

# **Neuropeptides CRH, SP, HK-1 and inflammatory cytokines IL-6, TNF are increased in serum of patients with Fibromyalgia Syndrome implicating mast cells**

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## Running Title Page

**Running Title:** Neuroimmune markers in fibromyalgia

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**Number of Text pages:** 17

**Numbers of Figures:** 5

**Numbers of References:** 123

**Numbers of words in the Abstract:** 259

**Numbers of words in the Introduction:** 561

**Numbers of words in the Discussion:** 2054

### Abbreviations:

Blood-brain-barrier (BBB); cerebrospinal fluid (CSF); chronic fatigue syndrome (CFS); corticotropin releasing hormone (CRH); enzyme-immunosorbent assay (ELISA); Fibromyalgia Syndrome (FMS); hemokinin-1 (HK-1); interstitial cystitis/bladder pain syndrome (IC/BPS); irritable bowel syndrome (IBS); mast cells (MCs); myogenic temporomandibular disorder (TMD); neurotensin (NT); Peripheral Blood Mononuclear cells (PBMCs); phosphate-buffered saline (PBS); post-traumatic stress disorder (PTSD); Pain Visual Analog Scale (PVAS); substance P (SP); tumor necrosis factor (TNF); vascular endothelial growth factor (VEGF).

**Section Assignment:** Drug Discovery and Translational Medicine

## Abstract

Fibromyalgia Syndrome (FMS) is a chronic, idiopathic condition of widespread musculoskeletal pain, affecting more women than men. Even though clinical studies have provided evidence of altered central pain pathways, the lack of definitive pathogenesis or reliable objective markers has hampered development of effective treatments. Here we report that the neuropeptides corticotropin-releasing hormone (CRH), substance P (SP) and its structurally related Hemokinin-1 (HK-1) were significantly ( $p=0.026$ ,  $p<0.0001$  and  $p=0.002$ , respectively) elevated ( $0.82\pm 0.57$  ng/mL,  $0.39\pm 0.18$  ng/mL and  $7.98\pm 3.12$  ng/mL, respectively) in the serum of patients with FMS as compared to healthy controls ( $0.49\pm 0.26$  ng/mL,  $0.12\pm 0.1$  ng/mL and  $5.71\pm 1.08$  ng/mL, respectively). Moreover, SP and HK-1 levels were positively correlated (Pearson's  $r=0.45$ ,  $p=0.002$ ) in FMS. The serum concentrations of the inflammatory cytokines IL-6 and TNF were also significantly ( $p=0.029$  and  $p=0.006$ , respectively) higher ( $2.97\pm 2.35$  pg/mL and  $0.92\pm 0.31$  pg/mL, respectively) in the FMS group as compared to healthy subjects ( $1.79\pm 0.62$  pg/mL and  $0.69\pm 0.16$  pg/mL, respectively). In contrast, serum IL-31 and IL-33 levels were significantly lower ( $p=0.0001$  and  $p=0.044$ , respectively) in the FMS patients ( $849.5\pm 1005$  pg/mL and  $923.2\pm 1284$  pg/mL, respectively) in comparison to healthy controls ( $1281\pm 806.4$  pg/mL and  $3149\pm 4073$  pg/mL, respectively). FMS serum levels of neurotensin were not different from controls. We had previously shown that CRH and SP stimulate IL-6 and TNF release from mast cells (MCs). Our current results indicate that neuropeptides could stimulate MCs to secrete inflammatory cytokines that contribute importantly to the symptoms of FMS. Treatment directed at preventing the secretion or antagonizing these elevated neuroimmune markers, both centrally and peripherally, may prove to be useful in the management of FMS.

## Introduction

Fibromyalgia Syndrome (FMS) is a chronic, medical condition characterized by widespread musculoskeletal pain, soft tissue tenderness, sleep dysfunction, stiffness, fatigue, and cognitive dysfunction (Clauw, et al., 2011; Schmidt-Wilcke and Clauw, 2011; Clauw, 2014; Theoharides, et al., 2015b) FMS is estimated to affect 2–8% of the adult population and is considered to be the most common cause of generalized, musculoskeletal pain in women between the ages of 20 and 55 years. (Branco, et al., 2010) Some investigators believe that FMS belongs to a family of overlapping conditions such as chronic fatigue syndrome (CFS), irritable bowel syndrome (IBS), functional dyspepsia, myogenic temporomandibular disorder (TMD), tension headache, myofascial pain syndrome, restless leg syndrome, interstitial cystitis/bladder pain syndrome (IC/BPS), post-traumatic stress disorder (PTSD) and Gulf War syndrome. (Yunus, 2007; Theoharides, 2013) FMS may be triggered by Lyme disease, but in that case, antibiotics do not appear to be effective. (Dinerman and Steere, 1992) It should be pointed out that the pathogenesis of most of these conditions is controversial, so as new information accumulates, they will likely appear to be less similar to each other than is currently perceived. Even though many patients with FMS can meet diagnostic criteria for CFS, there are distinct differences between these two groups. (Abbi and Natelson, 2013)

Diagnostic criteria for FMS have developed as a work-in-progress over the last ten years, (McBeth and Mulvey, 2012; Wolfe and Walitt, 2013) but reliable diagnostic or prognostic laboratory markers would still be welcome additions. Recent research regarding the etiology of FMS has focused on central sensitization, neuroinflammation, allergens, infectious agents, irritants, chemical exposures, or physiologic stress. (Russell, 1998; Arnold, 2010; Russell, et al., 1994) The mediators of inflammation would include neuropeptides, cytokines, growth factors

and neurotransmitters. Indeed, some neurochemical mediators have been found to be abnormal in patients with FMS. (Russell and Larson, 2009; Ceko, et al., 2012)

Mast cells (MCs) are involved in allergic conditions, (Theoharides, et al., 2015f) but can also be viewed as mediators of systemic inflammation. (Theoharides, et al., 2010a; Galli, et al., 2008b) It has been suggested that MCs may be involved in FMS, (Lucas, et al., 2006; Pollack, 2014) as well as other comorbid conditions. (Theoharides, 2013) The numbers of MCs were significantly increased in the papillary dermis of FMS patients. (Blanco, et al., 2010) Moreover, chronic urticaria, which involves MCs, has been identified in some FMS patients. (Torresani, et al., 2009) However, the numbers of MCs may not be as important as the degree of their activation or the specific mediators that they secrete.(Theoharides, et al., 2012)

Activated MCs release numerous vasoactive, neurosensitizing and pro-inflammatory mediators (Theoharides, et al., 2015f) that could contribute to FMS symptoms. (Theoharides, et al., 2010a) In particular, MCs can release certain mediators selectively (Theoharides, et al., 2007) as well as IL-6 without degranulation. (Kandere-Grzybowska, et al., 2003) MCs are located perivascularly in close proximity to neurons both in the skin (Paus, et al., 2006) and in the diencephalon. (Rozniecki, et al., 1999; Dimitriadou, et al., 1997) Increased levels of the neuropeptides corticotropin-releasing hormone (CRH) (Theoharides, et al., 1995) and substance P (SP) may be secreted in response to physiological or psychological stress and could then stimulate MCs to secrete TNF.(Theoharides, et al., 2010b)

Here we report that the neuropeptides CRH, SP, and its structurally related Hemokinin-1 (HK-1), as well as the cytokines IL-6 and TNF, are significantly elevated in the serum of patients with FMS when compared to healthy controls.

## Methods

Blood was obtained from patients (all female 28-64 years of age) with FMS. Their demographic characteristics are shown in Table 1. About 70% of these patients were medically referred to one of the authors (IJR) for clinical evaluation and as potential candidates for an ongoing research study about FMS. The source of the medical referrals was an academic secondary care orthopedic clinic of the Bexar County Health Care System, affiliated with the University of Texas Health Science Center at San Antonio, to which they had been referred by their primary care physicians because of hand pain. At screening by the orthopedic physician assistants, who had been previously-trained in the FMS examination by one of the authors [IJR], those patients were found to meet clinical criteria for FMS and not to have convincing evidence for a compressive neuropathy [e.g., carpal tunnel syndrome, CTS]. The remaining 30% were self-referred because of a physician- or presumptive self-diagnosis of FMS. All of the participants met 1990 American College of Rheumatology Research Classification Criteria for a diagnosis of FMS and had a pain severity of at least 40 mm, using the Pain Visual Analog Scale (1-100 mm). Potential subjects were excluded if they had a comorbid rheumatic disease, severe osteoarthritis in weight-bearing joints, an unstable or untreated endocrinopathy, any clinically significant abnormality in screening clinical laboratory tests, a severe debilitating organ failure (including heart disease, renal failure, hepatic failure), systemic cancer in the prior 6 months, uncontrolled systemic hypertension, dementia, aphasia, or other deficits of cognition or speech/language function, a history of drug or alcohol dependence, having taken long-acting opioids in the prior three months, lactating or pregnant women, women of child-bearing potential without a mechanical/barrier or oral anti-conceptive treatment, having fainted within the last six months, having received an investigational drug or device within 30 days prior to starting the

study. The clinical protocol of this research study was approved by the University of Texas Health Science Center in San Antonio Institutional Review Board (IRB#901-5003-203). Patients signed informed consent to participate in the study before any research-related procedures were initiated. Serum was separated from other blood components using standard SST tube methodology. The samples were number coded and no personal identifiers or protected health information accompanied the samples. Within 30 minutes of collection, the serum was aliquoted and frozen at  $-70^{\circ}\text{C}$  until analyzed.

Serum was also obtained from healthy subjects (5 male and 15 female, 25-65 years of age) who had no history of musculoskeletal pain or any evidence of inflammation. The normal controls were not related to any of the FMS patient group and were recruited from the Boston area or purchased from BBI Solutions (Cardiff, U.K.). Serum samples were labeled only with a code number, the age and gender of the subjects. All control blood samples were processed immediately after phlebotomy and the serum was stored in  $-80^{\circ}\text{C}$  until it was used for analysis.

The numbers of patients included in the various measurements varied because the amounts of serum available were not consistent for all samples. The levels of SP were measured first and as subsequent measurements were made, the amounts of serum remaining decreased progressively until quantities were not sufficient for some additional tests. This was true for both the FMS and normal control serum samples.

### **Extraction of serum peptides**

The extraction of serum peptides was performed using a SEP-COLUMN containing 200 mg of C18 (Cat. No. RK-SEPCOL-1), Buffer A (Cat. No. RK-BA-1) and Buffer B (Cat. No. RK-BB-1) (Phoenix Pharmaceuticals, Inc., Burlingame, CA, USA). A combination of a centrifugal concentrator (Savant Speedvac SVC 100H) and a lyophilizer (Edwards K4 Modulyo Freeze Dryer, West Sussex,

England) was used for drying the samples after extraction. First, Speedvac was used to dry the samples for approximately 15 minutes in order to remove the organic layer. The remaining sample was snap-frozen in liquid nitrogen and freeze-dried overnight using a lyophilizer. The dried extracts were then reconstituted with 1x assay buffer and phosphate-buffered saline (PBS) for measurement of CRH and neurotensin (NT) in human serum samples.

### **Assessment of markers levels in serum**

Human serum CRH, SP and NT levels were measured using commercially available enzyme-immunosorbent assay (ELISA) kits (Phoenix Pharmaceuticals, Inc., Burlingame, CA, USA) according to the manufacturers' protocol. HK-1 levels were measured using commercially available ELISA kits from Peninsula Laboratories International, Inc. (San Carlos, CA, USA). Human serum IL-31, IL-6, IL-33 and TNF levels were determined using commercially available ELISA kits from R&D Systems (Minneapolis, MN, USA).

### **Statistical Analysis**

All of the data were validated and inspected for outliers. The results are presented as scattergrams with symbols representing individual data points and the horizontal lines representing the mean for each group. Normality of distribution was checked with the Shapiro-Wilk's test. Comparisons between the FMS group and the healthy controls were performed using the non-parametric Mann-Whitney U-test or the unpaired t-test. Pearson correlation analysis was performed between SP and HK-1 serum levels in FMS patients. A result was considered significant at a P value <0.05. The analysis was performed by using the GraphPad Prism version 5.0 software (GraphPad Software, San Diego, CA, USA).



## Results

The demographic characteristics of the subjects included in this study are presented in Table 1. The FMS patients consisted of 84 females with a mean age of  $47.9 \pm 11.2$  years. Ninety percent were Caucasian (35% European Caucasian, 55% Hispanic Caucasian). The average educational achievement was 13.6 years. Forty percent were gainfully employed. The healthy control group consisted of 15 females and 5 males mean age of  $38.2 \pm 10.6$  years. One hundred percent were Caucasian. The important differences between FMS and healthy control groups were related to diagnosis of a painful multimodal medical condition in the FMS group, but not present in the healthy control group.

Serum levels of the neuropeptides CRH and SP were significantly ( $p=0.026$  and  $p<0.0001$ , respectively) elevated ( $0.82 \pm 0.57$  ng/mL and  $0.39 \pm 0.18$  ng/mL, respectively) in patients with FMS as compared to healthy controls ( $0.49 \pm 0.26$  ng/mL and  $0.12 \pm 0.1$  ng/mL, respectively) (Fig. 1A, B). However, there was no correlation between CRH and SP serum levels.

The serum levels of HK-1 were increased ( $p=0.002$ ) in FMS patients ( $7.98 \pm 3.12$  ng/mL) as compared to normal controls ( $5.71 \pm 1.08$  ng/mL) (Fig.2A). Moreover, there was a significant correlation between serum levels of HK-1 and SP ( $r=0.45$ ,  $p=0.002$ ), but not CRH (Fig. 2B).

There was no statistical difference in serum levels of NT between FMS patients and healthy controls (data not shown).

The mean serum levels of the cytokines IL-6 and TNF were significantly ( $p=0.029$  and  $p=0.006$ , respectively) increased ( $2.97 \pm 2.35$  pg/mL and  $0.92 \pm 0.31$  pg/mL, respectively) in patients with FMS as compared to healthy controls ( $1.79 \pm 0.62$  pg/mL and  $0.69 \pm 0.16$  pg/mL, respectively) (Fig. 3A, B).

Serum IL-31 and IL-33 levels were significantly ( $p=0.0001$  and  $p=0.044$ , respectively) lower ( $923.2 \pm 1284$  pg/mL and  $849.5 \pm 1005$  pg/mL, respectively) in patients with FMS when compared with the healthy controls ( $3149 \pm 4073$  pg/mL and  $1281 \pm 806.4$  pg/mL, respectively) (Fig. 4A, B).

## Discussion

The demographic characteristics of the FMS and control subjects were comparable (Table 1), but it is important to point out that the FMS group was characterized only by painful multimodal symptoms not present in the healthy control group. Hence, the differences in the biomarkers reported here are clinically significant. In particular, our study shows that the neuropeptides CRH, SP and the SP-related HK-1 are significantly elevated in the serum of FMS patients in comparison to controls. This is the first time to our knowledge that CRH and HK-1 are shown to be increased in the serum of FMS patients.

The neuroimmune findings reported here fit in a “unified” model proposed earlier, but based on CSF measurements. (Russell and Larson, 2009) One study showed that CRH was elevated in the cerebrospinal fluid (CSF) of FMS patients and was associated with pain, but not fatigue symptoms. (McLean, et al., 2006) The increased serum CRH reported in the current study may indicate some level of physical or psychological stress that may exacerbate FMS symptoms. (Geenen, et al., 2002; Fischer, et al., 2015; Fischer, et al., 2015) CRH is typically secreted from the hypothalamus under the influence of stress and activates the HPA axis, but has also been shown to induce inflammation. (Chrousos, 1995) CRH-positive nerve endings have been localized in the median eminence of the hypothalamus, where MCs are most plentiful. (Rozniecki, et al., 1999) CRH can also be released from MCs (Kempuraj, et al., 2004), other immune cells (Karalis, et al., 1997) and skin cells. (Donelan, et al., 2006b) In fact, human MCs express mRNA and protein for CRHR-1, activation of which induces selective release of vascular endothelial growth factor (VEGF) (Cao, et al., 2005) leading to increased vascular permeability (Lytinas, et al., 2003) and disruption of the BBB (Theoharides and Konstantinidou,

2007) through brain MC activation. (Esposito, et al., 2002) and permitting potential toxins and other environmental triggers to enter the brain.

Our present findings support previous reports of elevated CSF concentrations of SP in FMS patients. (Russell, et al., 1994) Substance P is an eleven amino acid peptide originally isolated and characterized from the rat brain (Leeman and Ferguson, 2000) and has been involved in the pathogenesis of inflammation. (Saraceno, et al., 2006; Douglas and Leeman, 2011; O'Connor, et al., 2004; Steinhoff, et al., 2014; Richard, et al., 2015; Munoz and Covenas, 2014) The neurokinin-1 (NK-1) receptor for SP has been implicated in the pathophysiology of pain, but blockade of that receptor does not control the pain of FMS. (Greenwood-Van, et al., 2014; Russell, 2002) Substance P can stimulate a number of immune cells, especially MCs (Fewtrell, et al., 1982), to release TNF. (Ansel, et al., 1993; Okayama, et al., 1998 ; Okabe, et al., 2000; Theoharides, et al., 2010c; Theoharides, et al., 2010a) Moreover, SP can induce MCs to express CRHR-1 leading to an augmentation of the physiologic stress response. (Asadi, et al., 2012) It should be pointed out that depending when CRH is released and where in the brain, it may not necessarily activate the HPA axis and lead to increased serum cortisol. This may be the reason why serum morning cortisol is not different between FMS patients and controls, but evening cortisol is actually increased in FMS patients. (Fatima, et al., 2013)

It was recently reported that MCs can secrete HK-1, which augments their allergic stimulation.(Sumpter, et al., 2015) HK-1 is also expressed by other immune cells. (Klassert, et al., 2008) Both SP and HK-1 also help generate Th-17 by inducing IL-1 $\beta$  and TNF in monocytes. (Cunin, et al., 2011) HK-1 was shown to contract the human bronchi through activation of both NK-1 and NK-2 receptors. (Grassin-Delyle, et al., 2010)

Even though the effect of CRH on the skin was augmented by NT, (Donelan, et al., 2006a) NT was not increased in the serum of FMS patients. However, no one to date has studied the effect of CRH on MCs stimulation by SP.

Our data has shown that the mean serum levels of the inflammatory cytokine IL-6 are significantly elevated in FMS. There is increasing evidence that changes in this inflammatory cytokine levels may influence the severity of symptoms in FMS patients. (Carvalho, et al., 2008; Nugraha, et al., 2013) In agreement with our findings, other studies reported that IL-6 was increased in the serum of FMS patients (Hernandez, et al., 2010; Behm, et al., 2012; Ross, et al., 2010) and that its levels correlated with FMS severity. (Uceyler, et al., 2011) (Table 2) Nevertheless, some papers reported no difference in serum IL-6 levels between FMS patients and controls. (Gur, et al., 2002; Kim, et al., 2010; Wallace, et al., 2001) It should be, however, noted that the serum levels in the control subjects in these studies were unusually high (e.g.  $5.46 \pm 1.38$  pg/mL, (Gur, et al., 2002) compared to our controls ( $0.92 \pm 0.31$  pg/mL) or those reported by Hernandez et al. ( $0.92 \pm 0.32$  pg/mL). (Hernandez, et al., 2010)

The increased IL-6 levels may derive from MCs because acute restraint physiological stress of mice led to increased serum IL-6, which was entirely MC-dependent. (Geiss, et al., 2011) Moreover, increased serum IL-6 was associated with bone pain in patients with mastocytosis, (Theoharides, et al., 2015f) who often present with comorbid FMS. (Theoharides, et al., 2015f; Jennings, et al., 2014) It is important to note that patients with mastocytosis experience diffuse musculoskeletal pain (Delsignore, et al., 1996) and are often diagnosed with FMS. (Theoharides, et al., 2015c)

In the present study, we also found significantly increased serum TNF levels in patients with FMS in comparison to healthy controls. One previous study (using ELISA) also reported

increased plasma TNF in FMS patients, (Bazzichi, et al., 2007a) but other studies apparently found no difference in TNF serum levels between FMS patients and controls. (Wallace, et al., 2001; Garcia-Campayo, et al., 2008; Ross, et al., 2010) Surprisingly, another study reported decreased serum TNF levels in FMS patients as compared to controls, but the levels in both patients ( $20.42 \pm 7.24$  pg/mL) and controls ( $35.73 \pm 0.72$  pg/mL) were 20 times or more higher (Hernandez, et al., 2010) than the levels we report ( $1.79 \pm 0.62$  pg/mL and  $0.69 \pm 0.16$  pg/mL, respectively).

Several studies have reported elevated levels of the pro-inflammatory chemokine IL-8 (CXCL8) in both serum (Wallace, et al., 2001; Gur, et al., 2002; Ross, et al., 2010; Rodriguez-Pinto, et al., 2014; Kadetoff, et al., 2012; Bote, et al., 2012) and CSF (Kadetoff, et al., 2012) of patients with FMS (Table 2). Interestingly, one study reported that moderate (45 minutes cycling) exercise *decreased* the serum concentration of IL-8 in FMS patients, but *increased* it in healthy controls; there was also a decrease in the release of IL-6 and TNF from stimulated peripheral monocytes, in FMS patients as compared to healthy women. (Bote, et al., 2013) These finding may help to explain the apparent beneficial effect of mild exercise in FMS

One study showed a strong correlation between increased plasma levels of IL-17A and TNF in patients with FMS. (Pernambuco, et al., 2013) CSF and serum IL-17 also positively correlated with measures of subjective pain among FMS patients, (Meng, et al., 2013) depression and anxiety in patients with rheumatoid arthritis (Liu, et al., 2012) symptoms reported by 30-40% of patients with FMS. TNF and IL-17 seem to act together in perpetuating the inflammatory process. (Romero-Sanchez, et al., 2011; Griffin, et al., 2012) MC-derived IL-6 and TGF $\beta$  induce the development of Th-17 cells through dendritic cell maturation. (Dudeck, et al., 2011) Moreover, MCs can secrete IL-17, themselves, (Kenna and Brown, 2013) as shown both in

arthritic joints (Hueber, et al., 2010) and in psoriatic lesions.(Lin, et al., 2011)

We also measured IL-31 because it has been involved in allergies (Rabenhorst and Hartmann, 2014) and IL-33 because it is involved in autoimmunity and inflammation. (Theoharides, et al., 2015a) The serum levels of IL-31 and IL-33 were significantly lower in the FMS group compared to healthy controls.

It is obvious from the previous publications discussed, some of which have been reviewed before (Rodriguez-Pinto, et al., 2014) and are summarized in Table 2, that blood levels of cytokines vary considerably. There are a number of variables that could influence the levels of these blood biomarkers: (a) different assay methods, (b) pre- or post- menopausal female subjects, (c) differences in Bodily Mass Index (BMI), (d) serum or plasma levels may not correspond to or accurately reflect tissue or circulating blood cell cytokine expression or release, (e) may be affected by concurrent medications, and (f) serum cytokine levels may vary if obtained at different times of the day. For instance, it was recently reported that MCs release their mediators in a circadian mode. (Nakamura, et al., 2014) Multiple cytokine testing, rather than single measurement, especially at different times of the day, could be achieved by measuring them in 24 hr urine as it is done with MC mediator metabolites. (Divekar and Butterfield, 2015) In addition, measurements early and late in the course of FMS might prove to be useful. Finally, measuring gene expression of cytokines in relevant tissues maybe more accurate than blood levels.

We recently reviewed the pathophysiology of FMS (Theoharides, et al., 2015e) and the relative lack of reliable biomarkers or effective treatments. We now show that the neuropeptides CRH, SP and HK-1 are significantly elevated in the serum of FMS patients. These molecules could be released centrally and may cause focal inflammation leading to MC activation and pain.

(Heron and Dubayle, 2013) Peripheral inflammation may still have central effects. (Lampa, et al., 2012)

MCs and their mediators have been implicated in neuropsychiatric diseases (Theoharides, et al., 2004), IC/PBS (Sant, et al., 2007) and IBS. (Theoharides, et al., 2012) Increased number of activated MCs was also reported in skin biopsies of FMS patients. (Blanco, et al., 2010) MCs are located perivascularly close to neurons especially in the leptomeninges (Polyzoidis, et al., 2015), thalamus and hypothalamus. (Pang, et al., 1996) We hypothesize that environmental, immune and infectious triggers stimulate MCs leading to secretion of inflammatory mediators (Fig. 1). Stimulated MCs secrete vasoactive and pro-inflammatory mediators such as the preformed heparin, histamine, serotonin, proteases (e.g. tryptase) and TNF, as well as the *de novo* synthesized leukotrienes, prostaglandins, and cytokines (IL-1, IL-6, IL-8, TNF). At least histamine, prostaglandin D<sub>2</sub> (PGD<sub>2</sub>) and tryptase are known to stimulate sensory nerves and elicit pain. (Dai, et al., 2004; Chatterjea and Martinov, 2014) In addition, histamine, PGD<sub>2</sub>, IL-6, TNF and tryptase could also stimulate microglia, as well as CRH release from the hypothalamus. (Turnbull and Rivier, 1999) MC-microglia interactions are implicated in the pathogenesis of neuroinflammation. (Skaper, et al., 2012) In fact, CRH and microglia have been involved in the pathogenesis of mental disorders. (Kritas, et al., 2014)

Brain cells activated by these mediators or by CRH could then release HK-1 and SP, further stimulating MCs. Brain MCs were reported to synthesize and release TNF. (Cocchiara, et al., 1999) It is particularly important that MCs are the only immune cells that store *pre-formed* TNF, from which it can be secreted rapidly (Zhang, et al., 2011) and superactivate T cells. (Nakae, et al., 2006; Kempuraj, et al., 2008)



MCs derive from bone marrow progenitors and mature in tissues depending on microenvironmental conditions. (Galli, 1990) MCs are critical for the development of allergic reactions, (Theoharides, et al., 2015f) but are also implicated in immunity (Galli, et al., 2008a) and inflammation. (Theoharides, et al., 2010a; Theoharides, et al., 2015d) We have shown that certain natural flavonoids, (Middleton, et al., 2000) such as luteolin and quercetin (combination of which are found that in the dietary supplement FibroProtek®) can inhibit IL-6 (Kandere-Grzybowska, et al., 2006) and TNF (Kempuraj, et al., 2005; Weng, et al., 2014) release from stimulated MCs. Luteolin and quercetin could, therefore, be useful in FMS (Fig. 5). It is interesting that vitamin D inhibits MCs (Baroni, et al., 2007) and has been reported to regulate in inflammatory diseases. (Toniato, et al., 2015; Calton, et al., 2015)

## **Conclusion**

Our findings of significantly elevated serum levels of the neuropeptides CRH, SP, and its structurally related Hemokinin-1 (HK-1), as well as the cytokines IL-6 and TNF, in FMS patients compared to healthy controls may prove to be diagnostically useful. Preventing the secretion of CRH, SP and/or HK-1 and their ability to stimulate release of IL-6 and TNF from MCs, microglia or other immune cells or may constitute potential new treatment approaches for FMS.

### **Competing interests**

The authors declare that they have no competing interests.

Collection of the FMS samples was accomplished by IJR in the course of an Investigator Initiated Research (IIR) study, financially supported by Pfizer through an institutional grant.

### **Disclosure**

TCT is the inventor of US patents No. 7,906,153; No. 8,268,365 and PCT application No. 13/722, 397 for the treatment of neuroinflammatory conditions.

### **Authorship contributions**

The diagnosis of the FMS, the clinical evaluation of the FMS patients, and the collection of the serum samples from the FMS patients: IJR

Participated in research design: IT, TCT, IJR

Conducted experiments: IT

Performed data analysis: IT

Writing the manuscript: TCT, IT, JMS, RMG and IJR

## Reference List

Abbi B and Natelson BH (2013) Is chronic fatigue syndrome the same illness as fibromyalgia: evaluating the 'single syndrome' hypothesis. *QJM* **106**:3-9.

Ansel JC, Brown JR, Payan DG and Brown MA (1993) Substance P selectively activates TNF- $\alpha$  gene expression in murine mast cells. *J Immunol* **150**:4478-4485.

Arnold LM (2010) The pathophysiology, diagnosis and treatment of fibromyalgia. *Psychiatr Clin North Am* **33**:375-408.

Asadi S, Alysandratos KD, Angelidou A, Miniati A, Sismanopoulos N, Vasiadi M, Zhang B, Kalogeromitros D and Theoharides TC (2012) Substance P (SP) induces expression of functional corticotropin-releasing hormone receptor-1 (CRHR-1) in human mast cells. *J Invest Dermatol* **132**:324-329.

Baroni E, Biffi M, Benigni F, Monno A, Carlucci D, Carmeliet G, Bouillon R and D'Ambrosio D (2007) VDR-dependent regulation of mast cell maturation mediated by 1,25-dihydroxyvitamin D<sub>3</sub>. *J Leukoc Biol* **81**:250-262.

Bazzichi L, Rossi A, Massimetti G, Giannaccini G, Giuliano T, De FF, Ciapparelli A, Dell'Osso L and Bombardieri S (2007a) Cytokine patterns in fibromyalgia and their correlation with clinical manifestations. *Clin Exp Rheumatol* **25**:225-230.

Bazzichi L, Rossi A, Massimetti G, Giannaccini G, Giuliano T, De FF, Ciapparelli A, Dell'Osso L and Bombardieri S (2007b) Cytokine patterns in fibromyalgia and their correlation with clinical manifestations. *Clin Exp Rheumatol* **25**:225-230.

Behm FG, Gavin IM, Karpenko O, Lindgren V, Gaitonde S, Gashkoff PA and Gillis BS (2012) Unique immunologic patterns in fibromyalgia. *BMC Clin Pathol* **12**:25.

Blanco I, Beritze N, Arguelles M, Carcaba V, Fernandez F, Janciauskiene S, Oikonomopoulou K, de Serres FJ, Fernandez-Bustillo E and Hollenberg MD (2010) Abnormal overexpression of mastocytes in skin biopsies of fibromyalgia patients. *Clin Rheumatol* **29**:1403-1412.

Bote ME, Garcia JJ, Hinchado MD and Ortega E (2012) Inflammatory/stress feedback dysregulation in women with fibromyalgia. *Neuroimmunomodulation* **19**:343-351.

Bote ME, Garcia JJ, Hinchado MD and Ortega E (2013) Fibromyalgia: anti-inflammatory and stress responses after acute moderate exercise. *PLoS ONE* **8**:e74524.

Branco JC, Bannwarth B, Failde I, Abello CJ, Blotman F, Spaeth M, Saraiva F, Nacci F, Thomas E, Caubere JP, Le LK, Taieb C and Matucci-Cerinic M (2010) Prevalence of fibromyalgia: a survey in five European countries. *Semin Arthritis Rheum* **39**:448-453.

Calton EK, Keane KN, Newsholme P and Soares MJ (2015) The Impact of Vitamin D Levels on Inflammatory Status: A Systematic Review of Immune Cell Studies. *PLoS ONE* **10**:e0141770.

Cao J, Papadopoulou N, Kempuraj D, Boucher WS, Sugimoto K, Cetrulo CL and Theoharides TC (2005) Human mast cells express corticotropin-releasing hormone (CRH) receptors and CRH leads to selective secretion of vascular endothelial growth factor. *J Immunol* **174**:7665-7675.

Ceko M, Bushnell MC and Gracely RH (2012) Neurobiology underlying fibromyalgia symptoms. *Pain Res Treat* **2012**:585419.

Chatterjea D and Martinov T (2014) Mast cells: Versatile gatekeepers of pain. *Mol Immunol* **63**:38-44.

Chrousos GP (1995) The hypothalamic-pituitary-adrenal axis and immune-mediated inflammation. *N Engl J Med* **332**:1351-1362.

Clauw DJ (2014) Fibromyalgia: a clinical review. *JAMA* **311**:1547-1555.

Clauw DJ, Arnold LM and McCarberg BH (2011) The science of fibromyalgia. *Mayo Clin Proc* **86**:907-911.

Cocchiara R, Albeggiani G, Lampiasi N, Bongiovanni A, Azzolina A and Geraci D (1999) Histamine and tumor necrosis factor- $\alpha$  production from purified rat brain mast cells mediated by

substance P. *Neuroreport* **10**:575-578.

Cunin P, Caillon A, Corvaisier M, Garo E, Scotet M, Blanchard S, Delneste Y and Jeannin P (2011) The tachykinins substance P and hemokinin-1 favor the generation of human memory Th17 cells by inducing IL-1beta, IL-23, and TNF-like 1A expression by monocytes. *J Immunol* **186**:4175-4182.

Dai Y, Moriyama T, Higashi T, Togashi K, Kobayashi K, Yamanaka H, Tominaga M and Noguchi K (2004) Proteinase-activated receptor 2-mediated potentiation of transient receptor potential vanilloid subfamily 1 activity reveals a mechanism for proteinase-induced inflammatory pain. *J Neurosci* **24**:4293-4299.

Delsignore JL, Dvoretzky PM, Hicks DG, O'Keefe RJ and Rosier RN (1996) Mastocytosis presenting as a skeletal disorder. *Iowa Orthop J* **16**:126-134.

Dimitriadou V, Rouleau A, Trung Tuong MD, Newlands GJF, Miller HRP, Luffau G, Schwartz J-C and Garbarg M (1997) Functional relationships between sensory nerve fibers and mast cells of dura mater in normal and inflammatory conditions. *Neuroscience* **77**:829-839.

Dinerman H and Steere AC (1992) Lyme disease associated with fibromyalgia. *Ann Intern Med* **117**:281-285.

Divekar R and Butterfield J (2015) Urinary 11beta-PGF2alpha and N-methyl histamine correlate with bone marrow biopsy findings in mast cell disorders. *Allergy* **70**:1230-1238.

Donelan J, Boucher W, Papadopoulou N, Lytinas M, Papaliadis D and Theoharides TC (2006a) Corticotropin-releasing hormone induces skin vascular permeability through a neurotensin-dependent process. *Proc Natl Acad Sci USA* **103**:7759-7764.

Donelan J, Marchand J, Kempuraj D, Papadopoulou N and Theoharides TC (2006b) Perifollicular and perivascular mouse skin mast cells express corticotropin-releasing hormone receptor. *J Inv Dermatol* **126**:929-932.

Douglas SD and Leeman SE (2011) Neurokinin-1 receptor: functional significance in the immune system in reference to selected infections and inflammation. *Ann N Y Acad Sci* **1217**:83-95.

Dudeck A, Suender CA, Kostka SL, von SE and Maurer M (2011) Mast cells promote Th1 and Th17 responses by modulating dendritic cell maturation and function. *Eur J Immunol* **41**:1883-1893.

Esposito P, Chandler N, Kandere-Grzybowska K, Basu S, Jacobson S, Connolly R, Tutor D and Theoharides TC (2002) Corticotropin-releasing hormone (CRH) and brain mast cells regulate blood-brain-barrier permeability induced by acute stress. *J Pharmacol Exp Ther* **303**:1061-1066.

Fatima G, Das SK, Mahdi AA, Verma NS, Khan FH, Tiwari AM, Jafer T and Anjum B (2013) Circadian rhythm of serum cortisol in female patients with fibromyalgia syndrome. *Indian J Clin Biochem* **28**:181-184.

Fewtrell CM, Foreman JC, Jordan CC, Oehme P, Renner H and Stewart JM (1982) The effects of substance P on histamine and 5-hydroxytryptamine release in the rat. *J Physiol* **330**:393-411.

Fischer S, Doerr JM, Strahler J, Mewes R, Thieme K and Nater UM (2015) Stress exacerbates pain in the everyday lives of women with fibromyalgia syndrome-The role of cortisol and alpha-amylase. *Psychoneuroendocrinology* **63**:68-77.

Galli SJ (1990) New insights into "the riddle of the mast cells": microenvironmental regulation of mast cell development and phenotypic heterogeneity. *Lab Invest* **62**:5-33.

Galli SJ, Grimaldeston M and Tsai M (2008a) Immunomodulatory mast cells: negative, as well as positive, regulators of immunity. *Nat Rev Immunol* **8**:478-486.

Galli SJ, Tsai M and Piliponsky AM (2008b) The development of allergic inflammation. *Nature* **454**:445-454.

Garcia-Campayo J, Magdalena J, Magallon R, Fernandez-Garcia E, Salas M and Andres E (2008) A meta-analysis of the efficacy of fibromyalgia treatment according to level of care.



*Arthritis Res Ther* **10**:R81.

Garcia-Lozano JR, Capilla-Sevilla C, Garcia-Lopez O and Moreno-Gallego I (2008) Correlation between cytokines and anxious-depressive symptoms in patients with fibromyalgia. *Reumatol Clin* **4**:136-139.

Geenen R, Jacobs JW and Bijlsma JW (2002) Evaluation and management of endocrine dysfunction in fibromyalgia. *Rheum Dis Clin North Am* **28**:389-404.

Geiss A, Rohleder N and Anton F (2011) Evidence for an association between an enhanced reactivity of interleukin-6 levels and reduced glucocorticoid sensitivity in patients with fibromyalgia. *Psychoneuroendocrinology* **37**:671-684.

Grassin-Delye S, Naline E, Buenestado A, Risse PA, Sage E, Advenier C and Devillier P (2010) Expression and function of human hemokinin-1 in human and guinea pig airways. *Respir Res* **11**:139.

Greenwood-Van MB, Mohammadi E, Tyler K, Pietra C, Bee LA and Dickenson A (2014) Synergistic effect of 5-hydroxytryptamine 3 and neurokinin 1 receptor antagonism in rodent models of somatic and visceral pain. *J Pharmacol Exp Ther* **351**:146-152.

Griffin GK, Newton G, Tarrío ML, Bu DX, Maganto-Garcia E, Azcutia V, Alcaide P, Grabie N, Luscinskas FW, Croce KJ and Lichtman AH (2012) IL-17 and TNF-alpha sustain neutrophil

recruitment during inflammation through synergistic effects on endothelial activation. *J Immunol* **188**:6287-6299.

Gur A, Karakoc M, Nas K, Remzi, Cevik, Denli A and Sarac J (2002) Cytokines and depression in cases with fibromyalgia. *J Rheumatol* **29**:358-361.

Hernandez ME, Becerril E, Perez M, Leff P, Anton B, Estrada S, Estrada I, Sarasa M, Serrano E and Pavon L (2010) Proinflammatory cytokine levels in fibromyalgia patients are independent of body mass index. *BMC Res Notes* **3**:156.

Heron A and Dubayle D (2013) A focus on mast cells and pain. *J Neuroimmunol* **264**:1-7.

Hueber AJ, Asquith DL, Miller AM, Reilly J, Kerr S, Leipe J, Melendez AJ and McInnes IB (2010) Mast cells express IL-17A in rheumatoid arthritis synovium. *J Immunol* **184**:3336-3340.

Jennings S, Russell N, Jennings B, Slee V, Sterling L, Castells M, Valent P and Akin C (2014) The Mastocytosis Society survey on mast cell disorders: patient experiences and perceptions. *J Allergy Clin Immunol Pract* **2**:70-76.

Kadetoff D, Lampa J, Westman M, Andersson M and Kosek E (2012) Evidence of central inflammation in fibromyalgia-increased cerebrospinal fluid interleukin-8 levels. *J Neuroimmunol* **242**:33-38.

Kandere-Grzybowska K, Letourneau R, Kempuraj D, Donelan J, Poplawski S, Boucher W, Athanassiou A and Theoharides TC (2003) IL-1 induces vesicular secretion of IL-6 without degranulation from human mast cells. *J Immunol* **171**:4830-4836.

Kandere-Grzybowska K, Kempuraj D, Cao J, Cetrulo CL and Theoharides TC (2006) Regulation of IL-1-induced selective IL-6 release from human mast cells and inhibition by quercetin. *Br J Pharmacol* **148**:208-215.

Karalis K, Louis JM, Bae D, Hilderbrand H and Majzoub JA (1997) CRH and the immune system. *J Neuroimmunol* **72**:131-136.

Kempuraj D, Madhappan B, Christodoulou S, Boucher W, Cao J, Papadopoulou N, Cetrulo CL and Theoharides TC (2005) Flavonols inhibit proinflammatory mediator release, intracellular calcium ion levels and protein kinase C theta phosphorylation in human mast cells. *Br J Pharmacol* **145**:934-944.

Kempuraj D, Papadopoulou NG, Lytinas M, Huang M, Kandere-Grzybowska K, Madhappan B, Boucher W, Christodoulou S, Athanassiou A and Theoharides TC (2004) Corticotropin-releasing hormone and its structurally related urocortin are synthesized and secreted by human mast cells. *Endocrinology* **145**:43-48.

Kempuraj D, Tagen M, Iliopoulou BP, Clemons A, Vasiadi M, Boucher W, House M, Wolfberg A and Theoharides TC (2008) Luteolin inhibits myelin basic protein-induced human mast cell

activation and mast cell dependent stimulation of Jurkat T cells. *Br J Pharmacol* **155**:1076-1084.

Kenna TJ and Brown MA (2013) The role of IL-17-secreting mast cells in inflammatory joint disease. *Nat Rev Rheumatol* **9**:375-379.

Kim SK, Kim KS, Lee YS, Park SH and Choe JY (2010) Arterial stiffness and proinflammatory cytokines in fibromyalgia syndrome. *Clin Exp Rheumatol* **28**:S71-S77.

Klassert TE, Pinto F, Hernandez M, Candenias ML, Hernandez MC, Abreu J and Almeida TA (2008) Differential expression of neurokinin B and hemokinin-1 in human immune cells. *J Neuroimmunol* **196**:27-34.

Kritas SK, Saggini A, Cerulli G, Caraffa A, Antinolfi P, Pantalone A, Rosati M, Tei M, Speziali A, Saggini R and Conti P (2014) Corticotropin-releasing hormone, microglia and mental disorders. *Int J Immunopathol Pharmacol* **27**:163-167.

Lampa J, Westman M, Kadetoff D, Agreus AN, Le ME, Gillis-Haegerstrand C, Andersson M, Khademi M, Corr M, Christianson CA, Delaney A, Yaksh TL, Kosek E and Svensson CI (2012) Peripheral inflammatory disease associated with centrally activated IL-1 system in humans and mice. *Proc Natl Acad Sci U S A* **109**:12728-12733.

Leeman SE and Ferguson SL (2000) Substance P: an historical perspective. *Neuropeptides* **34**:249-254.

Lin AM, Rubin CJ, Khandpur R, Wang JY, Riblett M, Yalavarthi S, Villanueva EC, Shah P, Kaplan MJ and Bruce AT (2011) Mast Cells and Neutrophils Release IL-17 through Extracellular Trap Formation in Psoriasis. *J Immunol* **187**:490-500.

Liu Y, Ho RC and Mak A (2012) The role of interleukin (IL)-17 in anxiety and depression of patients with rheumatoid arthritis. *Int J Rheum Dis* **15**:183-187.

Lucas HJ, Brauch CM, Settas L and Theoharides TC (2006) Fibromyalgia--new concepts of pathogenesis and treatment. *Int J Immunopathol Pharmacol* **19**:5-10.

Lytinas M, Kempuraj D, Huang M, Boucher W, Esposito P and Theoharides TC (2003) Acute stress results in skin corticotropin-releasing hormone secretion, mast cell activation and vascular permeability, an effect mimicked by intradermal corticotropin-releasing hormone and inhibited by histamine-1 receptor antagonists. *Int Arch Allergy Immunol* **130**:224-231.

McBeth J and Mulvey MR (2012) Fibromyalgia: mechanisms and potential impact of the ACR 2010 classification criteria. *Nat Rev Rheumatol* **8**:108-116.

McLean SA, Williams DA, Stein PK, Harris RE, Lyden AK, Whalen G, Park KM, Liberzon I, Sen A, Gracely RH, Baraniuk JN and Clauw DJ (2006) Cerebrospinal fluid corticotropin-

releasing factor concentration is associated with pain but not fatigue symptoms in patients with fibromyalgia. *Neuropsychopharmacology* **31**:2776-2782.

Meng X, Zhang Y, Lao L, Saito R, Li A, Backman CM, Berman BM, Ren K, Wei PK and Zhang RX (2013) Spinal interleukin-17 promotes thermal hyperalgesia and NMDA NR1 phosphorylation in an inflammatory pain rat model. *Pain* **154**:294-305.

Middleton EJ, Kandaswami C and Theoharides TC (2000) The effects of plant flavonoids on mammalian cells: implications for inflammation, heart disease and cancer. *Pharmacol Rev* **52**:673-751.

Munoz M and Covenas R (2014) Involvement of substance P and the NK-1 receptor in human pathology. *Amino Acids* **46**:1727-1750.

Nakae S, Suto H, Iikura M, Kakurai M, Sedgwick JD, Tsai M and Galli SJ (2006) Mast cells enhance T cell activation: importance of mast cell costimulatory molecules and secreted TNF. *J Immunol* **176**:2238-2248.

Nakamura Y, Nakano N, Ishimaru K, Hara M, Ikegami T, Tahara Y, Katoh R, Ogawa H, Okumura K, Shibata S, Nishiyama C and Nakao A (2014) Circadian regulation of allergic reactions by the mast cell clock in mice. *J Allergy Clin Immunol* **133**:568-575.

O'Connor TM, O'Connell J, O'Brien DI, Goode T, Bredin CP and Shanahan F (2004) The role of substance P in inflammatory disease. *J Cell Physiol* **201**:167-180.

Okabe T, Hide M, Koro O and Yamamoto S (2000) Substance P induces tumor necrosis factor-alpha release from human skin via mitogen-activated protein kinase. *Eur J Pharmacol* **398**:309-315.

Okayama Y, Ono Y, Nakazawa T, Church MK and Mori M (1998) Human skin mast cells produce TNF-alpha by substance P. *Int Arch Allergy Immunol* **117 Suppl 1**:48-51.

Pang X, Letourneau R, Rozniecki JJ, Wang L and Theoharides TC (1996) Definitive characterization of rat hypothalamic mast cells. *Neuroscience* **73**:889-902.

Paus R, Theoharides TC and Arck PC (2006) Neuroimmunoendocrine circuitry of the 'brain-skin connection'. *Trends Immunol* **27**:32-39.

Pernambuco AP, Schetino LP, Alvim CC, Murad CM, Viana RS, Carvalho LS and Reis DA (2013) Increased levels of IL-17A in patients with fibromyalgia. *Clin Exp Rheumatol* **31**:S60-S63.

Pollack S (2014) Mast cells in fibromyalgia. *Clin Exp Rheumatol* **33**:(1 Suppl 88)-S140.

Polyzoidis S, Koletsa T, Panagiotidou S, Ashkan K and Theoharides TC (2015) Mast cells in meningiomas and brain inflammation. *J Neuroinflammation* **12**:170.

Rabenhorst A and Hartmann K (2014) Interleukin-31: a novel diagnostic marker of allergic diseases. *Curr Allergy Asthma Rep* **14**:423.

Richard AC, Ferdinand JR, Meylan F, Hayes ET, Gabay O and Siegel RM (2015) The TNF-family cytokine TL1A: from lymphocyte costimulator to disease co-conspirator. *J Leukoc Biol.*

Rodriguez-Pinto I, gmon-Levin N, Howard A and Shoenfeld Y (2014) Fibromyalgia and cytokines. *Immunol Lett.*

Romero-Sanchez C, Jaimes DA, Londono J, De AJ, Castellanos JE, Bello JM, Bautista W and Valle-Onate R (2011) Association between Th-17 cytokine profile and clinical features in patients with spondyloarthritis. *Clin Exp Rheumatol* **29**:828-834.

Ross RL, Jones KD, Bennett RM, Ward RL, Druker BJ and Wood LJ (2010) Preliminary Evidence of Increased Pain and Elevated Cytokines in Fibromyalgia Patients with Defective Growth Hormone Response to Exercise. *Open Immunol J* **3**:9-18.

Rozniecki JJ, Dimitriadou V, Lambracht-Hall M, Pang X and Theoharides TC (1999) Morphological and functional demonstration of rat dura mast cell-neuron interactions *in vitro*



and *in vivo*. *Brain Res* **849**:1-15.

Russell IJ (1998) Advances in fibromyalgia: possible role for central neurochemicals. *Am J Med Sci* **315**:377-384.

Russell IJ (2002) The promise of substance P inhibitors in fibromyalgia. *Rheum Dis Clin North Am* **28**:329-342.

Russell IJ and Larson AA (2009) Neurophysiopathogenesis of fibromyalgia syndrome: a unified hypothesis. *Rheum Dis Clin North Am* **35**:421-435.

Russell IJ, Orr MD, Littman B, Vipraio GA, Alboukrek D, Michalek JE, Lopez Y and MacKillip F (1994) Elevated cerebrospinal fluid levels of substance P in patients with the fibromyalgia syndrome. *Arthritis Rheum* **37**:1593-1601.

Sant GR, Kempuraj D, Marchand JE and Theoharides TC (2007) The mast cell in interstitial cystitis: role in pathophysiology and pathogenesis. *Urology* **69**:34-40.

Saraceno R, Kleyn CE, Terenghi G and Griffiths CE (2006) The role of neuropeptides in psoriasis. *Br J Dermatol* **155**:876-882.

Schmidt-Wilcke T and Clauw DJ (2011) Fibromyalgia: from pathophysiology to therapy. *Nat Rev Rheumatol* **7**:518-527.

Skaper SD, Giusti P and Facci L (2012) Microglia and mast cells: two tracks on the road to neuroinflammation. *FASEB J* **26**:3103-3117.

Steinhoff MS, von MB, Geppetti P, Pothoulakis C and Bunnett NW (2014) Tachykinins and their receptors: contributions to physiological control and the mechanisms of disease. *Physiol Rev* **94**:265-301.

Sumpter TL, Ho CH, Pleet AR, Tkacheva OA, Shufesky WJ, Rojas-Canales DM, Morelli AE and Larregina AT (2015) Autocrine hemokinin-1 functions as an endogenous adjuvant for IgE-mediated mast cell inflammatory responses. *J Allergy Clin Immunol* **135**:1019-1030.

Theoharides TC (2013) Atopic conditions in search of pathogenesis and therapy. *Clin Ther* **35**:544-547.

Theoharides TC, Alysandratos KD, Angelidou A, Delivanis DA, Sismanopoulos N, Zhang B, Asadi S, Vasiadi M, Weng Z, Miniati A and Kalogeromitros D (2010a) Mast cells and inflammation. *Biochim Biophys Acta* **1822**:21-33.

Theoharides TC, Asadi S, Chen J and Huizinga JD (2012) Irritable bowel syndrome and the elusive mast cells. *Am J Gastroenterol* **107**:727-729.

Theoharides TC, Kempuraj D, Tagen M, Conti P and Kalogeromitros D (2007) Differential release of mast cell mediators and the pathogenesis of inflammation. *Immunol Rev* **217**:65-78.

Theoharides TC and Konstantinidou A (2007) Corticotropin-releasing hormone and the blood-brain-barrier. *Front Biosci* **12**:1615-1628.

Theoharides TC, Petra AI, Taracanova A, Panagiotidou S and Conti P (2015a) Targeting IL-33 in autoimmunity and inflammation. *J Pharmacol Exp Ther* **354**:24-31.

Theoharides TC, Spanos CP, Pang X, Alferes L, Ligris K, Letourneau R, Rozniecki JJ, Webster E and Chrousos G (1995) Stress-induced intracranial mast cell degranulation. A corticotropin releasing hormone-mediated effect. *Endocrinology* **136**:5745-5750.

Theoharides TC, Stewart JM, Hatziagelaki E and Kolaitis G (2015b) Brain "fog," inflammation and obesity: key aspects of 2 neuropsychiatric disorders improved by luteolin. *Front Neurosci* **in press**.

Theoharides TC, Stewart JM, Hatziagelaki E and Kolaitis G (2015c) Brain "fog," inflammation and obesity: key aspects of neuropsychiatric disorders improved by luteolin. *Front Neurosci*

9:225.

Theoharides TC, Stewart JM and Panagiotidou S (2015d) Mast Cells, Brain Inflammation and Autism. *Eur J Pharmacol* **in press**.

Theoharides TC, Tsilioni I, Arbetman L, Panagiotidou S, Stewart JM, Gleason RM and Russell IJ (2015e) Fibromyalgia, a syndrome in search of pathogenesis and therapy. *J Pharmacol Exp Ther*.

Theoharides TC, Valent P and Akin C (2015f) Mast Cells, Mastocytosis, and Related Disorders. *N Engl J Med* **373**:163-172.

Theoharides TC, Weinkauff C and Conti P (2004) Brain cytokines and neuropsychiatric disorders. *J Clin Psychopharmacol* **24**:577-581.

Theoharides TC, Zhang B, Kempuraj D, Tagen M, Vasiadi M, Angelidou A, Alysandratos KD, Kalogeromitros D, Asadi S, Stavrianeas N, Peterson E, Leeman S and Conti P (2010b) IL-33 augments substance P-induced VEGF secretion from human mast cells and is increased in psoriatic skin. *Proc Natl Acad Sci U S A* **107**:4448-4453.

Theoharides TC, Zhang B, Kempuraj D, Tagen M, Vasiadi M, Angelidou A, Alysandratos KD, Kalogeromitros D, Asadi S, Stavrianeas N, Peterson E, Leeman S and Conti P (2010c) IL-33 augments substance P-induced VEGF secretion from human mast cells and is increased in

psoriatic skin. *Proc Natl Acad Sci U S A* **107**:4448-4453.

Toniato E, Spinasi E, Saggini A, Kritas SK, Caraffa A, Antinolfi P, Saggini R, Pandolfi F and Conti P (2015) IMMUNOMODULATORY EFFECTS OF VITAMIN D ON SKIN INFLAMMATION. *J Biol Regul Homeost Agents* **29**:563-567.

Torresani C, Bellafiore S and De PG (2009) Chronic urticaria is usually associated with fibromyalgia syndrome. *Acta Derm Venereol* **89**:389-392.

Turnbull AV and Rivier CL (1999) Regulation of the hypothalamic-pituitary-adrenal axis by cytokines: actions and mechanisms of action. *Physiol Rev* **79**:1-71.

Uceyler N, Hauser W and Sommer C (2011) Systematic review with meta-analysis: cytokines in fibromyalgia syndrome. *BMC Musculoskelet Disord* **12**:245.

Wallace DJ, Linker-Israeli M, Hallegua D, Silverman S, Silver D and Weisman MH (2001) Cytokines play an aetiopathogenic role in fibromyalgia: a hypothesis and pilot study. *Rheumatology (Oxford)* **40**:743-749.

Wang H, Moser M, Schiltenwolf M and Buchner M (2008) Circulating cytokine levels compared to pain in patients with fibromyalgia -- a prospective longitudinal study over 6 months  
1. *J Rheumatol* **35**:1366-1370.

Weng Z, Patel A, Panagiotidou S and Theoharides TC (2014) The novel flavone tetramethoxyluteolin is a potent inhibitor of human mast cells. *J Allergy Clin Immunol* **14**:1044-1052.

Wolfe F and Walitt B (2013) Culture, science and the changing nature of fibromyalgia. *Nat Rev Rheumatol* **9**:751-755.

Xiao Y, Haynes WL, Michalek JE and Russell IJ (2013) Elevated serum high-sensitivity C-reactive protein levels in fibromyalgia syndrome patients correlate with body mass index, interleukin-6, interleukin-8, erythrocyte sedimentation rate. *Rheumatol Int* **33**:1259-1264.

Yunus MB (2007) Fibromyalgia and overlapping disorders: the unifying concept of central sensitivity syndromes. *Semin Arthritis Rheum* **36**:339-356.

Zhang B, Alysandratos KD, Angelidou A, Asadi S, Sismanopoulos N, Delivanis DA, Weng Z, Miniati A, Vasiadi M, Katsarou-Katsari A, Miao B, Leeman SE, Kalogeromitros D and Theoharides TC (2011) Human mast cell degranulation and preformed TNF secretion require mitochondrial translocation to exocytosis sites: Relevance to atopic dermatitis. *J Allergy Clin Immunol* **127**:1522-1531.

## Footnotes

Aspects of our work described above were funded in part by National Institutes of Health [Grants NS38326 and AR47652], as well as the Michael and Katherine Johnson Family Fund to TCT. Other aspects were accomplished as part of an Investigator Initiated Research study funded by Pfizer in which IJR was the legal sponsor and principal investigator.

## Figure Legends

**Figure 1. (A, B) Comparison of serum CRH and SP levels in healthy controls and FMS patients.** Symbols represent individual data points, and the horizontal line represents the mean for each group.

**Figure 2. (A) Comparison of serum HK-1 levels in healthy controls and FMS patients.** Symbols represent individual data points, and the horizontal line represents the mean for each group. **(B) Correlation between serum HK-1 and SP levels.**

**Figure 3. (A, B) Comparison of serum IL-6 and TNF levels in healthy controls and FMS patients.** Symbols represent individual data points, and the horizontal line represents the mean for each group.

**Figure 4. (A, B) Comparison of serum IL-33 and IL-31 levels in healthy controls and FMS patients.** Symbols represent individual data points, and the horizontal line represents the mean for each group.

**Figure 5. Diagrammatic representation of the proposed interactions among neuropeptides, mast cells, inflammatory cytokines, neurons and FMS pathogenesis.** Environmental, immune and infectious triggers activate MCs leading to secretion of inflammatory mediators such as IL-6 and TNF which could further stimulate nerves to release CRH, HK-1 and SP, further stimulating MCs. Luteolin and quercetin could be of help by blocking MC stimulation and/or release of inflammatory mediators.



**Table 1. Demographic Characteristics of the Human Subject Participants**

<b>Characteristics</b>	<b>Fibromyalgia Syndrome (n=84)</b>	<b>Healthy Controls (n=20)</b>
<b>Gender (% female)</b>	100 %	75 %
<b>Age Range (mean years)</b>	28-64 (47.94±11.18)	25-65 (38.15±10.62)
<b>Ethnicity</b>	90 % Caucasian	100 % Caucasian
<b>Pain Severity (mean PVAS)</b>	67.7 mm	non-applicable

**PVAS = Pain Visual Analog Scale**

<b>Table 2</b>		<b>Reported cytokines/chemokines levels in FMS</b>		
<b>Cytokines</b>	<b>Assays</b>	<b>N*</b>	<b>Results</b>	<b>References</b>
<b>IL-6, TNF-<math>\alpha</math></b> (Serum)	ELISA	54:21 (IL-6) 43:17 (TNF- $\alpha$ )	IL-6, TNF- $\alpha$ $\uparrow$	Present results
<b>IL-4, IL-6, IL-8, TNF-<math>\alpha</math>,</b> (Serum)	Bio-Plex cytokine assay	20:80	IL-8, TNF- $\alpha$ $\uparrow$ IL-6 $\downarrow$ IL-4, IL-10 $\rightarrow$	(Wang, et al., 2008)
<b>IL-6, IL-8, TNF-<math>\alpha</math></b> (Serum)	Luminex	56:32	IL-8 $\downarrow$ IL-6, TNF- $\alpha$ $\rightarrow$ IL-6, IL-8, TNF- $\alpha$ $\downarrow$ in older FM patients	(Garcia-Lozano, et al., 2008)
<b>IL-1, IL-6, IL-8</b> (Serum)	ELISA	81:32	IL-8 $\uparrow$ IL-1, IL-6 $\rightarrow$	(Gur, et al., 2002)
<b>IL-8</b> (Serum)	ELISA	20:20	IL-8 $\uparrow$	(Bote, et al., 2012)
<b>IL-1<math>\alpha</math>, IL-1<math>\beta</math>, IL-6, IL-8, TNF-<math>\alpha</math></b> (Serum)	Luminex	7:12 (non-responders #)	IL-6, IL-8 $\uparrow$	(Ross, et al., 2010)
<b>IL-1<math>\beta</math>, IL-6, IL-8</b> (Serum)	ELISA	27:29	IL-8 $\uparrow$ IL-1 $\beta$ , IL-6 $\rightarrow$	(Kim, et al., 2010)
<b>IL-1<math>\beta</math>, IL-6, TNF-<math>\alpha</math></b> (Serum)	ELISA	64:25	IL-6 $\uparrow$ IL-1 $\beta$ , TNF- $\alpha$ $\downarrow$	(Hernandez, et al., 2010)
<b>IL-6, IL-8</b> (Serum)	ELISA	105:61	IL-8, IL-6 $\rightarrow$	(Xiao, et al., 2013)
<b>IL-1<math>\beta</math> IL-6, IL-8, TNF-<math>\alpha</math></b> (Serum)	ELISA	56:36	IL-8 $\uparrow$ IL-1 $\beta$ , IL-6, TNF- $\alpha$ $\rightarrow$	(Wallace, et al., 2001)
<b>IL-1b, IL-5, IL-6, IL-8, TNF-<math>\alpha</math></b> (Serum)	ELISA	15:15	IL-8 $\uparrow$ IL-1 $\beta$ $\rightarrow$	(Kadetoff, et al., 2012)
<b>IL-1, IL-6, IL-8, TNF- <math>\alpha</math></b> (Plasma)	ELISA	80:45	IL-8, TNF- $\alpha$ $\uparrow$	(Bazzichi, et al., 2007b)
<b>IL-6, IL-8,</b> (Plasma)	Luminex	39:47 (IL-6) 62:43 (IL-8)	IL-6, IL-8 $\downarrow$	(Behm, et al., 2012)

\*no of FMS patients: no of healthy controls; # non-responders = did not increase growth hormone levels after exercise

Fig. 1

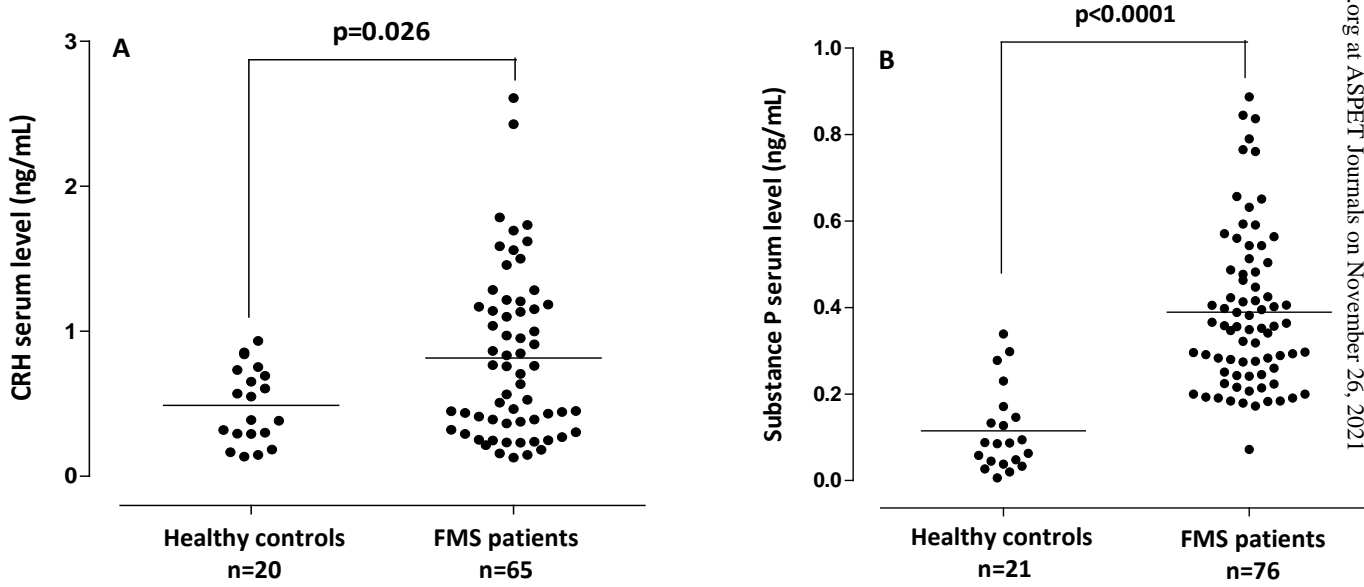


Fig.2

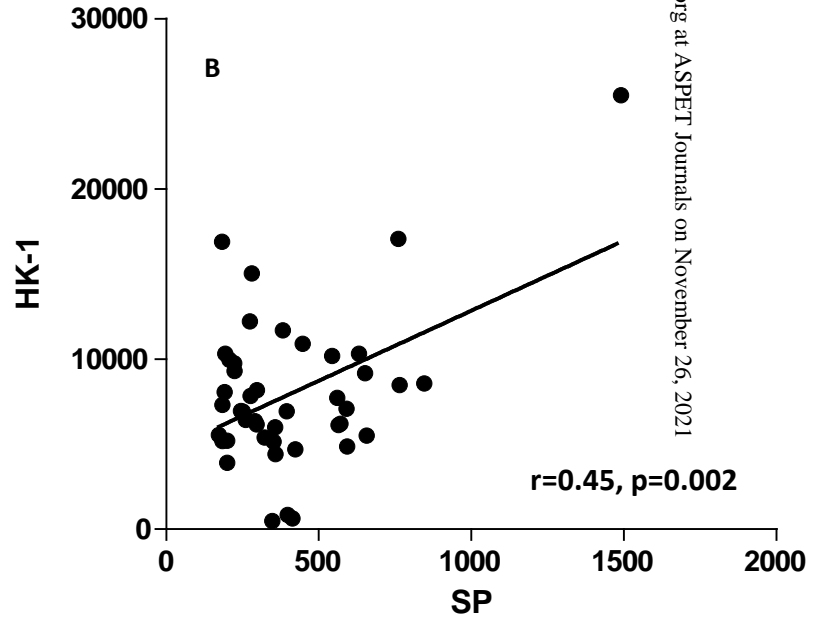
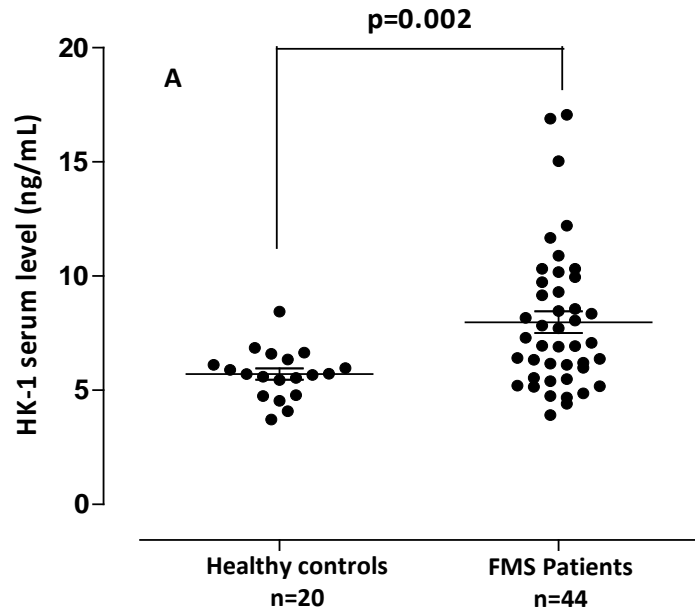
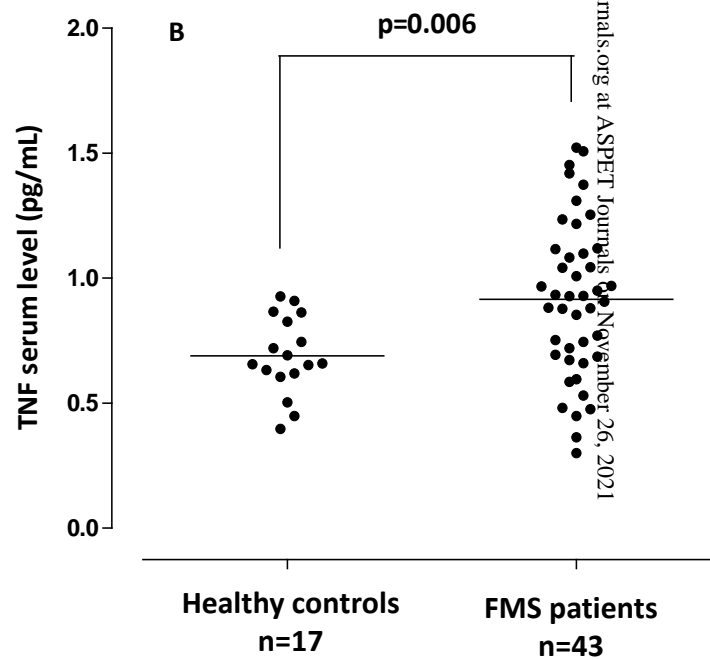
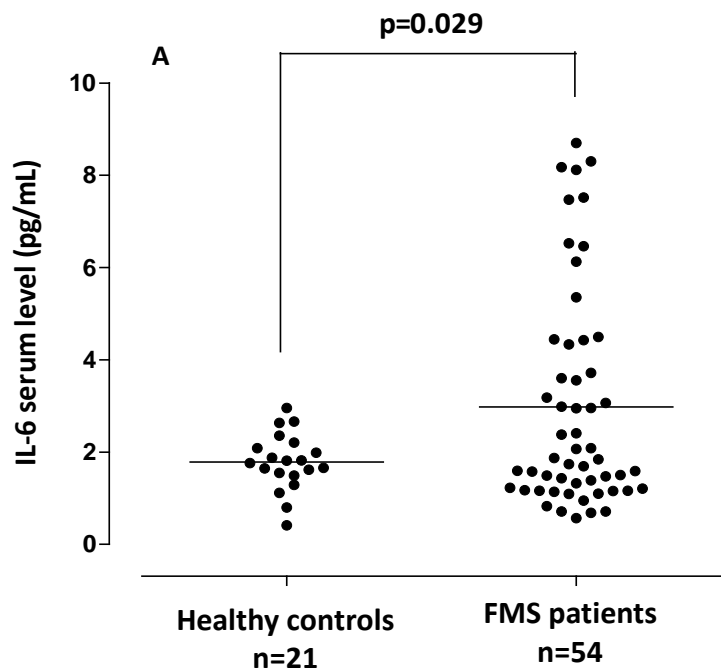


Fig. 3



**Fig. 4**

