Severe Glucose-6-Phosphate Dehydrogenase (G6PD) Deficiency Associated with Chronic Hemolytic Anemia, Granulocyte Dysfunction, and Increased Susceptibility to Infections: Description of a New Molecular Variant (G6PD Barcelona)


Molecular, kinetic, and functional studies were carried out on erythrocytes and leukocytes in a Spanish male with G6PD deficiency, congenital nonspherocytic hemolytic anemia (CNSHA), and increased susceptibility to infections. G6PD activity was absent in patient's red cells and was about 2% of normal in leukocytes. Molecular studies using standard methods (WHO, 1967) showed G6PD in the patient to have a slightly fast electrophoretic mobility at pH 8.0 with otherwise normal properties (heat stability at 48°C, apparent affinity for substrates, optimum pH, and utilization of substrate analogues). Other tests showed the patient's granulocytes to engulf latex particles normally, but to have impaired reduction of nitroblue tetrazolium and ferricytochrome-c as well as reduced iodination. Chemotaxis and random migration of the patient's granulocytes were normal as were myeloperoxidase, leukocyte alkaline phosphatase (LAP), and ultrastructural features. The molecular characteristics of G6PD in the patient differed from those of all previously reported variants associated with CNSHA, so the present variant was provisionally called G6PD Barcelona to distinguish it from other G6PD variants previously described. Possible mechanisms for the severe deficiency of G6PD in erythrocytes and granulocytes were investigated by studies on the immunologic specific activity of the mutant enzyme.

GLUCOSE-6-PHOSPHATE dehydrogenase (G6PD, EC 1.1.49) deficiency is the most common genetically determined enzymatic abnormality in humans.1-3 It has probably affected more than 100 million males and the variability of the clinical expression of G6PD deficiency is paralleled by the different biochemical characteristics of the variant enzymes. While the majority of individuals with G6PD deficiency are either hematologically normal or show hemolysis only when exposed to exogenous agents,1,2 other G6PD variants are associated with chronic hemolytic anemia.4,5 Chronic hemolytic anemia in patients with severely reduced activity of G6PD in leukocytes is rarely associated with increased susceptibility to recurrent bacterial or fungal infections or with a clinical picture similar to that of chronic granulomatous disease (CGD).6,8 Although chronic hemolytic anemia is usually observed in association with rare structural G6PD mutants,1-5 the molecular characteristics of severely deficient G6PD variants associated with increased susceptibility to infections due to functional granulocyte defects are unknown. To date, only six patients with a deficiency of leukocyte G6PD severe enough to enhance susceptibility to infection have been reported,6,8 and in no case have the molecular properties of the variant enzyme been characterized. It might be noted, however, that in the patient studied by Gray et al.9 molecular and immunologic studies were performed that revealed the complete absence of G6PD, making kinetic and other measurements impossible.

This article describes the clinical, biochemical, and functional studies performed in a patient with severe G6PD deficiency, chronic nonspherocytic hemolytic anemia (CNSHA), and increased susceptibility to bacterial infections. The virtual absence of red cell G6PD activity was accompanied by a severely reduced granulocyte enzyme activity and phagocytic dysfunction.

We found the molecular properties of the enzyme to differ from all other previously described G6PD-deficient variants associated with CNSHA. We describe the enzyme in the present report under the provisional name “G6PD Barcelona.”

MATERIALS AND METHODS

Case Report

The patient was a white male of Spanish origin (Badajoz, Extremadura Province). He was 34 yr old at the time of this study in 1980. He was examined initially at our clinic in 1972 because of a history of fever, jaundice, and hepatitis. At age of 4 yr, the patient had jaundice accompanied by low-grade fever, chills, dark urine, scleral icterus, and sometimes bilateral lumbar pain. These conditions persisted in variable intensity throughout childhood. The patient frequently had severe hemolytic crisis in the course of recurrent infections of upper respiratory tract during childhood, and repeated blood transfusions were required to main-
G6PD DEFICIENCY

The patient had three episodes of bacterial pneumonia with a protracted course between the ages of 25 and 34, with pleural effusion and bilateral multifocal pneumonia infiltrates during two of the episodes. The patient was anemic at the time of the study, and laboratory tests gave the following values: hemoglobin 8.2 g/dl, packed cell volume 0.21, corrected reticulocyte count 20%, total and indirect serum bilirubin 36.76 μ mole/liter and 32.49 μ mole/liter, respectively, leukocyte count of 14 x 10^9/liter with 90% neutrophils, 36.76 μ mole/liter and 32.49 μ mole/liter, respectively, urine albumin 2 and 6% lymphocytes. Total serum proteins was 56 g/liter.

**General Hematologic Studies**

Routine hematologic tests were done by standard methods. Hemoglobin electrophoresis was performed on cellulose acetate strips, and thermostable hemoglobin study, erythrocyte enzyme assays, red cell glutathion concentration, and glutathione stability test were performed by the methods cited.

**Molecular and Immunologic Studies of G6PD**

Blood from the patient and from normal control subjects was collected in heparin (10 U/ml) and stored at +4°C. Granulocytes were isolated from whole blood using the dextran T500 method, and G6PD assays of frozen-thawed lysates were performed by the method of Rattazzi. Molecular and Immunologic Studies of G6PD were done by standard methods. Hemoglobin electrophoresis was performed on cellulose acetate strips, and thermostable hemoglobin study, erythrocyte enzyme assays, red cell glutathion concentration, and glutathione stability test were performed by the methods cited.

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method and were processed and studied with the conventional ultrastructural technique. Micrographs were randomly obtained with a JEOL 100-B electron microscope at 80 kV and magnification of 8000. The magnification of the instrument was controlled by means of a carbon grating replica (Ladd Res, Int, Burlington, Vt., Catalogue number, 5000), and prints were obtained at final magnification of 16,000.

Twenty-five granulocytes from each individual were studied. Cytoplasmic and nuclear area of 250 granulocytes was determined by a planimetric method, and granules of each granulocyte section were counted.

Mean and standard deviation (SD) for the following parameters were computed: cellular area, cytoplasmic (C) and nuclear (n) areas, n/c index, and number of granules per cell.

RESULTS

General Hematologic Studies

The patient had severe hemolytic anemia characterized by persistently elevated reticulocyte counts (20%–30%). Occasional spherocytes and basophilic stippling, moderate poikilocytosis, and anisocytosis were seen in the stained smear of the patient's peripheral blood. No hemosiderin was present in his urine. The half-life (11Cr T1/2) of the patient's erythrocytes was 10 days, which is markedly below normal values (28–35 days), and there was evidence of splenic but not hepatic sequestration.

Electrophoresis and heat stability of the patient's hemoglobin were normal and the activity of all other erythrocyte enzymes were increased in accordance with the increased number of reticulocytes (Table 1). Erythrocyte osmotic fragility of fresh blood obtained from the patient was slightly reduced, and autohemolysis showed a Dacie I pattern that was corrected by ATP. Induced Heinz body test was strongly positive. The concentration of reduced glutathion (GSH) was 60 mg/dl of whole blood, which is just below the normal range (62–79 mg/dl), and GSH showed marked instability (–49%) after 2-hr incubation with acetylphenyl hydratase (APH).

Molecular and Immunologic Studies of G6PD

Molecular characteristics of the partially purified G6PD from the patient are summarized in Table 2. The results, representing the average of two separate studies, are compared to those of 50 normal subjects evaluated by identical methods in our laboratory and those of 30 subjects with the so-called G6PD Betica deficient variant, which has been found in about 60% of Spanish patients with acute hemolytic anemia due to G6PD deficiency.

The activity of G6PD was absent in the patient's erythrocytes and only about 2% of normal in leukocytes. Molecular studies of deficient G6PD showed normal heat stability, apparent affinity of G6PD for substrates (KmG6P, KmNADP), utilization of substrate analogues (2 dG6P and d-amino NADP), and optimum pH. The only molecular abnormality observed in G6PD from the patient was a slightly fast electrophoretic mobility (105% of normal B+ enzyme) in both leukocytes and semipurified enzyme preparation when a Tris-EDTA buffer system (pH 8.0) was used (Fig. 1). Immunologic determination of G6PD and enzymatic assays showed the newly synthesized enzyme in the patient's leukocytes to have an "immunologic specific activity" of 82%, which was only slightly below normal (Fig. 2).

Functional and Ultrastructural Studies on Granulocytes

Results of studies on granulocyte function are summarized in Table 3. Engulfment of latex particles

Table 1. Erythrocyte Enzyme Activities Other Than G6PD in the Patient and in Normal Controls

<table>
<thead>
<tr>
<th>Enzyme</th>
<th>Activity (U/g Hb)</th>
<th>Patient</th>
<th>Normal Mean ± 5D*</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hexokinase</td>
<td>1.8</td>
<td>1 ± 0.2</td>
<td>0.8–1.2</td>
<td></td>
</tr>
<tr>
<td>Phosphoglucone isomerase</td>
<td>49.6</td>
<td>47.5 ± 4.5</td>
<td>43–52</td>
<td></td>
</tr>
<tr>
<td>Phosphofructokinase</td>
<td>8.6</td>
<td>8.6 ± 1.6</td>
<td>7–10.2</td>
<td></td>
</tr>
<tr>
<td>Fructose diphosphate aldolase</td>
<td>5.6</td>
<td>3.3 ± 0.9</td>
<td>2.4–4.2</td>
<td></td>
</tr>
<tr>
<td>Glyceroldehyde-3-phosphate dehydrogenase</td>
<td>173.2</td>
<td>185 ± 27.6</td>
<td>157.4–212.6</td>
<td></td>
</tr>
<tr>
<td>Phosphoglycerate kinase</td>
<td>254.3</td>
<td>269 ± 35</td>
<td>234–304</td>
<td></td>
</tr>
<tr>
<td>Phosphoenol pyruvate hydratase</td>
<td>5.23</td>
<td>4.8 ± 0.6</td>
<td>4.2–5.4</td>
<td></td>
</tr>
<tr>
<td>Pyruvate kinase</td>
<td>18.4</td>
<td>10.5 ± 2.3</td>
<td>8.2–12.8</td>
<td></td>
</tr>
<tr>
<td>Triosephosphate isomerase</td>
<td>2,319.0</td>
<td>1,945 ± 374</td>
<td>1,571–2,319</td>
<td></td>
</tr>
<tr>
<td>Bisphosphoglycerate synthase</td>
<td>4.5</td>
<td>4.78 ± 1.06</td>
<td>3.72–5.84</td>
<td></td>
</tr>
<tr>
<td>Phosphoglycerate mutase</td>
<td>9.9</td>
<td>8.9 ± 1.78</td>
<td>9.12–12.68</td>
<td></td>
</tr>
<tr>
<td>6-Phosphoglucone dehydrogenase</td>
<td>11.6</td>
<td>7.34 ± 1.03</td>
<td>6.31–8.37</td>
<td></td>
</tr>
<tr>
<td>Glutathione reductase</td>
<td>11.3</td>
<td>6.1 ± 1.19</td>
<td>4.91–7.29</td>
<td></td>
</tr>
<tr>
<td>Glutathione peroxidase</td>
<td>23.0</td>
<td>17.6 ± 2.6</td>
<td>15–20.2</td>
<td></td>
</tr>
<tr>
<td>Adenylate kinase</td>
<td>142.8</td>
<td>141.8 ± 23.1</td>
<td>118.7–164.9</td>
<td></td>
</tr>
</tbody>
</table>

*Obtained with 50 hematologically normal blood donors.
Table 2. Molecular Characteristics of G6PD in the Patient, Normal White Controls and Subjects With the Common Spanish Variant G6PD Betica

<table>
<thead>
<tr>
<th></th>
<th>Patient</th>
<th>Normal B⁺ Enzyme (Mean ± SD)</th>
<th>G6PD Betica (Mean ± SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erythrocyte activity (U/g Hb)</td>
<td>0</td>
<td>7.97 ± 1.5</td>
<td>1.25 ± 1.25</td>
</tr>
<tr>
<td>Leukocyte activity (U/mg protein)</td>
<td>0.004</td>
<td>0.29 ± 0.03</td>
<td>0.23 ± 0.06</td>
</tr>
<tr>
<td>Electrophoretic mobility (% of normal B⁺ enzyme)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tris-EDTA-borate, pH 8.0</td>
<td>105</td>
<td>100</td>
<td>111 ± 2</td>
</tr>
<tr>
<td>Phosphate EDTA, pH 7.0</td>
<td>100</td>
<td>100</td>
<td>114 ± 2</td>
</tr>
<tr>
<td>K⁺-G6P (µM)</td>
<td>40</td>
<td>53.5 ± 6.5</td>
<td>55.5 ± 7.5</td>
</tr>
<tr>
<td>K⁺-NADP (µM)</td>
<td>6</td>
<td>7.69 ± 1.61</td>
<td>8 ± 1</td>
</tr>
<tr>
<td>Substrate analogues utilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2dG6P (% of G6P rate)</td>
<td>5</td>
<td>2.32 ± 0.51</td>
<td>2.61 ± 0.7</td>
</tr>
<tr>
<td>Deamino NAD⁺ (% of NADP rate)</td>
<td>60</td>
<td>51.5 ± 6.5</td>
<td>50 ± 8</td>
</tr>
<tr>
<td>Optimum pH</td>
<td>Normal</td>
<td>Inflexion</td>
<td>Normal</td>
</tr>
<tr>
<td>Heat stability at 46°C (residual activity after 60 min of incubation) (%)</td>
<td>68</td>
<td>70.5 ± 7.8</td>
<td>62 ± 9.3</td>
</tr>
<tr>
<td>Clinical manifestations</td>
<td>CNSHA</td>
<td>None</td>
<td>Favism</td>
</tr>
</tbody>
</table>

by the patient’s granulocytes was normal, whereas the cytochemical NBT reduction test was severely decreased. The spectrophotometric assay of zymosan-stimulated NBT reduction confirmed the results obtained with the cytochemical test. Accordingly, superoxide radical (O₂⁻) production measured through the ferricytochrome-c reduction and iodination test were strongly decreased in the patient’s granulocytes. On the other hand, MPO index, LAP score, chemotaxis, and random migration of patient’s PMN were within normal limits and ultrastructural studies provided no evidence for abnormalities either in size or in number of granules in the patient’s granulocytes (Table 4).

**DISCUSSION**

G6PD deficiency can be divided into four classes on the basis of erythrocyte enzyme activity and associated clinical manifestations. Class 1 deficiency is characterized by severely reduced activity of G6PD and chronic nonspherocytic hemolytic anemia (CNSHA); class 2 consists in a severe deficiency of G6PD usually not associated with hemolytic anemia; class 3 corresponds to moderate to mild G6PD deficiency; and class 4 refers to very mild or unapparent enzyme deficiency.

The enzyme variants within each class can be divided further on the basis of their electrophoretic mobility, kinetic characteristics, pH optima, and utilization of substrate analogues. In general, G6PD-deficient patients who suffer from CNSHA (class 1) have inherited an uncommon variant characterized by decreased G6PD activity in leukocytes and platelets, together with severe erythrocyte G6PD.

![Fig. 1](image1.png)  
**Fig. 1.** Starch-gel electrophoresis at pH 8.0 of partially purified G6PD from the patient and two controls. Electrophoretic mobility of G6PD Barcelona is intermediate between normal B⁺ enzyme and the fast Gd⁺+1A black variant. Arrow indicates sample origin (0).

![Fig. 2](image2.png)  
**Fig. 2.** Electroimmunodiffusion of normal B⁺ enzyme and deficient G6PD Barcelona obtained from freshly prepared leukocytes. In normal B⁺ enzyme, the activity of the first leukolyzate dilution applied to the gel is indicated. The other dilutions were in the ratio 1:2, 1:4, and 1:8. In deficient G6PD Barcelona, the activity of the first immunoprecipitate peak was obtained with an undiluted leukocyte extract containing 220 x 10⁶ µl white blood cells.
deficiency and CNSHA. The present patient has class 1 G6PD deficiency. As a rule, the variant enzyme in patients with class 1 G6PD deficiency shows grossly abnormal kinetic characteristics and/or decreased heat stability in vitro than can account for their defective function in vivo.1,2,15

It is noteworthy, therefore, that the present variant was characterized by normal in vitro heat stability and kinetic properties, unlike previously reported cases of class 1 G6PD deficiency.1,4,5 In addition, electrophoretic studies on the present variant showed the only G6PD abnormality to have slightly fast mobility at pH 8. Because the characteristics of the enzyme in the present patient appear to be unique, we propose that the enzyme be called G6PD Barcelona in order to distinguish it from other enzymes associated with class 1 G6PD deficiency.

The most interesting aspect of the present variant is its strongly decreased residual activity in leukocytes in absence of in vitro heat stability or strongly diminished immunologic specific activity. Therefore, it seems reasonable to assume that the main molecular mechanism of the enzymopathy is probably a decrease in the number of kinetically normal G6PD molecules rather than an accelerated breakdown of the enzyme shortly after its synthesis. The fast electrophoretic mobility of G6PD Barcelona can be explained either by the structural gene mutation itself or by posttranslational modifications of muted enzyme in vivo or during the purification process.

When sufficiently severe, leukocyte G6PD deficiency gives rise to metabolic and bactericidal defects of granulocytes and in some instances to clinical manifestations that resemble those of patients with chronic granulomatous disease (CGD).7,8 These two conditions usually differ, however, with respect to the time of appearance of infection and the presence of hemolytic anemia.6-8,14-17 Thus, none of the 50 different variants of G6PD deficiency associated with CNSHA gave rise to increased susceptibility to bacterial infections,1,2,4,5,13,32,33 and only 6 patients with G6PD deficiency, including the present case, are known in which CNSHA was associated with infections in the upper respiratory tract or urinary tract.7,8 The condition of these 6 patients was characterized by a complete absence of erythrocyte G6PD activity and a severely decreased (<5% of normal) enzyme activity in granulocytes which, like CGD granulocytes, lack respiratory burst, fail to stimulate hexosomonophosphate (HMP) shunt activity, do not reduce NBT to purple formazan, and do not generate bactericidal hydrogen peroxide during phagocytosis.7,8

Leukocytes in the present patient showed G6PD activity of about 2% of normal and as expected in accordance with the views of Baehner et al.,7 NBT reduction, ferricytochrome-c reduction, and iodination were markedly decreased in the patient’s granulocytes, suggesting abnormally low HMPS activation during phagocytosis. What is more, the patient had clinical signs of enhanced susceptibility to infection. It is not clear, however, whether the molecular abnormalities or the kinetic properties of G6PD Barcelona contributed to the severity of impairment in granulocyte function. To date, only one G6PD deficiency variant is known in which the advantageous kinetic properties of the mutant enzyme (G6PD Benavento-like) have been considered to provide an explanation for the absence of granulocyte bactericidal defect despite the presence of leukocyte G6PD activity below 5% of normal.38 The present variant has the same degree of leukocyte enzyme deficiency as seen in G6PD Benavento-like, but it shows a normal kinetic pattern. Perhaps the present variant is less efficient than G6PD Benavento-like for maintaining HMP shunt activation during
phagocytosis, thus leading to clinical manifestations of enhanced susceptibility to infections. Further studies are needed to investigate this possibility. Nevertheless, the present report provides further evidence for the role of G6PD in PMN function.

ACKNOWLEDGMENT

We are indebted to Dr. A. Kahn (Institut de Pathologie Moleculaire INSERM U.129, Paris) for providing us the anti-G6PD necessary for the immunologic studies, to M. J. Insa for her technical assistance, and to Teresa Martinez for typing the manuscript.

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