Evidence that protease activated receptor 2 expression is enhanced in human coronary atherosclerotic lesions

C Napoli, F de Nigris, J L Wallace, M D Hollenberg, G Tajana, G De Rosa, V Sica, G Cirino

METHODS

Human subjects

Arteries were collected from adult (mean age, 41.8 years; SD, 5.6; n = 8) and elderly (mean age, 70.5 years; SD, 5.1; n = 6) men subjected to necropsy at the University of Naples, who had died in traumatic accidents. They were included in our study only if they were men (to avoid sex related differences) and had no classic risk factors for atherosclerosis (family history of coronary heart disease, diabetes, smoking, hypertension, or dislipidaemia), which were assessed by detailed medical history of clinical records, as described previously.19 Our study protocol was approved by the local human ethical committee.

Preparation of arterial sections, histological analysis, and immunohistochemical analysis

Using a stereo microscope, the entire left anterior descending and the right coronary arteries were dissected from each patient, cut open, washed thoroughly with cold sterile phosphate buffered saline (PBS), and placed in ice cold PBS containing 50µM butylated hydroxytoluene, 0.001% aprotinin, 50mM EDTA, 1µM deferoxamine, and 0.008% chloramphenicol, equilibrated with nitrogen. One of these segments was immersed in ornithine transcarbamoylase, flash frozen in liquid nitrogen, and 30–40 sections (7 µm thick) were prepared for computerised morphometric determination of lipid rich lesions by oil red O staining, as described previously.19 Another arterial segment was fixed in buffered 10% formalin, paraffin wax embedded, and 12–15 serial sections (5–7 µm thick) were prepared for immunohistochemistry, as described previously.19–21 Alternate serial sections were immunostained with: (1) MDA2, a murine monoclonal antibody against malondialdehyde lysine epitopes of oxidised low density lipoprotein (oxLDL); (2) HAM-56, a monoclonal antibody against human macrophages/foam cells; B5, a rabbit polyclonal antibody against PAR-2; and SAM11, a mouse monoclonal antibody against human PAR-2. Sections containing at least one lesion showing substantial immunostaining were counted as positive, and results were expressed as per cent of all sections of the same artery.

RESULTS

PAR-2 expression was enhanced in human coronary atherosclerotic lesions. This phenomenon correlated with an increase in oxLDL epitopes in the coronary artery.

Conclusion: This study shows for the first time that PAR-2 expression is enhanced in human coronary atherosclerotic lesions, and suggests that PAR-2 dependent cellular trafficking may be one of the regulatory signalling responses to vascular injury. Further pharmacological studies will establish whether modulation (and in which direction) of PAR-2 represents a possible therapeutic target for controlling the vascular response to injury.
rabbit polyclonal antibody against PAR-2; 19–22; and (4) SAM11, a mouse monoclonal antibody against human PAR-2 (Zymed Laboratory, San Francisco, California, USA). All antibodies were used at a dilution between 1/500 and 1/100. Unless otherwise specified, epitopes recognised by the primary antibody were detected by an avidin–biotin–peroxidase method. 19–20 Immunohistochemical colocalisation using two antibodies was performed and analysed by computer assisted imaging software. 19–21

**Statistical analysis**

Results were analysed by one way ANOVA, followed by Bonferroni’s, and a p < 0.05 was considered to be significant. Numerical data obtained from immunohistochemistry were analysed for mean, variance, SD, kurtosis, and skew. Correlations between the results were also evaluated by linear regression analysis. All data were analysed by SPSS statistical package (SPSS Inc, San Diego, California, USA).

**RESULTS**

**Extent and maturity of atherosclerotic lesions**

Based on computer assisted imaging analysis of histological oil red O stained sections, we divided coronary atherosclerotic lesions into early class I lesions (fatty streaks), class II lesions (fibrous lesions), and advanced class III (fibroatheromatous lesions) and class IV (calcific lesions) lesions. The mean (SD) lumen stenosis of the lesions was 45% (6%) in adults and 65% (8%) in elderly men (p < 0.05). Mean intimal thickness increased with age in coronary arteries (p < 0.05). The nuclear density of the smooth muscle cells in the media, as an index of the maturity of the lesions, 19–20 varied with the stage of the lesions, and ranged from a mean (SD) of 752 (123) smooth muscle cell nuclei/mm² in adult coronary arteries to 1233 (227) in those from elderly men (p < 0.01). Data were not normally distributed in the lesions (cumulative skew of 2.04) and were therefore analysed by the Wilcoxon test.

**Immunohistochemistry**

Paraffin wax embedded serial sections of coronary arteries from the study population were immunostained and assessed for the intimal presence of oxLDL, macrophage derived foam cells, and PAR-2. Sections containing at least one lesion showing positive immunostaining were counted as positive, and results were expressed as per cent of all sections of the same artery, as described previously. 19–20 The early and transitional lesions (class I and II) contained significantly higher staining for PAR-2 than those of class IV (fig 1A–E). PAR-2 immunostaining was typically seen at the subendothelial space (table 1). Results obtained with both antibodies were highly correlated when all the lesions were considered (r = 0.72; p < 0.001).

Computer assisted imaging analysis of colocalisation (fig 1D, E) showed a positive immunohistochemical correlation between oxLDL and PAR-2 (B5 antibody) in class I and II lesions (r = 0.48 and 0.41, respectively; p < 0.01). The correlation between PAR-2 and oxLDL was also significant in class III lesions using the SAM11 antibody (r = 0.51; p < 0.01). Thus, as vascular inflammation increased the correlation between oxLDL and PAR-2 increased—the correlation between oxLDL and PAR-2 was stronger in class III lesions than in class I and II lesions. However, there were no correlations in class IV lesions (p = NS for both B5 and SAM11 antibodies), probably because multiple inflammatory pathways are simultaneously activated in such advanced atherosclerotic lesions. These immunostaining data reflected a simultaneous increase for both antibodies in the same areas and not increased numbers of nuclei in serial sections.

**DISCUSSION**

This is the first evidence that the PAR-2 protein is present in early coronary atherosclerotic lesions in humans without confounding risk factors for atherosclerosis. We have shown that calcific atherosclerotic lesions in coronary arteries (class IV) have reduced PAR-2 expression. The results are particularly consistent because the immunohistochemical data from the two independently prepared antisera (B5 and SAM11 antibodies) were the same.

The details of the complex framework of pathological processes leading to the formation of atherosclerotic lesions are well documented. Atherosclerosis based diseases are the leading cause of death and disability in the world. Because classic risk factors may increase per se the degree of coronary atherosclerosis and vascular inflammation, here, we selected prospectively only men who did not have the classic risk factors for the disease. 19 We showed that the presence of
PAR-2 protein in lesions was significantly related to oxidation specific epitopes of oxLDL (MDA-2 antibody) in class I, II, and III lesions. Clearly, the relative contribution of these potential mechanisms to atherogenesis and vascular inflammation, the functional relevance of changes in PAR-2 expression, and their interactions need to be investigated in experimental models of the disease, rather than in post-mortem tissues. Although this does not represent a causal association, differences in intracellular and extracellular oxidative processes could exist in human coronary arteries, which in turn may affect PAR-2 dependent gene expression. Obviously, it is well recognised that atherogenesis is a complex inflammatory disease. It is therefore possible that a broad spectrum of inflammatory and oxidation sensitive genes could be activated, especially in class II and III lesions. Thus, the mechanism involving PAR-2 activation and oxidation sensitive pathways in the arterial wall could perpetuate the condition of “oxidative stress and inflammation”. We cannot establish whether increased in situ PAR-2 expression is harmful or just a compensatory mechanism, or whether it is secondary to the atherogenic and/or inflammatory process; however, when atherogenesis affects coronary arteries, this may induce activation of PAR-2 in a vicious cycle. Further studies are also needed to establish whether the changes in protein concentrations are the result of increased gene expression or stabilisation of the protein.

Previous data also indicate that PAR-2 plays an important role in myocardial ischaemia–reperfusion injury. An inflammatory state in which a large amount of oxygen radicals are generated at reflow. This further suggests a broad spectrum of oxidation sensitive PAR-2 activities in the cardiovascular system. Thus, the PAR-2 dependent network may play a pivotal role in the inflammatory response and oxidation injury to tissue. In this context, vascular inflammation linked to atherosclerosis may represent an additional scenario for the action of PAR-2.

"We showed that the presence of protease activated receptor 2 in lesions was significantly related to oxidation specific epitopes of oxidised low density lipoprotein (MDA-2 antibody) in class I, II, and III lesions”

Previous data in other models, recent data on the angio genesis promoting effect of PAR-2, and our results indicate that PAR-2 may not necessarily play a pathological role in vascular inflammation. It could reflect a more complex pathophysiological situation, where arteries try to counterbalance the vascular damage caused by atherogenesis by inducing a protective response. In line with this assumption, bacterial proteinases activate PAR-2 on neutrophils, suggesting that PAR-2 may constitute one of the first protective mechanisms that signal invasion of bacterial pathogens by activating a primary inflammatory response. This last consideration might also fit in with the hypothesis that infection and inflammation trigger acute coronary syndromes. Once it is established whether PAR-2 expression is a primary or a secondary response and whether this expression is harmful or just a compensatory mechanism, inducing a protective response, modulation of PAR-2 may represent a possible therapeutic target for controlling the vascular response to injury.


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J Clin Pathol 2004 57: 513-516
doi: 10.1136/jcp.2003.015156

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