Myeloid-derived suppressor cells (MDSCs) are naturally occurring leukocytes that develop from immature myeloid cells under inflammatory conditions that were discovered initially in the context of tumor immunity. Because of their robust immune inhibitory activities, there has been growing interest in MDSC-based cellular therapies for transplant tolerance induction. Indeed, various pre-clinical studies have introduced in vivo expansion or adoptive transfer of MDSC as a promising therapeutic strategy leading to a profound extension of allograft survival due to suppression of alloreactive T cells. However, several limitations of cellular therapies using MDSCs remain to be addressed, including their heterogeneous nature and limited expansion capacity. Metabolic reprogramming plays a crucial role for differentiation, proliferation and effector function of immune cells. Notably, recent reports have focused on a distinct metabolic phenotype underlying the differentiation of MDSCs in an inflammatory microenvironment representing a regulatory target. A better understanding of the metabolic reprogramming of MDSCs may thus provide novel insights for MDSC-based treatment approaches in transplantation. In this review, we will summarize recent, interdisciplinary findings on MDSCs metabolic reprogramming, dissect the underlying molecular mechanisms and discuss the relevance for potential treatment approaches in solid-organ transplantation.

© 2023 International Society for Cell & Gene Therapy. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/)

Introduction

Although clinical solid-organ transplantation has improved short-term outcomes, the procedure still faces limitations due to substantial side effects of immunosuppression and compromised long-term organ survival [1]. Calcineurin inhibitors, as the backbone of immunosuppression, are associated with nephrotoxicity, cardiovascular and metabolic side effects, as well as increased risk of opportunistic infections and de novo malignancies [2]. Moreover, current first-line immunosuppressive drugs have shown limited effects on chronic rejection, impeding long-term graft survival even under strict follow-up and maintenance immunosuppression [1,3]. To further improve the quality and expectation of life of transplant recipients, innovative therapeutic solutions are required. Of note, inducing transplant tolerance has been considered as a desirable solution, as it enables organ acceptance without the need for long-term immunosuppression [2].

Myeloid-derived suppressor cells (MDSCs) are a heterogeneous population of immature myeloid progenitor cells with potent immunosuppressive activity, which has led the focus on investigating their therapeutic potential for allogeneic transplantation [4,5]. It is now generally accepted that MDSCs play an important role for the regulation of alloreactive responses [6,7]. MDSCs have been shown to expand early after transplantation [8], migrate to the allograft and suppress alloreactive T-cell responses [4]. At the same time, MDSCs were shown to facilitate allograft tolerance through promoting the development and recruitment of regulatory T cells (Treg) [9]. Of relevance, MDSC infusion has been demonstrated to prevent the rejection of allogeneic transplantation of pancreatic islets [10]. Similarly, adoptive transfer of in vitro-induced MDSCs prolonged allograft survival in a model of murine heart transplantation [11]. Moreover, targeted depletion of MDSCs leads to cardiac allograft rejection in recipient mice that had been treated with donor splenocyte transfusion and anti-CD40L, known to prevent transplant rejection [12], underscoring the essential role of MDSCs for induction and maintenance of transplant tolerance. In human studies, expansion of MDSCs has been observed in peripheral blood of kidney transplant recipients [8,13] (Table 1) [14–23]. Expanding the number of MDSCs and modifying their functional capacities to enhance their inhibitory effects on alloimmune responses is a promising approach for organ transplantation. The transduction of human monocytes with FADD-like
interleukin (IL)-1β—converting enzyme-inhibitory protein (c-FLIP)—expressing lentiviruses, for instance, increased the suppressive activity on stimulated T cells and abrogated graft-versus-host disease in a xenograft model upon adoptive transfer, leading to improved long-term survival of recipient mice when compared with those receiving luciferase-expressing (control) monocytes. Strikingly, c-FLIP—transduced monocytes exerted more prominent suppression on graft-versus-host disease when compared with thawed human Tregs [24]. These rodent and human data encourage efforts to recruit MDSCs as a therapeutic approach in transplantation.

MDSCs as a therapeutic approach in transplantation.

Tregs [24]. These rodent and human data encourage efforts to recruit MDSCs as a therapeutic approach in transplantation when compared with thawed human graft-versus-host disease when compared with thawed human Tregs, which suppresses the immune response and promotes graft survival [14].

Recipient-derived monocyte MDSCs prolong graft survival via inactivating T-cell response and nTreg infiltration [15]. Importantly, MDSCs can promote the expansion of CD4+Foxp3+Treg, which suppresses the immune response and promotes graft survival [13].

Monocytic and promyelocytic MDSCs contribute to immune tolerance in haplo-identical allogeneic HSC transplantation [14]. Notably, distinct features of different immune cells reprogram the expression of critical metabolic enzymes and rewire metabolic reprogramming represents a promising target for immunoregulation [25].

Drugs such as rapamycin (RPM), cyclosporine A (CsA) and tacrolimus interfere with complex metabolic and immunological signaling pathways affecting different cells, and MDSCs are no exception. Although CsA appears to promote the proliferation of MDSCs and thus enhance immunosuppression [19,20], RPM appears to inhibit the differentiation and proliferation of MDSCs as well as their immunosuppressive effect on T cells [15]. A detailed understanding of these interactions is needed for clinical application, but it seems worthwhile to investigate. MDSCs proliferate after transplantation and inhibit graft rejection, but durable graft tolerance has not been achieved in preclinical studies with MDSCs [4,17].

Given the advancements made in cancer research, cellular metabolic reprogramming represents a promising target for immunoregulation in transplantation [25,26]. Upon activation, immune cells reprogram the expression of critical metabolic enzymes and rewire metabolic pathways to overcome the bioenergetic and biosynthetic demand [26,27]. Notably, distinct features of different immune cells in metabolic reprogramming provide the opportunity to target specific subsets, allowing tailored immunosuppression [25], which constitutes a major goal of current transplant research in order to lower systemic side effects and provide long-term immune tolerance. Indeed, several studies have reported on targeted immune cell reprogramming towards an anti-inflammatory phenotype, setting the cornerstones for further investigations of this therapeutic approach. M1 macrophages, for instance, have been skewed towards M2 macrophages by dimethyl fumarate, metformin or TEPP-46 [28], whereas T cells have been successfully repolarized towards Tregs by dimethyl fumarate or RPM in multiple sclerosis [29].

Phenotype and Function of MDSCs

MDSCs in both human and mice are heterogeneous and can be classified into two major groups according to their origin from the granulocytic or monocytic myeloid cell lineages, monocytic MDSCs (M-MDSCs) and polymorphonuclear MDSCs (PMN-MDSCs) [2]. Both MDSC subsets have been characterized by expression of CD11b, whereas their phenotype can be distinguished according to the expression of distinct surface markers. Hence, in mice, M-MDSCs display a CD11b+Gr-1medLy6chiLy6gCD49d+ phenotype whereas PMN-MDSCs are defined as CD11b+Gr-1lowLy6ch/Ly6g+CD49d+. In humans, in turn, M-MDSCs are characterized as CD11b+CD14HLA-DR~CD15− and PMN-MDSCs as CD11b+CD14+CD15+(orCD66b) [14,33]. Of note, human MDSCs also comprise another distinct group of myeloid precursor cells that are defined as Lin-HLA-DR-CD33+ early-stage MDSCs which, however, only account for up to 5% of the total MDSCs population [5,34] (Table 2). In transplantation, alterations in MDSC subsets are rarely reported. In a murine cardiac transplant model, most posttransplant splenic MDSCs had been CD11b+Ly6C+Ly6G−PMN-MDSCs [4], whereas CD11b+CD33+HLA-RR−M-MDSCs in contrast had been the predominant subset in the peripheral blood of human kidney transplant recipients [8,13].

One of the key functions of MDSCs is T-cell suppression. Data from studies have focused solely on T-cell immunity as major drivers of allograft rejection. However, other critical immune cell components such has MDSCs remained largely unexplored. Although the metabolic phenotype and adaptations of MDSCs to hypoxic and inflammatory environments have been thoroughly characterized in cancer research, little effort has been made to translate this knowledge to the field of transplantation, where metabolic treatments are gaining increasing interest. Therefore, in the present review, we introduce MDSCs and their metabolic characteristics, dissect the underlying molecular mechanisms in MDSCs metabolic reprogramming and delineate the relevance for potential treatment approaches in solid organ transplantation.
which impairs T-cell proliferation by inducing apoptosis, suppressing T-cell mitogenic responses or inhibiting major histocompatibility complex class II expression [36–38]. In addition, M-MDSCs up-regulate the expression of immunosuppressive cytokines such as IL-10 and transforming growth factor-β, as well as immune regulatory cell-surface molecules like membrane-bound programed death receptor ligand 1 (PD-L1) [39]. PMN-MDSCs, in turn, have been characterized to exert their suppressive effects on immune responses promoting the generation of reactive oxygen species (ROS) and arginase 1. In detail, MDSCs express NADPH oxidase 2 (Nox2) catalyzing the production of ROS, whereas increased expression of arginase-1 causes a reduction of local L-arginine and cysteine levels, which constitute a key nutrition for T-cell proliferation and function [40,41]. Noteworthy, the described dichotomy does not imply an exclusive dependency pathways [6,12]. IFN-γ-dependent pathways [6,12]. IFN-γ seems to play a crucial role for tolerance induction in transplantation, as tolerance is not induced in IFN-γ-deficient recipient mice due to active CD28 and CD40 ligand T-cell co-stimulation pathways, resulting in the proliferation of alloreactive effector T lymphocytes [44]. iNOS-expressing MDSCs seem essential for prolonging graft survival through stimulation of IFN-γ secretion in Tregs [18]. In addition, CCL5 secreted by graft penetrating MDSCs has been shown to promote the accumulation of Tregs in tolerized kidney grafts [13,45,46]. Conversely, the increase in Tregs augmented the number of MDSCs in the peripheral blood of the recipient, in the spleen and in the graft itself [47]. Other mechanisms of MDSC-mediated immunosuppression that are mediated by both M-MDSCs and PMN-MDSCs include blockade of T-cell homing through reducing L-selectin expression on T cells [48], ectoenzyme-induced adenosine production [49] and Fas/FasL-dependent apoptosis of cytotoxic T cells [50]. Notably, a recent study showed a novel mechanism in which MDSC-derivied methylglyoxal can be transferred to T cells via cell-cell transfer. Subsequently, methylglyoxal then paralyzed T-cell effector function through metabolic inhibition of these cells [51] (Table 2).

Metabolic Reprogramming Orchestrating the Immunosuppressive Effects of MDSCs on T-Cell Immunity After Transplantation

Metabolic reprogramming is a general term initially derived from cancer research for the response of cells to crucial changes in the surrounding microenvironment, involving altered expression in critical metabolic enzymes, metabolites and metabolic pathways, which in turn leads to altered functions [32,53]. Following transplantation, significant perturbation in both the systemic environment [54] as well as in the allograft microenvironment [55] can be observed deriving from ischemia–reperfusion injury (IRI), shear forces and alloimmune responses, which in turn affect the metabolic phenotype and function of immune cells, including MDSCs.

MDSCs rapidly expand after transplantation exerting immunosuppressive effects through mechanisms described previously [56]. Triggered by external stimuli, metabolic reprogramming of MDSCs hereby alters the acquisition and processing of nutrients in order to meet the requirement of augmented energy supply and biosynthetic intermediates [57] for proliferation and generation of effector molecules [4]. Oxidative stress for instance, can be recognized by general control nonderepressible 2 (GCN2) acting as an environmental sensor crucially involved in the instigation of MDSC metabolic reprogramming through inducing the upregulation of ATF4, a transcription factor that regulates the expression of genes involved in amino acid metabolism, oxidative stress and the unfolded protein response [58]. During metabolic reprogramming glucose, lipid and amino acid metabolism undergo significant alteration tightly regulating MDSC effector pathways (Table 3).

Glucose Metabolism

Glucose is the major source of cellular energy and converted into ATP through glycolysis and oxidative phosphorylation [59]. Oxygen-rich environments cause immune cells including quiescent naïve T cells, B cells and monocytes to prioritize glucose flux for maximum ATP production through mitochondrial oxidation [60,61]. In an inflammatory microenvironment, various activated immune cells including T effector cells [62,63], M1 macrophages [64] as well as neutrophils [65,66] recruit aerobic glycolysis to generate energy and biosynthetic intermediates within a shorter time period when compared with oxidative phosphorylation.

Notably, dynamic metabolic flux analysis revealed that MDSCs recruit glycolysis as the major metabolic pathway of glucose regardless of oxygen availability and activation status [5,67,68]. Thus, MDSCs were found to upregulate glycolytic genes, increase glucose uptake and reduce oxygen consumption during differentiation and activation [67]. Thereby, hypoxia-inducible-factor-1-alpha (HIF-1α) constitutes a key transcriptional factor that regulates the expression of glycolytic enzymes and promotes anaerobic glycolysis in MDSCs [69]. In addition, the mammalian target of rapamycin (mTOR) pathway has also been identified to increase glucose uptake and glycolytic enzyme expression [70]. Inhibiting MDSCs-derived glycolysis with 2-

### Table 2 Phenotype and function of MDSC subsets in humans and mice.

<table>
<thead>
<tr>
<th>Cell-specification</th>
<th>M-MDSC</th>
<th>PMN-MDSC</th>
<th>e-MDSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mice</td>
<td>CD11b^+Gr-1^+Ly6C^+Ly6G^-CD49d^-</td>
<td>CD11b^+Gr-1^+Ly6C^+Ly6G^-CD49d^-</td>
<td>Lin^+CD13/14/19/56/HLA-DR^+CD33^+</td>
</tr>
<tr>
<td>Human</td>
<td>CD11b^+Gr-1^+Ly6C^+Ly6G^-CD49d^-</td>
<td>CD11b^+Gr-1^+Ly6C^-CD49d^-</td>
<td>Poorly understood</td>
</tr>
<tr>
<td>General function</td>
<td>Blocking of T cell homing; Promotion of Treg development, ectoenzyme-induced adenosine production, Fas/FasL-dependent apoptosis induction of cytotoxic T cells, Methylglyoxal-mediated effector T-cell paralyzation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Surface markers defining the phenotype of M-MDSCs, PMN-MDSCs and e-MDSCs in human and mice are shown. In addition, cell-specific function of each subset as well as general functions common in distinct subsets are outlined.
The differentiation of MDSCs in vitro [15].

Hypoxia is the most important inducer of HIF-1α [71] and during organ transplantation, limited arterial blood supply causes an ischemic state with tissue hypoxia that induces an anaerobic metabolism with increasing lactate levels and ROS production [72]. Meanwhile, chronic transplant vasculopathy leads to abnormal blood flow patterns with subsequent local hypoxia in long-term surviving organs [73]. HIF-1α, upregulated in response to tissue hypoxia, has thereby been delineated as a cardinal factor dampening the pathological consequences of IRI inevitably accompanying organ transplantation [74], as well as a key feature of intragraft microenvironment in chronic allograft injury [73]. HIF-1α has namely been shown to improve mitochondrial respiratory function through the phosphoinositide 3-kinase/AKT and Janus kinase 2/STAT3 pathways [75] while mitigating cellular oxidative stress and ROS production through frataxin [76]. Notably, HIF-1α has also been characterized as a key transcriptional factor that regulates the expression of glycolytic enzymes as well as lactate transporters and promotes glycolysis in MDSCs [69], thus accelerating differentiation and proliferation under organ hypoxia. In addition, HIF-1α has been shown to increase the expression of PD-L1, an immune checkpoint receptor, which mediates the inhibition of T cells by binding to the PD-L1 receptor of T cells. Moreover, acidic microenvironment caused by hypoxia has been characterized to increase the proliferation of MDSCs and strengthen their suppressive activity on T cells, compromising CD4+ T-cell proliferation and CD8+ T-cell–derived IFN-γ production via the HIF-1α pathway [63]. Furthermore, local tissue hypoxia activates SIRT1 in MDSCs, which in turn exerts agonistic effects with HIF-1α deacetylating several of its downstream targets, thus mediating the differentiation of MDSCs towards a regulatory and immunosuppressive M2-phenotype. Of note, SIRT1 deficiency was found to impair M2-MDSCs with compromised glycolytic activity and lower arginase activity as well as IL-10 and TGF-β1 expression. These studies indicate that hypoxia/HIF-1α signaling is a potent inducer of immunosuppression by enhancing glycolysis in MDSCs. Of note, aerobic glycolysis does not only work as an energy generation pathway for MDSCs, but also constitutes a critical regulator of redox homeostasis. Thus, phosphoenolpyruvate generated through augmented aerobic glycolysis, for instance, has been identified as glycolytic intermediate with antioxidant activity that restrains self-damage by ROS generated during the effector response of MDSCs [77], which may also interfere with the impact of exogenous ROS, deriving from instance for IFI following transplantation, on MDSCs (Table 2, A).

**Lipid Metabolism**

Lipid metabolism constitutes a cardinal pathway for the suppressive function of MDSCs on the local microenvironment. The major pathway of cellular lipid metabolism is fatty acid β-oxidation (FAO). Studies in cancer showed that MDSCs, upon infiltrating the tumor and becoming activated, increased the uptake of lipids by the upregulation of the scavenger receptor CD36 through STAT3 and STAT5 signaling [70,78]. Peroxisome proliferator–activator receptors signaling pathway sense the increased level of fatty acids and regulate downstream lipid metabolic pathways [79]. Thus, mitochondrial electron transfer complex and the key enzymes in tricarboxylic acid cycle are upregulated, promoting FAO and TCA. These metabolic reprogramming events shift the primary source of energy generation from glycolysis to FAO. Indeed, compared with peripheral MDSCs, tumor-infiltrating MDSCs showed increased mitochondrial mass, oxygen consumption and FAO-derived ATP generation [78]. Notably, in MDSC, FAO also displays the primary source of biosynthetic intermediates for the generation of FA, AA and ribose, which are essential for further synthesis of anti-inflammatory molecules such as IL-10, PD-1 and iNOS. IL-10, in turn, has been dissected to exert strong immunosuppressive effects on allogeneous ROS, deriving from instance for IFI following transplantation [80]. Of note, FAO also serves as the cardinal resource for the expression of pro-inflammatory cytokines such as IL-2. However, MDSCs have been delineated to display a primarily anti-inflammatory secretome in transplantation with IL-10 representing a cardinal cytokine [16]. The lipid metabolism of MDSCs has furthermore been associated with a suppressive function on dendritic cells (DCs). Accumulated lipids in PMN-MDSCs are hereby oxidized through ROS and MPO and subsequently transferred to DCs inhibiting their antigen cross-presentation and their orientation on major histocompatibility complex class II in cancer [81]. This, in turn, blocks antigen-mediated cross-presentation and inhibits T-cell stimulation, which is of translational relevance for transplantation as antigen cross-presentation represents a crucial step in the initiation of T-cell allo-immune responses [82]. Of note, extracellular oxidized lipids can also be taken up by T cells through CD36, subsequently leading to T-cell exhaustion mediated by p38 signaling [83]. Clearance of cellular oxidized lipids in T cells by overexpression of glutathione peroxidase 4, in turn, has been shown to restore the effector function in vivo [79]. Supporting the importance of lipid metabolism for the immunosuppressive function of MDSCs was the observation that an inhibition

**Table 3**

Overview of metabolic pathways involved in MDSC-derived immunosuppressive function on T cells.

<table>
<thead>
<tr>
<th>Metabolic pathway/product</th>
<th>Regulated effector function</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Glucose metabolism HIF-1α</td>
<td>Differentiation and proliferation under hypoxia PD-L1 expression Inhibition of CD4 proliferation Inhibition of CD8 IFN-γ production</td>
</tr>
<tr>
<td>Sirt1/HIF-1α</td>
<td>M2 polarization II-10 and TGF-β expression</td>
</tr>
<tr>
<td>Phosphoenolpyruvate</td>
<td>Restraining ROS self-damage</td>
</tr>
<tr>
<td>B Lipid metabolism FAO</td>
<td>IL-10, PD-1, iNOS expression</td>
</tr>
<tr>
<td>FA, AA, chole</td>
<td>CD8+ suppression</td>
</tr>
<tr>
<td>C Amino acid metabolism Arginase/iNOS</td>
<td>Decreasing CD3 Expression Inhibition of T-cell proliferation Blocking T-cell Trafficking</td>
</tr>
<tr>
<td>Arg depletion NO release</td>
<td></td>
</tr>
<tr>
<td>Trp depletion Cell cycle arrest of T cells in G1</td>
<td>Inhibition of T-cell–derived IFN-γ expression Increasing Treg frequencies</td>
</tr>
<tr>
<td>Kyn, 3-HK, 3-HAA</td>
<td>Suppression of T-cell proliferation</td>
</tr>
<tr>
<td>QUIN</td>
<td>TH2 polarization Inhibition of T-cell IFN-γ and TNF-α production</td>
</tr>
<tr>
<td>3005.66</td>
<td>3005.61</td>
</tr>
<tr>
<td>2150</td>
<td>2260</td>
</tr>
<tr>
<td>2003.74</td>
<td>6011.22</td>
</tr>
<tr>
<td>6011.22</td>
<td>4900</td>
</tr>
<tr>
<td>3005.66</td>
<td>2260</td>
</tr>
<tr>
<td>2003.74</td>
<td>33011.19</td>
</tr>
</tbody>
</table>

Overview of metabolic pathways and their downstream metabolite products of (A) glucose metabolism (B) lipid metabolism and (C) amino acid metabolism. Every suitable list the regulated effector function of MDSCs on T cells regulated by the reflective metabolic pathway. HIF-1α, hypoxia-inducible-factor-1-alpha; IDO, indoleamine 2,3-dioxygenase; IFN-γ, interferon-γ; IL-10, interleukin-10; iNOS, inducible nitric oxide synthase; Kyn, kynurenine; M-MDSC, monocytic myeloid-derived suppressor cell; PD-1, programmed cell death protein 1; PD-L1, programmed cell death ligand 1; QUIN, quinolinic acid; ROS, reactive oxygen species; TGF-β, transforming growth factor-β.
of FA uptake blocking fatty acid transporter 2 [84] or CD36 [85] through pharmacological inhibition or genetic deletion, abrogated the suppressive effects of MDSCs on CD8⁺ T-cells (Table 2, B).

Amino Acid (AA) Metabolism

AA metabolism represents a critical mechanism of MDSC effector function mediating T-cell immunosuppression since arginine, tryptophan and cysteine are essential amino acids for T-cell function. MDSCs can deplete these AA from the microenvironment and thus starve T cells, leading to impaired T-cell survival, proliferation and function. Moreover, several products of AA metabolism inhibit T-cell immune responses through different signal pathways.

MDSCs metabolize arginine though arginase-I and iNOS. Upon activation through IFN-γ, MDSCs have been shown to take up large amounts of Arg by inducing the cationic AA transporter 2, Arg-1 and iNOS. The reduction of local Arg levels in turn leads to decreased T-cell-derived CD3ε expression, thus compromising T-cell antigen-specific proliferation [86]. In addition, increased levels of NO released by iNOS in MDSCs further exert significant suppressive effects on T-cell function [32,87]. Thus, MDSCs have been shown to inhibit allorreactive T-cell expansion via iNOS, thus promoting allograft survival of kidney transplants [18]. Similarly, adoptive transfer of tumor necrosis factor-α–induced MDSCs prevented allograft rejection in male-to-female skin transplants through inhibiting T-cell proliferation that was abrogated in the presence of an NO-inhibitor or following genetic-depletion of NO [18]. Notably, PMN-MDSCs and M-MDSCs display divergent features of Arg metabolism with PMN-MDSCs expressing greater levels of Arg-1, and M-MDSCs exhibiting higher levels of iNOS [68].

Indoleamine 2, 3-dioxygenase (IDO) is the key enzyme of tryptophan metabolism in the kynurenine (Kyn) pathway. MDSCs have been shown to exhibit an increased IDO expression and augmented Kyn pathway causing a metabolization of Trp from the surrounding microenvironment associated with decreased Trp levels [88]. T cells in turn have been found highly sensitive for Trp shortage causing their cell-cycle arrest in the G1 phase [89], thus compromising T-cell-derived immune responses. Indeed, IDO expression was found to be critical, inhibiting T-cell–driven allo-immune responses with abrogated long-term cardiac allograft survival in CTLA4-lg–treated mice deficient for IDO [90]. Moreover, genetically induced IDO over-expression has been shown to suppress allograft rejection of cardiac allografts [91] and small bowel transplants [92] in mice through inhibiting T-cell–derived IFN-γ expression and increased Treg frequencies.

Noteworthy, recent studies have demonstrated an entwined pathway of arginine and tryptophan immunometabolism, leading to immunosuppressive function of DCs, which can be mediated by Arg1–MDSCs. Hereby,IDO1 phosphorylation and consequent activation of immunosuppressive, non-enzymatic IDO1 signaling in DCs was dependent on previous expression of Arg1 and Arg1-dependent production of polyamines which in turn can be released by MDSCs [93]. Thus, joint regulation of arginine and tryptophan metabolism could represent an important target for regulating immunomodulatory effects of MDSCs.

Of additional relevance, downstream products of the Trp metabolism display bioactive compounds that further restrain T-cell derived immune response. Thus, Kyn, 3-hydroxykynurenine and 3-hydroxyanthranilic acid (3-HAA) were shown to strongly suppress T-cell proliferation in mixed leukocyte reactions leading to a prolonged rat skin allograft survival [94]. Similarly, 3-HAA also prevented the rejection of rat cardiac allografts diminishing the proliferation of T cells that could not be restimulated by donor-specific DCs [95]. Moreover, 3-hydroxykynurenine and 3-HAA were shown to compromise T-cell proliferation, thus preventing T-cell–induced kidney allograft rejection and protect the tubular epithelial cell from injury in pigs [96]. Quinolinic acid, another immunoregulatory metabolite from Kyn pathway [97], has been shown to shift the human immune balance towards a regulatory Th2-dominated phenotype while inhibiting Th1-cell–derived INF-γ and tumor necrosis factor-α production through agonistic effects on D-methyl-D-aspartate receptors [98]. Notably, Th-1-cell–derived IFN-γ production has been identified as the major driver of acute rejection [99] whereas Th2-cells are accreditied an immune regulatory function in transplantation [100,101] (Table 2, C).

Effects of Immunosuppressants on MDSC Metabolic Reprogramming

The calcineurin inhibitors, CsA and tacrolimus, constitute the backbone of the current first-line immunosuppressive regimen. Experimentally, in vitro and in vivo data from murine transplant models showed that CsA promoted MDSCs proliferation and enhanced their immunosuppressive function on alloreactive T cells [19,20]. Hereby, the calcineurin-NFATc pathway is the primary target of CsA regulating AA metabolism of MDSCs through regulating IDO and iNOS. Notably, inhibition of NFAT by CsA in MDSCs up-regulated IDO enhancing Trp metabolism as well as production the downstream immunosuppressive metabolite KYNA (Figure 1A). Thus, CsA treated MDSCs compromised both CD4⁺ – as well as CD8⁺– T-cell–derived INF-γ production, increased Treg differentiation and promoted allograft survival when compared to PBS treated MDSCs in a model of murine skin transplantation [19]. Of note, impeding IDO expression with an IDO-inhibitor reversed the augmented immunosuppressive capacity of CsA treated MDSCs on T cells [19].

Moreover, CsA treatment of MDSCs increased levels of iNOS which convert Arg to immunosuppressive NO, thus restraining CD8⁺- and CD4⁺ T-cell differentiation while prolonging survival of murine skin grafts [20] (Figure 1A). Regarding tumor cells, MDSCs isolated from tumour-treated lung transplantation recipients were able to inhibit T-cell proliferation in vitro [8]. However, it remains to be investigated whether tumour cells affects MDCCs AA metabolism via NFAT signaling similar to CsA.

RPM, an mTOR-specific inhibitor, has been broadly established for the treatment of allograft rejection following kidney transplantation [102]. In addition to its efficient effects on T-cell subsets [103], RPM has been found to regulate innate immune homeostasis also impacting MDSCs in transplantation. Thereby, RPM inhibited MDSC differentiation, proliferation and immunosuppressive effects on T cells through directly impeding glycolysis with down-regulated glycolytic enzymes hexokinase 2, phosphofructokinase 1, pyruvate kinase muscle as well as the transporter Glut1, both in vitro in sorted granulocyte-macrophage (GM)-colony-stimulating factor (CSF)–induced MDSCs and in vivo in induced M-MDSCs of AlloSkin-grafted mice [17] (Figure 1B). Similarly, genetically altered mice deficient for mTOR also showed decreased levels of M-MDSCs in skin-grafts as well as draining lymph nodes in addition to compromised inhibitory effects on CD4⁺– as well as CD8⁺–T-cell proliferation. Moreover, RPM also inhibited iNOS and Arg-1 as well as HO-1, IDO and NOX2 expression underlying the impaired immunosuppressive function of MDSCs on T-cells [17] (Figure 1B). Consistent with these experimental data, a clinical study reported that MDSCs isolated from kidney transplant recipients that had been treated with RPM failed to inhibit T-cell proliferation through decreased iNOS activity [8]. Of note, RPM also increased MDSCs recruitment to murine cardiac allografts leading to prolonged allograft survival [21].

Exogenous glucocorticoid (GC) doses positively correlated with the level of MDSCs in human transplant recipients [22]. In murine experiments, GC prolonged allograft by enhancing MDSCs recruitment and suppressive function [23]. Mechanistically, GCs augment the expression of iNOS and NO in MDSCs following binding of the GC receptor, thus impeding T-cell function [23] (Figure 1C). In a recent
study, this effect was further attributed to an inhibition of HIF-1α–driven glycolysis upon activation of MDSCs. However further insights on metabolic changes such as the lipid metabolism that is known to display the major energy source upon MDSCs activation had not been explored [104].

Costimulatory receptors are a class of molecules expressed by T cells regulating activation and generation of effector T-cell responses. Blockade of costimulatory signals represents a promising strategy to control T-cell responses. As the most recognized molecule, CTLA4-Ig has been shown to dampen activation of naive T cells by blocking costimulation via CD28 [105]. Murine experiments and clinical trials have demonstrated the efficacy of CTLA4-Ig in the treatment of acute rejection [106–108]. Notably, in a randomized controlled trial in patients with advanced-stage melanoma, CTLA4-Ig treatment was found to decrease PMN-MDSC levels and compromise Arg1 expression [109]. However, the underlying mechanism of this effect remained unclear.

Metabolic Optimization of MDSCs for Transplantation

Besides inhibiting the rejection of allografts following transplantation, mechanistic animal studies have further delineated MDSCs as essential component for the development and maintenance of immune tolerance [12]. Thus, MDSCs have emerged as a novel, cellular treatment opportunity to improve outcomes of transplant recipients. However, preclinical studies with MDSCs failed to achieve durable transplant tolerance [4,17] and haven’t been any reports concerning MDSCs infusion in human transplant recipients.

Since metabolic reprogramming has been identified to crucially mediate differentiation, proliferative expansion and the immunosuppressive effects of MDSCs, manipulating or supplementing cardinal metabolic pathways may augment MDSCs function and improve treatment approaches. As a proof of concept, targeting metabolic reprogramming in other cellular therapies could improve the survival and expansion of in vitro–cultured cells [110–112].

Unlike cancer research, which aims to inhibit the suppressive function of MDSCs and enhance T–cell–derived anti-tumor immune responses through metabolic reprogramming, transplantation requires the opposite approach. Targeting MDSCs metabolism during transplantation can be achieved in vitro before adoptive transfer by altering the culture conditions or by genetic modification. Moreover, in vivo drug treatments and diet alterations could be recruited while ex vivo organ perfusion offers a treatment approach between ex- and implantation.

As described previously, MDSCs are highly dependent on increasing their glycolytic activity to differentiate and expand. In a tumor derived microenvironment hypoxia and excessive lactate levels force adjacent cells to adapt their metabolism with MDSCs upregulating their aerobic glycolysis. Thus, promoting MDSCs derived glycolysis in vitro may increase proliferation and survival before cellular therapy. Indeed, subjecting MDSCs to metformin that enhances the glycolytic function of MDSCs and enhances T-cell function through metabolic reprogramming, transplantation can be achieved in vitro before adoptive transfer by altering the culture conditions or by genetic modification. Moreover, in vivo drug treatments and diet alterations could be recruited while ex vivo organ perfusion offers a treatment approach between ex- and implantation.

As described previously, MDSCs are highly dependent on increasing their glycolytic activity to differentiate and expand. In a tumor derived microenvironment hypoxia and excessive lactate levels force adjacent cells to adapt their metabolism with MDSCs upregulating their aerobic glycolysis. Thus, promoting MDSCs derived glycolysis in vitro may increase proliferation and survival before cellular therapy. Indeed, subjecting MDSCs to metformin that enhances the glycolytic function of MDSCs and enhances T-cell function through metabolic reprogramming, transplantation can be achieved in vitro before adoptive transfer by altering the culture conditions or by genetic modification. Moreover, in vivo drug treatments and diet alterations could be recruited while ex vivo organ perfusion offers a treatment approach between ex- and implantation.
translational relevance for clinical application. Namely, allograft-transplanted mice subjected to RPM displayed reduced MDSC frequencies with impeded immunosuppressive effects on T cells through compromised glycolysis, which was reversed upon treatment with metformin [15] (Figure 1D). Of note, metformin has been shown to improve immune homeostasis through reduced Th17-cell and increased T-cell frequencies in kidney transplant recipients treated with tacrolimus [114]. Exogenous lactate as a product of glycolysis has been shown to increase the percentage of MDSCs derived from in vitro–cultured mouse bone marrow cells stimulated with GM-CSF and IL-6, which may improve culture conditions to expand MDSCs generation (Figure 1E). At the same time, MDSCs have also been shown to depend on sufficient glucose supply in order to exert glycolytic activity in vivo. Namely, depletion of glucose levels using a ketogenic diet to lower lactate production by glycolytic tumors resulted in smaller tumors, decreased MDSC frequency, and improved T-cell immune responses [115]. Diets for patients following transplantation should therefore ensure sufficient glucose supply with normoglycemia (Figure 1F). Notably, further studies have delineated stronger immunosuppressive capacity of MDSCs when stimulated with lactate via the HIF-1α pathway [115].

HIF-1α, in turn, constitutes a key transcriptional factor that regulates the expression of glycolytic enzymes and promotes glycolysis in MDSCs [69]. HIF-1α can be induced in vitro through hypoxic preconditioning of cells, thus providing another opportunity to boost MDSCs differentiation and function (Figure 1G). Preconditioning of mesenchymal stroma cells in hypoxic conditions prior to transplantation for instance, has been shown to improve cell survival through a metabolic switch towards a more glycolytic state mediated by HIF-1α activation [116]. Moreover, augmenting MDSCs derived HIF-1α–mediated glycolysis could also be performed through pharmacologically stabilization. In support, treating mice treated to IRI with GSK360A that inhibits the prolyl hydroxylase domain-containing enzyme led to an increased expression of HIF-1α-regulated genes such as pyruvate dehydrogenase kinase-1 and hexokinase II, thus comprising oxidative stress (Figure 1H). Equitable results were achieved in vitro treating a cardiac cell line [74]. Notably, drugs stabilizing HIF-1α or exerting agonistic effects are already clinically available or tested in trials [117]. These drugs could either be applied in vitro to MDSCs before cellular therapy to boost differentiation and proliferation; to transplant recipients potentially exerting dichotomous, beneficial effects on both, IRI and MDSC function; or during ex vivo organ perfusion. Thereby, allograft resident MDSCs could be manipulated either through decreasing local oxygen delivery or treating organs with HIF-1α agonistic drugs and via increasing HIF-1α levels (Figure 1G and 1H).

At least, increasing FAO of MDSCs through altering culture conditions or genetic modification of MDSCs during in vitro expansion could display another approach to improve their immunosuppressive function. Strikingly, subjecting murine and human MDSCs to very low-density lipoproteins promoted INOS expression and augmented the suppressive effects on T-cell proliferation [85]. The expression of the fatty acid translocase CD36 mediating FA uptake has hereby been identified as a crucial mediator [85]. Of note, CD36 expression is regulated through STAT3 [118]. Thus, augmenting MDSCs FAO could be orchestrated by expanding MDSCs in the presence of very low-density lipoprotein, which may also promote the immunosuppressive function of these cells (Figure 1I). Moreover, culture conditions could be further optimized through supplementing a combination of GM-CSF, G-CSF, IL-4, IL-6, IL-10 and vascular endothelial growth factor that are recognized as the most important inducers of STAT3 in MDSCs [119], thus inducing CD36 expression and improving lipid uptake (Figure 1J). Furthermore, inhibiting the de novo synthesis of fatty acids, conversely increasing FAO, with small molecules such as soraphen A that impedes the acetyl-CoA carboxylase 1 and 2 may present an additional option (Figure 1K). Of note, disruption of fatty acid synthesis has been shown to prevent acute graft-versus-host diseases with diminished T-cell proliferation and augmented Treg frequencies [120]. At least genetic manipulation of MDSCs through lentiviral transduction could be employed to induce durable CD36 expression that may improve lipid uptake in vivo after adoptive transfer (Figure 1L). Supplementation of fatty acids to either transplant recipients or allografts during ex vivo organ perfusion may constitute a clinically implementable therapeutic approach to increase FA levels and improve recipient or donor derived MDSCs function, respectively (Figure 1M).

Concluding Remarks

Metabolic reprogramming constitutes a mechanistic underpinning of MDSCs immunosuppressive effector functions in the microenvironment of solid malignant tumors. From a clinical perspective, the detrimental immunosuppressive effects of MDSCs in cancer translate into beneficial effects in transplantation regulating allo-immune responses and prolonging allograft survival. Metabolic reprogramming of MDSCs may thus also be crucially affected in the inflammatory microenvironment of allografts, IRI and immunosuppressive drugs. However, thus far experimental studies investigating the relevance of metabolic reprogramming of MDSCs in the context of transplantation have been limited, and further investigations are required to confirm the outlined mechanisms in both pre-clinical experimental models and human studies. Moreover, despite axiomatic similarities, the tumor microenvironment differs from that of a transplanted organ undergoing IRI or acute rejections episodes, which needs to be considered when evaluating the transferability of mechanistic insights deriving from cancer studies.

With a view on future perspectives, the metabolic characteristics of MDSCs in transplantation require further investigation to evaluate the potential of targeting those pathways for tolerance induction. Therefore, experimental animal transplant models with integrative omics combining transcriptomics, proteomics and metabolomics could serve to evaluate the expression of metabolic enzymes as well as metabolite levels and evaluate the proportional interplay of metabolic pathways during metabolic reprogramming in the context of transplantation.

Targeting metabolic reprogramming of MDSCs either in vitro, in vivo or during ex vivo organ perfusion may ultimately provide novel treatment approaches to improve MDSCs derived tolerance induction or MDSCs based cell therapy approaches.

Funding

Jasper Iske was supported by the Junior Clinician Scientist Program of the Berlin Institute of Health. Yeqi Nian was supported by a grant (82101874) from the National Natural Science Foundation of China and an internal grant from Tianjin First Central Hospital.

Declaration of Competing Interest

The authors have no commercial, proprietary or financial interest in the products or companies described in this article.

Author Contributions

Conception and design of the study: JI and YN. Drafting and revising manuscript: YC, MR, SZS. All authors have approved the final article.

References


