Comparison of erythrocyte antioxidative enzyme activities between two types of haemoglobin H disease

S PRASARTKAEW, A BUNYARATVEJ, S FUCHAROEN,* P WASI*

From the Department of Pathology, Faculty of Medicine, Ramathibodi Hospital, and the *Department of Medicine, Faculty of Medicine, Siriraj Hospital, Mahidol University Bangkok, Thailand

SUMMARY The activities of erythrocyte antioxidative enzymes were measured in two groups of patients with different genotypes of haemoglobin (Hb) H disease: 21 with \( \alpha \)-thalassaemia 1 or \( \alpha \)-thalassaemia 2 (\( \alpha \)-thalassaemia 1/2) and 21 with \( \alpha \)-thalassaemia 1/Hb Constant Spring (HbCS). They were compared with 21 normal subjects. Both genotypes of Hb H disease had increased activities of erythrocyte superoxide dismutase (SOD), glutathione peroxidase (GSH-Px), and catalase when compared with those of controls. Comparison of the two genotypes showed that subjects with \( \alpha \)-thalassaemia 1/Hb CS, the more severe disease, had higher SOD and GSH-Px activities but lower catalase activity than those with \( \alpha \)-thalassaemia 1/2. This indicates that there are compensatory mechanisms in Hb H erythrocytes to cope with increased generation of oxygen free radicals as a result of increased excess \( \beta \) chain.

Autoxidation of haemoglobin can produce superoxide free radicals, which can cause red cell damage, leading to short red cell survival. Production of the superoxide is increased in the presence of isolated \( \alpha \) or \( \beta \) globin chains of the haemoglobin molecule. Haemoglobin (Hb) H disease, one of the thalassaemia syndromes, is characterised by excess \( \beta \) chains, which form relatively insoluble \( \beta _s \) (Hb H). This should lead to generation of an increased amount of superoxide. Evidence supporting this hypothesis is an increased erythrocyte superoxide dismutase (SOD) activity in Hb H patients. SOD is an enzyme that catalyses the breakdown of superoxide into the less potent oxidant \( \text{H}_2\text{O}_2 \) and oxygen to lessen the oxidative damage to the cell. The \( \text{H}_2\text{O}_2 \), still capable of producing cell damage, is further reduced to water and oxygen by glutathione peroxidase (GSH-Px) and catalase.

There are two common genotypes of Hb H disease: one results from double heterozygosity between \( \alpha \)-thalassaemia 1 and \( \alpha \)-thalassaemia 2 genes (\( \alpha \)-thalassaemia 1/2), and the other from concomitant inheritance of \( \alpha \)-thalassaemia 1 and Hb Constant Spring genes (HbCS). There are some differences between these two genotypes, with a greater proportion of red cells containing inclusion bodies, and higher levels of Hb Bart's and Hb H being seen in the Hb CS variety. These differences suggest that there might be different degrees of red cell oxidative stress and so we measured the activities of SOD, GSH-Px, and catalase in the red cells of the two types of Hb H disease.

Material and methods
Sixty three subjects were examined, 21 with genotypes \( \alpha \)-thalassaemia 1/2, 21 with Hb CS, and 21 normal controls. The patients were from the files of the division of haematology, department of medicine, faculty of medicine, Siriraj Hospital; the normal controls were laboratory staff. The patients had received no blood transfusions for at least three months before examination. All of them were in steady state. Detailed clinical and laboratory findings of the patients have been reported previously. Informed consent was obtained from all subjects.

Haematological studies
Red cell count, white cell count, mean corpuscular volume and haematocrit were determined in a Coulter counter, model ZF6. Haemoglobin concentrations were measured on a Coulter haemoglobinimeter. Haemoglobin types were identified by starch-gel electrophoresis, using tris-edetic acid-borate buffer (pH 8-6). Quantitation of Hb A\(_2\), Hb H, and Hb Bart's was performed by cellulose-acetate electrophoresis.

Accepted for publication 2 June 1986
PREPARATION OF HAEMOLYSATES FOR ENZYME ASSAY

The heparinised blood was centrifuged; plasma and buffy coat were removed by aspiration. Packed red cells were washed three times with ice cold isotonic buffer. Leucocytes and platelets were removed according to the method of Oski and Bowman. About a 20% red cell suspension was filtered through Whatman No 2 filter paper. The filtrate was collected, washed twice with 10 volumes of ice cold isotonic...
buffer, and resuspended to a 50% cell suspension. The cell suspension was haemolysed and assayed for SOD, GSH-Px, and catalase.

**ENZYME ASSAYS**

The method for SOD measurement is based on the ability of the enzyme to inhibit the reduction of nitroblue tetrazolium by superoxide radical, which is generated by the reaction of photoreduced riboflavin and oxygen. Measurement of erythrocyte GSH-Px activity depends on the oxidation of NADPH by the oxidised form of glutathione (GSSG), which is generated by a catalytic reaction of GSH-Px. The method for measuring catalase activity is based on the ability of catalase to decompose hydrogen peroxide. Units of the enzyme assays were reported as U/g Hb, U/ml red blood cells, and U/10^10 red blood cells.

### Results

Figs a–c show the results of SOD, GSH-Px, and catalase activities. Erythrocytes from both genotypes of Hb H disease had higher SOD activities than the normal erythrocytes in all units determined. The Hb CS erythrocytes also had higher SOD activities than the a-thalassaemia 1/2 erythrocytes, but only on the basis of U/g Hb and U/10^10 red blood cells not U/ml red blood cells.

Erythrocyte GSH-Px activity was higher in both genotypes when compared with normal values. GSH-Px activity was also higher in Hb CS erythrocytes compared with the values for a-thalassaemia 1/2 genotype in all respects.

Red cell catalase activity of a-thalassaemia 1/2 erythrocytes was higher than normal erythrocytes.

### Mean (SD) GSH-Px, catalase, and SOD, activities and concentrations of red cells in top and bottom layers

<table>
<thead>
<tr>
<th>Cell population</th>
<th>Reticulocyte count (%)</th>
<th>SOD (U/gHb)</th>
<th>GSH-Px (U/gHb)</th>
<th>Catalase (x 10^4 IU/gHb)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top layer (n = 6)</td>
<td>5.0 (0.4)</td>
<td>7214 (826)</td>
<td>65.09 (7.77)</td>
<td>31.52 (0.81)</td>
</tr>
<tr>
<td>Bottom layer (n = 6)</td>
<td>1.8 (0.3)</td>
<td>6897 (1120)</td>
<td>63.72 (4.77)</td>
<td>30.96 (3.06)</td>
</tr>
<tr>
<td>p value</td>
<td>&lt; 0.001</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>

Activities of erythrocyte antioxidant enzymes (a) superoxide dismutase, (b) glutathione peroxidase, and (c) catalase in normal subjects (N), patients with a-thalassaemia 1/2 (H), and those with HbCS (H + CS). Bars represent mean (SD).
only when expressed as U/g Hb and U/ml red blood cells, and catalase activity of Hb CS erythrocytes was statistically higher than normal only in U/g Hb. The activity of catalase was higher in α-thalassaemia 1/2 than in Hb CS, expressed both as U/g Hb and U/ml red blood cells. No statistical differences were found between the three groups when catalase activity was expressed as U/10^10 red blood cells.

To exclude the effect of excess young cells on enzyme activities whole blood from six patients was centrifuged and separated into top and bottom layers. Reticulocyte counts and the three enzyme activities were measured in both fractions (table). No significant differences in activities of all the studied enzymes were found between the top and the bottom layers.

Discussion

Red cells of patients with Hb H disease contain excess β-globin chains that are unstable and polymerise to form β₄ inclusion bodies. Concentrations of Hb H and the number of red cells containing inclusion bodies were greater in patients with the genotype of Hb CS compared with those with the genotype α-thalassaemia 1/2. ² In addition, the distribution pattern of inclusion bodies was also different between the two genotypes. ³ Our findings indicate that patients with the more severe disease, Hb CS, having a greater excess of β-globin chain, also have higher activities of SOD and GSH-Px but lower catalase activity than the milder genotype, α-thalassaemia 1/2.

Increased red cell SOD values in thalassaemic patients have previously been explained as a reaction to, or compensation for, the increased production of superoxide radicals, the amount of which is related to excess globin chain. ⁴ Our results show that the greater increase in SOD activity is seen in Hb CS erythrocytes which have the highest numbers of red cell inclusions, the highest Hb H concentrations, and the greatest clinical severity of the two genotypes.

The generally increased red cell GSH-Px activity in patients with Hb H disease we describe has previously been reported. ¹⁴ We found also that the values of GSH-Px are higher in the genotype Hb CS than the α-thalassaemia 1/2. The greater SOD activity in Hb CS erythrocytes probably generates a greater amount of H₂O₂, which in turn induces a compensatory rise in GSH-Px activity. An increase in red cell GSH-Px activity has been shown in vitro by the addition of acetylphenylhydrazine, an agent promoting release of superoxide radicals from haemoglobin. ¹⁵

The Hb CS erythrocytes produce higher concentrations of H₂O₂ than α-thalassaemia 1/2 erythrocytes. This study shows significantly lower red cell catalase activity (although higher than normal sub-

![Image](https://example.com/image1.png)

-only when expressed as U/g Hb and U/ml red blood cells, and catalase activity of Hb CS erythrocytes was statistically higher than normal only in U/g Hb. The activity of catalase was higher in α-thalassaemia 1/2 than in Hb CS, expressed both as U/g Hb and U/ml red blood cells. No statistical differences were found between the three groups when catalase activity was expressed as U/10^10 red blood cells.

To exclude the effect of excess young cells on enzyme activities whole blood from six patients was centrifuged and separated into top and bottom layers. Reticulocyte counts and the three enzyme activities were measured in both fractions (table). No significant differences in activities of all the studied enzymes were found between the top and the bottom layers.

Discussion

Red cells of patients with Hb H disease contain excess β-globin chains that are unstable and polymerise to form β₄ inclusion bodies. Concentrations of Hb H and the number of red cells containing inclusion bodies were greater in patients with the genotype of Hb CS compared with those with the genotype α-thalassaemia 1/2. ² In addition, the distribution pattern of inclusion bodies was also different between the two genotypes. ³ Our findings indicate that patients with the more severe disease, Hb CS, having a greater excess of β-globin chain, also have higher activities of SOD and GSH-Px but lower catalase activity than the milder genotype, α-thalassaemia 1/2.

Increased red cell SOD values in thalassaemic patients have previously been explained as a reaction to, or compensation for, the increased production of superoxide radicals, the amount of which is related to excess globin chain. ⁴ Our results show that the greater increase in SOD activity is seen in Hb CS erythrocytes which have the highest numbers of red cell inclusions, the highest Hb H concentrations, and the greatest clinical severity of the two genotypes.

The generally increased red cell GSH-Px activity in patients with Hb H disease we describe has previously been reported. ¹⁴ We found also that the values of GSH-Px are higher in the genotype Hb CS than the α-thalassaemia 1/2. The greater SOD activity in Hb CS erythrocytes probably generates a greater amount of H₂O₂, which in turn induces a compensatory rise in GSH-Px activity. An increase in red cell GSH-Px activity has been shown in vitro by the addition of acetylphenylhydrazine, an agent promoting release of superoxide radicals from haemoglobin. ¹⁵

The Hb CS erythrocytes produce higher concentrations of H₂O₂ than α-thalassaemia 1/2 erythrocytes. This study shows significantly lower red cell catalase activity (although higher than normal sub-

**References**

Erythrocyte antioxidative enzymes in haemoglobin H disease


Requests for reprints to: Dr A Bunyaratvej, Department of Pathology, Ramathibodi Hospital, Rama Road 6, Bangkok 10400, Thailand.