreen 96-well filter plates (MSISPS4510; Millipore) were coated by incubation overnight at 4°C with 2.5 μg/ml keyhole limpet hemocyanin (KLH), 10 μg/ml goat anti-human Ig polyclonal antibody (Invitrogen), or 30 μg/ml purified GpIIbIIIa (Kordia Science) and coated in PBS/CaCl_2 0.05%. 1 × 10^6 cells were serially diluted in culture medium in triplicate before transfer to ELISPOT plates and cultured 4–6 hours in complete culture medium at 37°C under an atmosphere containing 5% CO_2. The ELISPOT was revealed with biotinylated goat anti-human IgG Fc (Invitrogen), followed by HRP-conjugated avidin (Vector Laboratories) and developed using 3-amin-9-ethylcarbazole (Sigma-Aldrich). Spots were counted in wells showing more than 3 specific spots in an ELISPOT reader with the AID software (version 3.5; AutoImmun Diagnostika). When detected, IgG-secreting anti-GpIIbIIIa spot numbers were reported to IgG-positive spots. When no specific spot was detectable, a value “less than x” was assigned, with x corresponding to the frequency obtained if 1 GpIIbIIIa spot were detected at the lowest dilution. 

**Cytokine assays**

Culture supernatants of 1 × 10^6 spleen cells per ml plated in 24-well plates were collected at day 5. Quantitative determination of secreted cytokines was performed with the Bio-Rad human cytokine 27-plex assay, carried out according to the manufacturer’s instructions. The human TNFSF13B/BAFF, CXCL12 (Quantikine, RD systems), and APRIL (USCNK) immunoassays were carried out according to the manufacturer’s instructions. 

**Chemotaxis assay**

Chemotaxis assays were performed using transwell plates (Corning). CXCL12 (Peprotech) was added to wells of a 24-well plate at 100 ng/ml. 1 × 10^6 spleen cells were cultured overnight in the upper well. The migrating ASC population was estimated by FACS as CD3^-CD19^-CD27^-CD38^- cells present in the lower well. The chemotactic index was calculated as the number of cells migrating in the presence of chemokines versus the total number of cells. 

**Gene expression profiling**

RNA was isolated from sort-purified PC (CD19^-CD20^-CD27^-CD38^- HLA-DR^+) and PB (CD19^-CD20^-CD27^-CD38^- HLA-DR^-) from 3 spleens of HDs and of patients with ITP (ITPP, ITP2, ITP3). PC (CD3^-CD19^-CD27^-CD38^-) were isolated from 4 spleens of rituximab-treated patients (RTX1, RTX2, RTX6, RTX8). Total RNA was isolated using the RNeasy Micro Kit (Qiagen). RNA quality and concentration were assessed using RNA 6000 Pico LabChips with a 2100 Bioanalyzer (Agilent Technologies). Total RNA (10 ng) was preamplified by Ribo-SPiA (Ribo–single primer isothermal amplification) RNA Amplification using the Ovation Pico WTA Kit (NuGEN Technologies), fragmented, and labeled with biotin using the Encore Biotin Module (NuGEN Technologies), as recommended by the manufacturer. Expression analysis was performed using GeneChip Human U133 Plus 2.0 Arrays (Affymetrix). Gene expression levels were calculated using GCRMA, and flags were computed using MASS within R. To limit potentially biased measurements (background or saturating), all probes whose flags were absent or marginal were flagged as 0, whereas those present were flagged as 1. The group comparisons were done using a Student’s t test. To estimate the false discovery rate, we filtered the resulting P values at 0.05 (or 0.01 in certain cases) and considered data with 2- or 4-fold changes between samples. Data were subsequently compared to the gene ontology database (http://www.geneontology.org/). Complete data sets have been deposited in EMBL-EBI database (http://www.ebi.ac.uk/arrayexpress/, accession no. E-MEXP-3711). 

**Single-cell gene expression analysis**

Single splenic PC from 2 HDs and 2 rituximab-treated patients and single PB and PC from 2 patients with ITP were isolated by cell sorting. Cells were sorted in 5 μl of buffer containing the RT-PCR reagents and the pre-amplification primers (CellsDirect One-Step qRT-PCR mix, SuperScriptIII RT/Platinum TaqMix 2%, and TaqMan primers (x0.005) [Applied Biosystems)]. A list of primers is available in Supplemental Table 4. After reverse transcription and gene-specific preamplification, cDNAs were diluted 5 times and kept frozen at ~20°C. 10x primer solutions were prepared with 2x Assay Loading Reagent (Fluidigm). cDNA were mixed with TaqMan Universal PCR Master Mix 2x (Applied Biosystems) and x20 GE Sample Loading Reagent (Fluidigm). Assay mix and cDNA mix were then transferred in a 48.48 Dynamic Array primed chip, and real-time PCR was run according to the Fluidigm protocol. 100-cell and no-cell wells were used as positive and negative control, respectively. Data were analyzed using Fluidigm Real-Time PCR analysis software. HLA-DRB1, CD38, CD27, and CD3 genes were used as control genes. To limit potentially biased measurements, cells with less than 2 expressed genes among the 15 selected diagnostic genes were excluded from the analysis. PCA was performed with GeneSpring analysis software. PCA was performed with and without normalization of the Ct value for each gene with the R2M housekeeping gene. 

**Statistics**

Statistical comparisons were made with the nonparametric Mann-Whitney test, and the Wilcoxon signed-rank test was used for paired samples using GraphPad Prism. A P value of ≤ 0.05 was considered as significant. 

**Study approval**

The study was approved by the Agence de la Biomédecine and the Comité de Protection des Personnes (CPP) Ile de France-II for controls and by the CPP Ile de France-IX for patients with ITP. This study was conducted in accordance with the Helsinki Declaration, with informed consent obtained from each patient with ITP for collecting splenic samples. 

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