Research Article

The Correlation between the Increased Expression of Aquaporins on the Inner Limiting Membrane and the Occurrence of Diabetic Macular Edema

Yiqi Chen, Huan Chen, Chenxi Wang, Jiafeng Yu, Jiwei Tao, Jianbo Mao, and Lijun Shen

1Center for Rehabilitation Medicine, Department of Ophthalmology, Zhejiang Provincial People’s Hospital (Affiliated People’s Hospital, Hangzhou Medical College), Hangzhou, Zhejiang, China
2Department of Retina Center, Affiliated Eye Hospital of Wenzhou Medical University, Hangzhou, 310000 Zhejiang Province, China

Correspondence should be addressed to Lijun Shen; shenlj89@163.com

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Purpose. Diabetic macular edema (DME) is a major cause of vision loss in patients with diabetic retinopathy; this study is aimed at comparing the expression of aquaporins (AQPs) on the inner limiting membranes (ILMs) of various vitreoretinal diseases and investigating the role of aquaporins expressed on the ILMs in mediating the occurrence of DME. Methods. The whole-mounted ILM specimens surgically excised from patients with various vitreoretinal diseases (idiopathic macular hole, myopic traction maculopathy, and diabetic retinopathy) were analyzed by immunohistochemistry (IHC). The distribution and morphology of AQP4, AQP7, and AQP11 on the ILMs were correlated with immunohistochemical staining characteristics. Moreover, immunofluorescence of AQP4 was performed on the ILM specimens of the patient in four groups: the control group, negative control group, no DME group, and DME group. The immunofluorescence intensity value of AQP4 was measured using ImageJ. The difference between the four groups and the correction between the immunofluorescence value and central foveal thickness (CFT) were analyzed. Results. In IHC sections, the expression of AQP4, AQP7, and AQP11 on the ILMs were correlated with immunohistochemical staining characteristics. Moreover, immunofluorescence of AQP4 was performed on the ILM specimens of the patient in four groups: the control group, negative control group, no DME group, and DME group. The immunofluorescence intensity value of AQP4 was measured using ImageJ. The difference between the four groups and the correction between the immunofluorescence value and central foveal thickness (CFT) were analyzed. Results. In IHC sections, the expression of AQP4, AQP7, and AQP11 on the ILMs were correlated with immunohistochemical staining characteristics. Moreover, markedly higher fluorescence intensity of AQP4 of ILMs was determined in the DME group (51.05 ± 5.67) versus the other three groups (P < 0.001). A marked positive association was identified between the fluorescence intensity of AQP4 and CFT (r = 0.758; P = 0.011). Conclusions. AQP4, AQP7, and AQP11 can be expressed on human ILM in vivo. The increased expression of AQPs on the ILMs of DR may be associated with the occurrence of DME. Moreover, the degree of DME may be positively correlated with the expression of AQP4 on the ILMs.

1. Introduction

For retina, a vital sensory tissue, delicate fluid balance is required for the maintenance of cellular homeostasis and proper tissue functions. The water transport of cells through the plasma membrane is a vital molecular process, which enables glandular tissue to secrete fluid, fluid flow in tissues to exchange nutrients and metabolites, and cell volume modulation [1]. Aquaporin (AQP) is an important type of protein that regulates osmotic gradients and hydrostatic pressure to control the bidirectional movement of water across cell membranes [1]. It is repeatedly documented in animal models that AQP is implicated in the nosogenesis of retinal vascular disease, retinal nerve injury, and diabetic retinopathy [1–9]. Moreover, Vujosevic et al. has demonstrated that the biomarkers AQP1 and AQP4 in the aqueous humor of diabetic patients with diabetic retinopathy were significantly higher than nondiabetic patients, indicating that diabetes might have a strong effect on Müller cells [10].

Previous studies have shown that the internal limiting membrane (ILM) is anatomically organized by the basement membrane of Müller cells, located at the vitreoretinal
interface [11]. The mRNA expression of all AQP s, namely, AQP0 to AQP12, can be detected in the human retina [12], while only AQP4, AQP7, and AQP11 can be detected on human ILMs in vitro [13–15]. As the only human living retinal tissue currently available, there have not been many studies on the correlation between AQP and the pathogenesis of eye diseases. Therefore, the motivation of this study is to investigate whether AQP s on ILMs will undergo pathological changes in various vitreoretinal diseases, or whether these changes are related to the pathogenesis. Due to the unknown mechanism in the change of AQP s on ILMs and the undefined relationship between them and the occurrence of the disease, the content of this research constitutes its novelty.

This study is aimed at comparing the expression of AQP s on ILMs of various vitreoretinal diseases and investigating the role of AQP s expressed on the ILMs in mediating the occurrence of diabetic macular edema.

2. Materials and Methods

2.1. Subjects. A total of 64 eyes of 64 patients who had undergone vitrectomy with ILM peeling due to various vitreoretinal diseases were enrolled, including 19 patients with idiopathic macular hole (iMH), 9 patients with myopic traction maculopathy (MTM), and 36 patients with diabetic retinopathy (DR). Inclusion criteria for DR are as follows: patients with stage IV and above who underwent pars plana vitrectomy (PPV) for traction retinal detachment, vitreous hemorrhage (VH), etc. Inclusion criteria for MTM are as follows: (1) MTM diagnosed by optical coherence tomography (OCT), (2) highly myopic eyes defined as an axis length ≥ 26 mm or a spherical equivalent refractive error ≥ −6.00D, and (3) patients without other general diseases and can undergo surgery. Inclusion criteria for iMH are as follows: (1) OCT diagnosed as a full-thickness macular hole and (2) patients without other general diseases and can undergo surgery. Exclusion criteria are as follows: (1) previously received anti-VEGF drug therapy or macular laser photocoagulation and (2) previously received PPV treatment. The Institutional Review Board of Zhejiang Eye Hospital ratified the study, together with the module for patients’ informed consent.

The distribution and morphology of AQP4, AQP7, and AQP11 on ILMs were obtained by immunohistochemical staining. There were 3 specimens for each of the following three groups including the iMH group, MTM group, and DR group. The immunofluorescence staining of AQP4 was performed on ILM specimens of other patients. The corresponding study consists of four groups, with 8 iMH specimens in the control group, 2 iMH specimens and 6 DR specimens in the negative control group, 9 specimens in the no diabetic macular edema (DME) group, and 12 specimens in the DME group.

2.2. Surgical Techniques. Under retrobulbar anesthesia plus intravenous anesthesia, all operations were completed by the same surgeon. All patients underwent standard 3-port 23- or 25-gauge PPV. With the purpose of reducing phototoxicity and photoactivation of indocyanine green (ICG) while ensuring adequate surgical field, the endoillumination levels were adjusted to a minimum of <40%. After core vitrectomy, the posterior vitreous cortex was stained with triamcinolone acetonide (TA; 0.1 mL with the concentration of 0.1 mL/4 mg) and the residual vitreous was then removed as completely as possible. Epiretinal membrane was then peeled if present. After that, ILM was peeled within 2 papillary diameters (PD) of macular fovea with the aid of 0.17% ICG (Figure 1(a)). Excessive ICG was aspirated at once after injection to minimize possible toxicity to the tissue. For patients without DME, the residual posterior vitreous cortex in macular area was peeled together with the ILMs to prevent postoperative preretinal proliferation in macular area.

2.3. Tissue Preparation for Immunohistochemical (IHC) and Immunofluorescence (IF) Microscopy. Surgically excised ILM specimens for IHC and IF staining were placed onto glass slides and being processed with the use of a stereomicroscope (MS 5; Leica, Wetzlar, Germany). Precleaned microscope slides were prepared by adhering two secure seal spacers to each slide face, allowing two flat mounts per slide. Thereafter, the specimens were subjected to unfolding in 0.1 M phosphate-buffered saline (PBS; pH 7.4) and then immediate 4% paraformaldehyde immobilization (4°C) for ≥ 24 hours.
2.4. Immunohistochemistry (IHC) of Flat-Mounted ILM Specimens. Various antibodies were applied to label the AQPs that were in interest (anti-AQP4, 1:100, Thermo; anti-AQP7, 1:300, Novus; anti-AQP11, 1:50, Abcam). After tissue immobilization, specimens were treated with 3 rinses using 0.1 M PBS (pH 7.4) before approximately 5 min of indoor incubation with 3% H₂O₂. Then, the sections were subjected to another 3 rinses using 0.1 M PBS, followed by 1-2 hours or overnight incubation (4°C) with the primary antibodies at ambient temperature. After 3 PBS washes (3 min/time), the specimens were treated with the enhance labeled polymer system ELPS (Envision, Beijing Zhongshan Jinqiao Biotechnology Co. Ltd.) for 15-20 min at indoor temperature. After 15-20 min of immersion in the horseradish enzyme at room temperature, specimens were treated with 3 PBS washes (3 min/time) and then placed into the color developing agents for 3-15 min of incubation. After thorough rinsing, counterstaining, dehydration, hyalinization, and sealing, the sections were observed with optical microscopy.

2.5. Immunofluorescence of Flat-Mounted ILM Specimens. After fixation in 4% paraformaldehyde (PFA) overnight, the specimens were incubated in 0.3% BSA and 1% Triton X-100 for 30 minutes. Then, a 30 μL (1:240) diluent primary antibody, Aquaporin 4 Polyclonal Antibody) was added and incubated with the specimens overnight at 4°C. After that, excess primary antibodies were washed away after 3 rinses (5 min/time) with 0.01 M PBS (pH 7.4) on a shaking table. Then, the specimens were incubated in 30 μL (1:300) secondary antibody (Goat Anti-rabbit IgG/PE antibody (bs-0295G-PE)) for 1.5 hours at 37°C in darkroom. Finally, specimens were subjected to 3 rinses (5 min/time) with 0.01 M PBS on the shaking table in darkroom.

To prepare the specimens in the negative control group (the 2 iMH specimens and 6 DR specimens), the primary antibody was substituted with diluent and specimens were incubated with the secondary antibody alone. All other procedures were identical to the procedures illustrated above. Images were acquired using a confocal microscope (LSM880 with AiryScan+TP; ZEISS). All the acquisition parameters were kept the same at all times.

2.6. The Measurement of Fluorescence Intensity. After obtaining immunofluorescence images using ZEN (a

| Case | Eye | Age | Gender | Diagnosis       | Method               |
|------|-----|-----|--------|-----------------|----------------------|
| 1    | OS  | 55  | M      | DR, VH, DME    | Immunohistochemistry AQP4 |
| 2    | OS  | 59  | M      | DR, DME, VH    | Immunohistochemistry AQP4 |
| 3    | OD  | 56  | F      | DR, VH, DME    | Immunohistochemistry AQP4 |
| 4    | OS  | 54  | M      | iMH            | Immunohistochemistry AQP4 |
| 5    | OS  | 69  | F      | iMH            | Immunohistochemistry AQP4 |
| 6    | OS  | 65  | F      | iMH, ERM       | Immunohistochemistry AQP4 |
| 7    | OS  | 49  | F      | MHRD           | Immunohistochemistry AQP4 |
| 8    | OS  | 68  | F      | MHRD           | Immunohistochemistry AQP4 |
| 9    | OS  | 56  | M      | MHRD           | Immunohistochemistry AQP4 |
| 10   | OS  | 46  | F      | DR, VH, DME    | Immunohistochemistry AQP7 |
| 11   | OD  | 50  | F      | DR, DME        | Immunohistochemistry AQP7 |
| 12   | OS  | 63  | F      | DR, DME, VH, ERM | Immunohistochemistry AQP7 |
| 13   | OS  | 62  | M      | iMH            | Immunohistochemistry AQP7 |
| 14   | OD  | 35  | M      | iMH            | Immunohistochemistry AQP7 |
| 15   | OS  | 77  | F      | iMH, ERM       | Immunohistochemistry AQP7 |
| 16   | OS  | 61  | F      | MHRD           | Immunohistochemistry AQP7 |
| 17   | OD  | 49  | F      | MHRD           | Immunohistochemistry AQP7 |
| 18   | OD  | 53  | F      | MHRD, ERM      | Immunohistochemistry AQP7 |
| 19   | OS  | 66  | M      | DR, VH, DME    | Immunohistochemistry AQP11 |
| 20   | OD  | 64  | F      | DR, VH, DME    | Immunohistochemistry AQP11 |
| 21   | OD  | 56  | F      | DR, VH, DME    | Immunohistochemistry AQP11 |
| 22   | OS  | 69  | M      | iMH            | Immunohistochemistry AQP11 |
| 23   | OD  | 67  | M      | iMH, ERM       | Immunohistochemistry AQP11 |
| 24   | OD  | 56  | F      | iMH            | Immunohistochemistry AQP11 |
| 25   | OD  | 53  | F      | MHRD           | Immunohistochemistry AQP11 |
| 26   | OD  | 49  | F      | MHRD           | Immunohistochemistry AQP11 |
| 27   | OD  | 53  | F      | MHRD, ERM      | Immunohistochemistry AQP11 |

OD: right eye; OS: left eye; iMH: idiopathic macular hole; DR: diabetic retinopathy; VH: vitreous hemorrhage; MHRD: macular hole retinal detachment; DME: diabetic macular edema; ERM: epiretinal macular membrane; AQP: aquaporin.

Table 1: Clinical data of patients.
supporting software of confocal microscope), the open access software ImageJ was used to measure the fluorescence intensity of the proteins on ILM specimens that were positively stained. All images were transformed to 8-bit type and a threshold was set. Then, traced a rectangular box of similar size where the fluorescence intensity was uniformed by wand tool to measure values of the fluorescence intensity (Figure 1(b)).

2.7. Measurement of Central Foveal Thickness. With the use of the Spectralis optical coherence tomography (OCT; Heidelberg, Germany) instrument, retinal images were obtained from DR patients who could successfully completed the preoperative macular OCT scan. The central foveal thickness (CFT) corresponds to the distance from the ILM to the surface of the retinal pigment epithelium (RPE) at the fovea (Figure 1(c)). An average value was obtained from three consecutive CFT measurements.

2.8. Statistical Processing. SPSS v22.0 for Windows (SPSS, Inc., Chicago, IL) was responsible for statistical analysis. According to variance homogeneity of the fluorescence intensity of AQP4 evaluated by Levene’s test, the analysis was parametric and was displayed as mean ± standard deviation. One-way analysis of variance was employed for the determination of significant differences in AQP4 fluorescence intensity between the 4 groups. Correlation analysis between the AQP4 fluorescence value and CFT was made by Spearman’s rank correlation coefficients. P values < 0.05 were considered statistically significant.
3. Results

3.1. IHC. An immunohistochemical study was conducted on the ILM specimens of 9 patients separately with iMH, MTM, or DR with DME. The basic characteristics of these patients are summarized in Table 1. As shown in Figures 2–4, AQP4-positive, AQP7-positive, and AQP11-positive reactions were all abundantly observed on the ILMs of the DR with the DME group (Figures 2(a), 2(b), Figures 3(a), 3(b), Figures 4(a) and 4(b)). Some brown particles of AQP4-positive, AQP7-positive, and AQP11-positive reactions were irregularly gathered on the dense specimens, forming clusters on the ILMs of the DR with DME group (Figures 2(a), 2(b), Figures 3(a), 3(b), Figures 4(a), and 4(b)). Compared to the ILMs of iMH and MTM, on the three ILM specimens of DR with DME, respectively, seemed to be stained markedly positive for AQP4, AQP7, and AQP11 antibodies, indicating the possible association between the AQPs and macular edema.

3.2. Immunofluorescence. Another thirty-seven ILM specimens were collected for the AQP4 immunofluorescence study. They included 8 patients with iMH as the control group, 2 patients with iMH and 6 patients with DR as the negative control group, 9 patients with DR as the no DME group, and 12 patients with DME as the DME group. See Table 2 for patient basic characteristics.
As shown in Table 3 and Figure 5, the value of fluorescence intensity of AQP4 on ILMs in the negative control group (17.37 ± 5.81) was statistically lower versus the other three groups (control group, no DME group, and DME group, all \( P < 0.001 \)), indicating that AQP4 can be expressed on human ILM, though there may be differences in the degree of expression in different diseases. Moreover, the value of fluorescence intensity of AQP4 on ILMs in the DME group (51.05 ± 5.67) was evidently higher versus the other three groups (control group, negative control group, and no DME group, all \( P < 0.001 \)). However, there was no statistical difference between the value of fluorescence intensity of AQP4 on ILMs between the no DME group (36.79 ± 6.60) and the control group (38.01 ± 5.04; \( P = 0.669 \)).

3.3. The Correction between AQP4 Immunofluorescence Intensity Value and CFT. A total of twelve DR with DME patients were able to successfully complete preoperative macular OCT scan. The CFT value ranged from 212 to 730 \( \mu \text{m} \) (mean 491.36 ± 146.36 \( \mu \text{m} \)). As indicated by Figure 6, a marked positive association was determined between CFT and immunofluorescence intensity values of AQP4 (\( r = 0.758; \) \( P = 0.011 \)). There was a significant positive correlation between the AQP4 immunofluorescence intensity value and CFT.
4. Discussion

For the purpose of addressing the limitations of conventional sectioning and embedding preparation, this study analyzes AQP4, AQP7, and AQP11 on ILMs using flat-mount preparations, a procedure that makes the enface visualization of the whole ILM specimen possible. Unlike conventional sectioning preparations, flat-mount preparations can even detect the formation of single small cell clusters of ILM specimens that might be missed by serial-sectioning preparations [16].

In the present study, the result of AQPs IHC showed that AQP4, AQP7, and AQP11 could be detected on ILMs of various vitreoretinal diseases, confirming that AQP4, AQP7, and AQP11 can be expressed on the human ILMs in vivo for the first time. Moreover, the expression of AQP4, 7 and 11 on ILMs of DR with DME seemed all higher than the ILMs of iMH and MTM, indicating the increased

| Case | Group     | Eye | Age | Gender | Diagnosis | Intraoperative medications |
|------|-----------|-----|-----|--------|-----------|-----------------------------|
| 1    | Control   | OD  | 47  | F      | iMH       | TA/ICG                      |
| 2    | Control   | OS  | 57  | F      | iMH       | TA/ICG                      |
| 3    | Control   | OD  | 57  | F      | iMH       | TA/ICG                      |
| 4    | Control   | OD  | 64  | M      | iMH       | TA/ICG                      |
| 5    | Control   | OD  | 46  | F      | iMH       | TA/ICG                      |
| 6    | Control   | OD  | 56  | F      | iMH       | TA/ICG                      |
| 7    | Control   | OS  | 77  | F      | iMH       | TA/ICG                      |
| 8    | Control   | OD  | 67  | M      | iMH       | TA/ICG                      |
| 9    | Negative control | OS  | 69  | F      | iMH       | TA/ICG                      |
| 10   | Negative control | OD  | 71  | F      | iMH       | TA/ICG                      |
| 11   | Negative control | OS  | 49  | F      | PDR, DME  | TA/ICG                      |
| 12   | Negative control | OS  | 56  | M      | PDR       | TA/ICG                      |
| 13   | Negative control | OS  | 67  | M      | PDR       | TA/ICG                      |
| 14   | Negative control | OD  | 47  | F      | DR, DME   | TA/ICG                      |
| 15   | Negative control | OD  | 59  | M      | DR, DME   | TA/ICG                      |
| 16   | Negative control | OD  | 56  | F      | DR        | TA/ICG                      |
| 17   | No DME    | OD  | 48  | M      | DR        | TA/ICG                      |
| 18   | No DME    | OS  | 69  | F      | DR        | TA/ICG                      |
| 19   | No DME    | OD  | 64  | F      | DR        | TA/ICG                      |
| 20   | No DME    | OS  | 51  | M      | DR        | TA/ICG                      |
| 21   | No DME    | OD  | 73  | F      | DR        | TA/ICG                      |
| 22   | No DME    | OD  | 48  | F      | DR        | TA/ICG                      |
| 23   | No DME    | OS  | 56  | M      | PDR       | TA/ICG                      |
| 24   | No DME    | OS  | 66  | F      | PDR       | TA/ICG                      |
| 25   | No DME    | OS  | 69  | F      | VH, DR    | TA/ICG                      |
| 26   | DME       | OS  | 52  | M      | DR, DME   | TA/ICG                      |
| 27   | DME       | OS  | 66  | M      | VH, DME   | TA/ICG                      |
| 28   | DME       | OD  | 59  | M      | VH, DME   | TA/ICG                      |
| 29   | DME       | OS  | 54  | M      | VH, DME   | TA/ICG                      |
| 30   | DME       | OS  | 52  | F      | DR, DME   | TA/ICG                      |
| 31   | DME       | OD  | 56  | M      | DR, DME   | TA/ICG                      |
| 32   | DME       | OS  | 79  | M      | DR, DME   | TA/ICG                      |
| 33   | DME       | OS  | 55  | M      | DR, DME   | TA/ICG                      |
| 34   | DME       | OS  | 50  | F      | DR, DME   | TA/ICG                      |
| 35   | DME       | OD  | 73  | M      | DR, DME   | TA/ICG                      |
| 36   | DME       | OS  | 59  | M      | PDR, DME  | TA/ICG                      |
| 37   | DME       | OS  | 63  | F      | PDR, DME  | TA/ICG                      |

OD: right eye; OS: left eye; iMH: idiopathic macular hole; PDR: proliferative diabetic retinopathy; DR: diabetic retinopathy; VH: vitreous hemorrhage; DME: diabetic macular edema; ICG: indocyanine green; TA: triamcinolone acetonide.

Table 2: Clinical data of patients of four groups.
expression of AQPs on the ILMs of DR may be associated with the occurrence of DME. Under normal conditions, AQP7 is involved in maintaining the osmotic gradient across the outer membrane in the retina, which regulates the transport of water through the RPE into the choroid, thereby preventing patients from retinal detachment and subretinal edema [17]. Yakata et al. [18] indicated that AQP11 has a lower water permeability and is essential for maintaining endoplasmic reticulum homeostasis of vascular endothelial cells under the metabolic stress state of the liver and kidney [19]. In addition, pathogens, inflammatory factors, radiation, and other stress effects regulate AQP11 through signaling pathways such as JNK/NFκB, which in turn affect the differentiation process of lipid cells [20]. Previous studies indicated that AQP7 and AQP11 are mainly involved in the outflow channel of tissue water in the retinal nerve fiber layer and RPE layer, and AQP11 deletion at Müller glia can result in weakened capacity of cells to reduce cell volume through water outflow, which gives rise to cell swelling and consequently fatal retinal edema in ERU and other retinal diseases as well like DME [8]. However, in this study, AQP7 and AQP11 were increased on the ILM of diabetic retinopathy with macular edema compared with other patients.

Therefore, we hypothesize that AQP7 and AQP11 on the ILM may also participate in the water absorption process. The increase in water absorption causes an accumulation of water in the retina, while the expression of AQP7 and AQP11 in other retinal tissues is downregulated, decreases the outflow of water, and finally causes the retinal edema. Compared with AQP4, the water absorption function of AQP7 and AQP11 should be much weaker; therefore, the changes of AQP7 and AQP11 in the ILM of DR with DME are not significant. However, the regulation mechanism of AQPs is not completely clear by far, and further investigation is required. AQP7 and AQP11 are colocalized in the Müller cell endfeet at the ILM, while AQP4 is polarized distributed in Müller cells and mainly expressed in the endfeet membranes [12, 21]. According to the results of AQPs’ IHC in this study, AQP4 seemed to be, qualitatively, the most abundant among the three AQPs expressed on the ILMs, so we selected AQP4 as the protein for immunofluorescence detection.

The results of AQP4 immunofluorescence in this study identified statistically higher AQP4 fluorescence intensity in the DME group versus the other three groups. Moreover, there was a significant positive correlation between the AQP4 immunofluorescence intensity value and CFT, indicating that the increased expression of AQP4 on the ILMs of DR may be associated with the occurrence of DME, and the degree of DME may be positively correlated with the expression of AQP4 on the ILMs. Vujosevic et al. have demonstrated that diabetes might have a strong effect on Müller cells [10]. Functionally, expressing voltage-gated channels and neurotransmitter receptors, Müller cells can modulate neuronal viability via modulating the extracellular content of neuroactive substances (K+, glutamate, GABA, H+, etc.). Around the retinal vessels, there are Müller cell endfeet. AQP4 has abundant expression in the glial processes facing retinal capillaries, and the contact between end-feet with capillary endothelium can release K+, acid equivalents, and water, [22] which is in keeping with the role of AQP4 in water release to the capillaries, thus helping to maintain extracellular osmolality during neuronal activity. Oku et al. [7] have confirmed that nitric oxide (NO) increased not only AQP4 expression but also the volume of optic nerve astrocytes via the cGMP/protein kinase G axis. Therefore, we assume that osmotic pressure, oxygen concentration, hormones, neurotransmitters, cytokines, and other factors affect the expression of AQP4 through cGMP/PKG, MAPK [23], and other signaling pathways, thereby affecting the blood-retinal barrier and active transfer of water, K+, etc., leading to the formation of ischemia and edema in patients with diabetic retinopathy.

As an important type of protein that relies on osmotic gradients and hydrostatic pressure to control the bidirectional motion of water through the membrane, AQPs may be essential in the pathogenic mechanism of DME. Recently, PPV combined with ILM peeling was performed for refractory macular edema, with ideal clinical effects [24–26]. In previous studies, the authors indicated that the removal of ILM may release the mechanical traction on macula, exert interference with nutrition or oxygenation of retina, and remove the proteins and cytokines related to DME on the inner limiting membrane [26]. According to the results of this study, the increase in AQP expression on ILMs of DR may be associated with the occurrence of DME; therefore, the use of AQP antagonists or the inhibitors of the proteins related to the mechanism of AQP may have a preventive or therapeutic effect on DME, instead of just using anti-VEGF or corticosteroids on the conservative treatment. Cui et al. [27] found that intravitreal injection of AQP4 protein inhibitor such as AQP4 shRNA (R) lentivirus particles or negative lentivirus particles could enhance AQP4 expression in diabetic rat retina. So, the regulation of AQP4 on retinal function may reduce diabetic retinopathy.

As the only human living retinal tissue currently available [1], the ILM, located at the vitreoretinal interface, can be used as a medium to study abnormal changes of vitreous body and retina. So, this study attempted to analyze the abnormal expression of AQPs on the ILMs of various vitreoretinal human diseases for the first time and to explore

Table 3: Comparison of the AQP4 immuno-fluorescence intensity values of four groups.

| Group                        | AQP4 immunofluorescence intensity value | P value | Values are displayed as mean ± standard deviation. P values were computed with one-way analysis of variance; *P < 0.05, compared to the other three groups. DME: diabetic macular edema; AQP4: aquaporin 4; n: number. |
|------------------------------|----------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Control group, n = 8         | 38.01 ± 5.04                           |         |                                                                                                                                                                                                 |
| Negative control group, n = 8| 17.37 ± 5.81*                          |         |                                                                                                                                                                                                 |
| No DME group, n = 9          | 36.79 ± 6.60                           |         |                                                                                                                                                                                                 |
| DME group, n = 12            | 51.05 ± 5.67*                          | <0.0001 |                                                                                                                                                                                                 |

The increase in water absorption causes an accumulation of water in the retina, while the expression of AQP7 and AQP11 in other retinal tissues is downregulated, decreases the outflow of water, and finally causes the retinal edema. Compared with AQP4, the water absorption function of AQP7 and AQP11 should be much weaker; therefore, the changes of AQP7 and AQP11 in the ILM of DR with DME are not significant. However, the regulation mechanism of AQPs is not completely clear by far, and further investigation is required. AQP7 and AQP11 are colocalized in the Müller cell endfeet at the ILM, while AQP4 is polarized distributed in Müller cells and mainly expressed in the endfeet membranes [12, 21]. According to the results of AQPs’ IHC in this study, AQP4 seemed to be, qualitatively, the most abundant among the three AQPs expressed on the ILMs, so we selected AQP4 as the protein for immunofluorescence detection.
the correction between the degree of DME and the expression of AQP4 on the ILMs. This study still obtains some deficiencies and shows some room for improvement. Firstly, the sample size should be expanded, and the ILMs of DR patients without DME should be included in particular. Secondly, in this study, only preoperative OCT was observed. For some patients who could not complete the scan due to VH or severe cataract before surgery, it can be combined with intraoperative OCT. Thirdly, in the subsequent study, it can be combined with the patient’s follow-up. The prospect of this study is to further investigate whether AQP can be a treatment target on human retina disease and find out its clinical value.

5. Conclusions

In conclusion, AQP4, AQP7, and AQP11 can be expressed on the ILM of human in vivo. The increase in AQP expression on ILMs of DR may be associated with the occurrence of DME. Moreover, the degree of DME may be positively correlated with the expression of AQP4 on the ILMs.

Data Availability

The data that support the findings of this study are available from the corresponding author upon request.

Conflicts of Interest

All authors declare that there is no conflict of interest regarding the publication of this paper.
Authors’ Contributions

Yiqi Chen and Huan Chen conceived and designed the experiments. Huan Chen, Chenxi Wang, Jiafeng Yu, and Jiwei Tao performed the experiments and contributed with reagents/materials/analysis tools. Jianbo Mao and Lijun Shen provided guidance and corrections for research design, result analysis and data statistics. Huan Chen and Yiqi Chen wrote the paper. All contributing authors have read and approved the final version of the manuscript. Yiqi Chen and Huan Chen contributed equally to this work and are co-first authors.

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References

[1] K. L. Schey, Z. Wang, J. L. Wenke, and Y. Qi, “Aquaporins in the eye: expression, function, and roles in ocular disease,” Biochimica et Biophysica Acta (BBA)-General Subjects, vol. 1840, no. 5, pp. 1513–1523, 2014.
[2] K. Kaneko, K. Yagui, A. Tanaka et al., “Aquaporin 1 is required for hypoxia-inducible angiogenesis in human retinal vascular endothelial cells,” Microvascular Research, vol. 75, no. 3, pp. 297–301, 2008.
[3] M. Holllborn, S. Dukic-Stefanovic, T. Pannicke et al., “Expression of aquaporins in the retina of diabetic rats,” Current Eye Research, vol. 36, no. 9, pp. 850–856, 2011.
[4] A. Miki, A. Kanamori, A. Negi, M. Naka, and M. Nakamura, “Loss of aquaporin 9 expression adversely affects the survival of retinal ganglion cells,” The American Journal of Pathology, vol. 182, no. 5, pp. 1727–1739, 2013.
[5] H. Suzuki, H. Oku, T. Horie et al., “Changes in expression of aquaporin-4 and aquaporin-9 in optic nerve after crushing in rats,” PLoS One, vol. 9, no. 12, article e114694, 2014.
[6] M. Dal Monte, G. Nicchia, M. Cammalleri et al., “Aquaporin 4 is required to induce retinal angiogenesis in a mouse model of oxygen-induced retinopathy,” Acta Ophthalmologica, vol. 92, 2014.
[7] H. Oku, S. Morishita, T. Horie et al., “Nitric oxide increases the expression of aquaporin-4 protein in rat optic nerve astrocytes through the cyclic guanosine monophosphate/protein kinase g pathway,” Ophthalmic Research, vol. 54, no. 4, pp. 212–221, 2015.
[8] C. A. Deeg, B. Amann, K. Lutz et al., “Aquaporin 11, a regulator of water efflux at retinal Müller glial cell surface decreases concomitant with immune-mediated gliosis,” Journal of Neuroinflammation, vol. 13, pp. 1–12, 2016.
[9] S. Lassialle, F. Valamanesh, C. Klein, D. Hicks, M. Abitbol, and C. Versaux-Botteri, “Changes in aquaporin-4 and Kir4.1 expression in rats with inherited retinal dystrophy,” Experimental Eye Research, vol. 148, pp. 33–44, 2016.
[10] S. Vujosevic, A. Micera, S. Bini, M. Berton, G. Esposito, and E. Midena, “Aqueous humor biomarkers of Müller cell activation in diabetic eyes,” Investigative Ophthalmology & Visual Science, vol. 56, no. 6, pp. 3913–3918, 2015.
[11] N. Matsunaga, H. Ozeki, Y. Hirabayashi, S. Shimada, and Y. Ogura, “Histopathologic evaluation of the internal limiting membrane surgically excised from eyes with diabetic maculopathy,” Retina, vol. 25, no. 3, pp. 311–316, 2005.
[12] S. Tenckhoff, M. Holllborn, L. Kohlen, S. Wolf, P. Wiedemann, and A. Bringmann, “Diversity of aquaporin mRNAs expressed by rat and human retinas,” Neuroreport, vol. 16, no. 1, pp. 53–56, 2005.
[13] M. J. Goodyear, S. G. Crewther, and B. M. Junghans, “A role for aquaporin-4 in fluid regulation in the inner retina,” Visual Neuroscience, vol. 26, no. 2, pp. 159–165, 2009.
[14] T. L. Tran, T. Bek, M. la Cour et al., “Altered aquaporin expression in glaucoma eyes,” APMIS, vol. 122, no. 9, pp. 772–780, 2014.
[15] B. Amann, K. J. Kleinwort, S. Hirmer et al., “Expression and distribution pattern of aquaporin 4, 5 and 11 in retinas of 15 different species,” International Journal of Molecular Sciences, vol. 17, no. 7, article 1145, 2016.
[16] R. G. Schumman, K. H. Eibl, F. Zhao et al., “Immunocytochemical and ultrastructural evidence of glial cells and hylaocytes in internal limiting membrane specimens of idiopathic macular holes,” Investigative Ophthalmology & Visual Science, vol. 52, no. 11, pp. 7822–7834, 2011.
[17] T. L. Tran, T. Bek, L. Holm et al., “Aquaporins 6–12 in the human eye,” Acta Ophthalmologica, vol. 91, no. 6, pp. 557–563, 2013.
[18] K. Yakata, K. Tani, and Y. Fujiyoshi, “Water permeability and characterization of aquaporin-11,” Journal of Structural Biology, vol. 174, no. 2, pp. 315–320, 2011.
[19] A. Rojek, E.-M. Füchtbauer, A. Füchtbauer et al., “Liver-specific Aquaporin 11 knockout mice show rapid vacuolization of the rough endoplasmic reticulum in periportal hepatocytes after amino acid feeding,” American Journal of Physiology-Gastrointestinal and Liver Physiology, vol. 304, pp. G501–GG15, 2013.
[20] J. D. Chidak, T. Arsenijevic, F. Gregoire et al., “Involvement of JNK/NFkB signaling pathways in the lipopolysaccharide-induced modulation of aquaglyceroporin expression in 3T3-L1 cells differentiated into adipocytes,” International Journal of Molecular Sciences, vol. 17, no. 10, article 1742, 2016.
[21] E. A. Nagelhus, Y. Horio, A. Inanobe et al., “Immunogold evidence suggests that coupling of K+ siphoning and water transport in rat retinal Müller cells is mediated by a coenrichment of Kir 4.1 and AQP4 in specific membrane domains,” Glia, vol. 26, no. 1, pp. 47–54, 1999.
[22] S. Hamann, T. Zeuthen, M. L. Cour et al., “Aquaporins in complex tissues: distribution of aquaporins 1–5 in human and rat eye,” American Journal of Physiology-Cell Physiology, vol. 274, no. 5, pp. C1332–C1345, 1998.
[23] Y. Zheng, L. Wang, M. Chen, A. Pei, L. Xie, and S. Zhu, “Upregulation of mir-130b protects against cerebral ischemic injury by targeting water channel protein aquaporin 4 (AQP4),” American Journal of Translational Research, vol. 9, no. 7, pp. 3452–3461, 2017.
[24] Y. Ashamina, N. Tachi, Y. Ashashina, K. Yoshimura, Y. Ueta, and Y. Hashimoto, “Six-month postoperative outcomes of
intraoperative OCT-guided surgical cystotomy for refractory cystoid macular edema in diabetic eyes,” *Clinical Ophthalmology (Auckland, NZ)*, vol. Volume 11, pp. 2099–2105, 2017.

[25] K. Kumagai, M. Furukawa, N. Ogino, E. Larson, M. Iwaki, and N. Tachi, “Long-term follow-up of vitrectomy for diffuse non-tractional diabetic macular edema,” *Retina*, vol. 29, no. 4, pp. 464–472, 2009.

[26] F. Ghassemi, F. Bazvand, R. Roohipoor, M. Yaseri, N. Hassanpoor, and M. Zarei, “Outcomes of vitrectomy, membranectomy and internal limiting membrane peeling in patients with refractory diabetic macular edema and non-tractional epiretinal membrane,” *Journal of Current Ophthalmology*, vol. 28, no. 4, pp. 199–205, 2016.

[27] B. Cui, J.-H. Sun, F.-F. Xiang, L. Liu, and W.-J. Li, “Aquaporin 4 knockdown exacerbates streptozotocin-induced diabetic retinopathy through aggravating inflammatory response,” *Experimental Eye Research*, vol. 98, pp. 37–43, 2012.