Activation of the Kallikrein-Kinin System After Endotoxin Administration to Normal Human Volunteers


The objective of this study was to determine the role of the kallikrein-kinin system in healthy humans after intravenous administration of either Escherichia coli endotoxin or saline. We studied a total of 18 healthy nonsmoking volunteers, 23 to 38 years old, in an open-label study at the Critical Care Medicine Department, Clinical Center, National Institutes of Health (Bethesda, MD) in which some of the patients served as their own controls. After baseline data collection, the subjects received intravenously either E coli endotoxin (n = 15, 4 ng/kg of body weight) or saline (n = 8, controls). Signs, symptoms, systemic blood pressure, factor XII, plasma prekallikrein (PK), factor XI (FXI), antithrombin III (AT-III), high molecular weight kininogen (HK), and α2-macroglobulin–kallikrein complexes were measured at baseline and 1, 2, 3, 5, and 24 hours after injection of either saline or endotoxin. After infusion of endotoxin, we found the functional plasma levels of FXI decreased at 2 hours (P < .05) and at 5 hours (P < .05). Functional PK was significantly depressed by 2 hours (P < .05), at 5 hours (P < .05), and at 24 hours (P < .01), whereas the PK antigen was only low at 5 hours (P < .05). These changes were accompanied by a significant increase in circulating α2-macroglobulin–kallikrein complexes at 3 hours (P < .05) and 5 hours (P < .01). No significant changes occurred in the plasma levels of factor XII or HK. We concluded that clinical response to intravenous endotoxin in healthy human volunteers is associated with activation of the kallikrein-kinin systems. Further investigation is needed with specific inhibitors of the kallikrein-kinin system to define its primary or secondary role in the endotoxin-mediated reactions.

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the sequence of events that occurs in response to intravenous administration of endotoxin. In addition, we compared the data with previously reported effects of endotoxin (on the same group of normal volunteers) upon the cardiovascular and fibrinolytic systems as well as on the neutrophil function.

MATERIALS AND METHODS

Subjects and protocol. Eighteen healthy nonsmoking volunteers, 23 to 38 years old, participated in the study. The current investigation was performed simultaneously with an evaluation of the effects of endotoxin on hemodynamic and fibrinolytic systems. The results of these parts of the study have been published elsewhere.5,6 Five of the subjects underwent repeat control studies without endotoxin 3 months later. The protocol was approved by the Institutional Review Board on Human Experimentation at the National Institutes of Health, and written consent was obtained from all subjects.

Blood collection. Blood samples were obtained through the indwelling radial artery catheter at 1, 2, 3, and 5 hours after infusion of endotoxin or normal saline. Samples obtained 24 hours after the infusion were drawn from a peripheral vein. All samples were collected in plastic syringes and immediately transferred to plastic tubes containing 3.8% sodium citrate (9:1, vol:vol) that were kept on ice. The samples were centrifuged at 2,500 rpm at 4°C for 10 minutes, and the top two-thirds of the plasma layer was removed and stored at -70°C until the time of assay.

Endotoxin preparation. Purified lipopolysaccharide from Escherichia coli (US Standard Reference Endotoxin, lot EC-5, Bureau of Biologics, Food and Drug Administration, Bethesda, MD) was supplied as a sterile dry powder containing 1 mg (~10,000 U) of endotoxin, which was reconstituted before infusion with 5 mL of sterile water.

Assays of coagulation and contact activation. Antithrombin III (AT-III) was measured by a functional microplate assay using the Coatest Antithrombin Kit (Kabi Pharmacia, Franklin, OH).18 The assay measured the extent of hydrolysis of a chromogenic substrate, S-2302, by the residual thrombin after inhibition of a fixed amount of thrombin by the inhibitor in the plasma sample. C1 inhibitor was measured by the inhibition of plasma kallikrein using an amidolytic assay as previously described,19 with the following modifications. The plasma was methyamine treated as described and kallikrein was added to the methyamine-treated plasma as per the reference method to form the reaction mixture. The assay was adapted to a microplate by the addition of a dilution of reaction mixture at specific time intervals (0.5, 1, 1.5, 2 and 4 minutes) to a microplate well containing 190 mL of 50 mmol/L Tris-Cl, 0.1% polyethylene glycol, 2 mmol/L S-2302, pH 7.9. Each assay point was allowed to incubate with substrate for 10 minutes before addition of 50 mL 5% acetic acid to stop the cleavage of amidolytic substrate. The absorbance was read at 405 nm and the apparent rate constant determined as described19 and converted to micrograms per milliliter of C1 inhibitor. PK levels were determined by a functional assay, using the chromogenic substrate, S-2302 (Pro-Phe-Arg-p-nitroanilide).20 Plasma was depleted of proteolytic inhibitors by incubation with dithiol for 15 minutes. Zymogen PK in the plasma samples was then activated by incubation with plasma PK activator (Kabi) containing HK-activated FXII and ellagic acid. S-2302 was subsequently added to each sample, and the extent of hydrolysis of the substrate was proportional to the amount of PK in the plasma samples.

FXI functional activity was determined by a method developed in this laboratory.21 In brief, plasma FXI was activated by kaolin (0.1 µg/mL) for 50 minutes at 23°C after acid treatment. This reaction was performed in the presence of soybean trypsin inhibitor (1.6 µmol/L) to inhibit plasma kallikrein generation during the activation step. C28 trypsin inhibitor (0.01 µg/mL) prevented hydrolysis of the chromogenic substrate S-2366 by FXIIa, and after 10 minutes of incubation, the chromogenic substrate was added. HK and FXII activated factor activities were determined by a slight modification of the method described elsewhere.22 One hundred microliters of FXII-deficient plasma (George King Biomedical, Inc, Overland Park, KS), or total kininogen-deficient plasma (Williams plasma), 100 µL of 20 mmol/L Tris (hydroxyethyl)-aminomethane (Tris) HCl, pH 7.4, containing 0.15 mol/L NaCl, 100 µL of kaolin (5 mg/mL in saline), and 100 µL of 0.2% inosithin in buffer were mixed together. Normal pooled human plasma (10, 5, 2, and 1 µL) was added and incubated at 37°C for 8 minutes. Coagulation time was determined after the addition of 100 µL of 30 mmol/L CaCl₂. This procedure was used to generate a standard curve (log-log relationship). Samples for analysis were assayed under the same conditions, using 10 µL of the human plasma sample, and data were expressed as a percentage of normal pooled human plasma. One unit is defined as the amount of activity in 1 mL of normal pooled human plasma.

PK antigen was measured by a sandwich-type enzyme-linked immunosorbent assay (ELISA) using two mouse monoclonals against the heavy chain of PK. These two monoclonal antibodies (MoAbs) have previously been shown to have nonoverlapping binding sites.23 Microplate wells were coated with the first monoclonal, 13G11, at a concentration of 5 µg/mL in 0.166 mol/L H₂BO₄, 0.125 mol/L NaCl, pH 8.5 over night at 23°C. The following day, the microplate wells were blocked with 0.5% bovine serum albumin (BSA) in phosphate-buffered saline (PBS)-Tween for 1 hour at 23°C. Samples were diluted in PBS-Tween + BSA and incubated in the microplate wells for 2 hours at 23°C. The second monoclonal used, 10B6, was directly conjugated with alkaline phosphatase by the method of Voller et al.24 This conjugated monoclonal was diluted in PBS-Tween + BSA to approximately 2 µg/mL and incubated in the wells for 2 hours. Finally, substrate (p-nitrophenyl phosphate, 1.5 mg/mL) was added to the microplate wells, and the absorbance read at 405 nm.

α₂-Macroglobulin–kallikrein (α₂M-Kal) complexes were determined with a sandwich ELISA using Fab fragments of a polyclonal antibody to α₂M as the capturing antibody, and a unique MoAb to kallikrein heavy chain (13G11) to detect kallikrein complexed with α₂M.25 The lower detection limit of the assay is approximately 5 mmol/L when the blood is processed at 23°C.31

Statistics. Results are presented as means ± SD. The zero time point was designated as 100% (for PK and FXI) to decrease statistical variability and to eliminate the influence of small differences at baseline between the groups, which could bias comparisons made at subsequent time points. Absolute values are given for the α₂M-Kal complexes. A multiple-comparison procedure, the Bonferroni-t test,26 was used, which is based on the t-test and includes an appropriate correction for the multiple comparisons.

RESULTS

Functional PK levels were significantly lower in the endotoxin group as compared with controls at 2 hours after infusion (P < .05) with a slight recovery by 3 hours. The concentration of functional PK decreased further and remained low throughout the rest of the experimental protocol (5 and 24 hours, P < .05 and P < .01, respectively, Fig 1), suggesting that this contact phase protein may serve as an indicator of contact activation by endotoxin.

PK antigen levels were significantly decreased (Fig 2) only
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...140-1 endotoxin TT, 140-4 endotoxin 120-0 endotoxin 88 880 60 40 20 0 baseline value 2h 3h 5h 24h Fig 1. Time course of plasma PK functional values after injection of endotoxin. The functional assay was performed with a chromogenic substrate as outlined in Materials and Methods.

during the 5-hour time interval (P < .05), paralleling the decrease in the functional levels at the same time interval. The ratio of PK function to antigen did not differ significantly for the endotoxin group when compared with the saline group.

FXI levels were significantly decreased (Fig 3) by the 2-hour time interval (P < .05). Like the PK levels, a recovery was observed by the 3-hour time interval, with a subsequent decrease in the circulating levels by the 5-hour interval (P < .01, Fig 3). Unlike the PK levels, the FXI levels were found normal by 24 hours after infusion of endotoxin.

There were no significant differences between functional levels of FXII, HK, C1 inhibitor, or AT-III in the endotoxin group compared with the saline control (data not shown).

The concentration of a2M-Kal complexes was elevated fourfold in the endotoxin-treated group by 3 hours (P < .05) and fivefold by 5 hours (P < .01), with a decrease to normal in the circulating levels of complexes by 24 hours (Fig 4). All patients receiving endotoxin but none receiving saline showed elevated a2M-Kal complexes at 3 hours (range, 6.9 to 23 nmol/L) and at 5 hours (range, 11.4 to 17.5 nmol/L).

DISCUSSION

Our observations show that within 2 hours after the administration of endotoxin to normal humans, contact activation is initiated. PK and FXI decrease, and by 5 hours reach a nadir that is accompanied by a fivefold increase in

The temporal relationship of these responses to endotoxin can be related to previously published observations for the same or similar subjects describing hemodynamics and fibrinolytic responses to endotoxin.16,17 Endotoxin administration to normal humans results in a hyperdynamic cardiovascular state characterized by an elevated cardiac index and heart rate and by a decreased mean arterial pressure (MAP) and systemic vascular resistance.18 In retrospect, the initiation of this hyperdynamic cardiovascular response was associated with a decrease in functional levels of PK (2 hours), indicative of kallikrein generation. Activation of PK to kallikrein results in the generation of Bk from HK. Bk is one of the mediators of the pain and increased capillary permeability characteristic of the inflammatory response.15 We have recently shown, in an experimental model of lethal bacteremia (baboons), a significant correlation (Spearman R value of .929) between the decline in the levels of HK and the development of irreversible hypotension.13,27 In the current study, the small amount of kallikrein generated is
not sufficient to detectably alter the concentration of HK or C1 inhibitor. A modest decrease of 10% of HK would result in a concentration of 65 nmol/L Bk, which can contribute to the observed hemodynamic changes.

Previous work has shown that a small dose of endotoxin promotes plasminogen activation and its subsequent inhibition in normal subjects. Tissue plasminogen activators were found to be 7 times higher when compared with control values by 3 hours. We detected a,M-Kal complexes by 3 hours (Fig 4), with a maximum concentration by 5 hours, indicating formation of the active enzyme, kallikrein, and its subsequent inhibition. The pathophysiology role of intrinsic plasminogen activators as opposed to tissue plasminogen activators and urokinase is unclear. In vitro, kallikrein converts plasminogen to plasmin in an apparently stoichiometric reaction. However, the activity of activated FXI or FXIIa in plasma is calculated to be only 5% that of kallikrein. Recently, kallikrein has been shown to convert single-chain urokinase to the two-chain enzyme, which might account for enhanced fibrinolysis after exposure to activating surfaces. Whatever the mechanism, it is possible that contact activation may enhance the fibrinolytic system, which may lower the risk of fibrin deposition during endotoxemia.

Neutrophil activation with release of the neutral protease, elastase, occurs by 3 hours after endotoxin administration. Preliminary data has shown that neutrophils are primed in vivo to produce enhanced amounts of superoxide after endotoxin administration to humans. The priming of neutrophils occurred by 4 hours, but not at 15 minutes after endotoxin administration. Increased levels of a,M-Kal complexes, which result from kallikrein generation due to contact activation, become significant at 3 hours. Because kallikrein can induce neutrophil degranulation, this result suggests that contact activation contributes to the activation and priming of neutrophils in vivo after endotoxin administration. Recently, it has become apparent that many of the biologic effects of endotoxin are mediated by cytokines, mainly synthesized and released by macrophages, monocytes, and endothelial cells, including tumor necrosis factor (TNF), interleukin-1 (IL-1), IL-6, and IL-8. Michie et al reported release of TNF into the circulation after infusion of endotoxin but were unable to detect IL-1 in circulation and did not measure IL-6. Fong et al detected IL-6 in plasma, and Van Deventer et al confirmed that both TNF and IL-6 are released after endotoxin administration in human volunteers. In another study, the levels of cytokines correlated with fever. Furthermore, 30 to 45 minutes after endotoxin-induced release of TNF into the circulation, a steep increase in the plasma tissue plasminogen activator (t-PA) concentration was noted, followed by a decrease in MAP. In vitro, endotoxin and TNF both stimulate the release of plasminogen activator inhibitor (PAI) by endothelial cells, but decrease the synthesis of t-PA. Activation of the contact system in this study occurred within 120 minutes after the peak concentration of TNF (60 minutes). In agreement with the study of Van Der Poll et al, we found that in patients receiving a high dose of TNF as part of a protocol for cancer treatment (unpublished results), no activation of the contact system was detected even with sensitive techniques such as measurement of a,M-Kal complexes. These results suggest that TNF by itself cannot support contact activation and that endotoxin or other cytokines may be required for initiation of contact activation.

It has recently been shown that TNF primes human neutrophils for enhanced superoxide production in vitro, and kallikrein, which stimulates neutrophil degranulation, may enhance the effects.

We conclude that experimental endotoxemia in humans induces activation of the contact system. The activation of the contact system was found to be temporally associated with the hemodynamic changes induced by endotoxemia, as well as with changes in the neutrophil function and fibrinolytic system. The results indicate that a low dose of endotoxin may induce a prolonged activation of the contact system. Studies with contact system inhibitors are required to prove that it is an important mediator of the changes induced by the administration of endotoxin. Our most recent finding, that an MoAb to FXII, which blocks contact activation, ameliorates secondary hypotension in vivo in septic baboons, supports this proposition.

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REFERENCES