Effect of Granulocyte-Macrophage Colony-Stimulating Factor on Sepsis-Induced Organ Injury in Rats

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The administration of granulocyte-macrophage colony-stimulating factor (GM-CSF) to patients with severe active infections has been questioned because activation of neutrophils may cause tissue injury. To identify the effect of GM-CSF administration on severe sepsis, we examined the survival rate and pathologic changes in vital organs using the rat lethal sepsis model. Rats received 20 μg of recombinant murine GM-CSF (rmGM-CSF) 3 hours after the onset of peritoneal sepsis. The survival rate did not improve, and earlier deaths than in the control group were observed. In addition, the inhibition of early leukosequestration in the peritoneal cavity was seen in animals treated with GM-CSF. These results suggested that the administration of rmGM-CSF after the onset of sepsis was not beneficial; thus, we concluded that care should be taken in the clinical use of GM-CSF in severe infection.

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MATERIALS AND METHODS

CLP model. Male Wistar rats (Japan Animal, Osaka, Japan) weighing 200 to 250 g were used for all experiments. The procedure of Wichterle et al. was adapted to induce septic peritonitis. After overnight fasting, CLP was performed under light ether anesthesia. High-dose CLP was performed using anti-TNF antibody and IL-1-receptor antagonist have been clinically evaluated in SIRS as well as in some animal models. The first line of host defense is mainly initiated by neutrophils that can phagocytose and kill bacteria. Although neutrophils are also involved in the pathophysiology of SIRS, the role of hemopoietic cytokines such as granulocyte colony-stimulating factor (G-CSF) and granulocyte-macrophage colony-stimulating factor (GM-CSF) in the host defense mechanism against severe infection is very important.

We recently showed that administration of recombinant human G-CSF (rhG-CSF) after the onset of sepsis led to a significant therapeutic effect in decreasing the mortality from peritonitis-induced MOF. However, it was not clear whether GM-CSF also had therapeutic efficacy.

rhGM-CSF has been used clinically to shorten the duration of granulocytopenia after chemotherapy-induced myelosuppression. GM-CSF is a 22-kD glycoprotein that increases neutrophil production in bone marrow and enhances their functions, which include stimulation of degranulation, respiratory burst, phagocytic activity, and superoxide production by mature granulocytes. It also decreases neutrophil migration and may immobilize neutrophils in sites of inflammation.

This cytokine also increases the cytotoxicity of macrophages. Various reports have shown that prophylactic administration of GM-CSF significantly enhances host resistance to bacteria and decreases mortality in experimental animals.

However, these studies were examined using GM-CSF before the onset of bacteremia and sepsis. When GM-CSF is administered after the onset of infection, that is, when GM-CSF is given after the clinical diagnosis of infection, it is thought that it may prime or activate neutrophils and induce neutrophil-related tissue injury in remote organs during serious infection. It is important to clarify whether treatment with GM-CSF in a septic state is beneficial to the host.

To examine the effect of recombinant murine GM-CSF (rmGM-CSF) administration after the onset of infection, we chose the rat cecal ligation and puncture (CLP) model because it resembles the clinical profile of perforative peritonitis with Gram-negative bacteremia and produces chronic normotensive septic syndrome in animals. This is the same model as that in which we previously showed the therapeutic effect of G-CSF. At the same time, we examined the biochemical and pathologic changes after single administration of GM-CSF.

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Rats were subcutaneously injected with rmGM-CSF (20 μg) at a volume of 0.3 mL 3 hours after the induction of CLP because the first occurrence of bacteremia occurred 6 hours after induction in this model. Control rats received the same volume of physiologic saline. GM-CSF was administered 3 hours after CLP to compare the effect of G-CSF administration. In a previous study, G-CSF (15 μg) administration 3 hours after CLP was effective in reducing the mortality, but, when administered 6 hours after CLP, it was not effective. When G-CSF was administered at the same time as or 3 hours before CLP, there was also an improvement in survival, but it was less effective. As the therapeutic efficacy of GM-CSF was investigated, GM-CSF was not administered before or at the same time as induction of CLP. All experiments were conducted by the same person using the same general procedure, and survival experiments were performed blind. Blood samples were taken aseptically from the tail vein at suitable time intervals for hematologic and biochemical examinations. Solutions of rmGM-CSF and physiologic saline were not contaminated with endotoxin as determined by endotoxin analysis (Toxicolor test; Seikagaku Kogyo, Co, Ltd, Tokyo, Japan).

**Neutrophil counts in peritoneal lavage fluid.** Peritoneal neutrophils were obtained by peritoneal lavage from rats 6 or 18 hours after CLP. After laparotomy and under direct vision, 10 mL phosphate-buffered saline (PBS) was injected into the peritoneal cavity with care to avoid puncturing any abdominal viscera or lacerating the abdominal wall. Animals were gently agitated, after which lavage fluid was aspirated into a sterile 10-mL syringe, and the same procedure was then repeated. Cell separation was performed using a Ficoll-Paque density gradient that was obtained from Pharmacia Fine Chemicals (Uppsala, Sweden). Cells were centrifuged at 450g for 25 minutes. Contaminating red blood cells were removed by hypotonic lysis and then centrifuged at 150g for 5 minutes. The resultant pellet that was rich in neutrophils was resuspended in cold PBS and centrifuged at 150g for 5 minutes. After the final wash, cells were resuspended in 1.0 mL PBS and counted using a hemocytometer.

**Histologic examination.** After rats were killed and bled, the heart was flushed with normal saline. The liver, lungs, cecum, spleen, and kidneys were fixed in buffered formalin, embedded in paraffin, and stained with hematoxylin and eosin. Histologic examinations were performed by a pathologist (N.M.) in a blind manner.

**Statistical analysis.** Each group was composed of six rats. Survival data were analyzed using the Kaplan-Meier method, and variations are expressed as the standard deviation of the mean. Two-tailed P values were calculated using Student’s t-test for each analysis, and significance was determined or assumed when P < .05. Statistical analysis was performed on a Macintosh SE microcomputer using StatView SE+Graphics software (Abacus Concepts, Inc, Berkeley, CA).

**RESULTS**

Figure 1 shows the difference in survival rate after induction of CLP. Single subcutaneous administration of 20 μg rmGM-CSF 3 hours after induction of CLP showed no improvement in 48-hour survival rate compared with that for the control CLP group (rmGM-CSF, 0% (0 of 6); control, 16.7% (2 of 12)). The 12-hour survival rate in the rmGM-CSF 3 hours after induction of CLP was 20.0% (3 of 15) compared with the control group (100% (7 of 7)).
CSF group decreased to 66.7% (4 of 6) compared with that for the saline control group (100%, 12 of 12; P < .05). The physical appearance of rats receiving GM-CSF was not different from those receiving physiologic saline, although some animals receiving GM-CSF showed symptoms of serious illness such as restlessness or crouching without motion.

A temporary decrease in circulating leukocyte counts was induced after CLP. There was no difference in circulating leukocyte and neutrophil counts between the two groups (Fig 2).

In the GM-CSF group, neutrophil counts in peritoneal lavage fluid were significantly lower than those in the control CLP group at 6 hours after CLP. (6 hours, 7.2 ± 0.4 × 10⁶/mL v 22.2 ± 4.9 × 10⁶/mL, P < .05; 18 hours, 18.6 ± 2.4 × 10⁶/mL v 22.5 ± 4.1 × 10⁶/mL, respectively).

Figure 3 shows the histologic liver findings in the control and GM-CSF groups. Dilated hepatic sinusoids around the central veins, neutrophil infiltration, and proliferation of Kupffer cells were found in the control group. This is the picture of mild hepatic injury observed in shock. In the GM-CSF group, the changes appeared a little more marked, and centrilobular degeneration and necrotic changes (nuclear defects and swelling of the cytoplasm) were also observed.

No apparent differences could be found in other organs. Numerous neutrophil and macrophage infiltrations were noted in the pulmonary septa showing the features of respiratory failure. Acute inflammatory change and abscess formation composed of marked neutrophil accumulation and necrotic tissue could be seen in the cecal serosa suggesting acute supplicative panperitonitis. Congestion and cellular infiltration in the red pulp were found in the spleen. Only mild tubular dilatation was found in the kidneys, without tubular necrosis or degeneration.

Figure 4 shows the effect of rmGM-CSF on changes in biochemical test values indicating organ dysfunction after the induction of CLP. Subcutaneous administration of rmGM-CSF in the CLP model significantly increased the plasma glutamic-pyruvic transaminase (GPT) level 8 hours after the induction of CLP (P < .05). There were no significant change in the blood urea nitrogen (BUN) levels.

**DISCUSSION**

GM-CSF is now broadly used in immunocompromised patients suffering from various types of advanced cancer or acute immunodeficiency syndrome to increase neutrophil counts to the point where they can fight bacteria. However, it is not known whether GM-CSF administration is clinically safe and useful when it is administered as a host defense response modifier when infection is already present. Therefore, we induced severe peritonitis in a rat model and investigated the therapeutic effect of GM-CSF.

In the present model, early death, ie, before 12 hours after the onset of CLP, is rare. Progressive peritonitis leads to endotoxin shock and to mortality in the late septic phase. However, after GM-CSF administration, centrilobular necrosis in the liver was seen in the early stage, and the plasma GPT concentration increased earlier than in the control group. This suggests that the liver dysfunction may contribute to the earlier death seen in the GM-CSF–treated animals. Spolarics et al showed that neutrophils accumulated in the liver and lungs in normal rats 15 minutes after GM-CSF administration and that metabolic changes in the liver were also observed. For neutrophil-related liver injury, Hewett et al showed that administration of antibody to leukocytes reduced liver toxicity after injection of lipopolysaccharide (LPS) in a rat model. We previously showed that neutrophils activated by TNF could damage hepatocytes in vitro. Pathologic changes such as hepatic necrosis and cellular infiltration observed after the administration of LPS and TNF were almost the same as those in our present model. When GM-CSF was administered alone, these changes were not observed. Thus, endotoxin or TNF might be produced after CLP, and they might act along with GM-CSF. Because GM-CSF could induce production of TNF by fibroblasts in vitro, these pathologic changes in the liver might be mediated secondarily by the production of TNF. Gorgen et al reported that circulating TNF increased after the administration of GM-CSF to a galactosamine-induced liver dysfunction model, whereas it decreased after the administration of GM-CSF. This result supports the finding that TNF along with GM-CSF may take part in liver toxicity.

In the present study, neutrophil counts in peritoneal lavage
In the present study, the dose of GM-CSF was thought to be enough to induce neutrophilia in normal rats. Because the CLP model was a good sepsis model for induction of neutrophil sequestration into the peritoneal cavity, peripheral neutrophil counts did not increase even when the full dose of GM-CSF (20 μg) was administered after the onset of peritonitis. However, when half the dose of GM-CSF (10 μg) was administered after the onset of peritonitis, no adverse effects were observed in the present model (data not shown). This suggests that tissue injury may not be caused by activated neutrophils alone. When GM-CSF is administered to neutropenic animals before infectious episodes, neutrophil counts may return to the normal range, and endogenous cytokines induced by GM-CSF will increase the host defense against infection. TNF, which is induced by GM-CSF, induces tolerance to infection, and we can see the prophylactic effect of GM-CSF. However, GM-CSF administration after the onset of infection could stimulate a vicious cascade of cytokine production via macrophage stimulation, and then a detrimental effect might arise. This strongly indicates that the timing of administration is quite important in cytokine modulation for the treatment of infection.

Granowtitz et al.\(^{14}\) showed that when endotoxin was injected into human volunteers, serum GM-CSF could not be detected. Recently, we showed that serum IL-6 increased after surgery and during infection.\(^{25}\) We could also detect a simultaneous increase in serum G-CSF after surgery (unpublished data). Until now, we have speculated that IL-6 and G-CSF might act as host defense mediators similar to hormones. However, we could not detect any circulating TNF and IL-1 in these patients. This indicates that TNF and IL-1 along with GM-CSF may act only locally at the site of inflammation and mediate only via locally activated immune cells. Therefore, the systemic administration of such locally acting cytokines might be dangerous when infection is already present.

In the present study, we showed that administration of rmGM-CSF after the onset of peritonitis-induced sepsis failed to increase the survival rate in the rat CLP model. This indicates that the administration of GM-CSF for the treatment of severe peritonitis and its application to patients suffering from sepsis is not clinically recommended.

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