Inhibition of Intravascular Platelet Aggregation by Endothelium-Derived Relaxing Factor: Reversal by Red Blood Cells

By Donald S. Houston, Pauline Robinson, and Jon M. Gerrard

Studies were performed to determine whether endothelium-derived relaxing factor (EDRF) can inhibit platelet aggregation within the vascular lumen, and if so, whether the inhibition persists in the presence of red blood cells (RBCs). Canine femoral arteries mounted in an organ bath were perfused with physiologic saline solution to which acetylsalicylic acid was added to block prostacyclin formation. During contraction with phenylephrine, addition of acetylcholine to the perfusing solution to evoke EDRF release relaxed the vessel wall. Washed human platelets labeled with $^{14}$C-5-hydroxytryptamine were added to the perfusing solution, and activated by thrombin infused via a branch vessel. The perfusate was collected downstream and centrifuged; the fraction of $^{14}$C-5-hydroxytryptamine appearing in the supernatant reflected the degree of platelet activation. Stimulation of EDRF release with acetylsalicylic acid inhibited $^{14}$C-5-hydroxytryptamine release. Hemoglobin (Hb) (10 $\mu$g/mL) blocked vascular relaxation and platelet-inhibition. RBCs at a hematocrit of 10% (treated with echotoxiphate to block erythrocyte cholinesterase) did not prevent relaxation but reversed the platelet inhibition. Lower hematocrits did not completely block the inhibition. Thus, erythrocyte Hb may modulate the inhibition of intraluminal platelet aggregation by EDRF.

© 1990 by The American Society of Hematology.

From www.bloodjournal.org by guest on August 16, 2017. For personal use only.
bovine Hb, and phenylephrine hydrochloride were obtained from Sigma Chemical Co (St Louis, MO). Bovine thrombin (Thrombostat) was obtained from Parke-Davis (Scarborough, Ontario, Canada). Echitriophate iodide (Ayerst) was dissolved in the supplied diluent and stored refrigerated in this stock solution. [2-14C]-5-hydroxytryptamine binoxalate (2.2 GBq/mmol; 3.7 MBq/mL) was obtained from New England Nuclear (Boston MA).

Physiologic saline solution contained the following (except as noted, all concentrations given in millimolar): NaCl 118.3, KCl 4.7, CaCl2 1.2, MgSO4 1.2, KH2PO4 1.2, NaHCO3 25, Na2EDTA 0.026, and glucose 11.1; pH was adjusted to 7.4 after gassing with 5% CO2. When used for perfusion, 1 g/L bovine albumin was added. Wash solution (modified Hanks’ balanced salt solution) contained: NaCl 137, KCl 5.36, KH2PO4 0.441, Na2HPO4 0.177, NaHCO3 3.35, MgCl2 0.5, glucose 10, and 1 g/L bovine albumin; pH was adjusted to 7.35. Citrate anticoagulant contained: trisodium citrate 85, citric acid 65, glucose 111. Glutaraldehyde was diluted to 0.1% (vol/vol) in White’s saline (NaCl 120, KCl 5, MgSO4 2.3, Ca [NO3]2 3.2, NaHCO3 6.5, Na2HPO4 0.41, KH2PO4 0.19, Phenol Red 0.014; pH 7.4).

Aggregometry studies. Platelets prepared as above and suspended in physiologic saline solution with 1 g/L bovine albumin were studied in a light-transmission aggregometer (Payton Associates, Scarborough, Ontario, Canada). Aggregometry was performed at 37°C in 1-mL siliconized glass cuvettes, with magnetic stirring of the platelets. The baseline of the recording pen was set using the platelet suspension, and 100% aggregation was set using the physiologic saline solution. Light transmission was measured and percent aggregation recorded at 2 minutes after addition of bovine thrombin (0.25 U/mL). Aggregation was stopped 3 minutes after addition of the agonist by addition of an equal volume of 0.1% glutaraldehyde.

In cases where RBCs were incorporated in the suspension, the volume of physiologic saline solution was decreased accordingly so that the number of platelets was constant. Because of their opacity, when RBCs were present light transmission could not be recorded.

After aggregation was stopped, the samples were centrifuged at 800g for 10 minutes. Supernatant, 0.5 mL, was removed and 3.0 mL of scintillation fluid (Ecolite, ICN, Irvine, CA) added for scintillation counting. The pellet was suspended in 0.5 mL Tris HCl with 1% sodium dodecylsulphate and counted in the same way. 5-Hydroxytryptamine release was expressed as the number of counts in the supernatant divided by the total counts (pellet plus supernatant). In cases where the pellet contained RBCs, it was resuspended in 20 mL of physiologic saline solution to dilute the RBCs, which would otherwise interfere with the scintillation counting. An aliquot of 0.5 mL of this suspension was taken for counting; the total counts thus obtained were only slightly less than those obtained when no RBCs were included, indicating that there was no substantial quenching due to the RBCs.

Perfusion studies. After mounting in the tissue chamber, the arteries were perfused with physiologic saline solution with 1 g/L bovine albumin. Acetylsalicylic acid (10−4 mol/L) was added to the perfusion fluid for the initial 30 minutes to block endothelial production of prostacyclin. The vessels were then contracted by adding phenylephrine (3 × 10−6 to 10−5 mol/L) to the bath solution surrounding the vessel; the vessel remained in contact with phenylephrine for the remainder of the experiment. After a stable contraction had been obtained, presence of functional endothelium was demonstrated in each case by adding acetylcholine (10−4 mol/L) to the perfusion fluid and observing a relaxation in response to this endothelium-dependent vasodilator (Fig 2). Thrombin was then infused via the side branch at an initial rate of 1 U/mL (expressed as the final concentration after dilution in the perfusing stream). The response to thrombin was variable, but was consistently tachyphylactic; i.e., when relaxation occurred, the tension would spontaneously.
EDRF, PLATELETS, AND ERYTHROCYTES

Phenylephrine • Acetylcholine Phenylephrine
• Thrombin

Acetylcholine
Wash
Hemoglobin
Acetylcholine

1g 2 min

Fig 2. Isometric tension recording from a representative perfusion experiment. Phenylephrine (3 × 10⁻⁶ mol/L) is added to the bath surrounding the vessel; it remains in contact with the vessel wall for the remainder of the experiment. Acetylcholine (10⁻⁸ mol/L) is added to the perfusing solution: "Wash" denotes the change back to drug-free perfusing solution. Thrombin (1 U/mL) is infused via a proximal side branch, which continues throughout the remainder of the experiment (the dose is reduced to 0.25 U/mL after the second wash). Note that whereas the response to thrombin is tachyphylactic, the response to acetylcholine is not. The heavy double bars represent elision of time. Hb (10⁻⁵ mol/L) is added to the perfusing solution, a modest contraction of the vascular smooth muscle ensued. Additionally, platelet activation was significantly inhibited (¹⁴C-5-hydroxytryptamine release reduced by 17.5% ± 3.7% of the response to thrombin, n = 20 total experiments). This inhibitory effect was consistent and repeatable over the duration of an experiment for a given vessel (Fig 3).

Table 1. Aggregometry Experiments

<table>
<thead>
<tr>
<th>Aggregometry Experiments</th>
<th>0.25 U/mL</th>
<th>Unstimulated</th>
<th>Thrombin + Acetylcholine</th>
<th>Thrombin + Hb</th>
<th>Thrombin + Acetylcholine + Hb</th>
<th>Thrombin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 5)</td>
<td>(n = 5)</td>
<td>(n = 5)</td>
<td>(n = 4)</td>
<td>(n = 4)</td>
<td>(n = 5)</td>
</tr>
<tr>
<td>Aggregation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¹⁴C-5-HT release</td>
<td>58.2 ± 3.7</td>
<td>0</td>
<td>56.4 ± 3.1</td>
<td>58.5 ± 3.7</td>
<td>60.5 ± 4.1</td>
<td>56.1 ± 3.0</td>
</tr>
</tbody>
</table>
| Responses are expressed as percentages.
Thrombin 0.25 U/ml + ACh 1uM

Fig 3. Results of a perfusion experiment, in which platelet activation in transit through the vessel is reflected by the percentage of $^{14}$C label released into the supernatant of the perfusate collected downstream. In all but the last column ("Unstimulated"), thrombin is infused via a proximal side branch to activate the platelets. "ACh" signifies the addition of acetylcholine (10^{-6} mol/L) to the perfusion solution (light columns) during thrombin infusion.

DISCUSSION

The physiologic role of EDRF is not yet fully known. From observations that adenosine diphosphate and 5-hydroxytryptamine released from aggregating platelets can provoke endothelium-dependent relaxation in coronary arteries, it seems that one such role may be to promote vasodilatation at sites of platelet thrombus formation, and thereby protect arteries from occlusion.13 Inhibition of platelet aggregation by EDRF would further preserve blood flow. However, if the platelet-inhibitory action of EDRF were unregulated, it could cause a bleeding diathesis.

The current studies demonstrate that the endothelial cells of a perfused artery can inhibit the activation of platelets passing through the lumen. This inhibitory activity (triggered by acetylcholine) is almost certainly due to EDRF: the production of the other known endothelially derived platelet inhibitor, prostacyclin, is prevented by acetylsalicylic acid; and the inhibitory activity is blocked by Hb, a specific antagonist of EDRF activity.3 Experiments in the aggregometer confirm that acetylcholine does not directly inhibit platelet activation, nor does Hb augment it.

Several investigators have previously demonstrated that endothelium-derived relaxing factor can inhibit platelet aggregation and adhesion in vitro and in situ in a buffer-perfused lung. However, many of those studies have used cultured endothelial cells rather than intact vascular endothelium as the source of EDRF, and most have studied the platelets in the aggregometer. Two studies have demonstrated that systemic exposure to a large dose of carbamylcholine to release EDRF in vivo can inhibit platelet function (assessed by pulmonary platelet trapping or in vitro aggregometry); however, in those experiments one presumes that the entire body's endothelium has been activated. Thus, until now it has remained moot whether a conduit artery's endothelium in situ could release enough EDRF locally to inhibit platelets flowing through that artery. The present experiments confirm that it can.

Free Hb can block the platelet-inhibiting action of locally released EDRF. Whole blood contains about 200 to 250 times as much Hb as was required, in cell-free form, to abolish the platelet inhibition. However, it has not been clear whether the Hb contained within erythrocytes is available to bind EDRF. One study using a cascade bioassay system found that a concentration of rat RBCs “equivalent to 10^{-6} mol/L hemoglobin” could abolish endothelium-dependent relaxation when added downstream from the donor but upstream from the assay tissue. This number of RBCs would amount to a hematocrit of only about 0.02%. On the other hand, two studies have been able to demonstrate inhibition, presumed to be due to EDRF, of platelet aggregation in whole blood using electrical impedance-aggregometry.

The present experiments show that RBCs can block platelet inhibition by EDRF. Because a 10% hematocrit is sufficient to do so, it would appear that the endothelium of a large artery perfused in vivo by whole blood with a normal hematocrit would not be able to release enough EDRF to abolish platelet thrombus formation intraluminally. Even so, EDRF may still be able to inhibit platelet adhesion to the endothelial surface (and hence prevent initiation of thrombus formation): as erythrocytes tend to stream to the center of the lumen, platelets in the immediate vicinity of the endothelial cell may be exposed to inhibitory concentrations of EDRF. Furthermore, synergistic interaction between the antiaggregatory effects of EDRF and prostacyclin may amplify the effect of EDRF.

In contrast to their effect on platelet inhibition, RBCs do not block the relaxation of arterial smooth muscle evoked by EDRF release in response to acetylcholine. This is in keeping with in vivo observations of endothelium-dependent vasodilation in blood-perfused arteries. In contrast, the fact that free Hb can block smooth muscle relaxation may indicate that Hb can gain access to the subendothelial space and bind EDRF there; intact RBCs, needless to say, cannot do so.

The lack of inhibition of relaxation by intact RBCs demonstrates two other points. First, the blockade of acetylcholine’s inhibitory effect is not merely an artifact due to breakdown of acetylcholine by the RBCs; this confirms that treatment with echothiophate has effectively blocked...
ERYTHROCYTE ACETYLCHOLINESTERASE. Second, the effect of RBCs is not due simply to hemolysis and release of free Hb (although we cannot rule out the possibility that a slight degree of hemolysis may have occurred, which may have contributed somewhat to antagonizing the EDRF effect).

It is of interest that a hematocrit on the order of 10% appears necessary to block completely the platelet inhibition by EDRF. This is 40 to 50 times the concentration of free Hb needed to do so. This would suggest that the Hb contained within RBCs is in some way unable to freely interact with EDRF, even though it is generally supposed that nitric oxide (the putative chemical identity of EDRF) should be freely permeable through cell membranes. Streaming of RBCs to the center and platelets to the periphery of the lumen may explain this apparent discrepancy.

An intriguing speculation arises from the current result that a relatively large concentration of RBCs is needed to block the platelet-inhibiting action of EDRF. In anemia, platelets may be exposed to an increased tonic inhibitory effect of EDRF, and the bleeding time thereby prolonged. Such an inverse correlation between hematocrit and bleeding time has long been recognized clinically, although it has never been fully explained.

In summary, EDRF released from a conduit artery's endothelium can inhibit the activation of platelets in transit through the vessel. This effect, at least in large-caliber vessels, is blocked by the presence of RBCs.

ACKNOWLEDGMENT

The authors acknowledge the technical assistance of Esther Taylor, and thank Dr Luis Oppenheimer and Michael Hoppensack for provision of the arteries.

REFERENCES


Inhibition of intravascular platelet aggregation by endothelium-derived relaxing factor: reversal by red blood cells

DS Houston, P Robinson and JM Gerrard