A pathological role for damaged hyaluronan in synovitis

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Hyaluronan (hyaluronic acid, hyaluronate, see ref 1 for discussion of current nomenclature) is a linear repeating disaccharide, \( \beta-D\)-glucuronyl-\( \beta-D\)-N-acetylglucosamine, of high molecular weight (upwards of 10 000 000 daltons). It is almost ubiquitous in its distribution, being present in the interstitial spaces on most animal tissues.\(^1\) Hyaluronan also forms the central axis of the proteoglycan aggregates necessary for the functional integrity of articular cartilage and other extracellular matrices.\(^3\)

In its unaggregated form hyaluronan is secreted continuously into the joint space by elements of the synovium, though some contribution may be made by the chondrocyte.\(^4\) It comprises the major macromolecular species of the synovial fluid and is responsible for the unique viscoelastic properties of what is otherwise effectively a simple plasma dialysate. The secondary structure of the glycosaminoglycan chain consists of a fairly stiff helical ribbon stabilised by four internal hydrogen bonds per disaccharide unit. These lie parallel to the axis of the ribbon, and are supplemented by water bridges such that the molecule may take up the tertiary structure of a random coil in an aqueous environment at physiological pH.\(^5\) A fully hydrated molecule of hyaluronan of \( M_r = 4 \) megadaltons would comprise a chain of 10 000 disaccharide units and occupy a spherical domain with a diameter of about 0.5 microns. At a concentration of 1 mg/ml these domains would just touch each other with the virtual exclusion of all interdomain solvent. At concentrations greater than 1 mg/ml the domains overlap and intermingle forming a continuous three dimensional network solution with non-linear viscoelastic properties.\(^6\)\(^\text{-}\)\(^8\) This is the situation within normal synovial fluid where hyaluronan of \( M_r = 1\cdot6-10\cdot9 \) megadaltons is found at concentrations ranging from 1·45 to 3·12 mg/ml.\(^9\)\(^\text{-}\)\(^10\)

Hyaluronan is normally present in the serum in small amounts, of the order of 10–100 \( \mu \)g/l.\(^11\) Hyaluronan concentrations are raised up to sevenfold, however, in the sera of patients with rheumatoid arthritis and other inflammatory arthritides.\(^12\)\(^\text{-}\)\(^13\) Engstrom-Laurent and Hallgren have found early morning rises of serum hyaluronan in both patients and healthy controls, implying a relation with exercise and the movement of inflamed joints.\(^14\) These authors speculate that increased hyaluronan production and its intra-articular accumulation during overnight rest might in part account for the phenomenon of morning stiffness.

Hyaluronan and synovitis

In rheumatoid arthritis and other inflammatory arthritides synovial hyaluronan is fragmented and depolymerised with a corresponding reduction in synovial fluid viscosity. This leads to an increase in the synovial concentration of dialysable hyaluronan fragments and saccharide monomers. There is broad agreement among a number of studies showing an increase in the total amount, but a decrease in the concentration (1·09–1·20 mg/ml, probably a dilutional effect) and in the average molecular weight (1·2–4·5 megadaltons, data from ref 10) of hyaluronan in rheumatoid synovial fluids.\(^10\)\(^\text{-}\)\(^15\)\(^\text{-}\)\(^16\)

The apparent decrease in the weight average molecular mass of synovial hyaluronan in these patients may be explained in two ways: either by defective synthesis with premature termination of the nascent polysaccharide chain, or by fragmentation of the intact chain after secretion into the synovial cavity. Recent pulse-chase experiments have supported the view that the presence of short chain molecules of hyaluronan in arthritic synovial fluid is due to degradation after synthesis rather than to defective synthesis.\(^17\) As normal and inflammatory synovial fluids contain no hyaluronidase activity it has been inferred for some time that reactive oxygen derived radical species (RORS) cause hyaluronan depolymerisation.\(^18\)\(^\text{-}\)\(^20\) Broadly, the evidence derives from two approaches: (a) the demonstration of potential free radical generating systems within the joint and (b) the demonstration of hyaluronan degradation by such systems in vitro as shown by decreased viscometric parameters and apparent hyaluronan molecular mass when measured by gel filtration.

Free radicals and synovitis

There is an increasing body of evidence, both direct and indirect, implicating RORS in the generation and perpetuation of inflammation.\(^21\)\(^\text{-}\)\(^25\) Recent studies have shown the presence of systems prerequisite to the formation of such free radicals within the synovial membrane of the inflamed joint.\(^26\)\(^\text{-}\)\(^27\) Other studies have shown several products of free radical attack upon biological molecules and...
intracellular structures within the inflamed joint.\textsuperscript{28–31}

The generation of RORS, however, requires
The oxygen tension of inflammatory
synovial fluid is low; Lund-Olesen reported a
mean synovial P\textsubscript{O\textsubscript{2}} of 26 mmHg in 85 patients
with rheumatoid arthritis.\textsuperscript{32} Edwards \textit{et al}
found that the ability of stimulated rat neutro-
phils to produce RORS was in part dependent
on the ambient O\textsubscript{2} concentration.\textsuperscript{33} The
apparent paradox of finding RORS mediated
damage in a relatively hypoxic environment
may be resolved by considering the mechanism
of hypoxia/reperfusion injury.

Active synovitis is associated with increased
synovial oxygen demand, especially during the
proliferative phase, and with a corresponding
increase in blood flow.\textsuperscript{34} Synovial oxygen ten-
sion is critically dependent, therefore, upon the
maintenance of an adequate synovial blood
flow. Jayson and Dixon showed that the normal
human joint has a subatmospheric pressure at
rest, which remains subatmospheric during exercise,
whereas inflamed joints have resting
intra-articular pressures above one atmosphere,
which rise to exceed the local capillary perfusion
pressure when exercised.\textsuperscript{35} With hydrostatic
closure of the superficial capillary bed during
movement of the inflamed joint, the superven-
ing ischaemic hypoxia sets in motion a series of
biochemical events which uncouple some intra-
cellular redox systems leaving elements of
the synovial tissue poised to generate potentially
damaging RORS immediately on the reintroduc-
duction of oxygen. When joint movement stops
the intra-articular pressure fails, allowing re-
opening of the capillary bed. With the resto-
rative movement of synovial blood flow and oxygen delivery
diffuse RORS may be generated, including the
highly reactive hydroxyl (\textsuperscript{•}OH) radical by way of
the Fenton reaction.

\[\text{H}_2\text{O}_2 + \text{Fe}^{2+} \rightarrow \text{OH}^- + \text{OH}^- + \text{Fe}^{3+}\]

Details of these mechanisms and the evidence
for their involvement in synovitis are reviewed
elsewhere.\textsuperscript{36–39} The \textsuperscript{•}OH radical can attack a
wide range of biomolecules, including lipids,
proteins, and polysaccharides.

In 1986 we suggested that fluxes of oxygen
derived free radicals and other reactive oxygen
species are generated by means of continuous
hypoxia/reperfusion cycles within the inflamed
joint during movement associated with routine
daily activity, and that these fluxes are respon-
sible for damage to joint microvasculature and
parenchymal structures. Such reperfusion
cycle-driven fluxes would be inevitable in the
ambulatory patient, and would thereby per-
petuate the inflammatory state.\textsuperscript{37} This may
explain the dogged persistence of chronic
synovitis, and the well known, albeit transient,
therapeutic benefit of bed rest and joint splint-
age. It might be further supposed that with
accumulated damage over a period of time the
reperfusion potential of the microvasculature
would progressively decline. This might offer
an explanation as to why some cases of rheuma-
toid arthritis ultimately and spontaneously
‘burn out’.

Free radicals and hyaluronan
It has been shown by \gamma radiolysis that hyaluronan
is susceptible to hydroxyl radical attack.\textsuperscript{18, 19}
We have presented elsewhere direct evidence
for RORS mediated damage to hyaluronan in
the synovial fluid and serum of patients with
inflammatory joint disorders.\textsuperscript{38–39} Methods
using high resolution, high field proton Hahn
spin-echo Fourier transform nuclear magnetic
resonance spectroscopy (SEFT-NMR) have
been developed to study oxidative damage to
hyaluronan in vitro by RORS generated by \gamma
irradiation and to characterise the end products.
This powerful technique has the advantage of
allowing a detailed analysis of small molecules
suspended in complex biological fluids with
minimal manipulation of the sample. SEFT-
NMR has also been used to study oxidative
damage to synovial fluid hyaluronan in vivo by
RORS generated during hypoxic/reperfusion
injury, and to detect the end products of RORS
mediated hyaluronan degradation both in the
synovial fluid and in the serum of patients with
inflammatory joint disease.

The first of these studies\textsuperscript{38} showed that
free radical attack on pure hyaluronan in vitro
results in the formation of metabolites, includ-
ing formate and very low molecular weight
(M\textsubscript{r}=ca 1000) oligosaccharides containing N-
acetylglucosamine. This would correspond to a
fragment containing two disaccharide units of a
hyaluronan chain. These species have also been
detected by SEFT-NMR in the synovial fluid
from patients with inflammatory joint diseases
but not from normal or non-inflammatory
controls. Both these species, however, were
seen in the non-inflammatory synovial fluids
after \gamma irradiation. \gamma Irradiation (which generates
\textsuperscript{•}OH radicals from water) of normal serum
results in the generation of formate resonances
only. These presumably derive from glyco-
proteins and other non-hyaluronan carbo-
hydrate systems present in the serum. No
oligosaccharide resonances were seen (normal
serum contains only tiny amounts of hyaluronan),
suggesting that the saccharide moieties of glyco-
proteins are not the substrate for its appearance
in the patients’ synovial fluid.

These studies were extended to the hypoxia/
reperfusion model\textsuperscript{39} (more fully described in ref
40), and 20 patients with rheumatoid arthritis
with clinically evident knee effusions were
exercised either by isometric quadriceps con-
traction or by walking up stairs for two minutes.
Serial synovial fluid samples were aspirated
after exercise every two minutes until the knee
was dry. In 15 of the patients analysis of these
spectra showed an induction or increase in
intensity after exercise of a resonance attribut-
ble to a low molecular mass oligosaccharide
(figure) identical with that seen in the previous
series. The intensity of this resonance was
maximal at four minutes after exercise. The
spectra also indicated an increase in formate
concentrations after exercise consistent with
\textsuperscript{•}OH radical attack on synovial carbohydrate
systems, including hyaluronan.

We interpret these data to support the hypo-
thesis that oxygen free radicals generated by
exercise-induced hypoxia/reperfusion cycles
Hahn performed knee standardised resonance spectra of oligosaccharide peak exercise; after seen clearly a larger magnetic mode in A. I. B. peak at 2-0 ppm located slightly downfield at 2-0 4 ppm is clearly seen to rise after exercise of the inflamed joint, reaching a maximum at four minutes after exercise. Nuclear magnetic resonance measurements on these samples were performed on a JOEL TNM-GS X spectrometer operating in quadrature mode at 500 MHz.

Proton Hahn spin-echo Fourier transform nuclear magnetic resonance spectra of a rheumatoid effusion aspirated from the knee of a rested patient: (A) immediately before a standardised two minute period of exercise; (B) immediately after exercise; and (C) four minutes after exercise. The oligosaccharide peak (arrowed on the descending shoulder of a larger peak located slightly downfield) at 2-0 4 ppm is clearly seen to rise after exercise of the inflamed joint, reaching a maximum at four minutes after exercise.

Hyaluronan, some biological considerations
Hyaluronan is far from an inert space filler or static scaffolding for other extracellular matrix molecules. It is thought to have an important role in biological activities as diverse as cellular motility, cell-cell interaction, development and differentiation, cell-matrix adhesion, and the ordering of the extracellular matrix.41

Cells from a variety of tissues have been shown to bear fairly specific high affinity hyaluronan receptors at their surfaces.42,43 The hyaluronan receptor is a transmembrane glycoprotein of Mv 85 000,44 whose intracellular face seems to interact with the actin filaments of the cytoskeleton.45 Clustering of these receptors by cooperative binding to hexasaccharide sequences of a single high molecular weight molecule of hyaluronan may have far reaching effects on the cell's behaviour and interaction with its environment. Bound hyaluronan molecules may provide a physical barrier at the cell surface both to cell-cell communication and to cell-substrate adhesion. By controlling the dispersal of hyaluronan receptors through elements of the cytoskeleton, the cell may be able to vary its adhesive properties and even membrane fluidity at different parts of its surface. It may even use such a mechanism to modulate its sensitivity to chemical messengers such as hormones or chemotactic gradients. The receptor also binds chondroitin sulphate, albeit much less avidly.46

This differential binding may provide further environmental information to the cell, which might be important in directing cell migration. Subsets of inflammatory cell populations bear cell-surface hyaluronan receptors.47 It is not unreasonable to suppose that some of their activities may be determined, or at least influenced, by the hyaluronan status of their immediate environment. Several studies have suggested that high molecular mass hyaluronan inhibits cellular proliferation of endothelial cells,48 fibrocytes,49 and mitogen stimulated lymphocytes,50 whereas low molecular mass fragments have the converse effect. High molecular mass hyaluronan has been shown to inhibit phagocytosis, with low molecular mass fragments having a stimulatory effect.51,52 Low molecular mass fragments have been shown to stimulate angiogenesis, an important feature of early inflammation.53 Synovial production of inflammatory mediators, such as prostaglandin E2, has been shown to be reduced by the administration of exogenous hyaluronan in a molecular mass dependent manner comparable with the oral administration of non-steroidal anti-inflammatory drugs.54

Speculations
We believe that the effects of free radical mediated damage to hyaluronan within the joint extend beyond the rheological consequences of
reduced synovial fluid viscosity. We suggest that at least some of the products of synovial hyaluronan breakdown may not only be induced by, but subsequently contribute to, the cyclical hypoxia/reperfusion injury of synovitis. Damaged hyaluronan would thereby constitute the substrate of a positive feedback loop, promoting perpetuation of the inflammatory state.

The very low molecular mass hyaluronan fragments which we have identified might compete with native hyaluronan for the hexa-saccharide recognition sites on the hyaluronan receptor or perhaps alter their binding constants, thus interfering with receptor clustering and cellular behaviour. Fragment polarity as well as size may be important here.

Formate is toxic in its own right, being the principal active metabolite of methanol poisoning. It contributes substantially to the metabolic acidosis associated with this condition in humans. It is also known to inhibit mitochondrial respiration in vitro, which may be responsible for its ocular toxicity. The development of animal models for the demonstration of a putative participation of formate in inflammation is hampered by species differences in formate handling.

Conclusions

Native hyaluronan is an important structural and dynamic element crucial to the functioning of the normal synovial joint. Fragmentation of the molecule would be expected to disrupt the network lattice of synovial hyaluronan with deleterious mechanical consequences to the joint. We further contend that low molecular weight products of free radical mediated hyaluronan degradation, such as formate and oligosaccharides less than three disaccharide units in length, may, quite apart from expressing any proinflammatory potential of their own, interfere with normal hyaluronan-cell and hyaluronan-matrix relationships, aggravating and contributing to the perpetuation of synovitis.

Over the past 15 years a number of clinical trials of several different preparations of intra-articularly administered hyaluronan in the treatment of arthritic conditions have been undertaken. Although methodological variations make direct comparisons difficult, there is a broad consensus that this treatment reduces the pain of osteoarthritis. Some studies indicate that this effect may be long lived, lasting six months or more, implying that 'normalising' the intra-articular environment may stimulate the hyaluronan sequestering cells. Although side effects are uncommon, several studies report a cohort of patients who experience a transient increase in pain and swelling in the treated knee, usually lasting for no more than a few days.

We suggest that vicosupplementation with exogenous hyaluronan of specified molecular weight to promote the secretion by the synovium of intact native hyaluronan, thereby restoring the normal hyaluronan status of the joint, is only half the story. In the face of continuing hyaluronan degradation within the joint this has the effect of simply providing further substrate for the generation of potentially damaging end products, and therefore the procedure eventually becomes self defeating. This may explain the side effect of an acute transient synovitis seen in some patients. To be effective vicosupplementation must be combined with a strategy to prevent the intrasynovial degradation of hyaluronan itself.


Underhill C B, Green S J, Cologno P M, Tarone G. The hyaluronate receptor is identical to a glycoprotein of 85,000 Mr (gp 85) as shown by a monoclonal antibody that interferes with binding activity. J Biol Chem 1987; 262: 3142-6.

