Maternal anti-platelet β3 integrins impair angiogenesis and cause intracranial hemorrhage

Issaka Yougbaré, … , John Freedman, Heyu Ni


Fetal and neonatal alloimmune thrombocytopenia (FNAIT) is a life-threatening disease in which intracranial hemorrhage (ICH) is the major risk. Although thrombocytopenia, which is caused by maternal antibodies against β3 integrin and occasionally by maternal antibodies against other platelet antigens, such as glycoprotein GPIbα, has long been assumed to be the cause of bleeding, the mechanism of ICH has not been adequately explored. Utilizing murine models of FNAIT and a high-frequency ultrasound imaging system, we found that ICH only occurred in fetuses and neonates with anti–β3 integrin–mediated, but not anti-GPIbα–mediated, FNAIT, despite similar thrombocytopenia in both groups. Only anti–β3 integrin–mediated FNAIT reduced brain and retina vessel density, impaired angiogenic signaling, and increased endothelial cell apoptosis, all of which were abrogated by maternal administration of intravenous immunoglobulin (IVIG). ICH and impairment of retinal angiogenesis were further reproduced in neonates by injection of anti–β3 integrin, but not anti-GPIbα antisera. Utilizing cultured human endothelial cells, we found that cell proliferation, network formation, and AKT phosphorylation were inhibited only by murine anti–β3 integrin antisera and human anti–HPA-1a IgG purified from mothers with FNAIT children. Our data suggest that fetal hemostasis is distinct and that impairment of angiogenesis rather than thrombocytopenia likely causes FNAIT-associated ICH. Additionally, our results indicate that maternal IVIG therapy can effectively prevent this devastating disorder.

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Fetal and neonatal alloimmune thrombocytopenia (FNAIT) is a life-threatening disease in which intracranial hemorrhage (ICH) is the major risk. Although thrombocytopenia, which is caused by maternal antibodies against β3 integrin and occasionally by maternal antibodies against other platelet antigens, such as glycoprotein GPIbα, has long been assumed to be the cause of bleeding, the mechanism of ICH has not been adequately explored. Utilizing murine models of FNAIT and a high-frequency ultrasound imaging system, we found that ICH only occurred in fetuses and neonates with anti-β3 integrin–mediated, but not anti-GPIbα–mediated, FNAIT, despite similar thrombocytopenia in both groups. Only anti-β3 integrin–mediated FNAIT reduced brain and retina vessel density, impaired angiogenic signaling, and increased endothelial cell apoptosis, all of which were abrogated by maternal administration of intravenous immunoglobulin (IVIG). ICH and impairment of retinal angiogenesis were further reproduced in neonates by injection of anti–β3 integrin, but not anti-GPIbα antisera. Utilizing cultured human endothelial cells, we found that cell proliferation, network formation, and AKT phosphorylation were inhibited only by murine anti–β3 integrin antiserum and human anti–HPA-1a IgG purified from mothers with FNAIT children. Our data suggest that fetal hemostasis is distinct and that impairment of angiogenesis rather than thrombocytopenia likely causes FNAIT-associated ICH. Additionally, our results indicate that maternal IVIG therapy can effectively prevent this devastating disorder.

Introduction

Fetal and neonatal alloimmune thrombocytopenia (FNAIT) is a severe bleeding disorder in which maternal antibodies cross the placenta and destroy fetal/neonatal platelets (1–3). FNAIT occurs in approximately 0.5 to 1.5 per 1,000 live-born neonates, but this does not include miscarriages in utero, as has been reported (4, 5). There are 33 reported human platelet antigens (HPAs) that can be recognized by maternal antibodies in FNAIT, and approximately half are located in the different regions of the extracellular domain of GPIIIa (β3 integrin [β3] subunit) (1, 6). At least one antigen (HPA-2) is located on GPIbα (6, 7). In people of mixed European descent, 80% to 90% of cases are due to antibodies targeting HPA-1a on β3. Severe bleeding is a hallmark of FNAIT, particularly intracranial hemorrhage (ICH), which can occur in fetuses as early as the 14th week of pregnancy and in 10% to 20% of neonates and can lead to neurological impairment or death in both fetuses and neonates (8–10). The pathogenic mechanism leading to the devastating ICH has, however, never been adequately explored.

Thrombocytopenia has generally been considered to be the cause of ICH. However, mice deficient in the hematopoietic subunit of the transcription factor NF-E2 (Nfe2−/−), which lack circulation platelets, can survive in utero with no significant bleeding observed in fetuses or neonates after delivery by Caesarean section (11). NF-E2-deficient mice have a diminutive fraction (1%–3%) of platelet-like particles in their blood, which respond poorly to platelet agonists and have a markedly decreased binding ability for fibrinogen. This suggests that thrombocytopenia may not be essential for the development of ICH in fetuses. Consistently, in a murine model, antibody-mediated platelet depletion alone did not result in hemorrhage (12, 13). Interestingly, fibrinogen-deficient mice also did not experience bleeding in utero, and no obvious hemorrhage was found in their brains, despite a lack of fibrin clots in the fetuses (14–16). More strikingly, mouse fetuses with a combined deficiency in platelets (Nfe2−/−) and fibrinogen exhibited normal embryonic development and were morphologically indistinguishable from their WT controls at 18.5 days postcoitum (17). Therefore, it is likely that neither thrombocytopenia nor deficiency in blood coagulation is crucial for the development of ICH in FNAIT, particularly in utero.

On the other hand, several pieces of evidence suggest that impaired angiogenesis may contribute to hemorrhage during embryogenesis, particularly in the brain (18, 19). Several coagulation factors (e.g., tissue factor, thrombin, etc.) also play important...
roles in angiogenesis (20, 21), which may explain why hemorrhage was observed in fetuses deficient in these genes, but not in fibrinogen and/or NF-E2 (17, 20). It has been reported that development of the central nervous system required vascularization through angiogenesis, impairment of which led to cranial hemorrhage (22, 23). In a zebrafish model, impaired angiogenic signaling that affects vascular stability resulted in development of severe hemorrhage in the brain without obvious bleeding in other organs during embryogenesis (23). In a rabbit model of germinal matrix hemorrhage, it was shown that enhanced angiogenesis caused vascular immaturity and led to ICH (24). However, whether abnormalities in angiogenesis contribute to ICH in FNAIT has not previously been addressed.

The integrin αIIbβ3 is the most abundant glycoprotein on platelets. The β3 subunit is also coexpressed with the αV subunit (i.e., αVβ3) on proliferating endothelial cells (ECs) during angiogenesis (25–28). However, the exact role of αVβ3 integrin in angiogenesis is still controversial (29, 30). Earlier studies demonstrated that αVβ3 was required for angiogenesis (25) and that αVβ3 antagonists promoted tumor regression by inducing apoptosis of angiogenic blood vessels (26). Evidence also showed that integrin αVβ3 cooperated with VEGFR-2 in pro-angiogenic signaling (31, 32) and that AKT phosphorylation was essential in VEGF-mediated postneonatal angiogenesis (33). Interestingly, enhanced pathological angiogenesis and tumor growth were also observed in mice lacking β3 (30). These studies clearly demonstrate that β3 plays an important role in angiogenesis, although whether it is supportive or suppressive remains debatable. Further investigation of the role of β3 in angiogenesis is important, not only for understanding its broad impact on vascular biology, but also potentially for understanding its effect on FNAIT and fetal development.

The brain is one of the most angiogenic organs in the developing fetus, and integrins containing αV subunits (e.g., αVβ3) have been shown to be required for proper capillary development within the central nervous system (34, 35). It may be that by crossreacting with ECs, anti-β3 antibodies can affect angiogenesis and ICH in FNAIT. To test this hypothesis, we employed...
The context of fetal development, and this is targeted by maternal anti-platelet antibodies leading to ICH. These findings may shift the prevailing view that thrombocytopenia is the cause of ICH in FNAIT and may alter the current therapeutic strategy, which focuses on the improvement of platelet counts in patients. The present study may not only provide insights into developing new therapies to control ICH in FNAIT; it may also have an impact on other angiogenesis-related disorders.

Results

Anti-β3–, but not anti-GPIbα–mediated FNAIT caused ICH. We used our established murine models of FNAIT (2, 37, 40) to investigate the mechanism of ICH in affected fetuses and neonates. To mimic exposure to β3 or GPIbα during conception, Itgb3−/− and Gpibα−/−
mice (referred to hereafter as β3–/– and GPIbα+/−) were transfused with WT platelets. Anti-β3 or anti-GPIbα antibodies were detected (Figure 1A), and these immunized mice were subsequently bred with WT males. We found similar severity of thrombocytopenia in the heterozygote (−/+; Figure 1B) neonates delivered from naive mothers and those with anti-β3 antibody on retinal vascular development, we injected anti-GPIbα or anti-β3 antisera into the respective heterozygote neonates shortly after delivery. We found that anti-β3, but not anti-GPIbα, antisera significantly impaired vessel development in neonates (Figure 2, E and F).

To confirm the impairment of angiogenesis in affected fetuses, we assessed retinal vascular development (which begins postnatally in mice), staining the retinal vasculature with an anti-collagen antibody. Vascular development was impaired in the retinas of anti-β3–mediated FNAIT pups (Figure 2, C and D), but developed normally in both naive control pups and anti-GPIbα–mediated FNAIT pups (Figure 2, C and D). To demonstrate the direct effect of anti-β3 antibody on retinal vascular development, we injected anti-GPIbα or anti-β3 antisera into the respective heterozygote neonates shortly after delivery. We found that anti-β3, but not anti-GPIbα, antisera significantly impaired vessel development in neonates (Figure 2, E and F).

We then investigated EC apoptosis in the brains of developing neonates. Using TUNEL and immunofluorescent von Willebrand Factor (vWF) staining, we observed that anti-β3–mediated FNAIT neonates exhibited increased EC apoptosis in their brains, but did not detect any significant increase in apoptosis of ECs in the brains of heterozygotes delivered from naive mothers and those with anti-GPIbα–mediated FNAIT (Figure 3, A and B). These results were further confirmed by staining for CD31 and TUNEL (Supple-

Figure 3. Increased apoptosis in the brain vessels of anti-β3–mediated FNAIT pups. (A) Representative images of TUNEL (green) and vWF (red) costaining are presented. (B) Area of colocalized fluorescence (yellow) was quantified using ImageJ. Increased apoptosis was detected in the brain blood vessels of anti-β3–mediated FNAIT pups compared with naive controls and anti-GPIbα–mediated FNAIT pups. Statistical analysis was performed using 1-way ANOVA followed by Bonferroni’s post-hoc test. Mean ± SEM. n = 3–6 mice per group. ***P < 0.001. Scale bar: 50 μm. Original magnification, ×40.
ing at E.0.5. The pups delivered from the albumin-treated mothers with high anti-β3 antibody titer developed FNAIT and exhibited decreased vessel density in both the brain (Figure 5, A and C) and retina (Figure 5, B and D), whereas IVIG treatment decreased EC apoptosis and restored vascular development (Figure 5, A–D, and Supplemental Figure 3). These findings reveal a new mechanism of action of IVIG in FNAIT treatment and demonstrate that it not only improves thrombocytopenia, but also ameliorates vascular pathology in anti-β3–mediated FNAIT.

EC proliferation, network formation, and AKT phosphorylation are inhibited by human and mouse anti-β3 antibodies in vitro. In order to investigate how anti-β3 antibodies impair vessel development, we examined EC proliferation and network formation in vitro. Human anti–HPA-1a IgG bound to HUVECs (Figure 6A) and inhibited their proliferation (Figure 6B). HUVECs treated with murine anti-β3 sera also exhibited reduced proliferation (Figure 6C) with a dose-dependent impairment of network formation on Matrigel (Figure 6D). In contrast, with naive or anti-GPIbα sera treatment, no significant difference was found in HUVEC proliferation (Figure 6C) or capillary-like network formation (Figure 6D). Importantly, incubation with anti–HPA-1a IgG resulted in significantly decreased HUVEC network formation (Figure 6E) compared with the use of control IgG–treated cells. We found that anti-β3 IgG has a similar inhibitory effect, when compared with cyclic arginine-glycine-aspartic acid
(RGD) peptides that target αvβ3 integrin, on HUVEC proliferation and invasion in Matrigel matrix (Supplemental Figure 4). Subsequent experiments with anti-β3 IgG and anti-HPA-1a IgG showed a significant reduction of EC adhesion to a fibronectin-coated surface (Supplemental Figure 4).

We performed Western blotting to assess the phosphorylation of AKT, a downstream target of VEGFR-2 that supports EC survival and is involved in EC network formation. We pretreated HUVECs with mouse anti-sera, anti–HPA-1a IgG, or human negative control IgG. Murine anti-sera, anti–HPA-1a IgG, or human negative control IgG, whereas human negative control IgG did not (Figure 7A). In addition, human anti–HPA-1a IgG increased proapoptotic signaling through caspase-3 activation (Figure 7B). These results suggest that the reduced vessel density observed in the murine model of FNAIT is probably caused by impaired EC proliferation and network formation, both essential stages of angiogenesis.

Discussion

Thrombocytopenia caused by maternal anti-platelet antibodies has long been considered the cause of ICH in FNAIT. In this study, using both active and passive murine models of FNAIT, we clearly demonstrate that ICH only occurred in anti-β3–mediated, but not anti-GP Ibα–mediated FNAIT despite similar thrombocytopenia induced by anti-GP Ibα antibodies. Anti-β3 antibodies also induced ICH in αIIb−/− pups without any thrombocytopenia. We further found that anti-β3 antibodies inhibited angiogenic signaling, induced EC apoptosis, and decreased the vessel density in affected brains and retinas. Both anti-β3 antisera and anti–HPA-1a IgG inhibited EC proliferation and network formation in vitro and induced impairment of AKT and other angiogenic signaling. These data suggested that impairment of angiogenesis rather than thrombocytopenia is the critical cause of the ICH in FNAIT, although we cannot exclude that thrombocytopenia may synergistically contribute to the hemorrhage. This information may shift the prevailing view of the mechanism of this bleeding disorder in FNAIT, particularly in fetuses. Furthermore, we demonstrated that maternal administration of IVIG can prevent this devastating disorder.

Bleeding usually occurs when the blood vessel is injured (45–47). Platelet adhesion and aggregation at the site of injury have been considered as the primary wave of hemostasis. Activation of the coagulation system that converts fibrinogen to fibrin is the subsequent event that further enhances hemostasis (48, 49). In addition to the primary wave, activated platelets can also provide a negatively charged surface (e.g., phosphatidylserine) for thrombin generation that can markedly accelerate blood coagulation and hemostasis (50). It has therefore been generally accepted that thrombocytopenia caused by maternal anti-platelet antibodies is the reason for ICH in FNAIT.

There are several pieces of evidence, however, that challenge this dogma. In NF-E2–deficient mice, which lack circulating platelets, no significant bleeding was detected in fetuses or neonates after delivery by Caesarean section (11). Fibrinogen-deficient mice, which completely lack fibrin, also did not develop bleeding or ICH in utero. Even more surprisingly, in mice with double deficiencies of NF-E2 and fibrinogen, the fetuses were still well developed and lacked signs of hemorrhage in utero. Interestingly, in contrast to NF-E2 or fibrinogen single-deficient mice, no double-deficient mice survived beyond 2 to 3 days after birth due to bleeding caused by the trauma of vaginal delivery and/or minor trauma ex utero (17). This suggests that platelets and fibrin play important roles in hemostasis postnatally. In human patients, up to 80% of FNAIT cases occur in utero, indicating that ICH, in these cases at least, is not caused by the trauma of birth (51), and importantly, ICH has been observed in some patients whose platelet counts are within normal range (52, 53). Therefore, in contrast with bleeding disorders after birth, it is probable that neither platelets nor impaired fibrin clot is crucial for the maintenance of hemostasis in fetuses. This suggests that another mechanism or mechanisms (17, 20) may play an even more important role than these 2 classical hemostatic pathways in fetal hemostasis that protect fetuses from ICH.
Given the ethical difficulties in performing basic research on human fetuses and neonates in life-threatening FNAIT, animal models are necessary. Notably, there are at least 16 HPAs identified on the human β3 subunit. It is currently unknown which antigen has higher risk of causing ICH, although HPA-1a and HPA-4a (polymorphism of residue 33 and residue 143 in the β3 subunit) are the reported most common antigens to cause FNAIT in people of mixed European and Asian descent, respectively. Difficulties in studying the ratio of ICH cases to individual HPA are due to the lack of information on miscarriages caused by incompatibility of these HPAs and their related ICH; many of these are not reported, although miscarriage can occur in up to 50% in humans and a significant number of them are caused by FNAIT (3, 4, 54). Since these 16 HPAs are located throughout the extracellular β3 subunit (from residue 33 to residue 636), study of the immune response to the entire β3 subunit is important. We therefore used β3- and GPIbα-deficient female mice to develop murine models, which recapitulate human mothers who developed antibodies targeting...
ated, but not in anti-GPIbα–mediated, FNAIT. Retinal vascular development was similarly impaired when pups were passively injected with anti-sera, consistent with an earlier study with a peptide inhibitor of αVβ3 integrins (56). It is currently unknown how important this finding is, but our data may explain the visual impairment in some cases of FNAIT (57).

The role of endothelial β3 in angiogenesis remains unclear. Studies in chicken chorioallantoic membrane and murine tumor models demonstrated that αVβ3 integrin is required for angiogenesis and that αVβ3 antagonists (both antibody and cyclic RGD peptide) inhibited this process (25, 26, 28). Interestingly, β3-deficient mice have been successfully generated (58), and enhanced angiogenesis was also reported in arterial and tumor tissues of these genetically targeted mice (30). It is currently unknown whether the enhanced pathogenic angiogenesis is due to compensatory mechanisms (e.g., upregulated VEGFR-2) that occurred in gene-deficient mice (30). Using β3+/− fetuses/neonates, our data demonstrate that targeting β3 with antibodies inhibited angiogenesis. These data may have, at least partially, clarified a paradigm from a controversy and further demonstrated that integrin αVβ3 plays an important role in angiogenesis during development and that this process can be targeted by maternal anti-β3 antibodies.

In addition to being expressed on platelets and ECs, integrin αVβ3 is also expressed on the invasive trophoblast cells during placental growth (59). Trophoblast migration and invasion into multiple alloantigens. To further confirm our observations in these murine models, we also used human anti–HPA-1a alloantibodies. Our findings that impairment of angiogenesis is the mechanism, or at least the major mechanism, that causes ICH in fetuses are consistent with the earlier observations in zebra fish and rabbit models (23, 24). However, in contrast with these 2 genetically targeted animal models, our models were established with maternal antibodies against fetal platelet proteins. To exclude other possible pathogenic effects of anti-β3 antibodies, we examined complement activity and found no significant enhancement of C5a in the affected fetal brain tissues (data not shown). We also did not observe obvious antibody-dependent cell-mediated cytotoxic effect on ECs in the immunohistochemistry assays on the fetal brains. In contrast, antiangiogenic effects were observed by vessel density (Figures 2 and 3), EC apoptosis, alterations of angiogenic factors (downregulated VEGF, FGF-acid, MMP-8, and endothelin-1; upregulated TSP-1), and AKT signaling (Figure 4). These effects were reproduced in vitro in cultured HUVECs, in that EC proliferation, network formation, AKT phosphorylation, and proangiogenic signaling were inhibited by anti-β3 antisera. Importantly, these effects were also observed when HUVECs were treated with human anti–HPA-1a IgG (Figures 6 and 7).

We further studied the murine retinal vasculature. This model has been widely used for investigating angiogenesis, as retinal vessels develop de novo over the first 2 postnatal weeks (55). Reduced retinal vessel density was observed only in anti-β3–mediated, but not in anti-GPIbα–mediated, FNAIT. Retinal vascular development was similarly impaired when pups were passively injected with anti-sera, consistent with an earlier study with a peptide inhibitor of αVβ3 integrins (56). It is currently unknown how important this finding is, but our data may explain the visual impairment in some cases of FNAIT (57).

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In addition to being expressed on platelets and ECs, integrin αVβ3 is also expressed on the invasive trophoblast cells during placental growth (59). Trophoblast migration and invasion into
the maternal decidua is essential for placental angiogenesis during pregnancy. Invasive trophoblast cells replace existing vascular ECs in the placental spiral arteries, which lowers maternal vascular resistance and increases uteroplacental blood flow. Inadequate migration and invasion of trophoblast has been reported in complications of pregnancy, including miscarriage, preclampsia, and intrauterine growth restriction (IUGR) (60). Therefore, in addition to ICH that may be caused by maternal anti-β3 antibodies, it is possible that these antibodies may also target αvβ3 integrin on trophoblasts (59) and impair placenta angiogenesis, leading to placental dysfunction and IUGR, or even miscarriage, in FNAIT.

Clinical management of FNAIT is still a challenge (1, 3, 4, 61), but IVIG has been demonstrated to be a useful therapy for this disease. We previously demonstrated that IVIG downregulated both maternal and neonatal circulating levels of anti-platelet antibodies (40), although IVIG did not show antiidiotype activity and did not significantly inhibit the binding of anti-β3 antibodies to platelets (40). Subsequently, we demonstrated that the neonatal Fc receptor (FcRn) is required for transplacental transport of maternal IgGs to the fetus, which can be blocked by IVIG. In addition, IVIG can downregulate maternal antibodies in both FcRn-dependent (likely via the enhancement of IgG clearance) and -independent pathways (probably T and B cell tolerance) (2). It is therefore conceivable that maternal IVIG administration may markedly decrease the level of circulating pathogenic antibodies available to bind to platelets and ECs, which ameliorates both thrombocytopenia and antiangiogenesis-mediated ICH. We cannot, based on the current study, reach a conclusion regarding whether IVIG can directly affect ECs and/or systemic platelet-mediated cytotoxicity (41, 42), which may also be important for its mechanisms of action against ICH. Future studies may be able to address these questions.

In summary, to the best of our knowledge, the current study provides the first direct evidence that vascular impairments occur in anti-β3-mediated FNAIT. The findings also demonstrate that αvβ3 integrin plays an important role in angiogenesis during fetal development. Our data suggest that impaired angiogenesis, instead of thrombocytopenia, is the key cause of ICH in FNAIT; although thrombocytopenia and coagulation-factor deficiencies may synergistically contribute to this disease process. We demonstrated that maternal administration of IVIG can rescue fetal and neonatal angiogenesis and prevent ICH (Figure 6). This suggests that therapies that decrease antiangiogenic effects induced by anti-β3 antibodies (e.g., IVIG, anti-FcRn, etc.) (2, 40) may be more efficient than fetal platelet transfusion. Platelet transfusion, however, may be critical to controlling bleeding after birth, as suggested from both clinical and animal studies (1, 3, 17, 62). These findings may shift the prevailing view and advance our understanding of the pathogenesis of FNAIT and may contribute markedly to improvements in the clinical management of this life-threatening disease.

Methods

Mice. β3–/–, α1b–/–, and GPIbα–/– mice were provided by Richard O. Hynes (Massachusetts Institute of Technology, Boston, Massachusetts, USA) (40, 58), Mortimer Poncz (University of Pennsylvania, Philadelphia, Pennsylvania, USA) and Jon Frampton (University of Birmingham, Birmingham, United Kingdom), and Jerry Ware and Zaviero M. Ruggeri (The Scripps Research Institute, La Jolla, California, USA) (37). Both GPIbα–/– and β3–/– mice were backcrossed to a BALB/c background 10 times and bred to generate syngeneic gene-deficient mice. Experiments were performed when mice were 7 to 10 weeks of age. BALB/c WT mice were purchased from Charles River.

Reagents. Rabbit anti-mouse phosphorylated (catalog 9271) and total AKT (catalog 4685) antibodies were obtained from Cell Signaling Technology. Rabbit anti-human (crossreacts with mouse) vWF (catalog AB7356), rabbit anti-mouse collagen IV (catalog AB2031), and rabbit anti-mouse active (cleaved) caspase-3 antibodies (catalog PC679) were purchased from Millipore. Alexa Fluor 488–conjugated goat anti-rabbit IgG (catalog A11094), Alexa Fluor 594–conjugated goat anti-rabbit IgG (catalog A11020) were acquired from Invitrogen. Growth factor-reduced Matrigel was obtained from BD Biosciences. Anti-phospho ERK1/2 (catalog 4370) antibodies were from Cell Signaling Technologies. Anti-CD31 (catalog Ab24960) and anti-smooth muscle actin (catalog Ab5694) antibodies were from Abcam. Thiazolyl blue tetrazolium bromide and DMSO were obtained from Sigma-Aldrich. The EGM-2 bullet kit and HUVECs were from Lonza. HPA-1a IgG was provided by Bjorn Skogen’s group from University Hospital of North Norway. The angiogenesis array was purchased from R&D Systems. Flat-bottomed microtiter Costar plates for MAIPA assays were from Corning. Mouse anti-mouse mAbs against β3 were generated from β3-deficient mice immunized with BALB/c platelets and characterized using flow cytometry, Western blotting, and immunoprecipitation.

Murine model of FNAIT. Active FNAIT models were previously described (2, 37, 40, 63); briefly, β3–/– and GPIbα–/– female mice were immunized twice weekly via tail-vein injections of 1 × 10^6 gel-filtered WT platelets (64–66). The immunized females were bred with WT males. The passive FNAIT model was established by postnatal intrauterine injection of 50 μl of antisera generated from naive and immunized β3–/– or GPIbα–/– mice.

Platelet enumeration. Blood (10 μl) was collected from P2 neonates via carotid bleeding and immediately diluted to 1:25 in 240 μl of 1% (v/v) EDTA/PBS, pH 7.4. Platelet-rich plasma (PRP) was isolated by centrifugation at 220 g for 2 minutes, and 50 μl PRP was diluted 1:200 in 9.95 ml Isoton II Diluent. Platelet counts were determined with a Z2 Series Coulter Counter (Beckman Coulter). Thrombocytopenia was defined as a platelet count less than or equal to 100 × 10^3/l.

Detection of anti-β3 or anti-GPIbα antibodies via flow cytometry. Whole blood was collected from the immunized mice via the saphenous vein, both prior to and following platelet immunizations, and allowed to clot. Sera were obtained by centrifuging clotted blood at 9600 g for 5 minutes and were diluted in PBS. 10^6 WT platelets were incubated with diluted sera (1:100) for 1 hour. Samples were washed and incubated with FITC-conjugated anti-mouse IgG for 30 minutes and then analyzed on a FACSCalibur flow cytometer (BD). The value for anti-platelet IgG is expressed as mean fluorescence intensity (MFI).

High-frequency ultrasound imaging of fetuses in utero. Ultrasound imaging was performed at E12.5, E15.5, and E17.5 in each mouse to determine embryo/fetus vitality and in utero ICH, as previously described (31, 67). Pregnant mice were anesthetized with 2% isoflurane (inhaled) and maintained on 1% during imaging. After abdomen shaving and skin clearing with hair removal cream (Nair), high-frequency ultrasound imaging was performed by nonlinear contrast imaging using a Vevo 2100 system and an MS550 transducer (32–56 MHz).
Histology, immunofluorescence, and TUNEL. For histological analysis, P2 mouse pup brain tissue was fixed in formalin, paraffin-embedded, sectioned (6–8 μm), transferred to glass slides, and stained with H&E using standard techniques. For immunohistochemistry staining, frozen tissue sections or ECs cultured on coverslips were fixed with paraformaldehyde (PFA) (4% w/v, 5 minutes), then incubated with primary antibody (anti-vWF and active form of caspase-3) overnight and secondary antibody (anti-rabbit IgG-Cy3 or Alexa Fluor 594–conjugated goat anti-rabbit IgG and Alexa Fluor 488–conjugated goat anti-rabbit IgG) for 1 hour, as previously described. Brain vessel density was stained with Isolectin IB4 conjugated to Alexa Fluor 594. Apoptosis in mouse brain tissue was detected via TUNEL staining with an In Situ Cell Death Detection Kit (Roche Diagnostics), according to the manufacturer’s protocol. Briefly, frozen tissue sections were fixed in PFA (4%, 5 minutes, room temperature [RT]) and permeabilized. Positive controls were treated with 100 U DNase I for 30 minutes at 37°C. Slides were mounted in VECTASHIELD mounting medium containing DAPI for nuclear counterstaining. Fluorescent images were acquired using a Nikon E800 fluorescence microscope (Nikon) and analyzed by ImageJ software (http://imagej.nih.gov/ij/).

Postnatal retina vessel development. The globe of the eye was removed from P2 pups and fixed in PFA (4%, 30 minutes). The retina was extracted and stored in methanol at −20°C until staining. Retinas were incubated with anti-collagen IV in BSA/PBS overnight at 4°C, then washed, and incubated with 1:400 Alexa Fluor 488–conjugated anti-rabbit IgG or directly stained with Alexa Fluor 594–conjugated isolec tin GS-IB4 (in BSA/PBS, 2 hours). Retinas were whole mounted, and images were acquired using a Nikon E800 fluorescence microscope. To measure the percentage of area covered by vessels, the pictures in red, green, and blue were split into 3 channels with ImageJ software, and only the green channel was considered for analysis. We first cleared the area covered by the optic nerve and inverted the image. The percentage of vessel area was measured in each picture accordingly with ImageJ. The mean percentage of area was calculated for each retina.

mAb immobilization of platelet antigens assay. mAb immobilization of platelet antigens (MAIPA) assay was performed as previously described (68, 69). Briefly, 96-well plates were coated with goat anti-mouse β3 antibody overnight. Human platelets or HUVECs were incubated with anti–HPA-1a IgG or negative IgG and a murine mAb against human β3 IgG (JAN D1) for 60 minutes. Opsonized platelets or HUVECs were solubilized with NP-40 lysis buffer overnight at 4°C. Complexes consisting of murine anti-human mAb, human anti–HPA-1a IgG, and platelet glycoproteins were captured on the ELISA plates. Human platelet antibodies were detected with a peroxidase-conjugated goat anti-human IgG (Beckman). Results were expressed in OD.

In vitro EC proliferation and tube-formation assays. HUVECs were cultured in endothelial basal medium plus growth supplements (EGM-2) and incubated in a humidified chamber at 37°C with 5% CO₂. Proliferation and tube-formation assays were conducted. For the proliferation assay, HUVECs were seeded into wells of a 96-well plate with 100 μl of EGM-2. After 24 hours, cells were incubated with fresh media containing naïve sera, anti-β3 sera, or anti-aPPIbs sera. After 12 hours, cells were incubated with thiazolyl blue tetrazolium bromide (MTT) (20 μl, 0.5 mg/ml, 3.5 hours). The supernatant was aspirated, and cells were lysed with DMSO for 15 minutes. Absorbance was read at 570 nm, with a reference wave length of 630 nm, on an optical plate reader, and proliferation was calculated as percentage of negative control. For the vascular-like network formation assay, wells of a 24-well plate were coated with 100 μl Matrigel. Cells were added to the wells and incubated with sera overnight. Images were captured with an inverted microscope under phase contrast. Network formation was quantified by measuring the total tube length.

Western blot and mouse angiogenesis antibody array analysis. In preparation for Western blotting, HUVECs were harvested from confluent flasks and treated with human IgG or mouse anti-sera. Cells were lysed in RIPA buffer and stored at −20°C until Western blotting. Protein (25 μg) from brain homogenate or cell lysate prepared in RIPA buffer was analyzed by Western blotting, as previously described (31). Briefly, protein samples were electrophoresed on 8% SDS polyacrylamide gels and electrotransferred onto PVDF membranes. Immunodetections were carried out with anti-mouse phospho-AKT and total AKT antibodies. For the angiogenic array, brain homogenates were subjected to immunoblotting, as recommended by the manufacturer (R&D System). Immobilized antibodies were detected with chemiluminescence using horseradish peroxidase–conjugated secondary antibodies, an ECL kit (GE Healthcare), and autoradiography on Kodak film.

Statistics. Data shown are mean ± SEM. Statistical comparisons were made using an unpaired, 2-tailed Student’s t test or 1-way ANOVA followed by Bonferroni’s post-hoc test, as appropriate. Densitometry and immunofluorescence analysis was performed using ImageJ software, and values were normalized to internal control or total AKT. Differences were considered statistically significant at P < 0.05.

Study approval. All mice were housed in the St. Michael’s Hospital Research Vivarium after the protocol was approved by the animal care committee.

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4. Curtis BR, McFarland JG. Human platelet anti-

5. Kjeldsen-Kragh J, et al. A screening and inter-

6. Mueller-Eckhardt C, et al. 348 cases of suspected

7. Bertrand G, Drame M, Martageix C, Kaplan

8. Silva F, Morais S, Sevivas T, Veiga R, Salvado R,


10. Cota F, et al. A severe case of intracranial hemor-

11. Curtis BR, McFarland JG. Human platelet anti-


mice are a model for Glanzmann thrombasthenia showing placental defects and reduced survival. *J Clin Invest.* 1999;103(2):229–238.


