Recombinant activated factor VII (rFVIIa) has been recently shown to prevent spontaneous bleeding in inhibitor-complicated haemophilia when administered once daily (Konkle et al., 2007; Young et al., 2012). The pro-haemostatic effect of rFVIIa prophylaxis is difficult to explain given its plasma half-life of 2 h.

In the literature, four mechanisms explaining the prophylactic efficacy of once-daily rFVIIa administration have been proposed, including the requirement of much lower doses of rFVIIa to prevent than to treat bleeding, improvement of endothelial cell permeability, uptake of rFVIIa by platelets, and redistribution of rFVIIa into the extravascular space (Lisman & de Groot, 2015). Accumulation of rFVIIa in bone and joints may explain the prophylactic activity of rFVIIa. One study suggested that rFVIIa was taken up by megakaryocytes within the bone marrow (Gopalakrishnan et al., 2010).

The present study tested the hypothesis that megakaryocytes that have taken up rFVIIa will produce rFVIIa-containing platelets, which may explain the prolonged haemostatic effect of rFVIIa in a prophylactic setting.

We used the megakaryoblastic cell line MEG-01, which was cultured and differentiated by valproic acid as described earlier (Kirschbaum et al., 2015). After at least 10 d of differentiation, different concentrations of rFVIIa were added to the culture medium and after 2 h, MEG-01 cells were either harvested or stimulated to produce platelet-like particles (PLPs) by addition of 100 ng/ml recombinant human thrombopoietin (rTHPO; Life Technologies, Carlsbad, CA, USA) for 3 d. Cells or PLPs were harvested by centrifugation, washed and lysed by freeze-thawing the samples twice.

We first showed that rFVIIa was dose-dependently taken up by MEG-01 cells (Fig 1A). After 3 d of rTHPO stimulation, hardly any rFVIIa was detected in the MEG-01 cells (Fig 1B). In contrast, the PLPs produced from these MEG-01 cells contained appreciable amounts of rFVIIa (Fig 1C), which suggests rFVIIa is selectively transferred to PLPs. Active selection of agents to be transferred to platelets in the process of megakaryocyte maturation has been previously demonstrated, as megakaryocytes transfer some, but not all, mRNA species examined to platelets (Cecchetti et al., 2011).
To confirm that rFVIIa is taken up by MEG-01 cells (and not just associated with the cell), we stained MEG-01 cells or PLPs for rFVIIa and examined cells using fluorescence microscopy. There was an ubiquitous presence of rFVIIa within the vast majority of cells (80–90%) in an apparent punctuate pattern at 2 h after the addition of rFVIIa to the culture medium (Fig 1D i), whereas no staining was detected in cells that had not been exposed to rFVIIa (Fig 1D ii). After 3 d of rTHPO stimulation, no rFVIIa staining was detected in the MEG-01 cells (Fig 1D iii). The MEG-01 cell-derived PLPs harvested at day 3, however, did stain positive for rFVIIa (Fig 1D iv). We also used flow cytometry to confirm the presence of rFVIIa within PLPs. rFVIIa was predominantly localized within the PLP because 55.6% ± 11.3% [mean ± SD, n = 3] of permeabilized cells stained positive for rFVIIa, compared to 19.9% ± 5.1% [mean ± SD, n = 3] of non-permeabilized cells (Fig 1E).

rFVIIa within PLPs is haemostatically active, as levels were determined in PLP lysates with a functional coagulation assay. To determine whether this functionally active rFVIIa contributes to haemostasis in a plasma environment, we performed in vitro thrombin generation measurements using plasma to which intact PLPs were added. Addition of rFVIIa-containing PLPs resulted in a profound shortening of...
the lag time of the thrombin generation curve in normal, FVII-, and FVIII-depleted plasma, compared to addition of PLPs generated from MEG-01 cells that had not been exposed to rFVIIa (Fig 1F). rFVIIa-containing PLPs also had a slight but significantly increased peak thrombin generation compared to control PLPs (Fig 1G). Whether rFVIIa in PLPs does not encounter inhibitors (such as tissue factor pathway inhibitor and antithrombin) or whether the rFVIIa measured in our assay only represents a fraction of total rFVIIa in PLPs, with the remainder being in complex with an inhibitor, requires further study.

We next assessed the mechanism of uptake of rFVIIa by MEG-01 cells. We hypothesized a role for negatively charged phospholipids, glycoprotein (GP)Ibα and endothelial protein C receptor (EPCR), which are all known binding partners for rFVIIa (Lisman & de Groot, 2015). GPIbα was hardly detected on the surface of differentiated MEG-01 cells: 2.5% ± 0.6% [(mean ± SD, n = 3) of cells stained positive for GPIbα, Fig 2A]. In contrast, EPCR was abundantly present on MEG-01 cells with 73.2% ± 11.8% (mean ± SD, n = 3) of cells staining positive (Fig 2B), which, to our knowledge, has not been reported before. Uptake of rFVIIa was not affected by Annexin A5, excluding a role for negatively charged phospholipids in rFVIIa uptake, but a 76.0% ± 8.7% [mean ± SD] reduction of rFVIIa uptake was observed in the presence of an antibody to EPCR (Fig 2C). Immunofluorescent staining of rFVIIa confirmed these results (Fig 2D). EPCR appears to fulfil multiple critical features in the mode of action of rFVIIa, including enhancement of haemostatic activity in the intravascular space (Pavani et al, 2014), improvement of endothelial barrier function (Sundaram et al, 2014), transport of rFVIIa to extravascular sites (Clark et al, 2012) and uptake by megakaryocytes in the bone marrow (this study).

Taken together, we demonstrate EPCR-dependent uptake of rFVIIa by megakaryocytes with subsequent production of rFVIIa-containing ‘prohaemostatic’ platelets. Whether this mechanism acts in vivo requires further study, but delayed generation of rFVIIa-containing platelets appears a plausible mechanism to partly explain the efficacy of once-daily rFVIIa prophylaxis in inhibitor-complicated haemophilia.

References


Author contributions

A.M. Schut and M. Kirschbaum participated in the design of the study, performed experiments, analysed and interpreted data and wrote the manuscript. J. Adelmeijer performed experiments, analysed and interpreted data. P.G. de Groot interpreted data. T. Lisman participated in the design of and supervised the study, interpreted data and wrote the manuscript. All authors revised and approved the manuscript.

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Conflict of interest

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Autoimmune thrombotic thrombocytopenic purpura associated with HHV8-related Multicentric Castleman disease

Thrombotic thrombocytopenic purpura (TTP) is a thrombotic microangiopathy (TMA) that results from severe ADAMTS13 (A Disintegrin And Metalloprotease with Thrombospondin type 1 motif member 13) deficiency. The main cause of TTP is autoantibodies against ADAMTS13 (Furlan et al., 1998; Tsai & Lian, 1998).

Multicentric Castleman disease (MCD) is a rare lymphoproliferative disorder, marked by recurrent flares of fever, lymphadenopathy and splenomegaly. MCD presents with cytopenias and elevated C reactive-protein (CRP). MCD is more frequent in association with human immunodeficiency virus (HIV) infection. Human herpes virus 8 (HHV8) is responsible for the onset of MCD (HHV8/MCD) in all HIV-associated MCD (HIV/MCD) and in half of HIV negative patients (Soulier et al, 1995; Oksenhendler et al, 1996).

Several autoimmune diseases have been associated with MCD (Muskardin et al, 2012). We report for the first time four cases of TTP associated with HHV8/MCD.

All the patients included in a prospective database for Castleman disease between 1 January 2003 and 1 October 2012 who presented with a TMA were included in this study. Patients’ records were reviewed using a pre-established chart. Thrombotic thrombocytopenic purpura was defined by TMA and severe ADAMTS13 deficiency (<5% activity). ADAMTS13 activity and anti-ADAMTS13

Table I. Characteristics of patients at TMA onset

<table>
<thead>
<tr>
<th></th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>56</td>
<td>44</td>
<td>52</td>
<td>42</td>
<td>48</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>Male</td>
<td>Male</td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>HIV (years since diagnosis)</td>
<td>*</td>
<td>4-6</td>
<td>11-3</td>
<td>13-4</td>
<td>11-28</td>
</tr>
<tr>
<td>CD4 cell count (x 10^9/l)</td>
<td>(1-562)</td>
<td>0-538</td>
<td>0-252</td>
<td>0-313</td>
<td>0-313$</td>
</tr>
<tr>
<td>HIV viral load (copies/ml)</td>
<td>*</td>
<td>300</td>
<td>48</td>
<td>397</td>
<td></td>
</tr>
<tr>
<td>Haemoglobin (g/l)</td>
<td>78</td>
<td>72</td>
<td>55</td>
<td>39</td>
<td>63-5</td>
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<tr>
<td>Reticulocyte count (x 10^9/l)</td>
<td>77</td>
<td>15</td>
<td>70</td>
<td>17</td>
<td>43-5</td>
</tr>
<tr>
<td>Platelet count (x 10^9/l)</td>
<td>3</td>
<td>22</td>
<td>18</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Schizocytes</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Creatinine (μmol/l)</td>
<td>180</td>
<td>177</td>
<td>193</td>
<td>76</td>
<td>178,5</td>
</tr>
<tr>
<td>LDH (u/l)</td>
<td>1800</td>
<td>1453</td>
<td>1600</td>
<td>2000</td>
<td>1700</td>
</tr>
<tr>
<td>CRP (mg/l)</td>
<td>80</td>
<td>85</td>
<td>81</td>
<td>333</td>
<td>83</td>
</tr>
<tr>
<td>HHV8 RT-PCR (copies/ml)</td>
<td>77,359</td>
<td>10,111</td>
<td>+†</td>
<td>151,189</td>
<td>77,359</td>
</tr>
<tr>
<td>ADAMTS13 (%activity)</td>
<td>&lt;5%</td>
<td>&lt;5%</td>
<td>&lt;5%</td>
<td>&lt;5%</td>
<td>&lt;5%</td>
</tr>
<tr>
<td>Anti-ADAMTS13 antibodies (u/ml)</td>
<td>&gt;100</td>
<td>84</td>
<td>74</td>
<td>70</td>
<td>79</td>
</tr>
<tr>
<td>Histological examination</td>
<td>Left axillary LAD</td>
<td>Infraclavicular LAD</td>
<td>Inguinal LAD consistent with HHV8/MCD and TMA without KS</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>KS (years since diagnosis)</td>
<td>Yes (2-6)</td>
<td>Yes‡</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

TMA, thrombotic microangiopathy; MCD, Multicentric Castleman disease; HIV, Human Immunodeficiency Virus; CRP, C-Reactive Protein; HHV8, Human Herpes Virus 8; RT-PCR, Real Time Polymerase Chain Reaction; ADAMTS13, A Disintegrin And Metalloprotease with Thrombospondin type 1 motif member 13; KS, Kaposi Sarcoma; LAD, Lymphadenopathy, NA, Not available.

*Not appropriate (HIV negative).
†Testing performed at another institution using qualitative PCR.
‡Diagnosis was concomitant with TMA.
§Patient 1 (HIV negative) not included.