Inhibition of Heparin Activity in Plasma by Soluble Fibrin: Evidence for Ternary Thrombin-Fibrin-Heparin Complex Formation

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The ability of heparin to dramatically enhance the inactivation of thrombin (IIa) by antithrombin III (ATIII) in buffer is negated through formation of a IIa-fibrin-heparin ternary complex (Hogg and Jackson, Proc Natl Acad Sci USA 86:2619, 1989; Hogg and Jackson, J Biol Chem 265:241, 1990). IIa, in this ternary complex, is protected from inactivation by ATIII. Our aim was to determine whether fibrin also compromises heparin efficacy in plasma. We found that soluble fibrin ablated the heparin-mediated prolongation of the thrombin time with half-maximal effect at 60 nmol/L fibrin. The heparin-mediated prolongation of the activated partial thromboplastin time (APTT) was also reduced by fibrin with half-maximal effects at 140 nmol/L fibrin using 0.12 U/mL heparin and 500 nmol/L fibrin using 0.25 U/mL heparin.

HEPARIN, A COMPLEX glycosaminoglycan of alternating D-glucosamine and uronic acid residues, is a potent anticoagulant of proven clinical value. Heparin is an effective antithrombotic because its primary target is the serine proteinase, thrombin (IIa), an enzyme central to the maintenance of hemostasis and the processes of thrombosis. Heparin dramatically accelerates the rate of inactivation of IIa by the serpin, antithrombin III (ATIII). It has been proposed that the predominant antithrombotic action of heparin in plasma is via the inhibition of IIa activation of the cofactors factors V and VIII, which in turn inhibits further IIa generation.1–3

Despite its excellent anticoagulant properties, there are some clinical situations in which heparin’s efficacy is limited. Recurrent coronary artery disease following thrombolytic therapy occurs in one third of patients, despite administration of heparin.4–6 Also, preventing the propagation of venous thrombosis requires higher concentrations of heparin than preventing its formation,7 and 25% of patients still have thrombus extension while receiving heparin treatment.8 These situations usually are characterized by dynamic thrombotic events with extensive IIa and fibrin formation.

Hogg and Jackson9 have shown in studies using purified proteins in a buffered system that the anticoagulant properties of heparin are negated by fibrin. They found that the second-order rate constant for inactivation of IIa by heparin-ATIII was reduced more than 300-fold by soluble fibrin with half-maximal effects at 20 nmol/L fibrin. These effects of fibrin were specific for IIa as fibrin had little effect on the inactivation of factor Xa by heparin-ATIII. Also, the effects were fibrin-specific, as fibrinogen and the plasmin-derived fibrinogen degradation products, fragments D and E, had only minor effects on IIa and factor Xa inactivation by heparin-ATIII. Subsequently, Weitz et al.10 showed that clot-bound IIa in plasma was similarly protected from inactivation by heparin-ATIII. They found that approximately 20 times more heparin was required to inactivate clot-bound IIa than solution-phase IIa.

The mechanism of inhibition of heparin activity by fibrin in plasma was determined by measuring IIa-ATIII complexes by enzyme-linked immunosorbent assay (ELISA). Fibrin was found to inhibit the heparin-catalyzed inactivation of IIa by ATIII with half-maximal effect at 97 ± 19 nmol/L fibrin. Fibrin had no effect on the heparin-catalyzed inactivation of factor Xa by ATIII in plasma, using either standard heparin, a heparinoid preparation (Orgaran; Organon, Lane Cove, Sydney, Australia), or low–molecular weight heparin. These findings imply that fibrin is a potent modulator of heparin activity in vivo by inhibiting heparin-catalyzed ATIII complex formation through formation of ternary IIa-fibrin-heparin complexes.

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which negate the heparin-catalyzed inactivation of IIa by ATIII. Furthermore, the results can explain why standard heparin is not optimal in the treatment of thromboses involving extensive IIa and fibrin formation, and suggest that low-molecular weight heparin will be more effective than standard heparin in preventing and treating such thromboses.

**MATERIALS AND METHODS**

*Chemicals.* Gly-Pro-Arg-Pro (GPRP) was synthesized in solid phase on phenylacetamidomethyl resin using an Applied Biosystem Peptide Synthesizer Model 430A (Applied Biosystem, Sydney, Australia) and N-butylxycarbonyl chemistry. Hydrogen fluoride cleavage of the fully protected peptide was performed by Applied Pty, Ltd, Parkville, Australia. Lyophilized crude peptides was solubilized in 0.5 mol/L tris-(hydroxymethyl)-aminomethane hydrochloride, 6 mol/L guanidine hydrochloride, pH 8.0, and purified by C18 reverse-phase chromatography (Delta Pak 15 C18-100A, Millipore Australia Pty, Ltd, Sydney, Australia) using a 0% to 70% linear acetonitrile gradient containing 0.1% trifluoroacetic acid. Peptide purity was determined by active site titration. 

*Sodium heparin.* Sodium heparin was from David Bull Laboratories Pty, Ltd (Melbourne, Australia) Fragmin from Fisons Pharmaceuticals (Casale Hill, Australia), and Orgaran from Organon Pty, Ltd (Lake Cove, Sydney, Australia). D-Phe-Pro-Arg-chloromethyl ketone (FPR-CH2Cl) was purchased from Calbiochem (San Diego, CA) and hexamethine bromide (Polybrene) from Sigma Chemical Co (St. Louis, MO).

*Proteins.* Human α-thrombin was supplied by Dr John Fenton (New York State Department of Health, Albany, NY). The active enzyme concentration was determined by active site titration. 

Fibrinogen was prepared from human fresh frozen plasma by modification of the method of Jakobsen and Kierulf as described by Hogg and Jackson. Fibrin IImonomer (fbinIIm) was prepared by clotting purified fibrinogen with α-thrombin and solubilizing the fibrin in 0.02 mol/L acetic acid. Plasma is able to support approximately 0.5 μmol/L fbinIIm in solution. This was tested by adding 20 μL of 5 μmol/L fbinIIm or 0.02 mol/L acetic acid to 180 μL of plasma, and monitoring turbidity at 405 nm as a function of time using a kinetic microplate reader (Molecular Devices, Menlo Park, CA). No change in turbidity of plasma containing 0.5 μmol/L fbinIIm relative to control plasma containing 2 mmol/L acetic acid was observed over 10 minutes. Also, the pH of plasma is essentially unchanged by the addition of 2 mmol/L acetic acid. In cases where the fibrin concentration exceeded 0.5 μmol/L/L, fbinIIm was prevented from polymerizing by 4 mmol/L of the tetrapeptide, GPRP.

*Fibrinogen.* Human α-thrombin was supplied by Dr John Fenton (New York State Department of Health, Albany, NY). The active enzyme concentration was determined by active site titration. 

*Plasma samples.* Platelet-poor plasma was prepared from whole blood anticoagulated with 2.2% trisodium citrate followed by centrifugation at 3,000g for 15 minutes. Pooled normal plasma was obtained from the Red Cross Blood Bank, Sydney, Australia. Plasma from one patient therapeutically anticoagulated with warfarin was prepared similarly. The plasma had an INR of 5.8 and an activated partial thromboplastin time (APTT) of 40.9 seconds. Plasma from a patient with lupus anticoagulant was also used as a control.

**RESULTS**

**Effect of fbinIIm on the heparin-mediated prolongation of the TT and APTT.** The effect of fbinIIm on the heparin-mediated prolongation of the TT of normal plasma is described in Fig 1. Normal plasma clotted with 20 mmol/L H2O was characterized by a TT of 10 ± 0.4 seconds. Heparin at 0.2 U/mL markedly prolonged the TT of normal plasma to 240 ± 6.3 seconds. The heparin-mediated prolongation of the TT was ablated by 272 nmol/L fbinIIm, restoring the TT to control times. The effect of fbinIIm was potent with half-maximal inhibition achieved at 60 nmol/L fbinIIm. In the absence of fbinIIm, the effects of fbinIIm on heparin activity were inde-
Effect of fbnIIm on the heparin-mediated prolongation of the TT. The TT (seconds) was measured as described in the Methods. The TT in the absence of heparin was 10 ± 0.4 seconds (---), which was unaffected by the presence of 272 nmol/L fbnIIm, 10 ± 0.1 seconds (data not shown). Half-maximal inhibition occurs at 60 nmol/L fbnIIm. The error bars represent the mean ± SD of triplicate experiments.

The effect of fbnIIm on the heparin-mediated prolongation of the APTT of normal plasma as a function of both fbnIIm and heparin concentration is shown in Fig 2. Heparin at 0.12 U/mL and 0.25 U/mL prolonged the APTT of normal plasma from a control time of 20 ± 0.7 seconds to 90 ± 2.3 and 235 seconds, respectively. FbnIIm attenuated both the 0.12 U/mL and 0.25 U/mL heparin-mediated prolongation of the APTT with half-maximal inhibition at approximately 140 nmol/L and 500 nmol/L fbnIIm, respectively. FbnIIm alone, 540 nmol/L, did not depress the APTT of normal plasma, 19 ± 0.6 seconds. Furthermore, 300 nmol/L fbnIIm had no effect on either the prolonged APTT of a plasma from a patient anticoagulated with warfarin or the prolonged APTT of a plasma due to the presence of a lupus anticoagulant. This indicates that the attenuation of the heparin-mediated prolongation of the APTT by fbnIIm is an effect specific for heparin. The effects of fbnIIm on heparin activity were independent of both the order of reagent addition and the time of sample preincubation (data not shown).

Effect of fbnIIm on the heparin-catalyzed inactivation of IIa by ATIII in plasma. The effect of fbnIIm on heparin-catalyzed IIa-ATIII complex formation in normal plasma is described in Fig 3. A concentration of IIa-ATIII complex of 0.7 ± 0.1 nmol/L resulted from the addition of 5 nmol/L IIa to normal plasma, which was unaffected by the presence of 2 μmol/L fbnIIm, 0.5 ± 0.1 nmol/L (data not shown). Heparin at 0.05 U/mL elevated the plasma concentration of IIa-ATIII complex to 3.3 ± 0.3 nmol/L. The heparin-mediated enhancement of IIa-ATIII complex formation was ablated

Fig 1. Effect of fbnIIm on the heparin-mediated prolongation of the TT. The TT (seconds) was measured as described in the Methods. The TT in the absence of heparin was 10 ± 0.4 seconds (---), which was unaffected by the presence of 272 nmol/L fbnIIm, 10 ± 0.1 seconds (data not shown). Half-maximal inhibition occurs at 60 nmol/L fbnIIm. The error bars represent the mean ± SD of triplicate experiments.

Fig 2. Effect of fbnIIm on the heparin-mediated prolongation of the APTT. The APTT (seconds) was measured as described in the Methods. Control plasma had an APTT of 20 ± 0.7 seconds (---), which was unaffected by the presence of 540 nmol/L fbnIIm, 19 ± 0.6 seconds (data not shown). Reactions contained either 0.12 U/mL (○) or 0.25 U/mL heparin (■). FbnIIm attenuated the heparin-mediated prolongation of the APTT with half-maximal inhibition at approximately 140 nmol/L and 500 nmol/L fbnIIm, respectively. The error bars represent the mean ± SD of triplicate determinations.

Fig 3. Effect of fbnIIm on the heparin-catalyzed inactivation of IIa by ATIII. IIa-ATIII complex concentration was determined by ELISA as described in the Methods. Reactions contained 0.05 U/mL heparin and were initiated by the addition of IIa to a final concentration of 5 nmol/L. A concentration of IIa-ATIII complex of 0.7 ± 0.1 nmol/L resulted from the addition of 5 nmol/L IIa to normal plasma (---), which was unaffected by the presence of 2 μmol/L fbnIIm, 0.5 ± 0.1 nmol/L (data not shown). Fit of the data to Equation 1 by least-squares regression with K4 the unknown parameter results in a K4 of 97 ± 19 nmol/L. The error bars represent the mean ± SD of quadruplicate experiments.
by fbnIIm. To calculate the half-maximal effect of fbnIIm, the data of Figure 3 were fit to Equation 1:

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\frac{[\text{IIa-ATIII}]_\text{max}}{[\text{IIa-ATIII}]_\text{max} - [\text{IIa-ATIII}]} = \frac{[\text{IIa-ATIII}]_\text{min} + \frac{K_d}{[\text{F}]} + [\text{IIa-ATIII}]}{K_d} \tag{1}
\]

where [F] is the free concentration of fbnIIm, K_d is the concentration of fbnIIm at half-maximal inhibition, [IIa-ATIII]_\text{max} is the concentration of IIa-ATIII complex in the absence of heparin and presence of 2 \mu mol/L fbnIIm, 0.5 \text{nmol/L}, and [IIa-ATIII]_\text{max} is the concentration of IIa-ATIII complex in the presence of 0.05 U/mL heparin, 3.3 \text{nmol/L}. Fit of the data of Fig 3 to Equation 1 by least squares regression \(^1\) with \(K_d\) the unknown parameter results in a \(K_d\) of 97 ± 19 nmol/L. This value is similar to the potency of fbnIIm on the heparin-mediated prolongation of the TT, 60 nmol/L (Fig 1).

Effect of fbnIIm on standard heparin, low-molecular weight heparin, and heparinoid-mediated factor Xa inactivation by ATIII in plasma. Comparison of the relative potencies of standard heparin, low-molecular weight heparin (Fragmin), and a heparinoid preparation (Orgaran) in catalyzing plasma factor Xa inactivation by ATIII and the susceptibility of their activity to modulation by fbnIIm is shown in Fig 4. The degree of heparin-mediated factor Xa inactivation is expressed in terms of the percentage of remaining factor Xa activity. In the absence of heparin, plasma had maximal factor Xa activity, which was not significantly altered by the presence of 2 \mu mol/L fbnIIm. Standard heparin, Orgaran and Fragmin at 0.8 U/mL depressed plasma factor Xa activity. Furthermore, the reduction in factor Xa activity was maintained in the presence of 2 \mu mol/L fbnIIm, indicating that the heparin-catalyzed inactivation of factor Xa by ATIII is not susceptible to modulation by fbnIIm.

**DISCUSSION**

The results demonstrate that soluble fbnIIm is a potent inhibitor of heparin activity in plasma as indicated by the TT and APTT assays. The heparin-mediated prolongation of the TT and APTT is ablated by fibrin with half-maximal effects at 60 nmol/L and 140 to 500 nmol/L fbnIIm, respectively. The less potent effect of fbnIIm on the heparin-mediated prolongation of the APTT is probably due to some protection of IIa from binding fbnIIm and heparin by the prothrombinase complex or to the lack of effect on factor Xa (see below), therefore leading to substantially more IIa than would be used in the TT. To determine the mechanism of this effect of fbnIIm on heparin activity in plasma, IIa-ATIII complex formation was measured as a function of heparin and fbnIIm concentrations. The heparin-catalyzed elevation of plasma IIa-ATIII complex concentration was attenuated by fbnIIm to control levels measured in the absence of heparin. Half-maximal inhibition was achieved at 97 ± 19 nmol/L fbnIIm, which correlates with the effect of fbnIIm in the TT assays. This value is similar to the half-maximal effect of fbnIIm on heparin-catalyzed inactivation of IIa by ATIII measured with purified proteins in a buffered system, 20 nmol/L.\(^9\)

The effects of fbnIIm on heparin activity in plasma reported herein parallel those of fbnIIm on heparin activity in a buffered system.\(^9\) In both the buffered and plasma systems fbnIIm essentially negates the anti-IIa effects of heparin and the half-maximal values for fbnIIm are similar, 20 nmol/L in buffer\(^9\) and 60 to 97 nmol/L in plasma. The potency of the effect of fbnIIm argues against the trivial explanation that fbnIIm is simply competing with ATIII for binding heparin. An example of a competitive heparin binding protein that competes effectively with ATIII and, therefore, makes heparin unavailable as a catalyst for inactivation of IIa by ATIII, is platelet factor 4. However, unlike platelet factor 4, fbnIIm binds heparin weakly with a dissociation constant of 5.7 \mu mol/L.\(^7\) Based on this dissociation constant, 300 nmol/L fbnIIm will have bound only 5% of the heparin in the TT and IIa-ATIII ELISA assays, whereas 300 nmol/L fbnIIm essentially ablated heparin activity in both these systems (equation 3 of reference 12 was used for this calculation).

These results are in accordance with the findings of Hogg and Jackson\(^\text{1,12}\) on the effects of fbnIIm on heparin activity in a buffered system. Therefore, the ternary complex model they proposed as the mechanism for the effect of fibrin most likely also applies in plasma. This ternary complex model is illustrated in Fig 5. In this model, fibrin exerts its effect on heparin activity by interfering with productive ternary IIa-heparin-ATIII complex formation, a prerequisite for efficient heparin action. This model also indicates that IIa and heparin both interact with fibrin through the central \(E\) domain. Support for this proposal comes from the following considera-
tively stabilized samples, fibrinogen is a trinodular structure containing two
binding sites for the FRS of IIa is composed of the amino
termini of both the alpha and beta chains and perhaps also
the gamma chain, which constitute the central E domain. The
binding site on fibrin for heparin has not been determined.

For example, clots formed from fibrinogen New York
fibrinogen indicate that the fibrin(ogen) Aa chain residues
27 to 50 constitute a binding site for the fibrinogen
recognition site (FRS) of IIa. There is evidence that the fibrin(ogen) Bβ chain also has a binding site for the FRS. For example, clots formed from fibrinogen New York I, which is missing Bβ residues 9 to 72, and fibrinogen Naples I, which has the single substitution Bβ Ala-68 to Thr, have markedly reduced IIa binding. Therefore, it is likely that the binding site for the FRS of IIa is composed of the amino termini of both the alpha and beta chains and perhaps also the gamma chain, which constitute the central E domain. The binding site on fibrin for heparin has not been determined.

FbnIIm had no effect on the heparin-catalyzed inactivation of factor Xa by ATIII in plasma, using either standard heparin, a heparinoid preparation or low-molecular weight heparin, indicating that the protective effect of FbnIIm on proteinase inactivation by heparin-ATIII is specific for IIa, which is in agreement with the findings of Hogg and Jackson who showed that fibrin had little effect on the heparin-catalyzed inactivation of factor Xa by ATIII in a buffered system. This is not surprising, as factor Xa does not interact with FbnIIm and interacts with heparin only weakly. Therefore, the ternary IIa-FbnIIm-heparin complexes, which prevent efficient inactivation of IIa by heparin-ATIII, do not form with factor Xa.

The concentration of soluble fibrin required to neutralize heparin activity in plasma is well within the expected range for the microenvironment of a thrombus. It is likely that the concentration of fibrin at a site of injury, both soluble and polymerized, will at least approach the plasma fibrinogen concentration, 6 μmol/L. Therefore, half-maximal inhibition of heparin activity is expected to occur when only 1% of the local fibrinogen concentration has been converted to fibrin.

IIa also interacts with fibrin polymer and heparin to form a IIa-fibrin polymer-heparin complex and Weitz et al have shown that IIa bound to a plasma derived fibrin clot is refractory to inactivation by heparin-ATIII. Therefore, it is likely that fibrin polymer, like fibrin monomer, also inhibits heparin activity in plasma through formation of a ternary complex with IIa and heparin. Okwusidi et al showed that the rate of heparin-catalyzed IIa-ATIII complex formation in plasma was enhanced up to twofold when plasma was defibrinated with Arvin. These investigators attributed this effect of Arvin to inhibition of heparin activity by soluble fibrin. In our opinion, the following explanation of their results is more likely. The effects they observed probably resulted from depletion of plasma fibrinogen by Arvin, thereby making it unavailable as a substrate for IIa. In other words, less fibrinogen was available to compete with ATIII for binding to the active site of IIa and the rate of IIa-ATIII complex formation increased. This hypothesis predicts that the rate of IIa-ATIII complex formation would also be faster in Arvin-treated plasma in the absence of heparin, and this is what Okwusidi et al found. Also, it is not unlikely that Arvin-derived fibrin may, in fact, be comparable to thrombin-derived fibrin in complexing with IIa and heparin and be active in inhibiting heparin activity.

IIa binds to approximately 300,000 glycosaminoglycan binding sites per endothelial cell with a dissociation constant in the low nanomolar range. This observation prompted Hogg and Jackson to suggest that endothelial cell surface glycosaminoglycans, like heparin, might also bind IIa and fibrin in a ternary complex and they proposed that formation of these complexes might be a mechanism whereby IIa is restricted to the microenvironment of the injury site. The evidence from these studies that IIa binds fibrin and heparin in plasma supports this hypothesis.

Reocclusion of coronary arteries following thrombolytic therapy and, in particular, the propagation of deep vein thromboses are dynamic thrombotic events usually characterized by extensive IIa and fibrin formation. Therefore, based on our results, it is not surprising that standard heparin has limited antithrombotic efficacy in these clinical situations. However, fibrin has no effect on the heparin-catalyzed
The inactivation of factor Xa by ATIII using either standard heparin, a heparinoid preparation or low-molecular weight heparin. Because low-molecular weight heparin has greater anti-Xa activity than anti-IIa activity, and because factor Xa inactivation is not inhibited by fibrin, these results suggest that low-molecular weight heparin may be more effective than standard heparin in preventing and treating the above-mentioned thromboses. Indeed, recent clinical data comparing the efficacy of standard versus low-molecular weight heparin in the treatment and prevention of deep vein thromboses suggests that low-molecular weight heparin is a more effective anticoagulant for the treatment of this condition.  

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Inhibition of heparin activity in plasma by soluble fibrin: evidence for ternary thrombin-fibrin-heparin complex formation

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