MUCOPOLYSACCHARIDES IN SYNOVIAL FLUID*
EFFECT OF ASPIRIN AND INDOMETHACIN ON HYALURONIC ACID

BY
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Intra-articular inflammation is associated with a reduction in viscosity of synovial fluid which is due
to changes in hyaluronic acid rather than in the protein component of the fluid (Kulonen, 1951;
Sundblad, 1953). Hyaluronic acid is a polymer of molecular weight greater than 1 x 10^6 made up
from repeating units of N-acetyl-D-glucosamine and D-glucuronic acid. It is present in concentrations
of about 0.1 g. per cent. or less in rheumatoid synovial fluids, compared with 0.3 g. per cent. in
normal fluids. Synovial fluid shows anomalous viscosity, i.e. the viscosity decreases with increasing
rate of shear, typical of a non-Newtonian fluid.
The relative viscosity of a solution of synovial fluid, defined as the viscosity of the solution divided
by the viscosity of the solvent, decreases with age (Jebens and Monk-Jones, 1959) and that of rheuma-
toid synovial fluid is usually lower than normal (Ropes, Robertson, Rossmeisl, Peabody, and Bauer,
1947; Ragan and Meyer, 1949). However, only slight reductions have been found when normal and
rheumatoid fluids have been diluted to the same low concentration (0.06 g. per cent.) of hyaluronic acid
(Hamerman and Schuster, 1958); this suggests that it is the amount rather than the nature of the
hyaluronic acid which determines the relative viscosity. Measurements of intrinsic viscosity,
determined by extrapolation of the specific viscosity (i.e. relative viscosity - 1) to zero concentration of
solute, and anomalous viscosity give a more accurate picture of the state of hyaluronic acid in solution.
The lower values of both these parameters for rheumatoid fluids have been attributed to a low
mean degree of polymerization of hyaluronic acid in rheumatoid disease (Seppälä, 1964; Brimacombe
and Webber, 1964). Changes similar to those found in rheumatoid fluid are obtained by enzymic depoly-
merization of hyaluronic acid (Barker, Baylyuk, Brimacombe, Hawkins, and Stacey, 1963), and
measuring the degree of polymerization of synovial hyaluronic acid might be expected to be a measure
of inflammatory activity.
The method of turbidimetric titration (Morey and Tamblyn, 1945; Harris and Miller, 1951), used to
determine the distribution of molecular size in polymers, was developed by Barker and others (1963)
to fingerprint small amounts (approximately 1 mg.) of hyaluronic acid from normal and pathological
synovial fluids and to provide evidence of molecular size and degree of homogeneity. Addition of the
detergent cetyl pyridinium chloride to a diluted
deproteinized solution of hyaluronic acid produces a
colloidal suspension, the turbidity of which can be
measured by its optical density. Solubility of the
colloidal suspension in salt solutions depends in part
on the molecular size of the polymers, and is greater
for smaller molecular weight polymers. Re-solution
of the suspension, with a decrease of optical density,
occurring with smaller molecules, i.e. if the hyaluronic
acid is depolymerized.

Two patterns of turbidity curves are obtained
with synovial hyaluronic acid (Figs 1 and 2, opposite).
Addition of detergent causes an initial rapid increase
in optical density, after which a slowly increasing
turbidity is obtained with normal fluids, whereas an
decrease in turbidity is observed with hyaluronic
acid from the synovial fluid of inflamed joints.
Barker and others (1963) considered that the
molecular size of hyaluronic acid is the predominant
factor in determining the shape of the turbidity
curve. Generally, the percentage of detergent
necessary to produce maximal turbidity decreased
with increased depolymerization of the hyaluronic
acid. The results of turbidimetric titration studies
of normal and rheumatoid synovial fluids were in
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good agreement with parallel studies of the intrinsic viscosities of the fluids. Chemical and enzymic degradation of hyaluronic acid from rheumatoid synovial fluid showed conclusively (Barker, Bayyuk, Brimacombe, Hawkins, and Stacey, 1964) that it has the same molecular structure though a shorter polymer length than hyaluronic acid from "normal" fluids obtained during meniscectomy, or from traumatic effusions. Changes in the degree of polymerization of human synovial hyaluronic acid have in this study been used to assess the effects of aspirin and indomethacin in the treatment of various forms of arthritis.

Material and Methods

57 samples of synovial fluid obtained from thirty patients were studied. Most of the aspirations were performed for diagnostic or therapeutic purposes; in the other cases the procedure was explained and the consent of the patient obtained. All patients having repeated joint aspirations were admitted to hospital and kept under standard conditions of activity.

Aspirin was given in doses of 4-5 g./day orally, and indomethacin in doses varying from 75 to 100mg./day orally or in suppositories. Samples of synovial fluid were aspirated from knee joints and cellular debris was removed by centrifuging for 20 min. at 1,000 G; the fluid was stored in sterile bottles at -25° C.

Hyaluronic acid was isolated from synovial fluid by digestion of the protein component with the proteolytic enzyme, pronase, and fractionation of the digest, according to molecular size, on Sephadex G 200 (Barker and others, 1963; Barker and Young, 1966).

A solution (1 mg./ml.) of Pronase P (K. and K. Organics Ltd.) in 0.1 M—phosphate buffer, pH 7, containing a trace of calcium chloride and saturated with chloroform, was sterilized by passage through a Hemming filter and mixed with synovial fluid (approximately one-half volume). After centrifugation for 10 min. at 35,000 G and 15° C., the supernatant was transferred to a sterile dialysis apparatus (Chelton and James, 1963) and dialysed under aseptic conditions at 37° C. for a total of 36 hours against two changes of phosphate buffer. The digest was fractionated on a column of Sephadex G 200 (2.4 x 45 cm.) equilibrated with phosphate buffer, and eluted with the same buffer at 15-20 ml./hr. The optical density at 280 mμ of each fraction (5 ml.) was determined, and fractions were also scanned for protein by the ninhydrin assay of Moore and Stein (1948). The fractions were assayed colorimetrically for hexuronic acid (to identify hyaluronic acid-containing fractions) by a modification (Gregory, 1960) of the Dische (1947) carboxazole reaction. A calibration curve was prepared using a standard solution of D-glucurono-γ-lactone. Optical densities were determined using a Unicam SP 500 or SP 1300 spectrophotometer, and in some cases the absorption spectrum in the range 300-700 cm.-1 was determined using a Unicam SP 800 spectrophotometer.

Fractions giving a positive reaction for uronic acid were bulked, dialysed exhaustively against distilled water, centrifuged, and filtered through a No. 3 sintered glass filter. An aliquot, containing 200-400 μg. hyaluronic acid as determined by the carboxazole reaction, was diluted to 35 ml. with filtered distilled water and titrated turbidimetrically with a filtered solution of 0.05 per cent. cetylpyridinium chloride as previously described (Barker and others, 1963). The optical density of the solution, corrected for dilution, was plotted against the volume of detergent (non-solvent) expressed as a percentage of the total volume.

Fig. 1.—Types of turbidity curve obtained with synovial hyaluronic acid of varying degrees of depolymerization (diagrammatic).

![Graph](http://ard.bmj.com/Ann Rheum Dis: first published as 10.1136/ard.27.3.264 on 1 May, 1968. Downloaded from http://ard.bmj.com/ on July 16, 2023 by guest. Protected by copyright.)

Fig. 2.—Typical turbidity curves obtained by using synovial fluid from various types of arthritis.
Results
Experiments were first designed to assess the effects of various procedures on hyaluronic acid within the joint. In Cases 1 to 4 (Table) polymerized hyaluronic acid remained unchanged after aspiration. (In Case 3 a low dose of aspirin 1·2 g./day has been ignored.) More important, in Cases 5 to 10 depolymerized hyaluronic acid was unaltered by aspiration and rest in bed for up to 16 days (Fig. 3). No attempt was made to drain the joint, and these results show that aspiration of a sample (10-20 ml.) of fluid left the hyaluronic acid unaffected. Synovial biopsies were performed using a small needle (Williamson and Holt, 1966a) and this had no effect. Fluid that was blood-stained or showed evidence of previous bleeding was discarded. As patients can seldom tolerate withdrawal of all treatment, paracetamol (usually 4 g. daily) was used as an analgesic, since it was found not to alter the shape of the turbidity curve. Results (Table) confirmed that depolymerized hyaluronic acid occurred in the joints of those with inflammatory forms of arthritis, such as rheumatoid arthritis, psoriatic arthritis, and the arthritis of ulcerative colitis or Crohn's disease. Occasionally, normal hyaluronic acid was found in patients with these diseases and it was assumed that the arthritis in the joint aspirated was quiescent; there was certainly clinical support for this. To obtain some idea of the rapidity of alteration of hyaluronic acid in response to inflammation, the treatment of Patient 21 was reduced from prednisone 10 mg. and aspirin 2·66 g. to prednisone 5 mg. over 24 hours. This caused clinical relapse and a decrease in the degree of polymerization of synovial hyaluronic acid as reflected by the shape of the turbidity curve (Fig. 4). Generally, the reverse change, improvement with treatment, was slower.

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![Fig. 3.—Synovial fluid before and after 16 days rest in bed.](http://ard.bmj.com/content/27/3/264/F3)

![Fig. 4.—Alteration in hyaluronic acid turbidity curve after reduction of prednisone from 10 to 5 mg. and stopping aspirin 2·66 g. for a period of 24 hours (Patient 20).](http://ard.bmj.com/content/27/3/264/F4)

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**Table**

**CLINICAL PARTICULARS OF THIRTY PATIENTS**

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Sex</th>
<th>Age (yrs)</th>
<th>Diagnosis</th>
<th>Duration of Disease (yrs)</th>
<th>Turbidity Curve</th>
<th>Interval between Aspirations (days)</th>
<th>Treatment since Previous Aspiration</th>
<th>ESR (mm./1 hr)</th>
<th>Clinical Observations</th>
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<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>60</td>
<td>OA</td>
<td>30</td>
<td>Normal</td>
<td>2</td>
<td>Rest in bed</td>
<td>9*</td>
<td>Symptomless</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>45</td>
<td>Psoriatic arthritis</td>
<td>10</td>
<td>Normal</td>
<td>6</td>
<td>Rest in bed</td>
<td>24†</td>
<td>Symptomless</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>60</td>
<td>RA</td>
<td>30</td>
<td>Normal</td>
<td>2</td>
<td>Rest in bed</td>
<td>30*</td>
<td>Symptomless</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>28</td>
<td>RA</td>
<td>15</td>
<td>Normal</td>
<td>2</td>
<td>Rest in bed</td>
<td>4†</td>
<td>Symptomless</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>50</td>
<td>RA</td>
<td>3</td>
<td>Re-solution</td>
<td>1</td>
<td>High dosage aspirin</td>
<td>88*</td>
<td>Severe</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Re-solution</td>
<td>7</td>
<td></td>
<td></td>
<td>Slight improvement</td>
</tr>
</tbody>
</table>

*ESR: Erythrocyte Sedimentation Rate*
Table I (continued)

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Sex</th>
<th>Age (yrs)</th>
<th>Diagnosis</th>
<th>Turbidity Curve</th>
<th>Interval between Aspirations (days)</th>
<th>Treatment since Previous Aspiration</th>
<th>ESR (mm./1 hr)</th>
<th>Clinical Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>F</td>
<td>43</td>
<td>RA</td>
<td>Re-solution</td>
<td>16 18</td>
<td>Indomethacin</td>
<td>52†</td>
<td>Slight improvement Relapse on placebo</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>57</td>
<td>RA</td>
<td>Re-solution</td>
<td>3 4</td>
<td>Indomethacin</td>
<td>28†</td>
<td>Moderate improvement</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>46</td>
<td>RA</td>
<td>Re-solution</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>60</td>
<td>RA</td>
<td>Re-solution</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>23</td>
<td>RA</td>
<td>Re-solution</td>
<td>2 7</td>
<td>High dosage aspirin</td>
<td>52†</td>
<td>Severe initial attack</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>54</td>
<td>OA</td>
<td>Normal</td>
<td>—</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>M</td>
<td>54</td>
<td>Psoriatic arthritis</td>
<td>Slight re-solution</td>
<td>—</td>
<td>None</td>
<td>None</td>
<td>44†</td>
</tr>
<tr>
<td>13</td>
<td>M</td>
<td>21</td>
<td>Reiter's syndrome</td>
<td>Normal</td>
<td>—</td>
<td>None</td>
<td>None</td>
<td>Symptomless effusion after acute attack</td>
</tr>
<tr>
<td>14</td>
<td>M</td>
<td>52</td>
<td>Reiter's syndrome</td>
<td>Re-solution</td>
<td>—</td>
<td>None</td>
<td>None</td>
<td>Severe initial attack</td>
</tr>
<tr>
<td>15</td>
<td>M</td>
<td>40</td>
<td>Reiter's syndrome</td>
<td>Re-solution</td>
<td>—</td>
<td>None</td>
<td>None</td>
<td>Severe initial attack</td>
</tr>
<tr>
<td>16</td>
<td>M</td>
<td>42</td>
<td>Gout</td>
<td>Normal</td>
<td>—</td>
<td>None</td>
<td>None</td>
<td>14†</td>
</tr>
<tr>
<td>17</td>
<td>M</td>
<td>66</td>
<td>Gout</td>
<td>Re-solution</td>
<td>—</td>
<td>None</td>
<td>None</td>
<td>Acute attack</td>
</tr>
<tr>
<td>18</td>
<td>F</td>
<td>52</td>
<td>Scleroderma</td>
<td>Slight re-solution</td>
<td>Normal</td>
<td>7</td>
<td>Indomethacin</td>
<td>Mild</td>
</tr>
<tr>
<td>19</td>
<td>F</td>
<td>20</td>
<td>Crohn's disease</td>
<td>Slight re-solution</td>
<td>—</td>
<td>None</td>
<td>None</td>
<td>Mild</td>
</tr>
<tr>
<td>20</td>
<td>M</td>
<td>28</td>
<td>Ulcerative colitis</td>
<td>Slight re-solution</td>
<td>—</td>
<td>None</td>
<td>None</td>
<td>Transient effusion</td>
</tr>
<tr>
<td>21</td>
<td>M</td>
<td>24</td>
<td>RA</td>
<td>Slight re-solution</td>
<td>1</td>
<td>Dose of prednisone reduced</td>
<td>—</td>
<td>None</td>
</tr>
<tr>
<td>22</td>
<td>M</td>
<td>60</td>
<td>RA</td>
<td>Re-solution</td>
<td>7 115†</td>
<td>High dosage aspirin</td>
<td>115*</td>
<td>Severe</td>
</tr>
<tr>
<td>23</td>
<td>F</td>
<td>45</td>
<td>RA</td>
<td>Re-solution</td>
<td>7 55*</td>
<td>High dosage aspirin</td>
<td>55*</td>
<td>Moderately severe No change</td>
</tr>
<tr>
<td>24</td>
<td>M</td>
<td>60</td>
<td>RA</td>
<td>Re-solution</td>
<td>5 87*</td>
<td>High dosage aspirin</td>
<td>87*</td>
<td>Moderately severe Slight improvement</td>
</tr>
<tr>
<td>25</td>
<td>F</td>
<td>72</td>
<td>RA and OA</td>
<td>Re-solution</td>
<td>7 10†</td>
<td>High dosage aspirin</td>
<td>10†</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>M</td>
<td>64</td>
<td>RA</td>
<td>Re-solution</td>
<td>7 57*</td>
<td>Aspirin Indomethacin</td>
<td>57*</td>
<td>Moderately severe Slight benefit</td>
</tr>
<tr>
<td>27</td>
<td>F</td>
<td>39</td>
<td>RA</td>
<td>Re-solution</td>
<td>7 43†</td>
<td>Indomethacin</td>
<td>43†</td>
<td>Moderately severe Good response on indomethacin Relapse on placebo</td>
</tr>
<tr>
<td>28</td>
<td>F</td>
<td>62</td>
<td>RA</td>
<td>Re-solution</td>
<td>14 49†</td>
<td>Indomethacin</td>
<td>49†</td>
<td>Moderately severe Good response</td>
</tr>
<tr>
<td>29</td>
<td>F</td>
<td>71</td>
<td>RA</td>
<td>Slight re-solution</td>
<td>10</td>
<td>Indomethacin</td>
<td>49†</td>
<td>Moderately severe Slight improvement</td>
</tr>
<tr>
<td>30</td>
<td>M</td>
<td>59</td>
<td>Psoriatic arthritis</td>
<td>Re-solution</td>
<td>12 16*</td>
<td>Indomethacin</td>
<td>16*</td>
<td>Mild Good response</td>
</tr>
</tbody>
</table>

*Westergren.  †Wintrobe.
The effect of indomethacin alone was tested in seven patients. Clinical response was usually rapid and concomitant improvement in the degree of polymerization of hyaluronic acid was seen convincingly in the first week (for example, Case 28, Fig. 5); all seven showed some improvement both clinically and by turbidity measurement.

The degree of polymerization of synovial hyaluronic acid from five of seven patients was increased by aspirin (for example, Case 25, Fig. 6). Aspirin was slower in its clinical action but also tended to restore the shape of the turbidity curve towards normal, although to a lesser degree than indomethacin.

**Discussion**

The shape of the turbidity curve reflects inflammatory activity within the joint, irrespective of the disease process. The cause of the depolymerization of hyaluronic acid is unknown. Lysosomal enzymes are present in excess in both synovial tissue (Luscombe, 1963; Hendry and Carr, 1963) and synovial fluid (Jacox and Feldmahn, 1955; Lehman, Kream, and Brogna, 1964; Caygill and Pitkeathly, 1966) in rheumatoid arthritis. Their presence in synovial fluid may result from destruction of the excess polymorphonuclear leucocytes, or from lymphocytic transformation, a change which can take place within the inflamed joint and may lead to increased lysosome production (Allison and Mallucci, 1964). The anti-inflammatory action of prednisone, indomethacin, and aspirin could then be explained by their action as lysosomal stabilizers, in blocking part of the inflammatory chain reaction at its terminal link. The adrenal glucocorticoids stabilize lysosome both in vitro and in vivo (Weissmann and Thomas, 1964). Acetylsalicylic acid has also recently been demonstrated biochemically to stabilize lysosomal membranes in vitro (Miller and Smith, 1966); no direct evidence has been published of lysosomal stabilization due to indomethacin, though inhibition of leucocytic infiltration and suppression of motility have been shown by Phelps and McCarty (1966). Histochemical staining of synovial smears from our patients has shown that all three drugs, prednisone, indomethacin, and aspirin, are also lysosomal stabilizers in vivo (Williamson and Holt, 1966b). Another possibility is that at the cellular level, indomethacin, salicylates, and hydrocortisone, which inhibit A.T.P. production (Whitehouse, 1964), could reduce hyaluronic acid synthesis and also prevent lysosomal activity. There may, however, be other reasons for the break-down of hyaluronic acid, and a hyaluronidase (exohexosaminidase) has been reported in synovial fluid and synovial tissue (Bollet, Bonner, and Nance, 1963).

Corticosteroids increase polymerization of hyaluronic acid (Barker and others, 1963), and this probably explains their effect in increasing the relative, intrinsic, and anomalous viscosity of synovial fluid by either local or systemic administration (Bauer, Giangisiracusa, and Ropes, 1950; Sundblad, Egelius, and Jonsson, 1954; Nääntä and Seppälä, 1962). Other explanations of their effect are that the less polymerized fraction is eliminated from the joint (Nääntä and Seppälä, 1962) or that they have a direct effect on the synthesis of hyaluronic acid in synovial tissue (Jessar, Ganzell, and Ragan, 1953; Sundblad and others, 1954). However, it is not known whether corticosteroids reduce the production of imperfectly-formed hyaluronic acid or decrease the rate of enzymic breakdown of normally-formed hyaluronic acid.

Hyaluronate turnover studies (Sandson, 1966) suggested a half-life in the normal calf joint of 15 to 24 hours, and that hyaluronic acid, once it is formed, is not degraded in synovial fluid. Similar studies in man might help to answer these questions.

The anti-inflammatory effect of both aspirin and indomethacin has been demonstrated using several animal models. In man some evidence has been obtained of an anti-inflammatory effect of aspirin.
in crystal-induced arthritis (Steele and McCarty, 1966) and of indomethacin in reducing skin inflammation in response to a variety of irritants (Heimeyer and Heilmeyer, 1965). Circumstantial evidence has also been obtained by noting measurable reduction of finger swelling in rheumatoid arthritis after each drug (Fremont-Smith and Bayles, 1965; Hart and Boardman, 1963). The present study demonstrates biochemically an anti-inflammatory action of both these drugs.

Summary

(1) Hyaluronic acid in synovial fluid is depolymerized in untreated inflammatory arthritis irrespective of the aetiology.

(2) A biochemical method of in vivo assessment of anti-inflammatory drugs is discussed.

(3) This method has been used to demonstrate an anti-inflammatory effect of indomethacin and aspirin in man.

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L’effet de traitements, quelle dépolymerise chez l’aspirine. L’effet anti-inflammatoire in vivo.

L’acide (1), (2), (3) est servant de antinflamatorios.

Les macopolysaccharides dans le liquide synovial
L’effet de l’aspirine et de l’indométhacine sur l’acide hyaluronique

RÉSUMÉ

1. L’acide hyaluronique dans le liquide synovial est dépolymerisé dans les cas d’arthrite inflammatoire non traités, quelle que soit son étiologie.

2. On discute une méthode biochimique d’évaluation in vivo des médicaments anti-inflammatoires.


Los mucopolisacaridos en el líquido sinovial
El efecto de la aspirina y de la indometacina sobre el ácido hialurónico

SUMARIO

1. El ácido hialurónico en el líquido sinovial se ve depolimerizado en los casos de artritis inflamatoria sin tratar, cualquiera sea la etiología.

2. Se discute un método bioquímico de valoración in vivo de los productos anti-inflamatorios.

3. Se empleó este método para demostrar el efecto anti inflamatorio de la indometacina y de la aspirina en el hombre.