

Forum Review

Mechanisms and Significance of Eryptosis

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ABSTRACT

Suicidal death of erythrocytes (eryptosis) is characterized by cell shrinkage, membrane blebbing, activation of proteases, and phosphatidylserine exposure at the outer membrane leaflet. Exposed phosphatidylserine is recognized by macrophages that engulf and degrade the affected cells. Eryptosis is triggered by erythrocyte injury after several stressors, including oxidative stress. Besides caspase activation after oxidative stress, two signaling pathways converge to trigger eryptosis: (a) formation of prostaglandin E_2 leads to activation of Ca^{2+} -permeable cation channels, and (b) the phospholipase A_2 -mediated release of platelet-activating factor activates a sphingomyelinase, leading to formation of ceramide. Increased cytosolic Ca^{2+} activity and enhanced ceramide levels lead to membrane scrambling with subsequent phosphatidylserine exposure. Moreover, Ca^{2+} activates Ca^{2+} -sensitive K^+ channels, leading to cellular KCl loss and cell shrinkage. In addition, Ca^{2+} stimulates the protease calpain, resulting in degradation of the cytoskeleton. Eryptosis is inhibited by erythropoietin, which thus extends the life span of circulating erythrocytes. Eryptosis may be a mechanism of defective erythrocytes to escape hemolysis. Conversely, excessive eryptosis favors the development of anemia. Conditions with excessive eryptosis include iron deficiency, lead or mercury intoxication, sickle cell anemia, thalassemia, glucose 6- phosphate dehydrogenase deficiency, malaria, and infection with hemolysin-forming pathogens. *Antioxid. Redox Signal.* 8, 1183–1192.

INTRODUCTION

ABUNDANT, DEFECTIVE OR POTENTIALLY HARMFUL NUCLEATED CELLS are disposed by apoptosis (7, 19, 50, 51, 89, 113, 121), which is triggered either by stimulation of respective receptors such as CD95 (26, 74) or by cell exposure to stressors such as oxidants, cytostatic drugs, radiation, or osmotic shock (12, 50, 108, 122). Typical apoptosis is paralleled by cell shrinkage, nuclear condensation, DNA fragmentation, mitochondrial depolarization, cell membrane blebbing, and breakdown of phosphatidylserine asymmetry of the plasma membrane and is associated with a loss of intracellular potassium (13, 14, 48, 50–52, 71, 73, 90, 100, 102, 127–130). Cells exposing phosphatidylserine at the cell surface are recognized by macrophages equipped with receptors specific for phosphatidylserine (39) and rapidly engulf and degrade the affected cells (9, 37). Accordingly, apoptosis allows the elimina-

tion of those cells without release of intracellular proteins, which would otherwise cause inflammation (51).

Erythrocytes are devoid of nuclei and mitochondria and thus lack crucial elements in the machinery of apoptosis. Thus until recently, dying erythrocytes have been considered to be eliminated by mechanisms other than apoptosis. Exposure of erythrocytes to the Ca^{2+} ionophore ionomycin, however, triggers cell shrinkage, membrane blebbing, and phosphatidylserine exposure, all typical features of apoptotic, nucleated cells (6, 20, 28). The cell shrinkage results from activation of the Ca^{2+} -sensitive “Gardos” K^+ channels (83), and the phosphatidylserine exposure has previously been thought to result from the activation of a Ca^{2+} -sensitive scramblase (31, 125, 131) and/or inhibition of a Ca^{2+} -sensitive and ATP-dependent aminophospholipid translocase (112).

In view of the similarities to and differences from the apoptosis program of nucleated cells (for details, see also Table 1),

TABLE 1. HALLMARKS OF APOPTOSIS AND ERYPTOSIS

<i>Apoptosis</i>	<i>Eryptosis</i>	<i>Literature</i>
Nuclear condensation, DNA fragmentation ¹	Nothing equivalent	1: (126)
Dissipation of the mitochondrial membrane potential ^{2,3}	Nothing equivalent	2: (94) 3: (49)
Cellular shrinkage ⁴	Cellular shrinkage ⁴	4: (72)
Apoptotic bodies ⁵	Vesiculation ⁶	5: (118) 6: (124)
Activation of caspases ⁷	In most cases, caspase-independent ^{8,9,10}	7: (122) 8: (6)
	Activation of μ -calpain ⁸	9: (20) 10: (77)
Phosphatidylserine exposure on the outer leaflet of the cell membrane ¹¹	Phosphatidylserine exposure on the outer leaflet of the erythrocyte membrane ⁹	11: (40) 9: (20)
Expression of different death receptors ¹²	Expression of CD95/FAS ¹³	12: (26) 13: (92)
Accumulation of ceramide by sphingomyelinase-mediated sphingomyelin breakdown ¹⁴ or enhanced ceramide synthesis ^{15,16}	Sphingomyelinase-induced ceramide formation ¹⁷	14: (53) 15: (123) 16: (15) 17: (81)
Increase of intracellular Ca^{2+} by release from the endoplasmic reticulum ¹⁸	Activation of Ca^{2+} permeable cation channels in the erythrocyte membrane ¹⁹	18: (111) 19: (75)

Apoptosis, programmed death of nucleated cells; eryptosis, programmed death of nucleus- and organelle-free, mature erythrocytes.

the term *eryptosis* has been coined to describe the suicidal death of erythrocytes (76). Eryptosis may be distinct from the mechanisms involved in erythrocyte aging (16, 66, 110) or neocytolysis, the death of newly formed erythrocytes (106). The present brief review describes the mechanisms leading to eryptosis and lists some diseases involving excessive eryptosis. Clearly, further research will disclose additional mechanisms operating in eryptosis and a variety of further clinical conditions displaying enhanced eryptosis.

CYCLOOXYGENASE ACTIVATION, PGE_2 FORMATION, AND ACTIVATION OF CATION CHANNELS

Hyperosmotic shock and Cl^- removal trigger the release of prostaglandin E_2 (PGE_2) (85). PGE_2 , in turn, activates nonselective cation channels (62, 85), increases the cytosolic Ca^{2+} concentration (63, 85), stimulates phosphatidylserine exposure at the erythrocyte surface (85), and triggers cell membrane vesiculation (1). Accordingly, osmotic cell shrinkage activates the cation channels (58) and triggers erythrocyte Ca^{2+} uptake (75). The same or similar channels are activated by oxidative stress (36), which similarly stimulates Ca^{2+} entry (75) and triggers phosphatidylserine exposure at the cell surface (Fig. 1). The channels are inhibited by intracellular or extracellular Cl^- (36, 58), and the activation of the cation

channels by Cl^- removal is abolished by the cyclooxygenase inhibitor diclophenac (85). Moreover, the phospholipase- A_2 inhibitors quinacrine and palmitoyl-trifluoromethyl-ketone and the cyclooxygenase inhibitors acetylsalicylic acid and diclophenac blunt the increase of phosphatidylserine exposure after Cl^- removal (85).

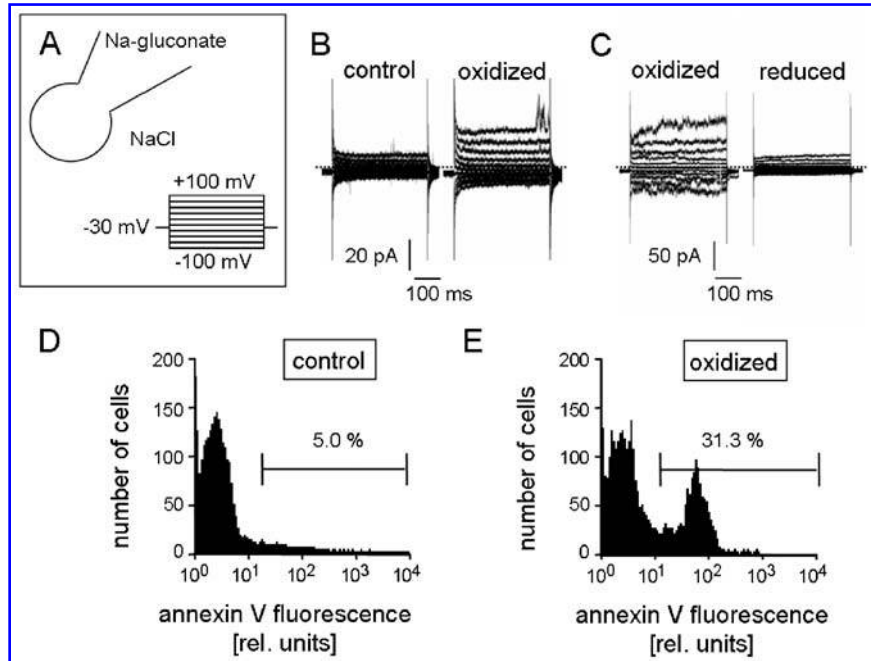
Besides its effect on phosphatidylserine scrambling (6, 20, 28), an increase of cytosolic Ca^{2+} stimulates the Ca^{2+} -sensitive "Gardos" K^+ channels in erythrocytes (10, 21, 41). The subsequent hyperpolarization of the cell membrane drives Cl^- in parallel to K^+ out of the cell. The cellular loss of KCl favors cell shrinkage. Moreover, the cellular loss of K^+ contributes to the triggering of eryptosis (83).

PGE_2 further activates the Ca^{2+} -dependent cysteine endopeptidase calpain, an effect, however, apparently not required for stimulation of phosphatidylserine exposure (85). Instead calpain degrades the cytoskeleton (103).

Energy depletion impairs the replenishment of GSH and thus weakens the antioxidative defense of the erythrocytes (8, 96). Accordingly, energy depletion similarly activates the cation channels and thus leads to eryptosis (80).

The cation channel inhibitors amiloride (75) and ethylisopropylamiloride (EIPA) (79) blunt the phosphatidylserine exposure after osmotic shock. Thus, activation of the cell volume-sensitive and oxidant-sensitive cation channel and subsequent Ca^{2+} entry contribute to the stimulation of erythrocyte scrambling after osmotic shock or oxidative stress.

FIG. 1. Activation of cation channels and triggering of phosphatidylserine exposure by oxidative stress. A–C: Dependence of the nonselective cation channel of human erythrocytes on redox potential. (A) Whole-cell recording from human erythrocytes. Currents were recorded with Na-gluconate pipette and NaCl bath solution (upper panel). Lower panel, Applied pulse protocol. Currents were evoked by 11 successive square pulses to voltages between -100 and $+100$ mV delivered in 20 -mV increments from a holding potential of -30 mV. The applied voltages refer to the cytoplasmic face of the membrane with respect to the extracellular space. (B) Current traces recorded by whole-cell patch-clamp recording before (control) and after addition of *tert*-butylhydroperoxide (*t*-BHP; 1 mM) to the bath solution (oxidation). (C) Current traces of oxidized erythrocytes (pretreatment with 1 mM *t*-BHP for 15 min) before (oxidized) and after bath application of dithiothreitol (1 mM; reduced). The currents of the individual square pulses are superimposed, and the zero current is indicated by a gray line. (D, E) Oxidation-stimulated phosphatidylserine (PS) exposure. Original histograms showing annexin V–dependent fluorescence as a measure of PS exposure of control (D) and oxidized (E) erythrocytes. PS exposure was analyzed after oxidizing erythrocytes with *t*-BHP (0 and 0.66 mM for 15 min) followed by further incubation in NaCl Ringer (24 h). The numbers depict the percentages of annexin V–positive cells.



PAF FORMATION AND STIMULATION OF SPHINGOMYELINASE

Beyond its effect on PGE_2 formation, erythrocyte shrinkage triggers the formation of platelet-activating factor (PAF) (81), which is involved in the regulation of inflammation, thrombosis, atherogenesis, and cardiovascular function (22, 45, 55, 97, 98, 114, 132). PAF then stimulates a sphingomyelinase, leading to the breakdown of sphingomyelin and release of ceramide from erythrocytes (81). Osmotic shock thus leads to the appearance of ceramide at the erythrocyte surface (77). At least partially because of ceramide formation, PAF triggers scrambling of the cell membrane with phosphatidylserine exposure at the erythrocyte surface. C_6 -ceramide as well as treatment with purified, bacterial sphingomyelinase similarly triggers phosphatidylserine scrambling (77). Moreover, eryptosis after osmotic shock is blunted by the sphingomyelinase inhibitor 3,4-dichloroisocoumarin. The stimulation of phosphatidylserine exposure is blunted by genetic knockout of PAF receptors (PAF-receptor knockout mice) and by the PAF-receptor antagonist ABT491 (81). PAF further activates Ca^{2+} -sensitive K^+ channels (Gardos channels) in the erythrocyte cell membrane (43) by sensitizing them for the stimulating effects of cytosolic Ca^{2+} (107). Conversely, PAF is released from erythrocyte progenitor cells on increase of cytosolic Ca^{2+} activity (34). The signaling through PAF does, however, not necessarily require elevated cytosolic

Ca^{2+} concentrations, and enhanced PAF levels at least partially account for Ca^{2+} -independent eryptosis (81).

RECEPTOR-MEDIATED ERYPTOSIS

In nucleated cells, ligation of death receptors at the cell surface leads to direct and fast activation of the death machinery (26, 88). Very recently, it was demonstrated that erythrocytes likewise undergo programmed cell death after ligation of specific surface antigens, such as glycophorin-C (56), the thrombospondin-1 receptor CD47 (57), and the death receptor CD95/Fas (92). Further efforts are required to elucidate the mechanisms and (patho-) physiologic role of receptor-mediated erythrocyte death.

REGULATION OF ERYPTOSIS BY PROTEIN KINASE C SIGNALING

Erythrocyte energy depletion enhances phosphorylation of membrane proteins by protein kinase C (PKC), leads to subsequent phosphatidylserine exposure at the cell surface and triggers cell shrinkage, effects mimicked by stimulation of PKC with phorbol esters or inhibition of protein phosphatases with okadaic acid (68). PKC activation has previously been

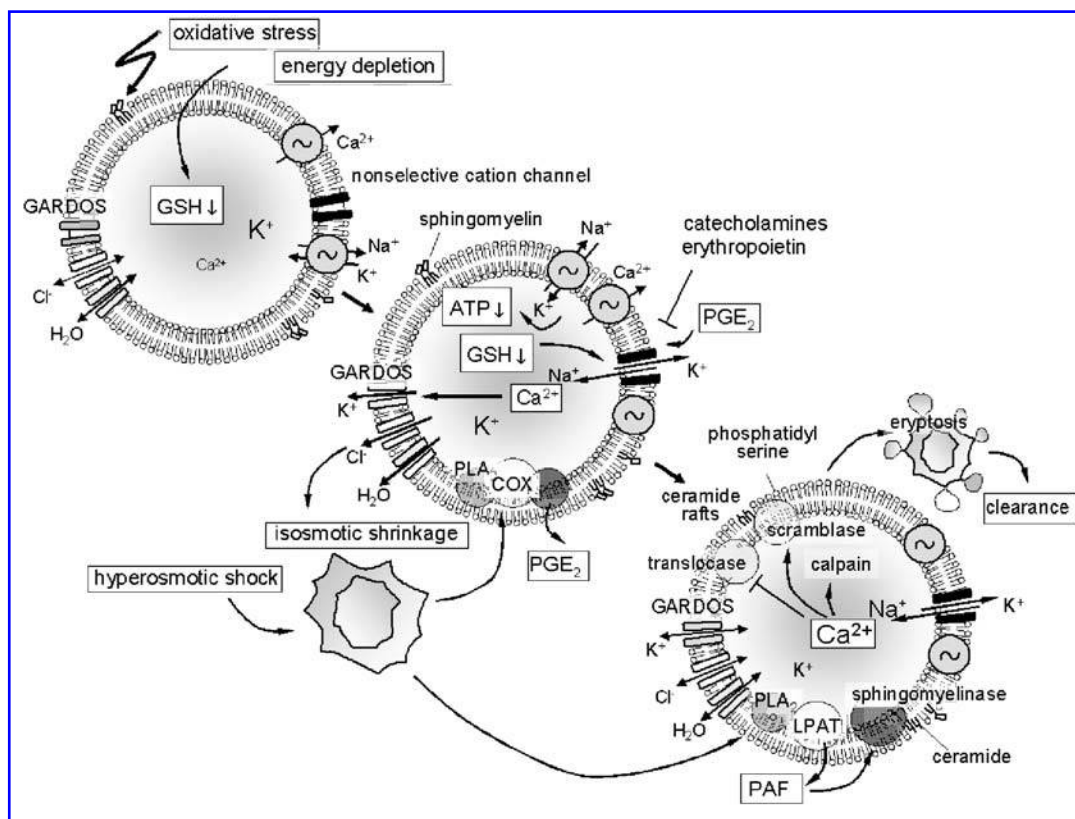


FIG. 2. Synopsis of the mechanisms and the signaling pathways involved in eryptosis. Signaling pathways leading to eryptosis (*i.e.*, cellular shrinkage, phosphatidylserine exposure and activation of calpains). COX, cyclooxygenase; GSH, reduced glutathione; Gardos, potassium channel; LPAT, lyso-PAF acetyl transferase; NSC, nonselective cation channel; PAF, platelet-activating factor; PGE₂, prostaglandin E₂; PLA₂, phospholipase A₂.

shown to stimulate erythrocyte Ca²⁺ entry (3) and phosphatidylserine exposure (30). PKC (EC 2.7.1.37) is a family of serine/threonine-specific protein kinases consisting of ≥10 members and requiring Ca²⁺, diacylglycerol, and a phospholipid for activation. PKC isoenzymes play an essential role in the regulation of diverse cellular functions including proliferation, differentiation, and apoptosis (101). Human erythrocytes express PKC isoenzymes mediating the phosphorylation of cytoskeletal proteins, such as band 4.1, 4.9, and adducin (27), and the human Na⁺/H⁺ antiporter NHE 1 (17). To date PKCα, PKCι, PKCμ, and PKCζ have been reported to be expressed in erythrocytes (47). Additional experiments are required to define the PKC isoforms involved in eryptosis and the interaction of PKC with the PGE₂-dependent and PAF-dependent signaling pathways.

ERYPTOSIS AFTER OXIDATIVE STRESS AND CASPASE ACTIVATION

Oxidative stress by exposure to *tert*-butylhydroperoxide or peroxynitrite, for instance, is a major cause of erythrocyte

injury (5, 18). It has been shown to activate aspartyl and cysteinyl proteases (95). Caspases have been shown to be expressed in erythrocytes (20, 91), to cleave the anion exchanger band 3 *in vitro* (91), and to stimulate phosphatidylserine exposure of erythrocytes (93). Conversely, eryptosis after ionomycin or hyperosmotic shock does not require activation of caspases (6, 77, 119).

Besides its effect on caspases, oxidative stress or defects of antioxidative defense (8, 25, 96) enhance Ca²⁺ entry via activation of the cation channels and thus stimulate eryptosis at least partially through channel activation (36). As illustrated in Fig. 1A–C, oxidation of erythrocytes with *tert*-butylhydroperoxide leads to an increase of the cation permeability of the membrane, an effect reversed by the reducing agent dithiothreitol. Oxidation with *tert*-butylhydroperoxide also enhanced erythrocyte annexin-V binding as a measure of phosphatidylserine exposure by some sixfold (Fig. 1D and E). Interestingly, not all erythrocytes of one population showed the same sensitivity against oxidative stress, and only one third of the population was shown to be annexin-V positive (Fig. 1E). Erythrocyte concentrates from one test person did contain subpopulations of erythrocytes that differed in their susceptibility to programmed cell death (85).

The heterogeneity of erythrocytes may in part be due to different ages.

Oxidative stress further activates erythrocyte Cl^- channels (59, 115), which are required for erythrocyte shrinkage and thus also participate in the triggering of eryptosis (100).

Antioxidants, such as vitamin E (46, 60, 69), glutathione (33), or the semisynthetic flavonoid 7-monohydroxyethylrutin (29) may protect erythrocytes from oxidative stress and thus presumably from eryptosis.

INHIBITION OF ERYPTOSIS BY ERYTHROPOIETIN AND CATECHOLAMINES

Erythropoietin not only inhibits apoptosis of erythrocytic progenitor cells (61, 104) but similarly blunts the suicidal death of mature erythrocytes. The hormone is effective through inhibition of the Ca^{2+} -permeable cation channels. Accordingly, the protective effect of erythropoietin is lost in the nominal absence of extracellular Ca^{2+} (99). The antieryptotic effect of erythropoietin presumably accounts for its ability to increase the life span of circulating cells (104).

Dopamine, isoproterenol, and epinephrine similarly inhibit the Ca^{2+} -permeable cation channels and thus interfere with eryptosis (84). The effect is presumably not relevant for physiologic regulation, as the concentrations of catecholamines required exceed those encountered *in vivo*. However, animal experiments revealed that the hematotoxicity (including red blood cell counts) of cyclophosphamide has been reduced by simultaneous dopamine treatment (70). Thus, administration of dopamine at pharmacologic doses may well be therapeutically applicable for the suppression of eryptosis.

CLINICAL CONDITIONS ASSOCIATED WITH ERYPTOSIS

A variety of clinical conditions decrease the life span of mature erythrocytes by facilitating eryptosis. Increased sensitivity of sickle cells and of glucose 6-phosphate dehydrogenase-deficient cells to osmotic shock and of sickle cells, thalassemic cells, and glucose 6-phosphate dehydrogenase-deficient cells to oxidative stress and to glucose depletion has been observed previously (80). The enhanced susceptibility to eryptosis is considered to decrease the erythrocyte life span in those disorders (80).

Similarly, iron-deficient erythrocytes are more sensitive to eryptosis (64). The enhanced eryptosis is at least partially the result of enhanced cation channel activity. Presumably, the decreased volume of iron-deficient erythrocytes decreases the threshold for the activation of the channel (36, 58). Interestingly, the enhanced exposure of phosphatidylserine on the surface of iron-deficient erythrocytes coincides with a substantial decrease of the life span of iron-deficient erythrocytes (64). Eryptosis is further triggered by exposure of erythrocytes to lead (65) or mercury (38), or by treatment with plasma from patients with recurrent hemolytic-uremic

syndrome (86). Thus, the typical anemia after lead intoxication is at least partially due to enhanced eryptosis.

Eryptosis may be relevant for the intraerythrocyte survival of the malaria pathogen *Plasmodium falciparum*, which activates presumably endogenous host cell channels via oxidation of the cell membrane (35, 59, 115). *Plasmodium falciparum* depends on the activation of those channels, as they allow the uptake of nutrients and the disposal of waste products (67). Activation of the cation channel might be required for increased uptake of Na^+ and Ca^{2+} by the parasitized erythrocyte. Cellular accumulation of Na^+ and Ca^{2+} is needed by the parasite. Ca^{2+} uptake by the parasite buffers erythrocytic Ca^{2+} concentration and thus delays eryptosis of the parasitized erythrocyte. Nevertheless, *Plasmodium* infection induces eryptosis (19), and eryptosis might lead to the recognition of the parasitized erythrocytes by macrophages.

Oxidant injury of erythrocytes and/or erythrocyte precursors may further occur in HIV (4, 32, 44, 105, 116). Moreover, eryptosis is triggered after exposure of erythrocytes to hemolysin Kanagawa from *Vibrio parahaemolyticus* (82), a marine bacterium causing gastroenteritis after ingestion of contaminated seafood. Thus, infection with hemolysin-producing pathogens triggers hemolysis as well as eryptosis.

Eryptosis not only decreases the life span of circulating erythrocytes but may also increase their adhesivity (24, 42, 109, 117). Phosphatidylserine-exposing erythrocytes may bind to receptors in the vascular wall and thus impede microcirculation (2, 23). Accordingly, annexin-binding erythrocytes may be trapped in renal medulla after ischemia of the mouse kidney (78). Phosphatidylserine-exposing cells may further participate in hemostasis (2) and may thus play a role in atherothrombosis (11, 54, 120).

Even though it is a pathophysiologic mechanism, eryptosis serves an important physiologic function (*i.e.*, the prevention of hemolysis). Energy depletion, defective Na^+/K^+ ATPase, or enhanced leakiness of the cell membrane eventually leads to cellular gain of Na^+ and Cl^- with osmotically obliged water, resulting in subsequent cell swelling (71). Initially, the entry of Na^+ is compensated by cellular loss of K^+ ; the decrease of the K^+ equilibrium potential leads, however, to gradual depolarization, which favors the entry of Cl^- . The cell swelling jeopardizes the integrity of the cell membrane. Rupture of the cell leads to release of hemoglobin, which may be filtered at the glomeruli of the kidney, precipitate in the acid lumen of the tubules, obliterate the tubules, and thus lead to renal failure. The phosphatidylserine exposure at the cell surface allows the macrophages to recognize defective erythrocytes and to clear them from circulating blood before hemolysis. Moreover, the activation of the Gardos K^+ channel delays swelling and disruption of defective erythrocytes, thus expanding the time allowed for macrophages to clear the injured erythrocytes from circulating blood.

CONCLUSIONS

As illustrated in Fig. 2, eryptosis is a complex machinery eventually leading to erythrocyte shrinkage and scrambling of the erythrocyte membrane, events preceding uptake of

affected erythrocytes by macrophages. The signaling of eryptosis includes PAF, ceramide, PGE₂, cation channels, protein kinase C, and in some instances, caspases. Eryptosis is presumably an important physiologic mechanism to forestall hemolysis of defective red blood cells. Accelerated eryptosis may lead to anemia due to excessive loss of circulating erythrocytes. We anticipate that future research will identify further signaling mechanisms participating in the triggering and execution of eryptosis and further disorders involving deranged eryptotic death of circulating erythrocytes.

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ABBREVIATIONS

ABT491, PAF receptor antagonist; CD47, cluster of differentiation 47; CD95/Fas, cluster of differentiation 95, a death receptor; COX, cyclooxygenase; EIPA, ethylisopropylamiloride; Gardos, potassium channel; GSH, reduced glutathione; HIV, human immunodeficiency virus; LPAT, lyso-PAF acetyl transferase; Na⁺/K⁺ATPase, sodium/potassium pump; NHE 1, Na⁺/H⁺ antiporter; NSC, nonselective cation channel; PAF, platelet-activating factor; PGE₂, prostaglandin E₂; PKC, protein kinase C; PLA₂, phospholipase A₂; PS, phosphatidylserine; *t*-BHP: *tert*-butylhydroperoxide.

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