Intravascular hemolysis triggers ADP-mediated generation of platelet-rich thrombi in precapillary pulmonary arterioles

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Introduction

Hemolysis is one of the major pathophysiological events associated with inherited and acquired disorders such as sickle cell disease (SCD) (1–3), thalassemia (1, 4), paroxysmal nocturnal hemoglobinuria (PNH) (5, 6), thrombotic thrombocytopenic purpura (TTP) (7, 8), hemolytic-uremic syndrome (HUS) (7, 9), sepsis (10, 11), and malaria (12). Intravascular hemolysis promotes the release of erythrocyte-derived damage-associated molecular pattern molecules (eDAMPs) — including cell-free hemoglobin, heme, uric acid, and adenosine diphosphate (ADP) — that may directly and/or indirectly promote thrombosis, endothelial dysfunction, and sterile inflammation (13–17). Although pulmonary thrombosis is a major clinical morbidity affecting patients with hemolytic disorders, how intravascular hemolysis promotes thrombosis in the lung remains poorly understood (18–26).

Hemolysis is associated with hemostatic abnormalities such as enhanced platelet activation and thrombin generation, elevated circulating tissue factor, and endothelial injury (1, 3, 5, 9, 15, 27–32). Thrombocytopenia, which is suggestive of intravascular platelet sequestration, is a risk factor for acute systemic and pulmonary complications of hemolytic disorders (8, 32–34). Importantly, autopsy and CT studies have identified platelet-rich thrombi occluding pulmonary artery branches and arterioles in patients with diverse hemolytic disorders (19, 20, 25, 35, 36). Taken together, these findings suggest that in situ platelet aggregation within the pulmonary vasculature may potentially contribute to acute hemolysis–induced pulmonary...
thrombosis. However, the in vivo evidence and the molecular mechanism of this pathophysiology have remained elusive. Here, we use quantitative fluorescence intravital lung microscopy (qFILM) to reveal that acute intravascular hemolysis triggers pulmonary thrombosis in mice, which is enabled by the occlusion of precapillary pulmonary arterioles by platelet-rich thrombi, leading to transient loss of blood flow in the lung. Our findings are the first in vivo studies to our knowledge to show that acute hemolysis–induced pulmonary thrombosis is largely mediated by ADP-dependent platelet purinergic signaling, leading to platelet activation and αIIbβ3-dependent platelet aggregation in the pulmonary arterioles.

Results

Intravascular hemolysis promotes platelet-dependent pulmonary arteriole thrombosis. qFILM revealed absence of pulmonary thrombosis in mice intravenously administered saline (control mice). In control mice, blood (purple fluorescence) was observed to flow unobstructed through the pulmonary vasculature, with erythrocytes visible as rapidly transiting dark cells (Supplemental Figure 1 and Supplemental Video 1; supplemental material available online with this article; https://doi.org/10.1172/jci.insight.139437DS1). Previously, intravascular administration of deionized water (dH2O) has been shown to trigger acute intravascular hemolysis in mice in vivo (37). qFILM revealed that intravascular administration of dH2O triggered the development of platelet-rich thrombi (green fluorescence) in the precapillary pulmonary arterioles of mice (Figure 1 and Supplemental Video 2). As shown in Supplemental Video 2, these thrombi were primarily formed in the pulmonary arteriolar bottlenecks (junction of pulmonary arteriole and capillaries) and resolved entirely over the next 2 minutes, resulting in a transient impairment of pulmonary blood flow. The time series of qFILM images were analyzed over several mice to determine the kinetics of pulmonary thrombosis in terms of 3 separate parameters: total pulmonary thrombi area as a function of time (Figure 1B), maximum pulmonary thrombi area (red arrow in Figure 1B), and AUC (Figure 2D) as described in Methods. Next, we used eptifibatide, which is an antagonist of platelet receptor αIIbβ3 (38) and FDA-approved drug for the prevention of platelet aggregation-dependent thrombosis in a broad range of ischemic coronary conditions, including percutaneous coronary intervention, acute coronary syndrome, and unstable angina (38). Remarkably, pretreatment with 10 mg/kg intravascular eptifibatide completely abrogated intravascular dH2O–triggered pulmonary thrombosis in mice (Figure 2, A and B, and Supplemental Video 3), which was evident by the significant reduction in both pulmonary thrombi maximum area (Figure 2, B and C) and AUC (Figure 2D). These findings indicate that pulmonary arteriole thrombosis triggered by acute intravascular hemolysis is predominantly dependent on platelet activation and subsequent aggregation.

Acute hemolysis–induced pulmonary thrombosis is unlikely to be thrombin dependent. Thrombin directly activates a number of coagulation factors, cleaves fibrinogen to fibrin, and stimulates protease activated receptors (PARs) on platelets to promote thrombosis (39, 40). Importantly, markers of thrombin generation, such as prothrombin fragment F1+2, thrombin-antithrombin III complexes, and D-dimers, have been found to be significantly elevated in diverse hemolytic disorders (9, 41–45). Therefore, we compared the pathophysiology of pulmonary thrombosis triggered by intravascular dH2O (acute hemolysis) to the one by intravascular thrombin. Unlike the transient pulmonary thrombosis triggered by acute hemolysis (Figure 1), mice challenged with 250 U/kg intravascular thrombin developed protracted pulmonary thrombosis, accompanied by the development of platelet-rich thrombi within the pulmonary arteriolar bottlenecks (Figure 3, A and C, and Supplemental Video 4). Subsequently, we examined the effect of 500 U/kg intravascular thrombin on the pulmonary thrombosis development in mice. A total of 75% of mice challenged with higher dose of 500 U/kg intravascular thrombin died, which was also accompanied by the loss of the pulmonary blood flow (Figure 3, B, D, and E, and Supplemental Video 5). Unexpectedly, the average pulmonary thrombi maximum area in mice administered 500 U/kg intravascular thrombin was not significantly higher than mice administered 250 U/kg intravascular thrombin (Figure 3F), which was probably caused by the pulmonary thrombosis in large arterial branches (>50 μm) upstream of pulmonary arterioles in mice administered 500 U/kg intravascular thrombin (Figure 3G and Supplemental Video 6). In contrast to the effect of eptifibatide on hemolysis-induced pulmonary thrombosis (Figure 2), eptifibatide failed to prevent severe pulmonary thrombosis (Figure 4, A and B, and Supplemental Video 7) and lethality (Figure 4C) following intravascular administration of 500 U/kg thrombin. The mean pulmonary thrombi maximum area in mice treated with eptifibatide before 500 U/kg intravascular thrombin was not different from mice treated with 500 U/kg intravascular thrombin only (Supplemental Figure 2), further suggesting that eptifibatide did not attenuate thrombin-triggered pulmonary arteri-
ole thrombosis in mice. This difference in the pathophysiology of acute hemolysis versus intravascular thrombin–induced pulmonary thrombosis suggests that thrombin generation most likely does not play a significant role in the pathogenesis of acute hemolysis–triggered pulmonary thrombosis.

Acute hemolysis–induced pulmonary thrombosis is likely to be ADP dependent. Intravascular hemolysis is also known to promote the release of ADP from erythrocytes (46–48), which can bind to P2Y1 and P2Y12 purinergic receptors on platelets to trigger platelet activation and subsequent aggregation (49, 50). Therefore, we next compared the pathophysiology of pulmonary thrombosis triggered by acute hemolysis to the one by intravascular administration of ADP. Similar to acute hemolysis (Figure 1), intravascular ADP led to the development of transient pulmonary thrombosis in mice in a dose-dependent manner (Figure 5). Mice treated with 0.5 mg/kg intravascular ADP manifested mild pulmonary thrombosis (Supplemental Figure 3 and Supplemental Video 8), while intravascular administration of 2.5 mg/kg ADP led to the development of medium (500–1000 μm²) and large (>1000 μm²) platelet-rich thrombi (green fluorescence) in the pulmonary arterioles (Figure 5A and Supplemental Video 9). Identical to acute hemolysis–induced pulmonary thrombosis (Figure 1), intravascular ADP–induced thrombi were initially unable to pass through the arteriolar bottlenecks, causing local impairments in blood flow. Pulmonary thrombosis started to resolve by t = 23 s and completely resolved by t = 2 minutes. Data are representative of 7 independent experiments. Platelets are shown in green and pulmonary microcirculation in purple. Asterisks denote alveoli. Dotted ellipses denote arteriolar bottlenecks. White arrow mark the direction of blood flow within the feeding arteriole. The diameter of the shown arteriole is 29 μm. Scale bar: 50 μm. Complete qFILM time series corresponding to A is shown in Supplemental Video 2. (B) Pulmonary thrombi area plotted as a function of time showing changes in the total area of platelet-rich thrombi following 150 μL IV dH₂O. Red arrow indicates pulmonary thrombi max area.

![Figure 1. Intravascular hemolysis triggers acute pulmonary thrombosis in mice.](https://doi.org/10.1172/jci.insight.139437)
the pulmonary thrombi maximum area was not significantly different between intravascular dH₂O and 0.5 mg/kg intravascular ADP–challenged mice. The similarities in the pathophysiology of acute hemolysis and intravascular ADP–induced pulmonary thrombosis suggest that ADP released from lysed erythrocytes most likely plays a major role in the pathogenesis of acute hemolysis–triggered pulmonary thrombosis.

ADP activates platelet P2Y₁₂ receptor to promote hemolysis-induced pulmonary thrombosis. Next, we tested whether inhibiting ADP-dependent platelet activation prevents acute hemolysis–induced pulmonary thrombosis in mice. Prasugrel is a thienopyridine class of drug, which is used clinically to treat patients with acute coronary syndrome who are undergoing percutaneous coronary intervention (52, 53). When taken orally, the active metabolite of prasugrel acts as a selective, irreversible, and potent platelet P2Y₁₂ receptor antagonist and prevents ADP-dependent platelet activation (54). We pretreated mice with 3 or 10 mg/kg prasugrel by oral gavage (PO) for 2 days and before inducing acute intravascular hemolysis by intravascular administering dH₂O. Remarkably, prasugrel pretreatment inhibited acute hemolysis–induced pulmonary arteriole thrombosis in a dose-dependent manner (Figure 7 and Supplemental Figure 6). Prasugrel inhibited both the formation and subsequent sequestration of platelet-rich thrombi in the pulmonary arterioles (Figure 7, A and B; Supplemental Figure 6, A and B; and Supplemental Videos 11 and 12). The pulmonary thrombi maximum area (Figure 7, B and C, and Supplemental Figure 6, B and C) and AUC

Figure 2. Acute hemolysis–induced pulmonary thrombosis is αIIbβ3-dependent. (A) WT mice were intravascularly (IV) administrated with 150 μL dH₂O to trigger acute hemolysis with or without IV administration of 10 mg/kg αIIbβ3 inhibitor (eptifibatide) 15 minutes before IV dH₂O. Pulmonary circulation was imaged using quantitative fluorescence intravital lung microscopy (qFILM). qFILM images of the same field of view (FOV) at 6 different time points are shown to assess the effect of 10 mg/kg IV eptifibatide on the development of 150 μL IV dH₂O–dependent pulmonary thrombosis. t = 0 seconds (s) corresponds to time point before and t > 0 s correspond to time points immediately following IV dH₂O administration. Pulmonary thrombosis was absent at t = 0 s. dH₂O failed to evoke pulmonary thrombosis in mouse pretreated with eptifibatide. Platelets (green) and pulmonary microcirculation (purple). Asterisks denote alveoli. White arrow marks the direction of blood flow within the feeding arteriole. The diameter of the shown arteriole is 30 μm. Scale bar: 50 μm. Also refer to Supplemental Video 3. (B) Pulmonary thrombi area plotted as a function of time for the FOV shown in A. Red arrow indicates pulmonary thrombi maximum area. (C and D) Pulmonary thrombi max area and AUC in mice with (n = 3 mice) or without (n = 7 mice) pretreatment with 10 mg/kg IV eptifibatide before 150 μL IV dH₂O. Pulmonary thrombi max area and AUC were estimated as described in Methods. Pulmonary thrombi max area and AUC were compared using Wilcoxon-Mann-Whitney test. Data are shown as mean ± SEM. *P < 0.05 when comparing with and without 10 mg/kg IV eptifibatide pretreatment.
Figure 3. Thrombin triggers protracted and lethal pulmonary thrombosis in mice. WT mice were administered IV with 250 U/kg (n = 5 mice) or 500 U/kg (n = 4 mice) thrombin, and pulmonary circulation was imaged using qFILM. (A) qFILM images of the same FOV at different time points are shown. t = 0 seconds (s) corresponds to time point before and t > 0 s correspond to time points following IV thrombin administration. Pulmonary thrombosis was absent at t = 0 s. Platelets are shown in green and pulmonary microcirculation in purple. (A) Following 250 U/kg IV thrombin, small (<500 μm²) and medium (500–1000 μm²) platelet-rich thrombi (white arrowheads) sequestered in the pulmonary arteriole (t = 10–12 s) and obstructed blood flow (t = 20 s). (B) Following 500 U/kg IV thrombin, small (<500 μm²) and medium (500–1000 μm²) platelet-rich thrombi (white arrowheads) sequestered in the pulmonary arteriole to occlude the arteriolar bottlenecks. The mouse died by t = 3 minutes, leading to arrest of pulmonary blood flow, which was evident by the reduced intensity of vascular dye (purple fluorescence) and stationary erythrocytes (Supplemental Video 5). Asterisks denote alveoli. White arrow mark the direction of blood flow. The diameters of the arterioles shown in A and B are 39 μm and 44 μm, respectively. Complete qFILM time series corresponding to A and B are shown in Supplemental Videos 4 and 5, respectively. (C and D) Pulmonary thrombi area plotted as a function of time following 250 U/kg (C) and 500 U/kg (D) IV thrombin within FOVs shown in A and B, respectively. Red and black arrows indicate pulmonary thrombi maximum area values and the time of mouse death following 500 U/kg IV thrombin, respectively. (E) Survival rate during qFILM experiments in WT mice IV administered with either 250 U/kg (n = 5 mice) or 500 U/kg (n = 4) thrombin (P = 0.046, log-rank test). (F) Pulmonary thrombi max areas in mice following 250 U/kg (n = 5 mice) and 500 U/kg (n = 4 mice) IV thrombin. Pulmonary thrombi max areas were compared using Wilcoxon-Mann-Whitney test. Data are shown as mean ± SEM. (G) Three-dimensional qFILM image of a lethal pulmonary thrombosis developed within a large pulmonary arteriole (57 μm) of a mouse administered with 500 U/kg IV thrombin. Platelets (green) and pulmonary microcirculation (purple). Refer to Supplemental Video 6. Scale bar: 50 μm.
(Figure 7D) were significantly attenuated in mice treated with prasugrel before intravascular dH₂O. As shown in Supplemental Videos 11 and 12, mice pretreated with prasugrel before intravascular dH₂O did not develop medium and large platelet-rich thrombi (>500 μm²) observed in intravascular dH₂O–administered mice (Figure 1 and Supplemental Video 2). Although small platelet-rich thrombi (<500 μm²) were still observed in the pulmonary arterioles of prasugrel treated mice, these thrombi were too small to obstruct the pulmonary blood flow (Figure 7A; Supplemental Figure 6A; and Supplemental Videos 11 and 12). These findings suggest that ADP-dependent platelet P2Y₁₂ signaling plays a major role in acute hemolysis–induced pulmonary arteriole thrombosis.

**Discussion**

Epidemiological evidence suggests that in situ pulmonary thrombosis is a major pathological event contributing to cardiopulmonary morbidities associated with hemolytic disorders; however, the molecular, cellular, and biophysical mechanisms of hemolysis-induced pulmonary thrombosis remain incompletely understood (19, 20, 35, 36). To address this, we have used intravital microscopy to study the kinetics of pulmonary thrombosis.
bosis progression in mice, following acute intravascular hemolysis (intravascular dH₂O). Acute hemolysis led to transient pulmonary thrombosis in mice, which was caused by the development of platelet-rich thrombi in the precapillary pulmonary arterioles, leading to impairment of pulmonary blood flow.

We found that acute intravascular hemolysis led to transient nonlethal pulmonary arteriole thrombosis in mice, which was dependent on αIIbβ3-mediated platelet aggregation. Previous studies suggest that ADP released from lysed erythrocytes may play a role in platelet activation (47, 55). Although ADP is known to activate platelet-purinergic receptors P2Y₁ and P2Y₁₂ to induce platelet shape change, degranulation and reversible aggregation in vitro (56) — a role for ADP-dependent purinergic signaling in hemolysis-induced pulmonary thrombosis in vivo — has never been reported. We show for the first time to our knowledge that pulmonary thrombosis triggered by acute hemolysis shares pathogenesis with ADP but not thrombin-triggered pulmonary thrombosis in mice in vivo. We also show that acute hemolysis–induced pulmonary thrombosis is abolished following the inhibition of platelet P2Y₁₂ receptor signaling. Taken together, these findings suggest that ADP released during acute hemolysis activates purinergic signaling in platelets to promote αIIbβ3-dependent acute reversible pulmonary arteriole thrombosis.

Our current study has a few limitations that need to be addressed in future investigations. First, the current study investigates the mechanism of pulmonary thrombosis secondary to acute intravascular hemolysis. Importantly, low-grade chronic hemolysis also occurs in several hemolytic disorders (1, 5, 8, 10, 15) and could
possibly have additional implications on pulmonary thrombosis that did not manifest in our acute hemolysis model. Second, anionic phospholipids exposed on lysed-erythrocyte membrane fragments also promote coagulation and, therefore, may contribute to hemolysis-induced pulmonary thrombosis (1, 42). Third, von Willebrand factor (VWF) released by injured endothelium may also contribute to pulmonary thrombosis by promoting platelet adhesion and activation (57). Indeed, platelet interaction with VWF has been shown to play a crucial role in the pathophysiology of multiple hemolytic disorders including TTP (7, 8, 20, 58). Fourth, nitric oxide (NO) depletion and ROS generation by cell-free hemoglobin may also contribute to hemolysis-induced platelet activation and pulmonary thrombosis (3, 17, 27, 55). Fifth, although thrombin did not seem to play a direct role in our study, thrombin generation may still contribute to acute hemolysis–triggered pulmonary thrombosis by unknown mechanisms. Sixth, changes in the vascular tone caused by thrombin or adenosine generated during hemolysis may regulate the pathogenesis of acute hemolysis–induced pulmonary thrombosis. Notwithstanding these limitations, the current study is the first to our knowledge to use intravital lung microscopy in live mice to reveal that platelet-purinergic signaling promotes platelet-dependent pulmonary arteriole thrombosis associated with acute intravascular hemolysis.

**Methods**

**Reagents, animals, and surgical preparation.** WT C57BL/6J mice (8–12 weeks old) were purchased from the Jackson Laboratory. See Supplemental Methods for details on used reagents and mouse surgical preparation.
**Figure 7. Inhibition of platelet P2Y₁₂ receptor abrogates hemolysis-induced pulmonary thrombosis in mice.**

(A) WT mice were administered 10 mg/kg prasugrel by oral gavage and then IV challenged with 150 μL dH₂O. Pulmonary circulation was imaged using quantitative fluorescence intravital lung microscopy (qFILM). qFILM images of the same field of view (FOV) at 6 different time points are shown. t = 0 seconds (s) corresponds to time point before and t > 0 s correspond to time points immediately following IV dH₂O administration. Pulmonary thrombosis was absent at t = 0 s. dH₂O failed to evoke pulmonary thrombosis in mouse pretreated with prasugrel. Platelets (green) and pulmonary microcirculation (purple). Asterisks denote alveoli. White arrows mark the direction of blood flow within the feeding arterioles. The diameter of the arteriole shown is 30 μm. Scale bar: 50 μm. Also refer to Supplemental Video 11. (B) Pulmonary thrombi area plotted as a function of time for the FOV shown in A. Red arrow indicates pulmonary thrombi maximum area. (C and D) Pulmonary thrombi max area and AUC in mice with (n = 6 mice) or without (n = 7 mice) pretreatment with prasugrel before IV dH₂O. Pulmonary thrombi max area and AUC were estimated as described in Methods. Pulmonary thrombi max area and AUC were compared using Wilcoxon-Mann-Whitney test. Data are shown as mean ± SEM. *P < 0.05, **P < 0.01 when comparing with and without prasugrel pretreatment.

**qFILM of pulmonary thrombosis.** The current study is an adaptation of qFILM approach used previously (59–63). qFILM of the mouse pulmonary microcirculation was performed using a Nikon A1R Multi-Photon-Excitation (MPE) Ni-E upright motorized microscope (Nikon Instruments). Two-dimensional time series of qFILM images were acquired with NIS-Elements software using a prechirped Chameleon Laser Vision (Coherent) emitting an excitation wavelength of 850 nm, an APO LWD 25× water immersion objective with 1.1 NA, a high-speed resonant scanning mode capable of acquisition at 512 × 512 resolution with 2× line averaging and bidirectional scanning (~15 frames per second), and 4 GaAsP NDD detectors. The 4 detectors collected fluorescent light transmitted through 450/20
of platelet-rich thrombi were sequestered within the precapillary pulmonary arterioles and extending downstream to the pulmonary capillaries. Two-dimensional sizes (areas in μm²) of platelet-rich thrombi were measured using qFILM image processing and data analysis. Refer to Supplemental Methods for details on qFILM image processing.

Statistics. Pulmonary thrombi max area and AUC were compared between groups using the Wilcoxon-Mann-Whitney test (when the data was not normally distributed) or the 2-tailed unpaired Student’s t test (when the data was normally distributed). Survival data were compared using Kaplan-Meier log-rank (Mantel-Cox) test. Data are shown as mean ± SEM. P value of less than 0.05 was used to determine significance.

Author contributions
TB designed, performed, and analyzed the qFILM experiments and wrote the manuscript. RV, MFB, and SCW contributed to the qFILM experiments. ET was responsible for mouse colony management. MVR, MDN, and MTG were involved in experimental design and manuscript writing. PS was responsible for experimental design, manuscript writing, and project supervision. TB and PS wrote the manuscript with consultation and contribution from all coauthors.
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