Thrombin Mutant W215A/E217A Treatment Improves Neurological Outcome and Reduces Cerebral Infarct Size in a Mouse Model of Ischemic Stroke

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**Background and Purpose**—Treatment of ischemic stroke by activation of endogenous plasminogen using tissue plasminogen activator is limited by bleeding side effects. In mice, treatment of experimental ischemic stroke with activated protein C improves outcomes; however, activated protein C also has bleeding side effects. In contrast, activation of endogenous protein C using thrombin mutant W215A/E217A (WE) is antithrombotic without hemostasis impairment in primates. Therefore, we investigated the outcome of WE-treated experimental ischemic stroke in mice.

**Methods**—The middle cerebral artery was occluded with a filament for 60 minutes to induce ischemic stroke. Vehicle, recombinant WE, or tissue plasminogen activator was administered during middle cerebral artery occlusion or 2 hours after middle cerebral artery occlusion. Neurological performance was scored daily. Intracranial bleeding and cerebral infarct size, defined by 2,3,5-triphenyltetrazolium chloride exclusion, were determined on autopsy. Hemostasis was evaluated using tail bleeding tests.

**Results**—WE improved neurological performance scores, increased laser Doppler flowmetry-monitored post-middle cerebral artery occlusion reperfusion of the parietal cortex, and reduced 2,3,5-triphenyltetrazolium chloride-defined cerebral infarct size versus vehicle controls. However, unlike tissue plasminogen activator, WE did not increase tail bleeding or intracranial hemorrhage.

**Conclusions**—WE treatment is neuroprotective without hemostasis impairment in experimental acute ischemic stroke in mice and thus may provide an alternative to tissue plasminogen activator for stroke treatment. (Stroke. 2011;42:1736-1741.)

Key Words: antithrombotics • ischemic stroke • thrombin • thrombolysis

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E arly thrombolysis with recombinant human tissue plasminogen activator (tPA) is currently the only Food and Drug Administration-approved causal treatment for acute ischemic stroke. Through enzymatic induction of endogenous plasmin-catalyzed fibrinolysis, tPA treatment promotes reperfusion and improves long-term clinical outcomes.1 However, tPA increases the incidence of intracerebral hemorrhage and may have neurotoxic effects in experimental stroke.2–4

Experimental data suggest that the use of recombinant activated protein C (APC), which inhibits activated factors V and VIII, improves stroke outcomes.5,6 Beyond its anticoagulant activity, APC therapy is vasculoprotective and neuroprotective, and it helps to maintain the integrity of the blood–brain barrier;7–10 however, systemic APC administration also can impair hemostasis.6,11 Potentially safer alternatives to recombinant APC administration include the use of innovative APC mutants with reduced anticoagulant activity11 or the direct activation of endogenous protein C by thrombin in vivo.

The essential serine protease thrombin catalyzes site-specific procoagulant and anticoagulant events.12 Low doses of infused thrombin are antithrombotic through activation of endogenous protein C; however, thrombin also has concurrent prothrombotic effects.13 Alanine scanning studies identified several key residues involved in thrombin substrate specificity,14,15 and thrombin analogs with reduced procoagu-lant activity have been designed. The thrombin mutant W217A/E217A (WE) has significantly reduced catalytic activity toward fibrinogen and protease-activated receptors but retains activity toward protein C in the presence of thrombomodulin.16 WE treatment is as antithrombotic as interventional doses of low-molecular-weight heparin or APC, but without significant hemostasis impairment in baboons.17,18
Based on the observed dissociation of antithrombotic and antihemostatic effects of WE in primates, we hypothesized that WE administration may provide a safe approach to early treatment of stroke. We therefore investigated the effect of WE administration in a murine middle cerebral artery occlusion (MCAO) model of acute ischemic stroke.

Materials and Methods

Mouse Model of Acute Ischemic Stroke

Animal experiments were approved by the Institutional Animal Care and Use Committee. Three month-old male C57Bl/6 mice (Charles River Laboratories, Madison, WI) weighing 21 to 27 grams were anesthetized with 5.0% isoflurane. Anesthesia was maintained with 1.0 to 1.5% isoflurane in 37% oxygen. Rectal temperature was maintained at 37.0°C±0.5°C. A laser Doppler flowmetry (LDF) probe (Moor Instruments Ltd) was secured over the right parietal bone to monitor focal changes of cortical perfusion. Ischemic stroke was induced by surgical deployment of a silicone-coated (Xantopren Comfort Light and hardener mix; Heraeus), heat-blunted 6-nylon filament through the right external carotid artery to achieve MCAO, as described.19 The beginning of focal cerebral ischemia was defined as a decrease in LDF signal to <20% of the pre-MCAO baseline. After 60 minutes, the filament was removed and reperfusion was monitored with LDF. In selected experiments, extensive perfusion deficit of the affected hemisphere during MCAO was verified with optical microangiography, as described.20

Treatment of Stroke

Recombinant human WE was prepared by site-directed mutagenesis, as described.16 Recombinant human tPA, Alteplase (Actovein; Genentech), was purchased. Treatments were randomly assigned and administered, either during cerebral ischemia (before filament removal) or during reperfusion, 2 hours after removal of the filament from the MCA. For treatment during occlusion, single bolus vehicle (physiological saline with 2.5% dextrose), WE (25 μg/kg), or tPA (2.5 mg/kg) were administered in 185 μL volume through the isolated right femoral vein after 15 minutes of sustained ischemia as defined by LDF. For treatments administered 2 hours after MCAO, animals received a 45-minute intravenous infusion of 185 μL of vehicle, WE (25 μg/kg), or tPA (10 mg/kg). The bolus and infusion doses of tPA and WE were selected based on previous studies in mice and primates.3,7,17

Neurological Evaluation

After MCAO and treatment administration, mice were allowed to recover and neurological deficit was assessed the next day. Neurological performance scores were assessed daily using a modified 5-point Hara scale (0, no neurological signs; 1, flexion of the contralateral torso; 2, circling to the contralateral side but normal posture at rest; 3, leaning to the contralateral side at rest; 4, no spontaneous motor activity; 5, death).21 Scores were ranked from 0 to 5 at intervals of 0.5; animals demonstrating neurological signs defined by LDF. For treatments administered 2 hours after MCAO, performance scores on a modified Hara scale, assessed 24 hours after the MCAO procedure, were significantly better (nonischemic) hemisphere to represent the TTC-defined infarct volume. Edema was indirectly calculated from morphometric data as the percent increase in size of the ipsilateral hemisphere over the contralateral hemisphere.

Results

WE Is Neuroprotective in a Mouse Model of MCAO-Induced Ischemic Stroke

To visualize the extensive ischemia of the parietal region induced by MCAO, we performed optical microangiography imaging of animals that received a bolus of vehicle, WE (25 μg/kg), or tPA (2.5 mg/kg). Images obtained before MCAO, during MCAO, and after MCAO were consistent with LDF probe data (Table 1), confirming that blood perfusion of the affected hemisphere was significantly decreased during MCAO (Figure 1).

To evaluate the neurological outcomes of WE treatment of acute ischemic stroke, animals were administered vehicle, WE (25 μg/kg), or tPA (2.5 mg/kg) during cerebral ischemia. Performance scores on a modified Hara scale, assessed 24 hours after the MCAO procedure, were significantly better for WE-treated mice than for vehicle-treated or tPA-treated animals (Figure 2A).
WE Reduces Infarct Size After Cerebral Ischemia

On morphometric analysis, the relative volume of TTC-defined infarction of the affected hemisphere was significantly smaller in both WE-treated and tPA-treated (26% and 36% respectively) than in vehicle-treated mice, suggesting neuroprotection by both enzymes (Figure 2). No differences in the relative increase in size of the infarcted hemisphere (interpreted as edema) were observed between treatments (data not shown).

WE Treatment After MCAO Improves Neurological Outcome

To evaluate the efficacy of WE administration after MCAO, we infused vehicle, WE (25 μg/kg), or tPA (10 mg/kg) 2 hours after removal of the filament and monitored neurological deficits and survival for 1 week. On neurological assessment on days 3 to 7 after MCAO, performance scores in both WE-treated and tPA-treated mice were significantly better than in vehicle-treated mice (Figure 3A). Both WE-treated and tPA-treated mice showed significant improvement in neurological scores over the 7 days of observation, whereas neurological scores in vehicle-treated mice were unchanged (Figure 3A). Survival curves of WE-treated animals trended toward an increase in survival beyond vehicle-treated animals (P=0.06; Figure 3B). Therefore, administration of WE after MCAO improves neurological function over 7 days and may lead to an increased survival benefit.

WE Treatment Does Not Impair Hemostasis

Hemostasis impairment tests were used to assess treatment safety. On autopsy, brain sections were examined for the presence of macroscopic intracranial hemorrhage. No instance of visible hemorrhage was observed in vehicle-treated animals (0/12). Macroscopic hemorrhage was seen in 14% (2/14) of mice treated with WE; there was no statistical difference from vehicle treatment. Macroscopic intracranial hemorrhage was observed in 44% (7/16) of mice that received tPA (P=0.006 versus vehicle).

The effect of WE (25 μg/kg) on murine hemostasis was evaluated 15 minutes after administration. Tail bleeding times in WE-treated mice were comparable to vehicle-treated mice (Figure 4A). In contrast, tPA (2.5 mg/kg) significantly prolonged tail bleeding time in comparison to both vehicle and WE treatment. Further, the blood volume loss from tPA-treated mice was 3-fold greater than the blood loss from vehicle-treated or WE-treated mice (Figure 4B).

No significant prolongation of APTT was observed for WE-treated or tPA-treated animals (Table 2), although a transient increase of APTT was observed after the administration of 10-fold higher doses of WE (data not shown), consistent with anticoagulant concentrations of endogenous APC in the circulation, as seen in primates after WE administration. To examine the effects of WE and tPA on fibrinolysis, the plasma clot lysis time was recorded after APTT measurements. In plasma from tPA-treated mice, APTT clots lysed in 82.4 ± 3.1 seconds, whereas no lysis was observed over a 240-second period of observation with vehicle or WE treatment. No differences in plasma thrombin times were observed in vehicle-treated, WE-treated, or tPA-treated animals (Table 2). These data suggest that adminis-
treatment of WE did not significantly interfere with the hemostasis of mice.

Discussion
We evaluated the efficacy and safety of WE treatment of MCAO-induced ischemic stroke in mice. Our data show that WE administration during MCAO improved neurological outcomes and reduced TTC-defined infarct size 24 hours after induction of ischemic stroke, with an efficacy that was comparable to tPA. Moreover, WE treatment 2 hours after MCAO also improved neurological performance over 1 week of observation.

Our information about the pathomechanism of progressive cerebral infarctions and ischemic stroke induced by surgical placement of the filament into the MCA in our model remains limited. The reduced LDF after MCAO reperfusion in vehicle-treated mice could have various explanations, ranging from distal plugs attributable to denudation of the endothelium during introduction of the filament, vasospasm, or progressive distal thrombosis attributable to ischemic endothelial injury. As measured by LDF, significant reperfusion benefit achieved by both a thrombolytic (tPA) and an antithrombotic (WE) agent is suggestive of the formation of distal throm-
The neurological stabilization of the enzyme in the inactive $E^*$ form of thrombin.24 Enzymatic activity is restored in the presence of thrombomodulin and, because protein C is a natural substrate for the complex, the mutant effectively generates APC in vitro as well as in vivo.16,17,25 In addition to anticoagulant properties, APC is directly cytoprotective, exerting neuroprotective effects in experimental ischemic stroke.5,7–9 The neurological outcome benefit observed with WE treatment of stroke may have resulted from neuroprotective effects of the intravascular generation of endogenous APC.

Although systemic administration of APC is neuroprotective in this model, circulating APC can disrupt hemostasis.5,11 As an alternative to using the native enzyme, APC variants with reduced anticoagulant activity have been engineered to exploit the antiapoptotic activity of the enzyme. In a mouse model of ischemic stroke, variant 3K3A-APC, with reduced anticoagulant activity ($\approx 90\%$ reduction from wild-type), stabilizes the enzyme in the inactive $E^*$ form of thrombin.24 Thrombin time measurements after administration of vehicle, tPA (2.5 mg/kg), or APC (2.5 mg/kg). Fifteen minutes after administration, blood was drawn into sodium citrate and plasma prepared by centrifugation. Plasma APTT and thrombin times were measured at 10.0±1.0 and 10.5±1.0 minutes, respectively, after the blood draw. Values are mean±SEM from 5 to 6 experiments.

### Table 2. Plasma Activated Partial Thromboplastin Time and Thrombin Time Measurements After Administration of Vehicle, W215A/E217A, or Tissue Plasminogen Activator

<table>
<thead>
<tr>
<th>Treatment</th>
<th>APTT</th>
<th>Thrombin Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle</td>
<td>25.2±0.9</td>
<td>13.6±0.5</td>
</tr>
<tr>
<td>WE</td>
<td>26.2±1.1</td>
<td>14.7±0.6</td>
</tr>
<tr>
<td>tPA</td>
<td>27.8±0.8</td>
<td>13.3±0.4</td>
</tr>
</tbody>
</table>

Anesthetized mice were administered a bolus of vehicle, WE (25 μg/kg), or tPA (2.5 mg/kg). Fifteen minutes after administration, blood was drawn into sodium citrate and plasma prepared by centrifugation. Plasma APTT and thrombin times were measured at 10.0±1.0 and 10.5±1.0 minutes, respectively, after the blood draw. Values are mean±SEM from 5 to 6 experiments. APTT indicates activated partial thromboplastin time; tPA, tissue plasminogen activator; WE, W215A/E217A.

Antithrombotic agents have proven effective at reducing infarct size and improving neurological outcomes. However, the associated bleeding risks can outweigh the benefits. Balancing the antithrombotic and neuroprotective benefits while minimizing the antihemostatic risks remain the critical hurdle in acute ischemic stroke treatment. The ability of WE to act safely with efficacy that may be comparable to tPA makes it a promising candidate for the treatment of ischemic stroke. Further studies are needed to optimize the methods, duration, dosing, and timing of WE administration to improve the long-term outcomes in various models of stroke that assess both antithrombotic and neuroprotective activities of the treatment.

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### References


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