Early Responses of VEGF during Acute Lung Injury Induced by Seawater Immersion after Open Chest Trauma

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Key Words
Acute lung injury · Immersion, seawater · Open chest trauma · Vascular endothelial growth factor

Abstract
Background: Immersion in seawater after open chest trauma may induce acute lung injury. Higher osmotic pressure is one of the main characteristics of seawater. The effects of vascular endothelial growth factor (VEGF) on endothelial cell permeability and proliferation have been demonstrated in studies. The early responses and effects of the VEGF on acute lung injury induced by seawater immersion after open chest trauma (SWI-ALI) are unknown. Objective: To investigate the levels of VEGF and its receptors in SWI-ALI and further explore whether the levels of VEGFs are connected with the pathogenesis of SWI-ALI. Methods: We put dogs into group 'seawater' and group 'control'. The control group only suffered from open chest trauma, whereas the seawater group was exposed to seawater after trauma. The levels of total protein in plasma and bronchoalveolar lavage fluid were measured to calculate the pulmonary permeability index. 0, 2, 4, 6 and 8 h after open chest trauma, the plasma samples were collected to test the levels of VEGFs with ELISA kit. Western blotting and real-time RT-PCR were used to measure the VEGF levels in lung. Results: Compared with control animals, plasma osmotic pressure, VEGF and sVEGFR-1 significantly increased in plasma, while VEGF and VEGFR-2 significantly increased in seawater-immersion lung tissue. The levels of VEGF in plasma were significantly correlated with plasma osmotic pressure and pulmonary permeability index. Conclusion: Early release of VEGFs increases pulmonary vascular permeability and partially leads to the development of SWI-ALI. VEGFs may have a crucial role in the early onset of SWI-ALI.

Introduction

Acute lung injury (ALI) can result from a direct insult in the lung or an indirect insult from other organs mediated through the systemic circulation [1]. ALI is characterized by enhancement of pulmonary permeability and severe interstitial edema [2]. Seawater is a mixture of various salts and water, which has a salinity of 35 parts per thousand. Compared with the environment within mammals, seawater has a higher osmotic pressure, a lower temperature and an abundance of salts [3]. Seawater immersion after open chest trauma may induce acute lung...
VEGF Early Response in Acute Lung Injury

**Materials and Methods**

**Animal Models**

For all experiments, we used 16 healthy grown-up dogs, each weighing 15–20 kg. Dogs were purchased from Beijing KeYu animal cultivation center (The SCXF, Beijing, 2002), with no preference for sex. Dogs were housed in a conventional animal facility. Prior to experimental intervention, the dogs were allowed to acclimatize for at least 1 week in the animal facility to recover from transportation. All investigations involving experimental dogs were reviewed and approved by the institutional review board of Beijing Naval General Hospital Animal Care and Use Committee. All animals received care in compliance with the Principles of Laboratory Animal Care formulated by the National Society for Medical Research, and the Guide for the Care and Use of Experimental Animals formulated by the National Council on Animal Care.

These animals were randomized into a ‘seawater’ (SW) group and control group, with 8 animals grouping each. The animals in the control group only suffered from open chest trauma, whereas those in the SW group were exposed to seawater after open chest trauma.

The dog model of SWI-ALI was performed as previously described in detail [4]. Briefly, all animals were anesthetized with intramuscular injection of ketamine (20 mg/kg). Anesthesia was continuously maintained with ketamine throughout the experiment. The incision, 0.5 cm in diameter, was made with a sharp instrument in the forth intercostal of the right chest to form the opened pneumothorax in all experimental animals. In group SW, seawater (35 ml/kg) was infused into the pleural cavity. Then the incision skins of all experimental animals were sutured in 10 min. The right carotid artery was cannulated in every animals for measurement of mean arterial blood pressure. The right jugular vein was cannulated in every animal for drawing blood for analysis. The oxygen index (PaO₂/FiO₂), a ratio of arterial partial pressure of oxygen (PaO₂) to fraction of inspired oxygen (FiO₂) of ≤300 mm Hg (40 Kp) is the standard to prove the success of the SWI-ALI model.

The experimental seawater was made according to the standard of the Third Institute of Oceanography of the State Ocean Bureau: osmotic pressure was 1,250–1,350 mmol/l, pH was 8.20, proportion was 1.05–1.06. Laboratory temperature was 25 °C, man-made seawater temperature was 22 °C.

**Sample Collection**

Blood samples were collected at 0, 2, 4, 6 and 8 h after open chest trauma. Bronchoalveolar lavage (BAL) was performed by instilling 15 ml of saline through the endotracheal tube and gently aspirating back at 8 h after trauma. This was repeated twice. Later, 8 h after trauma, the dogs received intracardiac injection of 15 ml of 15% KCl and then were sacrificed. The lungs were removed for immunohistochemistry. BALF and blood samples were centrifuged at 3,000 g for 10 min, and the supernatant was stored at −20°C until measurement of protein concentration. Lung samples were stored at −80°C until use.

**Assessment of Acute Lung Injury**

The plasma osmotic pressure (POP) and electrolyte concentration were measured with blood samples collected at 0, 2, 4, 6 and 8 h after trauma. We measured the total protein concentration in BAL fluid and plasma collected at 8 h after trauma. We then calculated the protein concentration ratio of BAL/plasma, known as pulmonary permeability index (PPI).

**Enzyme-Linked Immunosorbent Assay**

VEGF and sVEGFR₃ levels were determined in plasma samples using an ELISA kit (dogs VEGF/sVEGFR₃; Sunbio, Beijing, China). An automatic multifunction microplate reader (Multiskan MK3, Thermo, USA) was used to read the value. Assays were performed in duplicate following the manufacturer’s instructions.
**Table 1. Reference sequence and primer sequences used for the oligonucleotide**

<table>
<thead>
<tr>
<th>Gene</th>
<th>Reference sequence</th>
<th>Sense primer</th>
<th>Antisense primer</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEGF</td>
<td>AF133250</td>
<td>5'-ggctgctgtgattagctagg-3'</td>
<td>5'-gggacgtccagagctat-3'</td>
</tr>
<tr>
<td>VEGFR-2</td>
<td>DQ269018</td>
<td>5'-atccagctacgcat-3'</td>
<td>5'-igtcatgctcctagaa-3'</td>
</tr>
<tr>
<td>GAPDH</td>
<td>NM001003142.1</td>
<td>5'-aacatccctctccag-3'</td>
<td>5'-gaccacggctcctcag-3'</td>
</tr>
</tbody>
</table>

**Table 2. The changes of VEGFs in plasma with timing (pg/ml) (n = 8, x ± s)**

<table>
<thead>
<tr>
<th>Groups</th>
<th>0 h</th>
<th>2 h</th>
<th>4 h</th>
<th>6 h</th>
<th>8 h</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEGF in control</td>
<td>23.75 ± 1.91</td>
<td>26.02 ± 2.59</td>
<td>26.09 ± 2.39</td>
<td>28.06 ± 3.65</td>
<td>27.28 ± 2.27</td>
</tr>
<tr>
<td>VEGF in SW</td>
<td>23.32 ± 2.03</td>
<td>31.43 ± 7.03</td>
<td>38.91 ± 4.75**</td>
<td>57.89 ± 12.69**</td>
<td>63.46 ± 10.16**</td>
</tr>
<tr>
<td>sVEGFR1 in control</td>
<td>0.56 ± 0.07</td>
<td>0.61 ± 0.12</td>
<td>0.69 ± 0.27</td>
<td>0.63 ± 0.16</td>
<td>0.61 ± 0.13**</td>
</tr>
<tr>
<td>sVEGFR1 in SW</td>
<td>0.60 ± 0.09</td>
<td>0.81 ± 0.15**</td>
<td>1.04 ± 0.21**</td>
<td>1.61 ± 0.28**</td>
<td>1.92 ± 0.32**</td>
</tr>
</tbody>
</table>

* p < 0.05, compared with the control group; ** p < 0.05, compared with the onset (0 h) in the same group.

**Immunohistochemistry**

For immunohistochemistry, lung tissue slides (5 μm) were pre-treated with 0.25% Triton X-100 for 5 min and blocked for endogenous peroxidase and biotin with 0.3% H2O2. The slides were incubated with designated primary antibodies, with a dilution of 1:100 for VEGF (sc-80439; Santa Cruz Biotechnology, Santa Cruz, Calif., USA), for overnight at 4°C, and then with a secondary antibody for 1 h. PVDF were incubated with the designated primary antibodies (mouse monoclonal antibody against VEGF of dog, sc-80439; Santa Cruz Biotechnology) at 1:1,000 dilution overnight at 4°C. The blot was washed with TBS-T containing 0.05% Tween 20 and incubated for 2–3 h at room temperature with horseradish peroxidase-conjugated goat anti-mouse (1:3,000 dilution) IgG (ZB-2301; Zhong Shan Biotechnology, Beijing, China). After washing, the blots were visualized with an enhanced chemiluminescence detection kit (ZLI-9032; Zhong Shan Biotechnology). We stripped and reprobed blots with antibody for β-actin as a control. Autoradiographs were quantified by using a densitometer (GS-690; Bio-Rad Laboratories) and normalized to the β-actin control.

**Real-Time RT-PCR to Detect mRNA Synthesis of Encoding VEGFs**

Quantitative real-time RT-PCR analysis of the mRNA expression of VEGF and VEGFR-2 were performed on RNA isolated from frozen lung tissue. Total RNA of tissue was extracted by using the RNA Extraction Kit (RNO302; Biomed). Total RNA was quantified at 260 and 280 nm, and sample integrity was checked by using 1% agarose gel electrophoresis. Total RNA (2 μg) was converted to cDNA; the reaction volume contained: 5 units of Moloney murine leukemia virus (MMLV) reverse transcriptase (Promega M170A) and 0.5 μg oligo deoxythymidine. The reaction continued for 1 h at 37°C. Reverse transcriptase-generated cDNAs encoding VEGF and GAPDH (used as a control of RNA integrity and internal standard) were amplified by PCR. Amplification of 5 μl of cDNA was performed using 0.2 nM sense and antisense VEGF primers and 2.5 units of Taq polymerase. The oligonucleotide primer sequences are shown in table 1. Samples were amplified for 40 PCR cycles. A 5-ml aliquot from each PCR reaction was subjected to polyacrylamide gel electrophoresis and visualized by autoradiography. Their authenticity was confirmed by direct nucleotide sequencing. All real-time RT-PCR studies were performed at least 4 times, using lung RNA from different animals.

**Statistical Analyses**

All data are expressed as mean ± standard deviation and were analyzed with SSPS 10.0 software. Two-way repeated measures analysis of variance (ANOVA) followed by Dunnett’s test for multiple time points observation or Student’s t test for single time point observation, and correlation among variables was assessed with Pearson’s correlation analysis (2-tailed). p values <0.05 were regarded as significant.
Results

VEGF Expression Is Up-Regulated in the Early Onset of SWI-ALI

Detection of Expression of VEGF and sVEGFR₁ in Plasma by ELISA

Expression patterns of VEGF and its soluble receptor (sVEGFR₁) in plasma from both the control and seawater groups are shown in table 2. Plasma levels of the investigated molecules were increased with time after trauma. There is a negligible increase in control animals. A significant increase of the VEGF and sVEGFR₁ levels was found in the seawater group, especially at 4 h after trauma, and achieved their peak at 6–8 h. The increase was significantly greater than that in the control group (p < 0.05).

Detection of Expression of VEGF in Lung Tissue by Immunohistochemistry

Figure 1 provides an overall impression of the changes of VEGF in different groups through the staining intensities in lung tissue. In control animal lungs (a), the alveolus structure retained its integrity, with mild capillary vessel congestion, there was little edema and few inflammatory cells in the alveolar spaces. The VEGF-positive reaction expression spot is less intense. In the SW animal lung tissue (b), there are visible interstitial and intra-alveolar edema and a greater area of VEGF-positive reaction expression. The quantization value suggested that there was a significant difference between the SW and control groups (27,744.75 ± 5,222.84 vs. 12,103.72 ± 551.93, p < 0.05).

Fig. 1. Immunohistochemistry for VEGF in the lung. VEGF-positive expression in lung was stained brown. Sections of lung from control dogs (a) and SW dogs (b) are shown with immunohistochemistry. Figure 1 provides an overall impression of the changes of VEGF in different groups through the staining intensities in lung tissue. In control animal lungs (a), the alveolus structure retained its integrity, with mild capillary vessel congestion, there was little edema and few inflammatory cells in the alveolar spaces. The VEGF-positive reaction expression spot is less intense. In the SW animal lung tissue (b), there are visible interstitial and intra-alveolar edema and a greater area of VEGF-positive reaction expression. The quantization value suggested that there was a significant difference between the SW and control groups (27,744.75 ± 5,222.84 vs. 12,103.72 ± 551.93, p < 0.05).
Detection of mRNA Synthesis of Encoding VEGF Proteins in Lung Tissue by RT-PCR

The mRNA synthesis encoding VEGF and VEGFR-2 protein in lung tissue were significantly increased in the SW group (fig. 2, table 3). VEGF mRNA: SW vs. control, $5.04 \pm 0.29$ vs. $0.25 \pm 0.04$, $p < 0.05$. VEGFR-2 mRNA: SW vs. control, $5.08 \pm 0.20$ vs. $5.08 \pm 0.20$, $p < 0.05$.

Correlation of VEGF with POP and PPI

We assessed the correlations among the level of VEGF protein in plasma, the POP and PPI with Pearson’s correlation analysis. POP was significantly positively correlated with PPI, with a Pearson’s correlation coefficient of...
VEGF protein levels in plasma were significantly positively correlated with PPI and POP (VEGF with PPI correlation coefficient = 0.596, p = 0.015; VEGF with POP correlation coefficient = 0.917, p = 0.000).

Discussion

Our experiment was the first attempt to investigate the levels of VEGF and its receptors in ALI induced by seawater immersion after open chest trauma. We chose dogs to duplicate SWI-ALI as they are a robust model that does not die quickly after trauma and seawater immersion. Further, large animals provide a model that is close to the clinical situation in humans.

We observed a significant increase of VEGF and sVEGFR1 in plasma of SWI-ALI. Increased VEGF levels in plasma from our results agree with some studies in ARDS patients [15] or animal models of ALI induced by other etiologies [16, 17]. The mechanism of increased VEGF levels in plasma may be associated with the following 2 factors: one is that alveolar macrophages and neutrophils are both potential sources of VEGF in ALI, and the activated alveolar macrophages and neutrophils produce plentiful VEGF [9, 15, 18]; the other factor is that a widespread destruction of the alveolar epithelial membrane in ALI leads to increased VEGF through a transepithelial VEGF gradient [19]. We also found that the levels of VEGF and VEGFR-2 increased in the lung tissue of SWI-ALI. The results seem contrary to other studies. The down-regulation of VEGF has been noted in ARDS patients [15] or in mouse lungs at 24 and 72 h after lipopolysaccharide injection [20]. There are 3 mechanisms to explain VEGF down-regulation during the critical phase of ALI. First, direct injury of alveolar epithelial cells and subsequent acute inflammatory responses may lead to cell death. As a result, death of alveolar epithelial cells may limit the production of VEGF in the lung [21]. Second, proteases released by the active neutrophils from acute inflammatory responses may cleave VEGF [22, 23]. Third, the breached alveolar epithelium leads VEGF to plasma through a transepithelial VEGF gradient. Studies from animal models as well as from ARDS patients have shown that decreased levels of VEGF in the lung are associated with a worse prognosis [21, 24]. Nevertheless, increases were noted not only in the VEGF protein levels (by Western blotting), but also the synthesis of mRNA encoding VEGF and VEGFR-2 protein (detected by real-time RT-PCR). So we speculate that the differences between our observation and other results may be explained by different timing after ALI/ARDS developed. Our present study was limited to the early onset of SWI-ALI, in the first 6–8 h. During the beginning of ALI, the activated alveolar macrophages and neutrophils produce plentiful VEGF in lung tissue [9], and the breach in the alveolar epithelium leads to VEGF being released from cytoplasm to the interstitial fluid [19]. These cause VEGF to be up-regulated in injured lung tissue. However, with the development of SWI-ALI, the levels of VEGF in the lung might decrease at the critical phase instead of increase at early-onset stage of SWI-ALI. This needs to be identified in our next work. In this study, we have detected, on the early onset of SWI-ALI, that the level of VEGF is up-regulated whether in plasma or in lung tissue.

The pleural space is a potential space within a closed environment. The volume of fluid in the pleural space is small, in the range of 0.2–0.5 ml. Mechanical disruption, or excess air, may induce inflammatory response and changes in the delicate environment. Inflammatory responses following the insult to the pleural space include release of chemokines to recruit neutrophils, mononuclear cells, and lymphocytes as well as the release of cytokines such as interleukin [25]. In our experiment, the levels of Na+ and Cl− in plasma and POP increased soon after immersion in seawater, attained a homeostasis in 2 h after trauma, and maintain the state throughout the process. It has been shown that seawater immersion after open chest trauma might worsen the changes in the delicate homeostatic balance of the pleural space and lung, lead to serious injury of pleural mesothelium and lung parenchyma and increase the pulmonary permeability. Therefore, the PPI has a significant positive correlation with POP.

The increased VEGF in the plasma was significantly positively correlated with PPI. Lung over-expression of VEGF contributes to protein leakage in the lung and the development of pulmonary edema by changing the state of the adherens junction complexes on the endothelium [23], and increases lung vascular permeability. The increased VEGF in the plasma was also significantly positively correlated with POP. It suggests that this change may be related to higher osmotic pressure after seawater immersion. The environment of higher plasma osmotic pressure induced by seawater immersion worsens the lung injury through enhancing the VEGF level and the alveolus-capillary membrane permeability. Hence, we conclude that seawater, which is characterized by higher osmotic pressure and abundance of salts, contributes to the elevated VEGF and PPI, and further develops to SWI-ALI.
**Conclusion**

This study has shown for the first time that increasing VEGF levels in intrapulmonary and plasma are associated with the early onset of SWI-ALI and elevated VEGF in plasma would be expected to contribute to abnormal capillary permeability. We speculate that significant and dynamic changes of the VEGF levels represent a marker of acute lung injury. VEGF may have diverse effects on different stages. We only collected plasma and lung tissue on the early onset of SWI-ALI and thus are unable to evaluate the levels and effects of VEGF on other phases of SWI-ALI. Therefore, further investigation is required to address the levels and effects of VEGF on other phases and to expound the intricate role of the VEGF system in SWI-ALI.

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**References**