Estimation of Systemic Complement C3 Activity in Age-Related Macular Degeneration

Sobha Sivaprasad, FRCS; Temi Adewoyin, MRCOphth; Tracey A. Bailey, PhD; Sam S. Dandekar, FRCOphth; Sharon Jenkins, MSc; Andrew R. Webster, FRCOphth; Ngaihang Victor Chong, FRCOphth

Objectives: To determine the role of systemic complement activation in the pathogenesis of age-related macular degeneration and to examine whether serum C3a des Arg reflects systemic complement activation, independent of individual complement component levels.

Methods: Plasma complement C3a des Arg levels and a single nucleotide polymorphism at position 402 of the complement factor H gene (CFH) were determined in 3 groups of subjects: 42 subjects with early age-related maculopathy, 42 subjects with neovascular (wet) age-related macular degeneration, and a control group of 38 subjects with no clinical evidence of age-related changes at the macula.

Results: The median (range) of plasma complement C3a des Arg levels in the age-related maculopathy and neovascular age-related macular degeneration groups were 52.6 (2.8-198.1) ng/mL and 60.9 (3.1-173.1) ng/mL, respectively. The levels were significantly raised compared with the control group (n=38), which had a median (range) plasma complement C3a des Arg level of 40.3 (6.1-81.7) ng/mL (analysis of variance, P=.02). The concentration of plasma C3a des Arg did not differ significantly between those with different CFH genotypes (P=.07).

Conclusion: Systemic activation of the complement system may contribute to the pathogenesis of age-related macular degeneration independent of CFH polymorphism.

Clinical Relevance: The results of this study may be relevant to aiming new treatment strategies toward reducing systemic low-grade inflammation.

Arch Ophthalmol. 2007;125:515-519
may also be associated with reduced risk of early or late AMD,16 although the link between the total serum cholesterol concentration and AMD remains unproven.17,18

Table 1. Stages of Age-Related Macular Degeneration

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Median (Range)</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0a</td>
<td>No signs of ARM</td>
<td>40.3 (6.1-81.7)</td>
<td>35.8 (23.4)</td>
</tr>
<tr>
<td>0b</td>
<td>Hard drusen (&lt;63 µm) only</td>
<td>52.6 (2.8-198.1)</td>
<td>67.0 (59.2)</td>
</tr>
<tr>
<td>1a</td>
<td>Soft distinct drusen (≥63 µm) only</td>
<td>60.9 (3.1-173.1)</td>
<td>68.3 (44.0)</td>
</tr>
<tr>
<td>1b</td>
<td>Pigmentary abnormalities only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a</td>
<td>Soft indistinct drusen (≥125 µm) or reticular drusen only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2b</td>
<td>Soft distinct drusen (≥125 µm) with pigmentary abnormalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Soft indistinct drusen (≥125 µm) or reticular drusen with pigmentary abnormalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Atrophic or neovascular AMD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: AMD, age-related macular degeneration; ARM, age-related maculopathy.

Table 2. Plasma C3a des Arg and C3 des Arg Levels in the 3 Disease States

<table>
<thead>
<tr>
<th>Disease State</th>
<th>Plasma C3a des Arg Level</th>
<th>Median (Range), ng/mL</th>
<th>Mean (SD), ng/mL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control (n = 38)</td>
<td></td>
<td>40.3 (6.1-81.7)</td>
<td>35.8 (23.4)</td>
</tr>
<tr>
<td>ARM (n = 42)</td>
<td></td>
<td>52.6 (2.8-198.1)</td>
<td>67.0 (59.2)</td>
</tr>
<tr>
<td>Neovascular AMD (n = 42)</td>
<td></td>
<td>60.9 (3.1-173.1)</td>
<td>68.3 (44.0)</td>
</tr>
</tbody>
</table>

Abbreviations: AMD, age-related macular degeneration; ARM, age-related maculopathy.

Color fundus photographs of the subjects were graded by 2 graders (S.S. and T.A.) using the nomenclature and classification recommended by the International ARM Epidemiological Study Group.19 Table 1 shows the classification used in this cohort. Subjects with stages 0a and 0b were categorized as the control group. Early age-related maculopathy was defined as the presence of stage 2b or 3. Neovascular AMD included subjects with newly diagnosed CNV. The graders were masked of the age and clinical history of the participants. Double grading for intraobserver and interobserver variability was performed. Discrepancies were resolved by discussion. If the grades in the 2 eyes were different, the subject was categorized according to the severity of changes in the worse eye.

BLOOD SAMPLES

Venous blood was collected from all of the subjects in heparin tubes (BD Diagnostics, Oxford, England), it was centrifuged for 15 minutes at 2000g at 4°C, and the plasma was aliquotted and stored at −70°C within an hour of collection and then thawed when required. The C3a des Arg at −70°C was stable up to 3 months from the date of collection. The samples were randomized so that the scientist (S.S. or T.A.B.) who analyzed the samples was masked to the clinical history of the subjects.

COMPETITIVE ENZYME-LINKED IMMUNOSORBENT ASSAY

A commercially available competitive enzyme-linked immunosorbent assay (ELISA) kit (Metachem Diagnostics, Ltd, Northampton, England) was used for the assay of plasma C3a des Arg. A brief outline of the assay design is explained here. Plasma proteins were precipitated from the sample with 10 N hydrochloric acid and 9 N sodium hydroxide, as whole proteins compete with the complement in the assay. The supernatant was then diluted 1:20–fold in fresh tubes. Microtiter plates coated with goat antibody specific to rabbit IgG were used in this competitive ELISA. First, 100 µL of the serially diluted standards and the diluted samples were placed in each well in duplicate. Controls included zero standard (B0) and assay buffer only (for nonspecific binding). Then, 50 µL of alkaline phosphatase conjugated with C3a des Arg was added to each well except the blank wells. The capture antibody used was 50 µL of rabbit polyclonal antibody to C3a des Arg. The plate was then incubated at room temperature for 2 hours at 300 rpm. After that, 3 washes with 200 µL of wash buffer (0.5 mL v/v 0.05% Tween in 1 L of tris-buffered saline) to each well were performed. Then, 200 µL of p-nitrophenylphosphate substrate solution (p-nitrophenylphosphate in buffer) was added to each well and incubated at 37°C for 1 hour followed by the addition of 50 µL of stop solution (trisodium phosphate in water) to each well. Absorbance was read at 405 nm using an automated plate reader (Dynex Technologies, West Sussex, England).

CALCULATION OF RESULTS

The net optical density (OD) bound for each standard and sample was calculated by subtracting the average nonspecific binding OD from the average bound OD. The percentage bound was calculated as net OD/net B0. OD × 100.

The standard curve was then plotted on a logarithmic graph of percentage bound vs concentration of human C3a des Arg for standards. The concentrations of plasma C3a des Arg in the samples were determined by interpolation. The correlation coefficient for the standard curve was 0.989. The mean intra-
The assay and interassay coefficients of variation were 11.2% and 28.8%, respectively.

The ELISA was repeated thrice on the same day and on 3 separate days to note the precision and reproducibility of the ELISA. The minimum detectable limit for C3a des Arg concentration was 0.120 ng/mL. The cross reactivity value with complement C3 was 1.28%. All of the randomized samples were assayed in triplicate using a total of 4 assay kits and performed in 2 days.

AMPLIFLUOR GENOTYPING TECHNIQUE FOR SINGLE NUCLEOTIDE POLYMORPHISM TYPING

Genomic DNA was extracted from peripheral blood leukocytes by using a standard protocol. Primers to identify the CFH Tyr402His single nucleotide polymorphism variant (rs1061170) were designed using an amplifluor assay (KBioSciences, Hertfordshire, England).

STATISTICAL ANALYSIS

The SPSS version 11.0 statistical software (SPSS, Inc, Chicago, Ill) was used for the analysis. The data were not normally distributed. Results of plasma C3a des Arg concentrations were reported as medians in the 3 groups and tested by analysis of variance. To assess the significance of the association between plasma C3a des Arg concentration and disease in each genotype category, linear regression analysis was performed after square root transformation of the outcome variable. Disease state was treated as a 3-level categorical variable with the control group as the baseline. One-way analysis of variance was performed to test the association between genotype and serum C3 levels. Statistical significance was set at 95% (P<.05).

RESULTS

CHARACTERISTICS OF SUBJECTS

Plasma complement C3a des Arg concentrations were analyzed in 122 subjects, including 42 with age-related maculopathy, 42 with neovascular AMD, and 38 controls. Age and sex distributions were similar in both groups of AMD and controls. The CNV group was evenly distributed in the 3 genotype groups (P=.72).

The results of this study suggest that plasma complement C3a des Arg concentration increases in subjects with AMD compared with age-matched controls. The estimation of plasma C3a des Arg concentration reflects systemic
complement activation, independent of individual complement component levels. The liver is the main source of complement synthesis, and the complement molecules constitute approximately 5% of the total serum proteins. Many extrahepatic cells such as monocytes, endothelial cells, epithelial cells, glial cells, and neurons also produce complements. Although plasma C3a des Arg concentration is only an indirect estimation of systemic complement activation, our study suggests that systemic activation of the complement system may play a role in the pathogenesis of AMD. Products of the complement cascade serve as a powerful chemotactic stimulus, reinforcing the inflammatory process. In addition, sublethal injury by complement proteins permits the release of growth factors.

Evidence from several studies shows that complements are involved in the pathogenesis of AMD. Drusen, the hallmark of AMD, constitute many components of the complement cascade including C3 complement fragments. Components of chronically sequestrated debris in AMD may be potential activators of the proteolytic cascade, including apoptotic cells, nuclear fragments, and membrane-bound vesicles. The results of our study suggest that systemic metabolic end products may also serve as powerful chemotactic stimuli for leukocytes via the complement cascade.

Complement activation has also been shown in a murine model of laser-induced CNV in C57BL/6 mice. Nozaki et al provided evidence that resident retinal pigment epithelial cells are the primary source of complement activation in a mouse model of CNV. Our study suggests that increased systemic C3 activation may augment the disease process in AMD.

Complement factor H is the main regulator of the activation of C3. Therefore, complement factor H deficiency would allow unhindered activation of C3. However, the results of our study showed that systemic C3 activation is not significantly influenced by the CFH genotype in AMD. It may be that the effects of the CFH polymorphism in AMD are manifested locally. The major weakness of this study is that C3a des Arg concentration is an indirect measure of C3 activation. Although to our knowledge this is the first study that reveals an association of systemic complement activation with AMD, it is difficult to make wide-ranging conclusions or assumptions based on these observations in view of the extreme variability in normative data of serum complements. However, this is an important starting point. Larger-scale future studies will be required to clarify the emerging relationship between C3 activation and AMD.

Submitted for Publication: June 4, 2006; final revision received July 22, 2006; accepted August 17, 2006.

Correspondence: Sobha Sivaraprasad, FRCS, Laser and Retinal Research Unit, King’s College Hospital, King’s College London, Denmark Hill, London SE5 9RS, England (senswathi@aol.com).

Financial Disclosure: None reported.

REFERENCES


Archives Web Quiz Winner

Congratulations to the winner of our November quiz, Ozgur Bulent Timucin, MD, Department of Ophthalmology, Uludag University, Bursa, Turkey. The correct answer to our November challenge was tuberculosis uveitis. For a complete discussion of this case, see the Clinicopathologic Reports, Case Reports, and Small Case Series section in the December ARCHIVES (Andreoli M, Husain D, Davis T, Loewenstein J. Chorioretinal changes heralding metastatic malignancy. Arch Ophthalmol. 2006;124:1790-1792).

Be sure to visit the Archives of Ophthalmology Web site (http://www.archophthalmol.com) and try your hand at our Clinical Challenge Interactive Quiz. We invite visitors to make a diagnosis based on selected information from a case report or other feature scheduled to be published in the following month’s print edition of the ARCHIVES. The first visitor to e-mail our Web editors with the correct answer will be recognized in the print journal and on our Web site and will also be able to choose one of the following books published by AMA Press: Clinical Eye Atlas, Clinical Retina, or Users’ Guides to the Medical Literature.