Neutrophil Life Span in Paroxysmal Nocturnal Hemoglobinuria

By Leonard H. Brubaker, Le Roy J. Essig, and Charles E. Mengel

We have studied neutrophil intravascular life span in six patients with paroxysmal nocturnal hemoglobinuria (PNH); four had normal neutrophil counts when studied and two were neutropenic. Five patients had enough circulating neutrophils to isolate for tests in vitro. Lysis of labeled neutrophils was greatly increased, compared to that of normal volunteers, when these neutrophils were incubated with acidified fresh serum as a source of active complement plus serum containing antineutrophil antibodies (from three different sources). Despite the in vitro lesion, however, each of these patients had a normal neutrophil intravascular life span as measured by the 32P-diisopropylfluorophosphate technique. One neutropenic patient, who had a normal neutrophil life span, had a shift of cells from the circulating to marginated pool of sufficient degree to cause the neutropenia. A second (severely) neutropenic patient was found to have developed extreme marrow hypoplasia, also explaining the neutropenia. Thus, in contrast to the shortened red cell life span, we have been unable to find a shortened neutrophil life span in PNH.

Paroxysmal nocturnal hemoglobinuria (PNH) is characterized in vitro by a marked lytic sensitivity of the patient’s red cells to complement. This phenomenon may be responsible for the shortened life span of the red cells. A similar increased lytic sensitivity to complement has been demonstrated in vitro for neutrophils and platelets. Since PNH patients are sometimes neutropenic, we have investigated the possibility that PNH patients have a shortened intravascular life span.

Materials and Methods

Patient Selection

We have studied a total of six patients with PNH. Some selected features of these patients are shown in Table I. Each patient exhibited features of intravascular hemolysis (hemoglobinemia, morning hemoglobinuria with clearing as the day progressed, absent serum haptoglobin, hemosiderinuria, and increased indirect reacting bilirubinemia). Each patient consistently showed a positive Ham test, thrombin test, sucrose lysis test, inulin test, and the four-tube complement lysis sensitivity test using high-titer cold-agglutinin sera as the antibody to sensitize the red cells. Their red cells had a low level of activity of acetylcholinesterase, and their neutrophils had low alkaline phosphatase activity.

Abbreviations used in this paper: PNH, paroxysmal nocturnal hemoglobinuria; t1/2, 50% clearance time; DF-32P, 32P-diisopropylfluorophosphate.

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Table 1. Data on PNH Patients in the Study

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Age (yr), Sex</th>
<th>Neutrophil Count* (cells/cu mm)</th>
<th>History of Aplastic Anemia</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30, F</td>
<td>4000-5700</td>
<td>Before PNH</td>
<td>Previously splenectomized and never neutropenic with PNH</td>
</tr>
<tr>
<td>2</td>
<td>54, M</td>
<td>2900</td>
<td>No</td>
<td>Never neutropenic with PNH</td>
</tr>
<tr>
<td>3</td>
<td>45, M</td>
<td>3000</td>
<td>No</td>
<td>Never neutropenic with PNH</td>
</tr>
<tr>
<td>4</td>
<td>50, M</td>
<td>2600</td>
<td>No</td>
<td>Never neutropenic with PNH</td>
</tr>
<tr>
<td>5</td>
<td>15, F</td>
<td>700</td>
<td>Developing aplasia</td>
<td>Falling neutrophil count</td>
</tr>
<tr>
<td>6</td>
<td>34, F</td>
<td>1300</td>
<td>Before PNH</td>
<td>Neutropenic since aplasia</td>
</tr>
</tbody>
</table>

*Normal range: 1830–7250 cells/cu mm.17

Neutrophil Lysis In Vitro

Each patient (except patient 5, who had too few neutrophils to study) was phlebotomized of 500 ml blood into acid citrate-dextrose USP Formula A anticoagulant, after giving appropriate informed consent. This blood was centrifuged in a refrigerated centrifuge at 1500 g for 3 min. The blood bag was carefully removed from the centrifuge, the plasma was removed, and theuffy-coat layer and the upper layer of red cells were carefully squeezed into a satellite bag. This buffy coat was mixed with an equal volume of 3% dextran (molecular weight 200,000), 0.45% saline, and 2.5% dextrose and allowed to settle. The white cell rich upper layer of dextran plasma was removed in approximately 30 min, centrifuged, and subjected to hypotonic lysis9 in order to remove the remaining few red cells. 32P-Diisopropylfluorophosphate (DF32P: PBI 18P, Amersham/Searle Co., Arlington Heights, Ill.) 5–20 μCi in 0.1 ml volume was added to the white cells contained in about 1 ml of 0.9% saline. This suspension was incubated at room temperature for 45 min. The white cells were then washed three times by resuspending in saline and centrifuging, then removing the supernatant saline containing the unattached isotope. At this point the white cell suspension consisted of approximately 90% neutrophils, 10% mononuclear cells, essentially no red cells, and only occasional platelets. The viability of the white cells was demonstrated by their ability to exclude trypan blue dye.

Simultaneously, fresh human serum was prepared from normal donors and adjusted to pH 6.6 (found to be the optimum pH) with HCl. Half of this serum was incubated at 56°C for 30 min, and the other half was kept in an ice bath.

Neutrophil antibody serum was obtained from various sources. One was a volunteer who had been immunized with allogenic white cells (kindly donated by Dr. Henry Wilson, Ohio State University Medical Center, Columbus, Ohio). Another was a patient with high-titer red cell cold agglutinins. Three of nine such patients in our experience had serum antineutrophil activity. Later, we used serum from a patient with cyclic neutropenia who had potent antineutrophil antibodies as demonstrated by the method of Boxer and Stossel.10

Incubation mixtures were then prepared containing 0.8 ml of serum, either fresh or fresh heat-treated, 0.1 ml of white cell suspension, and 0.1 ml of serum presumed to contain antineutrophil antibodies.

These mixtures were incubated at 37°C for 1 hr, except when the antiserum was from a patient with cold agglutinin disease. In the latter case, the mixture was preincubated at 0°C for 30 min followed by the 37°C incubation for 1 hr. Each tube was centrifuged at 1000 g for 10 min and the supernatant serum and cells were separated. The cells were solubilized with 1 ml of Soluene 100 (Packard Instrument Co., Downer’s Grove, Ill.) and counted in a liquid scintillation spectrometer. Because of the high energy of 32P, slight variations in quenching had little effect on the counts, so that no corrections were necessary. For each tube the percentage lysis was calculated by dividing the serum counts by the sum of serum and cell counts (× 100).

Omission of the antineutrophil antibody serum from the incubation mixture essentially eliminated the excess lysis seen when it was included with fresh serum and PNH white cells.

We verified that the PNH neutrophils were being lysed by incubation with fresh serum and antineutrophil antibody by examining the cells microscopically at the end of the incubation after adding trypan blue. The cells were noted to be degenerated and clumped, and nearly all took
up the stain. Normal neutrophils under the same conditions showed no such degeneration. PNH neutrophils similarly incubated with heat-inactivated fresh serum also showed no such degeneration, but appeared as normal neutrophils.

**Measurement of Neutrophil Life Span**

The DF$_{32}$P neutrophil survival study was done by a slight modification of the procedure of Mauer et al.\textsuperscript{11} as previously reported.\textsuperscript{12} From this procedure we obtained sequential values for specific white cell radioactivity expressed as the percentage of the expected specific activity if the labeled blood had been diluted to the calculated blood volume.\textsuperscript{13} The data were plotted in the usual fashion on a logarithmic scale against time on an arithmetic scale. The points so obtained were fitted to a straight line by standard computerized techniques and the theoretical line of best fit was utilized to calculate $a_{1/2}$. The subjects gave appropriate informed consent for these studies.

**RESULTS**

**Presence of In Vitro Lesion in PNH Neutrophils**

In vitro neutrophil lysis is shown in Table 2. Neutrophils from PNH patients had a greater percentage lysis than neutrophils from normal controls when these cells were incubated with complement (fresh human serum) and serum containing antineutrophil antibodies. When complement was inactivated (by heating to 56°C for 30 min) or antineutrophil antibody serum was omitted, the lysis of PNH neutrophils was similar to that of normal neutrophils under the same circumstances.

Figure 1 shows that exposure of one of these patient's neutrophils to various dilutions of complement produced a pattern of lysis that demonstrated a double population of cells, one more sensitive and one less sensitive. This pat-

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Source of Antibody</th>
<th>Neutrophil Counts (cells/cu mm)</th>
<th>In Vivo DF$_{32}$P Neutrophil Turnover Data $\frac{a}{1/2}$ (hr)</th>
<th>TBNP (x 10$^7$/kg)</th>
<th>CNP (x 10$^7$/kg)</th>
<th>MNP (x 10$^7$/kg)</th>
<th>NTR (x 10$^7$/kg/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>a</td>
<td>4000</td>
<td>5.7</td>
<td>89</td>
<td>79</td>
<td>10</td>
<td>260</td>
</tr>
<tr>
<td>2</td>
<td>b</td>
<td>5700</td>
<td>5.9</td>
<td>166</td>
<td>141</td>
<td>25</td>
<td>470</td>
</tr>
<tr>
<td>3</td>
<td>b</td>
<td>2900</td>
<td>8.2</td>
<td>106</td>
<td>46</td>
<td>60</td>
<td>220</td>
</tr>
<tr>
<td>4</td>
<td>c</td>
<td>3000</td>
<td>10.0</td>
<td>158</td>
<td>52</td>
<td>106</td>
<td>270</td>
</tr>
<tr>
<td>5</td>
<td>c</td>
<td>2600</td>
<td>8.0</td>
<td>146</td>
<td>40</td>
<td>106</td>
<td>300</td>
</tr>
<tr>
<td>6</td>
<td>c</td>
<td>700</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Percentage lysis (see Materials and Methods) of either PNH patient or normal control leukocytes (mostly neutrophils) incubated with fresh serum minus the percentage lysis (range 4%-16%) of the same cells incubated with heated (at 56°C for 30 min) fresh serum.

\footnotetext[1]{\textsuperscript{1}} a, serum from volunteer immunized against mixed human leukocytes (courtesy of Dr. Henry Wilson, Ohio State University Hospital); b, serum from patient with high-titer red cell cold agglutinins, also containing antineutrophil activity (see Materials and Methods); c, serum from patient with antineutrophil antibody demonstrated by method of Boxer and Stossel.\textsuperscript{10}

\footnotetext[1]{\textsuperscript{1}} NormaI range: 1830-7250 cells/cu mm.\textsuperscript{17}

\footnotetext[1]{\textsuperscript{1}} 50% survival time calculated from straight line of best fit for experimental points (normal 4-10 hr).\textsuperscript{14} TBNP, total-body neutrophil pool (normal 27-138);\textsuperscript{14} CNP, circulating neutrophil pool (normal 13-49);\textsuperscript{14} MNP, margined neutrophil pool (normal 0-85);\textsuperscript{18} NTR, neutrophil turnover rate (normal 62-400).\textsuperscript{14}
tern is characteristic of red cells in the disease. The percentage of more sensitive white cells was approximately 30%, similar to the approximately 25% sensitive red cells in the same patient as tested by Rosse and Dacie’s method.

**Results In Vivo**

The calculated \( \frac{t_{1/2}}{t} \) values for the DF\(^{32}\)P neutrophil survival procedure in these patients is shown in Table 2; it ranged from 5.7 to 10.0 hr. These values fall within the 95% limits for normals as published by Bishop et al.\(^{14}\) Our own values on seven normal controls and five otherwise hematologically normal patients with Hodgkin disease were 3.2–8.7 hr, calculated for the first 10 hr of the procedure.\(^{15}\) Table 2 also gives values for the total-body, circulating, and marginated neutrophil pools and the neutrophil turnover rates\(^{18}\) in these patients.

**Results in Neutropenic Patients**

Patients 5 and 6 were neutropenic at the time of the study. Patient 5 was so severely neutropenic that an adequate study could not be obtained. She had developed PNH without prior history of hematologic disease, but at the time we were able to study her she had developed aplastic anemia. The cellularity of her marrow biopsy was nearly zero and a differential count on the marrow smear was 91.5% lymphocytes, 2% total neutrophilic cells, and 2% total erythroid cells. (This sequence of events has been previously reported.)\(^{16}\) Thus, her neutropenia was predominantly due to lack of marrow production. This pattern persisted until her death from fulminating sepsis 3 mo after we had studied her.
Patient 6 was reported to have had aplastic anemia prior to developing PNH. At the time of our examination her bone marrow was 70% cellular with a myeloid to erythroid ratio of 0.3:1. Although her neutrophil count (1300/cu mm) was well below normal limits, her DF$^{32}$P study (Table 2) showed a normal $t_2$ and neutrophil turnover rate. The circulating neutrophil pool was below normal, but the marginated neutrophil pool was well within normal limits. Thus, her mild neutropenia was an example of "shift" neutropenia (shift from the circulating into the marginated pool), as defined by Bishop et al. She definitely did not have a shortened neutrophil life span, in contrast to her short red cell life span [evidenced by marked hemoglobinuria, hematocrit of 29%, reticulocyte count of 8.5%, doubly corrected reticulocyte production index of 3 (within the range for hemolytic anemia)], and average yearly transfusion requirement of 12 units.

**DISCUSSION**

These results indicate that patients with PNH have a membrane defect of their neutrophils that can be consistently demonstrated in vitro, as previously reported. This defect does not appear to be expressed in vivo, however. We were unable to demonstrate a shortened neutrophil life span in PNH patients whether neutropenic or not. Similarly, Aster and Enright demonstrated that the in vitro defect of PNH platelets is not accompanied by a shortened life span.

Both neutropenia and thrombocytopenia are commonly observed during the course of PNH, neutropenia being present at some time in about 60% of these patients. Our observations in neutropenic patients 5 and 6 strengthen the previous impression that the cause of neutropenia in PNH may be related to a defect in production, or at least is not related to a shortened life span.

Bacterial infections are also known to be frequent in patients with neutropenia due to deficient production. Patient 5 died of an acute, fulminating sepsis similar to other patients with severe neutropenia due to marrow production failure. It is possible that the lesion demonstrated in vitro in PNH neutrophils may also contribute to this susceptibility to bacterial infection in that the neutrophils may lyse at a time when they should be phagocytosing and killing bacteria even if they have survived normally up to that point.

Aster and Enright did not claim to have found a double population of platelets in PNH patients, one more and one less sensitive to the effects of complement and antibody, in contrast to the findings with PNH erythrocytes. Their white cell studies, however, did suggest a "sensitive" population consisting of 80% to 90% of the total $^{51}$Cr-labeled cells, the rest being an insensitive population. They attributed this finding to lymphocytes in the mixed white cell preparation which are known to label well with $^{51}$Cr. We used DF$^{32}$P, which is predominantly a neutrophil label, and also demonstrated a double population of cells (Fig. 1), thereby strengthening the evidence that the fundamental marrow lesion in PNH is a double population of undifferentiated stem cells, one giving rise to circulating blood cells with a membrane defect predisposing these cells to complement-mediated lysis and the other giving rise to more nearly normal circulating blood cells.
ACKNOWLEDGMENT

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REFERENCES


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