Plasma Endothelin-1, Cytokine, and Prostaglandin E2 Levels in Sickle Cell Disease and Acute Vaso-Occlusive Sickle Crisis

By Evangeline Graido-Gonzalez, James C. Doherty, Eric W. Bergreen, Gregory Organ, Margaret Telfer, and Marvin A. McMillen

The relative contributions of microvascular inflammation and vasomotor dysregulation to the development of acute vaso-occlusive crisis in sickle cell disease have been intensely studied. The present observational study was designed to examine the levels of circulating proinflammatory cytokines, anti-inflammatory cytokines, and vasoactive mediators during and after acute painful crisis. In symptomatic sickle cell patients, plasma levels of endothelin-1 and prostaglandin E2 were elevated during crises compared with healthy African-American controls. These levels had decreased, but not normalized, when patients were seen 1 to 3 weeks after discharge from hospital. Other mediators (tumor necrosis factor α [TNFα], interleukin-1β [IL-1β], IL-6, IL-8, and IL-10) were neither elevated in asymptomatic sickle cell disease nor in acute vaso-occlusive crisis. As a potent long-acting mediator of vasoconstriction and inflammation, endothelin-1 may play a key role in the cycle of ischemia and inflammation that initiates and sustains pain of crisis. The downregulatory effects of prostaglandin E2 on immune cell function may contribute to the increased susceptibility to infection observed in patients with sickle cell disease.

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CENTRAL CLINICAL ISSUE: that determines quality of life in patients with sickle cell disease is the occurrence of painful crisis, an episodic event producing several days of excruciating pain. Reduced deformability of hemoglobin-S (Hgb-S)-containing red blood cells can dramatically increase the viscosity of blood and lead to mechanical blockage of the microcirculation, but the reversibility of the crisis and the lack of widespread tissue necrosis associated with the crisis lead to the question of whether vasospasm and inflammation might play important roles in the pathophysiology of pain crisis.

Significant recent advances have occurred in understanding the interactions of the irreversibly sickled cell with the microvasculature. These have coincided with better understanding of endothelial cell regulation of vascular smooth muscle and vasomotor tone. The endothelial cell is a key regulator of the contractile status of vascular smooth muscle via the constitutive and regulated expression of nitric oxide (NO) and by the induced expression of endothelins and eicosanoids. A major area of current study is whether the vascular occlusion and the ischemia of sickle cell disease may be caused by endothelial cell dysregulation mediated by abnormal erythrocytes. Several studies have examined inflammatory mechanisms that may mediate adhesion of sickle erythrocytes to the endothelium. There is evidence to suggest that sickle erythrocytes may have direct or indirect effects upon vascular tone, exclusive of adhesion events, and that local control of vascular tone is abnormal not only during sickle cell crisis, but also in the steady state course of the disease. Inflammatory events (cytokine production and adhesion molecular expression) may also play a role in the pathogenesis of sickle crisis.

Endothelin-1 (ET-1) is a potent vasoconstrictor and proinflammatory agonist that has been shown to be elevated in sickle cell disease. The present observational study was designed to investigate plasma levels of ET-1, proinflammatory cytokines (tumor necrosis factor α [TNFα], interleukin-1β [IL-1β], IL-6, and IL-8), anti-inflammatory cytokines (IL-10), and counter-regulatory prostaglandin E2 (PGE2) in asymptomatic sickle cell disease and during pain crisis.

MATERIALS AND METHODS

Patients. Thirteen adult homozygous sickle cell patients had an extra tube of blood drawn at routine outpatient visits to confirm prior published results indicating high baseline levels of ET-1, giving a mean ET-1 level of 35 pg/mL with a range of 0 to 151 pg/mL (n = 13).
Commercially available enzyme-linked immunosorbent assay (ELISA) kits were used to determine plasma ET-1 and PGE2 (Amer- 
sham Life Science, Buckinghamshire, UK) and TNFα, IL-1β, IL-6, 
IL-8, and IL-10 (Immunotech Inc, Westbrook, ME). Each kit uses a 
quantitative immunometric sandwich ELISA performed on a 96-well 
plate coated with monoclonal antibody against the specific peptide, 
cytokine, or prostanoid to be tested. During an incubation period 
ranging from 2 to 24 hours at 4°C to 27°C (depending on the specific 
assay), ET-1, TNFα, IL-1β, IL-6, IL-8, IL-10, and PGE2 bind to the 
specific affixed monoclonal antibody. A monospecific antibody conjugat- 
gated horseradish peroxidase is added. During an additional incuba-

tion, the conjugate antibody binds to the affixed antibody/peptide or 
antibody/cytokine complexes. Upon addition of appropriate substrate, 
a peroxidase-dependent color reaction occurs that is proportional to the 
amount of bound peptide, cytokine, or prostanoid. Plates are scanned 
using a Bio-Whittaker Microplate Reader 2001 (Bio-Whittaker, Inc, 
Walkersville, MD) set at the appropriate wavelength for the color-

forming reaction. A standard curve is generated and specimen concentra-

tions are determined by comparing sample optical density with the 
values on the standard curve. All samples in this study were performed 
in duplicate, and sample variation was estimated at approximately 5%

Peak ET-1, cytokine, and PGE2 levels during crisis were recorded and 
were compared with postcrisis and control values. Results were 
compared by ANOVA and the Student’s unpaired two-tailed t-test. All 
data are presented as the mean ± standard error of mean.

RESULTS

Plasma ET-1 levels were significantly elevated relative to 
healthy controls (0.535 ± 0.508 pg/mL) in both patients in 
acute pain crisis (130.9 ± 23.1 pg/mL; *P < .0002) and those at 
postcrisis follow-up (23.69 ± 9.52 pg/mL; *P = .04) interpreted 
as their baseline symptom-free levels (Table 1). Postcrisis levels 
decreased significantly from levels drawn in crisis for all 
patients (*P < .0001).

Plasma PGE2 levels were also significantly elevated in crisis 
relative to healthy controls (316.3 ± 61.0 pg/mL; *P < .0001) and 
postcrisis patients (670.9 ± 61.0 pg/mL; *P = .003; Table 1). 
Similar to the pattern observed with respect to ET-1 levels, 
PGE2 levels in crisis were elevated compared with healthy 
controls and decreased postcrisis (*P = .048). Neither the levels 
of ET-1 nor those of PGE2 varied significantly during the crisis 
sampling period (Fig 1).

Plasma levels of TNFα, IL-1β, IL-6, IL-8, and IL-10 were 
not different between healthy controls and sickle cell patients 
(*P < .05), although a trend was observed in which TNFα and 
IL-10 remained higher than controls during and after crisis. 
No difference was observed between the levels in crisis 
and those of the same patients at postcrisis follow-up (*P > .05; 
Table 2).

DISCUSSION

The endothelins are a family of 21 amino acid peptides first 
characterized by Yanagisawa in 1988.4,5 Four endothelin sub- 
types have been identified. ET-1, the most prevalent subtype, 
is the most potent vasoconstrictor yet described. ET-1 is not only 
a vasoconstrictor of large arteries and veins, but also constricts 
the resistance arterioles and postcapillary venules.10 ET-1 is 
rapidly internalized by its target cells, and infused pharmaco-

logic doses are cleared from the circulation within minutes, 
principally by the lungs.11 The vasoconstriction lasts as long as 
1 hour. The two specific ET-1 receptors, ETR-A and ETR-B, are 
G-protein–coupled membrane receptors on vascular smooth 

muscle cells, and the cell response (ie, smooth muscle contraction) 
results from inositol-triphosphate–mediated increases in 
intracellular calcium.12 These receptors differ in their specifici-

ties for the various endothelin subtypes and in their tissue 
distribution.13 The endothelins have been found to have ele-

vated systemic levels in ischemic injury in acute respiratory 
distress syndrome, sepsis, and disseminated intravascular coagula-

tion.14,16 Endothelin antagonists have been developed and are 
currently being evaluated.17

Endothelins are also proinflammatory agonists. Stimulation 
of cultured human peripheral blood monocytes with ET-1 
causes monocyte production of inflammatory cytokines such as 
TNFα, IL-1β, IL-6, IL-8, granulocyte-macrophage colony- 
stimulating factor (GM-CSF), and substances that enhance 
neutrophil superoxide production.18-20 Endothelins cause neu-

trophil production of platelet-activating factor (PAF) and increase 
monocyte and neutrophil chemotaxis.21-23 Endothelins upregu-

late endothelial cell expression of intercellular adhesion mol-

ecule-1 (ICAM-1), vascular cell adhesion molecule-1 (VCAM-

1), and E-selectin, adhesion molecules that participate in the 
recruitment of leukocytes to sites of inflammation.24 Neutrophil 
proteases play a key role in clearing bioactive ET-1 from its 
precursor molecule.25,26

Inflammation appears to play a significant role in the 
vaso-occlusive crisis in sickle cell disease. Systemic levels of 
TNFα and IL-1β increase in sickle cell disease, as do soluble 
forms of ICAM-1, VCAM-1, and E-selectin.27,28 TNFα 
increases adherence of sickled cells to vascular endothelium, and 
circulating reticulocytes in sickle cell disease express both 
α4β1 integrin and glycoprotein IV (CD36), adhesion molecules 
capable of binding to VCAM-1.29,30 Adherence of sickle 
erythrocytes in the microcirculation may initiate the impairment 
of microcirculatory blood flow.31 The inflammatory mediators 
(TNFα, IL-1β, IL-6, and IL-8) show small changes in our study 
of pain crisis that fail to reach significance, but may play a role 
at the tissue level, where autocrine and paracrine effects 

predominate.

PAIN CRISIS

We demonstrate elevation of plasma ET-1 levels during 
sickle cell pain crisis and a decrease in ET-1 levels to higher 
than normal in the same patients after symptomatic recovery. 
Several reports have demonstrated increased levels of ET-1 in 
patients with asymptomatic sickle cell disease.5,7 We used a

<table>
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<tr>
<th>Table 1. Plasma ET-1 and PGE2 Levels in Healthy Controls, in Painful Crises, and During Recovery Phase</th>
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<tr>
<td>Healthy controls (n = 11)</td>
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<tr>
<td>Crisis sickle cell (n = 13)</td>
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<tr>
<td>Postcrisis sickle cell (n = 13)*†</td>
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*Statistically significant difference from controls (P < .05). 
†Statistically significant difference from postcrisis levels (P < .05). 
‡One to 3 weeks after discharge from hospital.
Fig 1. Plasma ET-1 and PGE₂ concentrations during the first 72 hours of hospitalization for sickle cell crisis and at time of asymptomatic follow-up. Although plasma ET-1 (A) and PGE₂ (B) levels appear to follow similar trends, neither varies significantly during the first 72 hours of hospitalization ($P > .05$). However, the mean peak crisis levels for each are elevated relative to those of the same patients when asymptomatic and are elevated relative to those of healthy age- and race-matched controls (Table 1). (ADM, admission time; 24H, 48H, and 72H indicate 24, 48, and 72 hours after admission, respectively; F/U, at time of postcrisis outpatient appointment). ( ), Sickle cell; ( ), control.

Table 2. Plasma Cytokine Levels in Healthy Controls, in Painful Crises, and During Recovery

<table>
<thead>
<tr>
<th></th>
<th>TNFα (pg/mL)</th>
<th>IL-1β (pg/mL)</th>
<th>IL-6 (pg/mL)</th>
<th>IL-8 (pg/mL)</th>
<th>IL-10 (pg/mL)</th>
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<tr>
<td>Controls (n = 11)</td>
<td>44.41 ± 15.68</td>
<td>186.4 ± 39.7</td>
<td>39.67 ± 23.51</td>
<td>224.2 ± 62.0</td>
<td>4.142 ± 2.556</td>
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<td>Crisis (n = 13)</td>
<td>61.21 ± 5.62</td>
<td>148.3 ± 31.0</td>
<td>41.74 ± 9.94</td>
<td>305.0 ± 34.2</td>
<td>20.53 ± 7.59</td>
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<td>$P$ values</td>
<td>&gt;.25</td>
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<td>Postcrisis (n = 13)</td>
<td>66.61 ± 6.07</td>
<td>146.6 ± 12.9</td>
<td>14.62 ± 7.33</td>
<td>243.6 ± 37.3</td>
<td>17.14 ± 11.11</td>
</tr>
<tr>
<td>$P$ values</td>
<td>&gt;.25</td>
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sensitive ELISA technology to measure ET-1 levels, whereas the previous studies used radioimmunoassays.6,7

The ET-1 levels observed may be derived from a variety of sources. Hypoxia is a potent stimulus to the production and release of ET-1 by vascular endothelial cells.22 There appears to be ET-1 production unique to sickle cell disease. Phelan et al33 demonstrated that cultured human umbilical vein endothelial cells experience a fourfold to eightfold greater transcriptional induction of the gene encoding ET-1 when exposed to sickled cells in vitro. Cultured bovine pulmonary artery endothelial cells transcribe increased amounts of ET-1 mRNA and release increased ET-1 peptide when exposed to plasma from sickle patients with acute chest syndrome and acute crisis.7 Plasma from the same patients at the time of symptom-free follow-up does not produce this effect.

ET-1 causes monocyte production of PGE2 in vitro.34 PGE2 downregulates inflammatory response by increasing intracellular cyclic AMP levels in immunohematologic cells.35 In monocytes and macrophages, PGE2 inhibits class II (Ia-DR) antigen expression, production of IL-1β, and antigen presentation.36-38 In lymphocytes, PGE2 impairs IL-2 production by T-helper cells and decreases response to IL-2.39 PGE2 production by so-called suppressor macrophages may downregulate the inflammatory process, thus preventing harmful systemic inflammation.40 PGE2 levels increased significantly during crisis in the present study and remained elevated after symptoms had resolved.

Patients with sickle cell disease are at increased risk for serious bacterial infections. This has been attributed to functional asplenia, impaired opsonic function, and activation of the alternative complement pathway. Defects in cell-mediated immunity have also been described, and patients with severe variants of the disease demonstrate defective random neutrophil migration, chemotactic activity, and lymphocyte transformation index.41,42 These effects may be attributable to chronic exposure to downregulatory mediators such as PGE2 and IL-10.43

The plasma levels of ET-1 and PGE2 in this study were elevated in 13 adult sickle cell patients in crisis compared with aged-matched African-American controls and with their own levels on asymptomatic follow-up. Whereas TNFα, IL-1β, IL-6, and IL-8 were only variably increased, there were high levels of counterregulatory PGE2 and IL-10. We conclude that endothelin could contribute to both the prolonged vasospasm and to inflammation in acute painful sickle cell crisis and that endothelin antagonist strategies might have utility in the treatment of this complex disorder.

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