Tissue Inhibitor of Metalloproteinase-3 Ameliorates Total Sublethal Hepatic Ischemia/Reperfusion Injury in a Rat Model

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Abstract

Orthotopic liver transplantation is the only treatment for end stage liver disease. Recipients outweigh the number of available healthy donor livers, and options for increasing the donor pool have included the use of marginal livers. Transplantation of marginal livers is a known risk factor for the development of primary non-function post-transplant. Although the precise cause of primary non-function is not known, ischemia/reperfusion (I/R) injury has been strongly implicated, and tumor necrosis factor-α (TNF-α) plays a critical role in the pathogenesis of I/R injury in liver tissue [11]. During ischemia, TNF-α levels peak during the early phase at 30 minutes to 2 hours after reperfusion due to increased production of reactive oxygen species [12]. The subsequent infiltration of innate immune cells to the liver results in the production of inflammatory cytokines such as IL-6, IL-12, and TNF-α, which play a critical role in the pathogenesis of I/R injury. The cytokine tumor necrosis factor-α (TNF-α) is a potent mediator of inflammation and is implicated in both the physiologic defensive response to and the pathogenesis of I/R injury [8,10]. TNF-α, a 185 amino acid (aa), 17 kiloDalton (kDa), glycosylated protein, is synthesized as the precursor protein proTNF-α (212 aa, 26 kDa). ProTNF-α is transported to the membrane, and in response to stimulus, the extracellular domain is cleaved by the sheddase TACE/ADAM-17 (ADAM-17). TACE/ADAM-17 is a metalloproteinase-17 (ADAM), releasing the soluble and active form of TNF-α. Active TNF-α binds to two receptors, TNF-α receptor 1 (TNFR1/p55/CD120a) and TNF-α receptor 2 (TNFR2/p75/CD120b). TNFR1 is expressed on almost all human cells, and the TNF-α–TNFR1 complex activates apoptosis as well as cell proliferation. TNFR2 is expressed primarily on immune cells, and unlike TNFR1, two ligands, TNF-α and TNF-β, bind TNFR2, resulting in transcriptional activation but not apoptosis. Thus, the interaction between TNF-α and TNFR1 affects a number of tissues due to TNFR1’s broad expression pattern and pleiotropic activation.

The regulation of TNF-α is critical in controlling inflammation and is mediated in part by TACE/ADAM-17. TACE/ADAM-17 is an 824 aa, 93 kDa protein which is a member of the disintigrin and metalloproteinase domain (ADAM) family [18]. TACE/ADAM-17 not only cleaves proTNF-α but also releases or sheds other ligands, including TNFR1, TNFR2, the interleukin-6 receptor (IL-6R), members of the membrane-bound epidermal growth factor (EGF) family, the Notch receptor, fractalkine/CX3CL1, L-selectin, and transforming growth factor (TGF) 

Keywords: Liver; Transplantation; Tumor necrosis factor-α; Tumor necrosis factor-α converting enzyme

Introduction

Orthotopic liver transplantation (OLT) is the treatment for end stage liver disease with 1- and 5-year national patient survival rates of 89% and 80%, respectively [1]. The number of potential recipients on the national waiting list far surpasses the number of healthy organs available per year for transplantation. The options for increasing the donor pool have included live donors, split livers, and marginal livers. Examples of marginal liver donors are livers from older donors, donors with significant macrovesitis and donors with anticipated long cold ischemia times [2]. Transplantation of marginal livers is a known risk factor for the development of primary non-function after liver transplantation [3]. Primary non-function is a common cause for re-transplantation and death early after OLT. Optimization of marginal liver grafts would expand their utilization without increasing the perioperative morbidity and mortality. Although the precise cause of primary non-function is not known, ischemia/reperfusion injury has been strongly implicated [4,5].

Hepatic I/R injury is a multifactorial event involving immunological responses such as cytokine and chemokine cascades, the complement system, and inflammation as well as other physiological pathways [6,7]. The cytokine tumor necrosis factor-α (TNF-α) plays a critical role in both the physiologic defensive response to and the pathogenesis of I/R injury in liver tissue [8-10]. TNF-α, a potent mediator of inflammation, is a soluble cytokine primarily produced by activated monocytes, macrophages, and T-lymphocytes. In studies of liver transplantation, TNF-α is implicated in both the physiologic defensive response to and the pathogenesis of I/R injury in liver tissue [11]. During ischemia, TNF-α levels peak during the early phase at 30 minutes to 2 hours after reperfusion due to increased production of reactive oxygen species [12]. The subsequent infiltration of innate immune cells to the liver results in additional TNF-α production, 6-48 hours after reperfusion. Data from experimental models of I/R injury in which TNF-α is blocked or decreased suggest a potential clinical benefit [13-17].
factor-a (TGF-α) [19]. TACE/ADAM-17 is, in turn, regulated by another endogenous protein, tissue inhibitor of metalloproteinases-3 (TIMP-3), a competitive inhibitor of TACE/ADAM-17 [20,21].

Efforts to regulate inflammation through TNF-α in I/R injury during transplantation have focused primarily on pre-treatment and continuous treatment of the recipient or the donor with immunosuppressive drugs such as tacrolimus (FK-506), sirolimus (rapamycin), cyclosporine A (CsA), and corticosteroids [22-28]. However, immunosuppression prior to I/R injury may not reduce tissue damage, and furthermore, may inhibit tissue regeneration and repair [29,30]. Direct and limited targeting of specific inflammatory pathways may alleviate I/R injury while retaining the physiological repair mechanisms. We previously reported that TACE/ADAM-17 is constitutively expressed in rat livers and up-regulated after partial hepatic I/R injury, and TIMP-3 had a protective effect on I/R injured livers [17]. We were interested in expanding our studies to induce I/R injury in a clinically applicable model. In this study, we examined the effect of inhibiting TACE/ADAM-17 with TIMP-3 in rats undergoing total sublethal hepatic ischemia.

Our data indicate that TIMP-3 protects the rat liver from injury during sublethal hepatic ischemia and reperfusion. Our studies suggest that a targeted approach to inhibit TNF-α in donor may protect the livers from extensive I/R damage prior to removal, and thus, result in a decreased likelihood of the explanted liver to fail, leading to either death or re-transplant for the recipient.

Material and Methods

Animals

Male Wistar rats weighing 150-170 g (Harlan Laboratories, Indianapolis, IN) were assigned by computer-generated randomized list to treatment (N=16) or control (N=16) animal designation. The study was approved by the Institutional Animal Care and Use Committee (IACUC) at Ochsner Clinical Foundation. The animals were housed at the animal facility of Ochsner Clinic Foundation in accordance with the guidelines of the National Institutes of Health for the use of experimental animals. Surgeries and lab analysis were done on site. Syringes for the treatments were filled by a third party and labeled with sequential numbers.

TIMP-3

Recombinant human TIMP-3, expressed in mouse NSO cells, was purchased from Sigma-Aldrich (St. Louis). The purified protein has an apparent molecular weight of approximately 30 kDa due to glycosylation. The lyophilized protein is reconstituted with sterile distilled water at a stock concentration of 0.2 μg/ml. The reconstituted TIMP-3 was used to treat animals at a concentration of 1000 ng per 1 kg of bodyweight.

Injury model

All animals were anesthetized with 2% isoflurane (Vedco, Inc., St. Joseph, MO), and each group of 16 rats was treated prior to injury induction with either saline (0.9% NaCl solution; sham treatment) or TIMP-3. Treatment was administered as a bolus injection intraperitoneally one hour before injury. After treatment, the animals were again anesthetized with 2% isoflurane and underwent laparotomy, exposing the hepatic vasculature. The sublethal ischemic injury model consisted of temporarily clamping (Schwartz micro serefines, Fine Science Tools, Foster City, CA) the bile duct, hepatic vein and hepatic artery for 30 minutes of total warm hepatic ischemia. The group was divided into 4 subgroups of which the livers were allowed to reperfuse for 6, 24, or 48 hours or 7 days. The 16 animals from the control group were subjected to anesthesia, laparotomy, clamp injury and reperfusion identical to the TIMP-3-treated group. Blood, liver tissue, and spleen tissue were collected before the animals were humanely euthanized.

Serum protein assays

The Infinity™ alanine aminotransferase (ALT) liquid stable reagent (Thermoelectron Company, Louisville, CO) was used to measure serum ALT levels according to the manufacturer’s protocol. Briefly, 30 μl of sample or standard was mixed with pre-warmed (5 minutes at 37°C) 300 μl of ALT reagent in a 96-well flat-bottom microplate. The plate was incubated at 37°C for 30 seconds, and the absorbance was measured at 340 nm in a Model 680XR microplate reader (Bio-Rad). At 60 minutes after the first measurement, a second absorbance at 340 nm was measured. The activity of ALT was calculated by the following equation: Activity (U/L) = (ΔA_{340nm}/min) (Factor) where Factor = [(Total reaction volume (mL) (1000)] / ([6.3] (Sample volume in mL) (cuvette pathlength in cm)). The protein levels of IL-6 and TNF-α were measured by ELISA with the Quantikine® Rat IL-6 Immunoassay and the Quantikine® Rat TNF-α Immunoassay kits (R&D Systems, Minneapolis, MN), respectively, according to the manufacturer’s protocol. Serum samples were allowed to clot for 30 minutes at room temperature and centrifuged at 1000 x g prior to analysis. The data are presented as means ± standard deviation, and comparisons between the groups were made by use of analysis of variance. A P value less than 0.05 was considered statistically significant.

RNA extraction and reverse transcription-polymerase chain reaction (RT-PCR)

Total RNA from liver tissues stabilized in RNA later solution (Qiagen, Valencia, CA) was extracted using the RNeasy Mini Kit (Qiagen). DNA contamination was eliminated by incubating the RNA with RNase-Free DNase (Promega, Madison, WI) for 10 minutes at room temperature. The RNA preparation was quantified by measuring A260 nm with a spectrophotometer. Reverse transcription of freshly prepared 1 μg RNA was performed in a total volume of 20 μl containing 10 mM dithiothreitol (DTT), 50 mM Tris-HCl, 3 mM MgCl2, 0.5 μM deoxynucleotide triphosphates (dNTPs), 200 ng random primers, and 10 units of Moloney murine leukemia virus reverse transcriptase (Invitrogen, Carlsbad, CA). The reaction mixture was incubated at 42°C for 1 hr for reverse transcription, followed by 95°C for 15 min to inactivate the reverse transcriptase. One microliter of the cDNA was used for PCR amplification in a total volume of 50 μl with 1X reaction mixture [10 mM Tris-HCl, 50 mM KCl, 1% Triton X-100, 2.5 mM MgCl2, 0.2 μM dNTPs, 0.4 μM specific primers, and two units of Taq DNA polymerase (Promega, Madison, WI)]. Twenty-five cycles of PCR amplification were performed, each cycle with denaturation at 94°C for 45 sec, annealing at 60°C for 30 sec, and elongation at 72°C for 45 sec. The primer sequences were as follows: rat TACE/ADAM-17 forward primer 5’ ACG TAA TTG AGC GGT TTT GG-3’ (nt 2181-2200), reverse primer 5’ GAC TGG TGG GTG TGT GAG GT-3’ (nt 2650-2631), GenBank accession A0102603; rat TNF-α forward primer 5’-TGA GCA CAG AAA GCA GCA TGC TC-3’ (nt 21-21), reverse primer 5’-CAT CTG CTG GTA CCA CCA GTT-3’ (nt 397-378), GenBank accession X66539; and rat glyceraldehyde 3-phosphate dehydrogenase, forward primer 5’ TCC TTC AAG ATT TTC AGC AA-3’ (nt 497-516), reverse primer 5’ AGA TCC ACA ACA GAT GAT ACA TT-3’ (nt 804-785), and GenBank accession BC059110. All primers were synthesized and purified by Integrated DNA Technologies (Corvalis, IA).
amplified PCR products were analyzed in a 1.5% agarose gel.

Histology
Liver tissues from both treated and untreated animals were harvested and immediately fixed in 10% formalin. All samples were sent to pathology for routine processing, including embedding, sectioning, and hemolysin–eosin staining. The stained sections were blinded and analyzed by a pathologist.

Results
TIMP-3 inhibition of TACE/ADAM-17 prevents cleavage of proTNF-α, presumably decreasing the availability of active, soluble TNF-α. To determine whether TIMP-3 treatment reduces the TNF-α level in livers undergoing total sub lethal hepatic ischemia in vivo, we utilized a rat I/R injury model. Analysis of serum samples showed that TNF-α levels for control animals were 60 pg/ml at 6 hours of reperfusion and peaked at 48 hrs while TIMP-3-treated animals had at least 2-fold less serum TNF-α when comparing all time points of reperfusion duration (Figure 1). Even more striking, at 48 hours of reperfusion, TNF-α levels for TIMP-3-treated were 10-fold lower than untreated animals, suggesting that pre-treatment of animals with TIMP-3 prior to I/R injury resulted in decreased production of TNF-α in the serum and that TIMP-3 treatment maintained a steady state TNF-α level in the serum, regardless of reperfusion duration.

Since TIMP-3 is a competitive inhibitor of TACE/ADAM-17, we expected that the lower levels of TNF-α in TIMP-3-treated animal were not due to transcriptional regulation. To confirm that TIMP-3 treatment did not affect gene expression, we performed RT-PCR to assess both TNF-α and TACE/ADAM-17 mRNAs. The expression of both genes in TIMP-3-treated animals (Figure 2, odd-numbered lanes) was the same as untreated animals (Figure 2, even numbered lanes), and the levels were the same for all reperfusion time points. Thus, the decreased serum levels in TIMP-3-treated rats prior to I/R induction was not due to regulation of TNF-α and TACE/ADAM-17 gene expression.

Since TNF-α signaling result in up-regulation of downstream pro-inflammatory cytokines, we next examined the effect of TIMP-3 on the levels of IL-6 which is expressed and secreted due to TNF-α induction. In saline-treated, negative control animals, serum IL-6 levels peaked to almost 150 pg/ml after 6 and 24 hours of reperfusion before decreasing to 93 pg/ml at 48 hours reperfusion and 65 pg/ml after 7 days of reperfusion (Figure 3). In contrast, the levels of serum IL-6 in TIMP-3-treated rats stayed almost the same at all reperfusion time points with a small peak at 24 hours: 28 pg/ml (6 hrs), 49 pg/ml (24 hrs), 28 pg/ml (48 hrs), and 30 pg/ml (7 days). The serum IL-6 levels mimic the TNF-α levels (compare Figure 1 and 3, TIMP-3), exhibiting steady state levels in pre-treated but not in untreated rats.

In our total sublethal I/R injury model here, TIMP-3-treatment of rats had reduced serum ALT levels by 2- to 3-fold after all time points of reperfusion as compared to the untreated control animals (Figure 4). While ALT levels was significantly different in untreated compared to TIMP-3-treated rats, histological examination of the liver tissue indicated a more gradual and subtle change until day 7 of reperfusion in which histological changes were much more pronounced. After ischemia induction and 6 hours of reperfusion, the TIMP-3-treated livers appear similar to untreated livers with little or no damage seen (compare Figure 5A and 5E). Untreated rats who underwent total sub lethal ischemia followed by 24 hours of reperfusion exhibited slight signs of liver architecture collapse as shown by the infiltration of red blood cells into the plates of hepatocytes (arrow, Figure 5B; compare with Figure 5F). Strangely, we did not see much difference in liver histology between untreated and treated livers after 48 hours reperfusion (compare Figure 5C and 5G). However, after 7 days of reperfusion, the untreated liver exhibited dramatic hemorrhaging (labeled “H,” Figure 5D). The increasing sinusoidal space (arrows, Figure 5D) is most likely due to lysis of the sinusoidal lining cells, leading to hemorrhaging. The TIMP-3-treated liver exhibited almost normal liver architecture after 7 days of reperfusion with slight hemorrhaging seen in the sinusoidal space (“Si” in Figure 5H).

**Figure 1:** TNF-α serum levels of TIMP-3-treated rats compared to saline-treated rats exposed to liver I/R injury. Rat blood samples were allowed to clot to isolate serum. Serum samples were quantified for TNF-α by ELISA as per manufacturer’s protocol. TNF-α levels on the Y-axis (pg/ml) are shown for TIMP-3-treated rats and saline-treated rats prior to ischemia/reperfusion injury. The X-axis indicates the length of reperfusion time for TIMP-3-treated and saline-treated rats.

**Figure 2:** Gene expression of TNF-α, TACE/ADAM-17, and GAPDH in liver tissue of TIMP-3-treated rats compared to saline-treated rats exposed to I/R injury. Total mRNA extracted from rat liver tissues were analyzed by RT-PCR for TNF-α, TACE/ADAM-17, and GAPDH mRNA. TIMP-3-treatment and saline treatment are denoted by + and −, respectively. All rats underwent 30 minute ischemia, followed by varying reperfusion duration (6 hrs, 24 hrs, 48 hrs or 7 days). The PCR products were analyzed by agarose gel electrophoresis, stained with ethidium bromide.

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TNF-α with a concomitant improvement in liver health as compared to untreated animals. In the present study, we exposed rats to 30 minutes of ischemia, followed by 6, 24, 48 hours or 7 days of reperfusion. The rats were either pre-treated with recombinant TIMP-3 or saline prior to induction of I/R injury. We show here that TIMP-3-treated rats exhibited decreased serum levels of TNF-α when subjected to total sub lethal hepatic I/R injury. The treated rats also had decreased IL-6, liver ALT and tissue damage. Our data suggest that in our rat model, TIMP-3 pre-treatment modulates the amount of active TNF-α in the serum up to 7 days, presumably by inhibiting TACE/ADAM-17 and preventing the release of soluble TNF-α.

We previously reported that TIMP-3 treatment of rats undergoing partial warm ischemia decreased the levels of serum TNF-α and protected the liver from tissue damage [17]. With the partial warm ischemia model, two other potential factors may play a role in regulating TACE/ADAM-17. First, allowing flow from the superior mesenteric vein into the right portal vein may have minimized bowel congestion and altered the circulation of cytokines from the bowel mucosa. We now induced ischemia by clamping the bile duct, portal vein, and the hepatic artery for 30 minute which renders 70% of the liver volume now induced ischemia by clamping the bile duct, portal vein, and the hepatic artery for 30 minute which renders 70% of the liver volume.

Discussion

TNF-α is a potent mediator of I/R injury [31], and the inhibition of TNFα appears to protect livers from damage [12]. TIMP-3 is a highly specific inhibitor of TACE/ADAM-17 and has been shown to regulate inflammation [32]. We hypothesized that I/R injury induces an inflammatory cascade and that TIMP-3 treatment of rats undergoing I/R injury to the liver would result in decreased levels of
We have shown a dose-dependent effect of TIMP-3-treated rats prior to inducing partial warm I/R injury [17]. While a dose of 100 ng/kg bodyweight also significantly decreased TNF-α and ALT levels by almost two-fold compared to the untreated rats, we chose the 1,000 ng/kg bodyweight dose due to the 4- to 5-fold decrease in serum TNF-α after 6 hours of reperfusion. More importantly, the ALT levels of the TIMP-3-treated rats at the 1,000 ng/kg dose exhibited low levels of ALT similar to normal non-ischemic animals. Thus, we used the 1,000 ng/kg TIMP-3 dose for the studies reported here. While we have been interested in examining TIMP-3 peptides as inhibitors rather than the full-length protein, peptide-length TIMP-3 appears to be ineffective at binding the active site of TACE/ADAM-17 as the endogenous TIMP-3 does. The N-terminal domain of TIMP-3 is effective; however, three disulfide bonds in the N-terminus domain result in folding TIMP-3 for specific contacts with TACE/ADAM-17 which cannot be mimicked at the peptide level [35,36]. Although present in the literature, synthetic TIMP-3 peptides that bind allosteric sites have not been tested for biological activity against TACE/ADAM-17 in vivo and would be interesting to test in our rat I/R model.

While several anti-TNF-α antibodies are approved for clinical use against chronic inflammatory diseases, particular for rheumatoid arthritis, few reports have demonstrated effective use of TNF-α antibody in liver I/R injury [37-39]. Ben-Ari et al. [15], previously demonstrated arthritis, few reports have demonstrated effective use of TNF-α antibody against TACE/ADAM-17. Interestingly, Ben-Ari et al. [15] showed that targeting the TNF-α gene with shRNA resulted in an almost 60% decrease in ALT levels with a concurrent 6-fold decrease in TNF-α protein. Hernandez-Alejandro et al. [42], as we have demonstrated in a small pilot study of human donors [41]. Antibody treatment, therefore, would be too late in preventing TNF-α from binding to TNF-α receptors. Hernandez-Alejandro et al. [42], recently showed that targeting the TNF-α gene with shRNA resulted in a 40% decrease in ALT and AST levels with normal liver histology in an I/R mouse model. The mice were treated with TNF-α shRNA two days prior to ischemia for 6 minutes and 6 hours of reperfusion. They did not measure serum TNF-α levels although the TNF-α mRNA was decreased by half compared to untreated control mice. TIMP-3 treatment in our rat model resulted in an almost 60% decrease in ALT levels with a concurrent 6-fold decrease in TNF-α protein.

The analysis of TIMP-3 metabolic turnover is an important issue, one that is the sole subject of investigation, particularly since cadaveric donors, prior to organ removal may improve donor liver health, and thereby, improve the outcome of the recipient. We suggest that TIMP-3 pre-treatment of the donor, particularly cadaveric donors, prior to organ removal may improve donor liver health, and thereby, improve the outcome of the recipient following liver transplantation.

TNF-α is a key mediator in inflammation, and inhibitors of TNF-α are effective for management of various autoimmune diseases such as Crohn’s disease and rheumatoid arthritis. Studies have now identified that TNF-α plays a critical role in I/R injury after solid organ transplantation and experimental models suggest that inhibition of TNF-α may prove to be beneficial in attenuating I/R injury. Most treatment options to alleviate damage due to I/R injury is to focus on the recipient. We suggest that TIMP-3 pre-treatment of the donor, particularly cadaveric donors, prior to organ removal may improve donor liver health, and thereby, improve the outcome of the recipient following liver transplantation.

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