Table 2 Risk factors for HCC development in all HBV-infected patients by univariate analysis

Factor	95% CI	*p* value
Age (years) (<50/≥50)	2.15–14.5	<0.001
Sex (male/female)	0.33–1.76	0.520
Initial diagnosis (chronic hepatitis/cirrhosis)	3.75–1.176	<0.001
HBe Ag (positive/negative)	0.31–1.29	0.209
HBV DNA (log copies/ml) (<7.0/>7.0)	0.33–1.35	0.262
AST (IU/l) (<40/≥40)	0.33–2.22	0.742
ALT (IU/l) (<40/≥40)	0.17–1.16	0.188
Total bilirubin (mg/dl) (<1.2/>1.2)	1.43–6.72	0.004
Alb (g/dl) (<3.8/≥3.8)	0.19–0.86	0.019
Platelets ($\times 10^4$/mm^3) (<14/≥14)	0.02–0.31	<0.001
Emergence of LAM-resistant viruses (positive/negative)	0.51–2.03	0.968
IVR (positive/negative)	0.52–3.25	0.575
MVR (positive/negative)	1.04–5.95	0.035

HCC Hepatocellular carcinoma, *HBV* hepatitis B virus, *CI* confidence interval, *HBe Ag* hepatitis B e antigen, *HBV* hepatitis B virus, *AST* aspartate aminotransferase, *ALT* alanine aminotransferase, *Alb* albumin, *IVR* initial viral response, *MVR* maintained viral response, *LAM* lamivudine

Table 3 Risk factors for HCC development in all HBV-infected patients by multivariate analysis

Factor	Category	Risk ratio	95% CI	*p* value
Age (years)	<50	1	1.08–9.53	0.036
	≥50	3.20		
Initial diagnosis	Chronic hepatitis	1	1.75–12.4	0.002
	Cirrhosis	4.64		
Platelets ($\times 10^4$/mm^8) (<14/≥14)	≥14	1	0.05–0.96	0.045
	<14	4.76		
MVR	Negative	1	1.09–6.56	0.032
	Positive	0.37		

HCC Hepatocellular carcinoma, *HBV* hepatitis B virus, *CI* confidence interval, *MVR* maintained viral response

Cumulative incidence of HCC development according to effectiveness of treatment (MVR vs. non-MVR)

Figure 2a shows the Kaplan–Meier curve of cumulative HCC incidence in all HBV-infected patients treated with LAM according to the effectiveness of treatment (MVR vs. non-MVR). The cumulative carcinogenesis rate for MVR-positive patients was 2% at 3 years, 4% at 5 years, and 6% at 7 years. On the other hand, the cumulative carcinogenesis rate for MVR-negative patients was 5% at 3 years, 13% at 5 years, and 16% at 7 years. MVR during LAM significantly suppressed the cumulative HCC incidence compared with non-MVR in all HBV-infected patients ($p = 0.035$).

Table 4 Risk factors for HCC development by univariate analysis (chronic hepatitis/cirrhosis)

	95% CI	*p* value
Chronic hepatitis		
Age (years) (<50/≥50)	0.26–8.38	0.002
Sex (male/female)	0.37–6.42	0.556
HBe Ag (positive/negative)	0.01–0.74	0.005
HBV DNA (log copies/ml) (<7.0/≥7.0)	0.11–1.99	0.296
AST (IU/l) (<40/≥40)	0.11–2.64	0.482
ALT (IU/l) (<40/≥40)	0.06–1.41	0.101
Total bilirubin (mg/dl) (<1.2/≥1.2)	0.67–6.67	0.574
Alb (g/dl) (<3.8/≥3.8)	0.13–8.58	0.960
Platelets ($\times 10^4$/mm^3) (<14/≥14)	0.01–0.72	0.004
Emergence of LAM-resistant viruses (positive/negative)	0.27–4.28	0.927
IVR (positive/negative)	0.29–8.67	0.590
MVR (positive/negative)	0.51–37.10	0.144
Cirrhosis		
Age (years) (<50/≥50)	0.86–6.17	0.089
Sex (male/female)	0.21–1.82	0.380
HBe Ag (positive/negative)	0.80–4.17	0.149
HBV DNA (log copies/ml) (<7.0/≥7.0)	0.40–2.01	0.795
AST (IU/l) (<40/≥40)	0.27–3.07	0.873
ALT (IU/l) (<40/≥40)	0.13–1.47	0.167
Total bilirubin (mg/dl) (<1.2/≥1.2)	0.82–4.80	0.126
Alb (g/dl) (<3.8/≥3.8)	0.28–1.58	0.354
Platelets ($\times 10^4$/mm^3) (<14/≥14)	0.03–1.51	0.084
Emergence of LAM-resistant viruses (positive/negative)	0.44–2.18	0.948
IVR (positive/negative)	0.90–8.32	0.063
MVR (positive/negative)	1.07–0.029	

HCC Hepatocellular carcinoma, *HBV* hepatitis B virus, *CI* confidence interval, *HBe Ag* hepatitis B e antigen, *HBV* hepatitis B virus, *AST* aspartate aminotransferase, *ALT* alanine aminotransferase, *Alb* albumin, *IVR* initial viral response, *MVR* maintained viral response

Figure 2b shows the Kaplan–Meier curve of the cumulative HCC incidence in chronic hepatitis patients according to the effectiveness of treatment (MVR vs. non-MVR). The cumulative carcinogenesis rate for MVR-positive patients was 0% at 3 years, 0% at 5 years, and 2% at 7 years. On the other hand, the cumulative carcinogenesis rate for MVR-negative patients was 2% at 3 years, 4% at 5 years, and 6% at 7 years. MVR during LAM did not significantly suppress the cumulative HCC incidence compared with non-MVR in the chronic hepatitis patients ($p = 0.144$).

Figure 2c shows the Kaplan–Meier curve of the cumulative HCC incidence in cirrhosis patients according to the effectiveness of treatment (MVR vs. non-MVR).

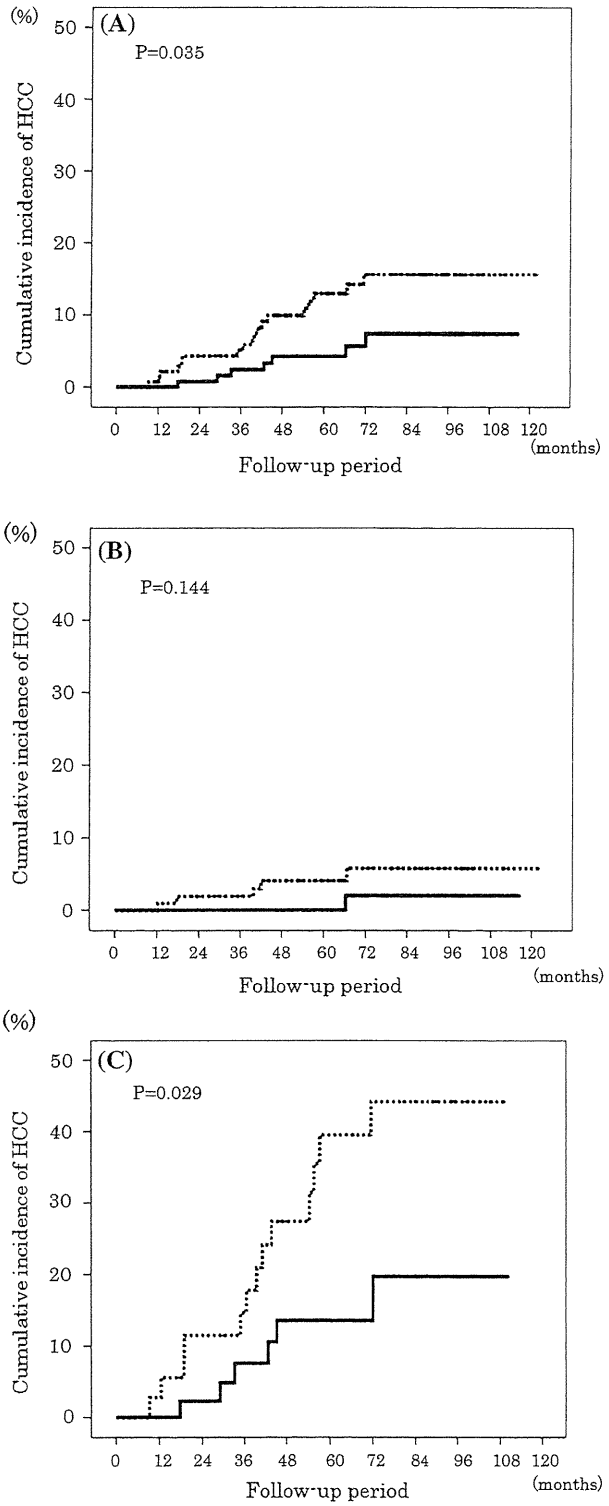

Fig. 2 Cumulative incidence of development of HCC according to the effectiveness of treatment (MVR vs. non-MVR). **a** All cases; **b** chronic hepatitis; **c** cirrhosis. *Solid lines* MVR, *dotted lines* non-MVR. *MVR* Maintained viral response

The cumulative carcinogenesis rate for MVR-positive patients was 8% at 3 years, 14% at 5 years, and 14% at 7 years. On the other hand, the cumulative carcinogenesis rate for MVR-negative patients was 18% at 3 years, 40% at 5 years, and 44% at 7 years. MVR during LAM significantly suppressed the cumulative HCC incidence compared with non-MVR in the cirrhosis patients ($p = 0.029$).

Relationship between IVR and MVR

Maintained viral response (MVR) was achieved by 142 (48%) of the 293 patients enrolled in this study. IVR was achieved by 204 (79%) of the 259 patients who were examined for IVR. The relationship between IVR and MVR is shown in Fig. 3; 60% (122/204) of the IVR-positive patients achieved an MVR, while only 16% (9/55) of the IVR-negative patients achieved an MVR ($p < 0.001$). The LAM-resistant YMDD mutant virus was found in 149 (51%) of all patients during follow-up, and in 52% (107/204) of the IVR-positive patients, a finding which was nearly equal to that for the IVR-negative patients (51%, 28/55). Among the IVR-positive patients, the MVR rate was lower in patients with the YMDD mutation, compared with that in those without the YMDD mutation (44%, 47/107 vs. 77%, 75/97, $p = 0.016$), while the MVR rates were low in the IVR-negative patients, irrespective of their YMDD mutation status (with and without the mutation, 15 vs. 18%, respectively). ADV was added to LAM treatment for 73 (68%) of the 107 IVR-positive patients with the YMDD mutation and 20 (36%) of the 55 IVR-negative patients with the YMDD mutation. However, MVR was only achieved at the low rates of 33% (24/73) for the former patients and 20% (4/20) for the latter.

Discussion

Lamivudine treatment has been shown to improve the liver histological findings in patients with HBV-infected liver disease by reducing the HBV load and stabilizing inflammatory activity [16–18]. One report has shown that LAM effectively reduced the incidence of HCC in patients with chronic hepatitis B, but the study only compared LAM-treated patients with non-treated patients in a matched case-controlled study [19]. However, there have been few detailed reports about the relationship between virological response and HCC development in HBV-infected patients during LAM treatment. In the present study, we retrospectively examined the incidence of HCC to clarify the indicators of LAM therapy, including median HBV-DNA levels, for reducing the risk of HCC in HBV-infected patients.

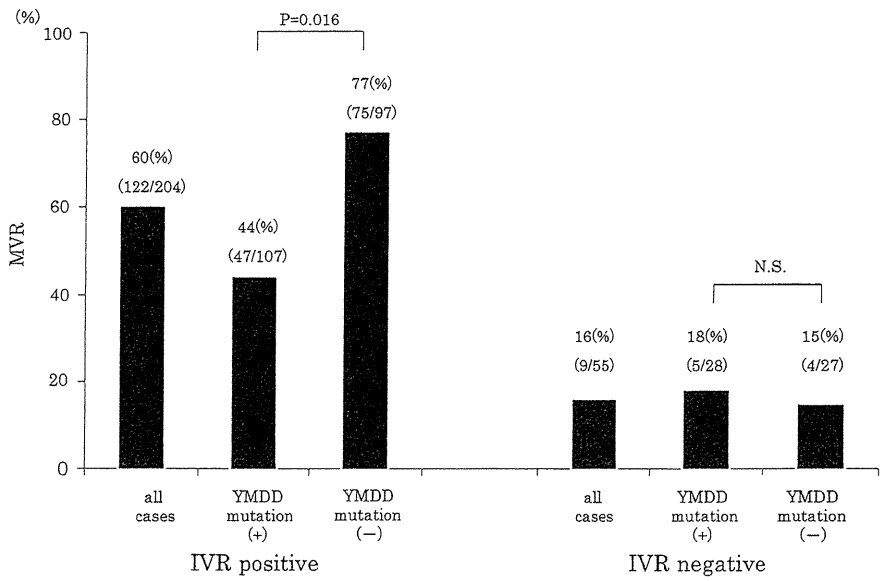

Fig. 3 Relationship between IVR and MVR. *IVR* Initial viral response, *MVR* maintained viral response, *N.S.* not significant

Many investigators have reported that serum HBV DNA levels higher than 4.0–4.5 log copies/ml before HBV treatment serve as a strong risk predictor of HCC [23–25]. Di Marco et al. [26] have reported that the incidence of HCC was higher in patients with serum HBV levels of more than 5.0 log copies/ml, at least once, during LAM therapy than in those in whom serum HBV levels were maintained at 5.0 log copies/ml or less. However, the add-on ADV therapy had not been adopted when the study of Di Marco et al. was reported. When the use of ADV is possible, an evaluation method is needed to measure the antiviral effects of nucleoside/nucleotide analogues against HBV-related liver disease. In the present study, we set the cut-off value for HBV-DNA at 4.0 log copies/ml. The basis of this cut-off value is that a serum HBV DNA level higher than 4.0 log copies/ml before HBV treatment was reported to serve as a strong risk predictor of HCC [23]. MVR, defined as a median HBV-DNA level of less than 4.0 log copies/ml measured every 6 months during therapy, was adopted as an indicator of viral replication, and non-MVR (median HBV-DNA >4.0 log copies/ml) during LAM therapy was shown to be significantly associated with the development of HCC in HBV-infected patients. We also found that a median HBV-DNA level of >4.0 log copies/ml during LAM therapy was a risk factor for HCC development. On the other hand, IVR, defined as HBV-DNA of <4.0 log copies/ml in the first 6 months of the follow-up period after the initiation of therapy, was not associated with the development of HCC in HBV patients in this study. As shown in Fig. 3, 84% of the IVR-negative patients could not achieve an MVR, suggesting that it is crucial to achieve an IVR in order to achieve an MVR. The reason why IVR was not a significant factor for MVR seemed to be the appearance of the YMDD mutation, which reduced the antiviral effect of LAM for HBV in IVR-positive patients. The LAM-resistant YMDD mutant virus was found in 52% of the IVR-positive patients. Although ADV was added to LAM treatment for 73 patients, only 33% of these patients could achieve an MVR. We speculate that the antiviral effect of ADV is not very strong [27] and it takes time to reduce the YMDD mutant virus, which may explain the low MVR rate (33%) in patients with the add-on ADV therapy. The immediate administration of ADV when the LAM-resistant YMDD mutant virus appears can be important [28]. A switch to ETV, which induces resistant virus less frequently, could also raise MVR rates among IVR-positive patients without the YMDD mutant virus.

As the duration of the add-on ADV therapy was included in this study, we compared the cumulative incidence of HCC in patients receiving LAM monotherapy with that in patients who also received the add-on ADV therapy. Sixteen (10%) of the 164 patients who received the LAM monotherapy developed HCC and the cumulative carcinogenesis rate was 6% at 3 years, 10% at 5 years, and 15% at 7 years. On the other hand, 16 (12%) of the 129 patients who received LAM plus ADV developed HCC and the cumulative carcinogenesis rate was 6% at 3 years, 12% at 5 years, and 14% at 7 years. No significant difference was found between these two groups ($p = 0.986$). In addition, we examined the cumulative incidence of HCC development according to the effectiveness of treatment (MVR vs. non-MVR) in patients for whom the observation period was terminated when ADV was added, and the same results were obtained (data not shown).

Older age (≥50 years), cirrhosis, and low platelet count ($<14 \times 10^4/mm^3$) were shown to be significantly associated with the development of HCC in patients with HBV infection. These results were consistent with those of

previous reports [29–31], suggesting that patients of older age with advanced fibrosis should be followed up carefully for longer periods in order to detect early stages of HCC even if LAM therapy does effectively suppress HBV. Of note, in the present study we estimated the cumulative HCC incidence according to the initial diagnosis of chronic hepatitis or cirrhosis. In the chronic hepatitis patients, older age (≥50 years), HBe Ag negativity, and low platelet count ($<14 \times 10^4/mm^3$) were significant risk factors for the development of HCC, but this was not the case in the cirrhosis patients. Because liver biopsies had not been performed, the liver fibrosis stage could not be evaluated with respect to the risk factors for HCC in this study. Instead, the factors of age, HBe Ag status, and platelet count may reflect the degree of liver fibrosis in chronic hepatitis patients. In fact, cirrhotic patients, in comparison with chronic hepatitis patients, were of older age (chronic hepatitis vs. cirrhosis: 46.3 ± 10.7 vs. 51.9 ± 9.8 years, $p < 0.001$), had higher rates of HBe Ag negativity (chronic hepatitis vs. cirrhosis: 39 vs. 51%, $p = 0.065$), and had lower platelet counts (chronic hepatitis vs. cirrhosis: 15.6 ± 4.9 vs. $9.3 \pm 3.8 \times 10^4/mm^3$, $p < 0.001$). This seems to explain why none of these factors were significant risk factors for HCC in cirrhotic patients. On the other hand, in the chronic hepatitis patients, MVR was not a significant factor for HCC development, while MVR was a significant factor for HCC development in the cirrhotic patients. We speculate that HBV suppression induced by LAM therapy could reduce the incidence of HCC in patients infected with HBV, especially those with cirrhosis, who displayed higher malignant potential. Investigation over a longer period is needed to clarify the effect of HBV suppression on the development of HCC in chronic hepatitis patients.

In conclusion, the present study shows that the attainment of an MVR induced by LAM therapy has a significant beneficial effect on the clinical course of HBV-infected patients by decreasing the incidence of HCC. The newer nucleotide analogues, such as ETV and tenofovir, should be able to further reduce the incidence of HCC, given their greater potency.

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Conflict of interest The authors declare that they have no conflict of interest.

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Delayed-Onset Caspase-Dependent Massive Hepatocyte Apoptosis upon Fas Activation in Bak/Bax-Deficient Mice

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The proapoptotic Bcl-2 family proteins Bak and Bax serve as an essential gateway to the mitochondrial pathway of apoptosis. When activated by BH3-only proteins, Bak/Bax triggers mitochondrial outer membrane permeabilization leading to release of cytochrome c followed by activation of initiator and then effector caspases to dismantle the cells. Hepatocytes are generally considered to be type II cells because, upon Fas stimulation, they are reported to require the BH3-only protein Bid to undergo apoptosis. However, the significance of Bak and Bax in the liver is unclear. To address this issue, we generated hepatocyte-specific Bak/Bax double knockout mice and administered Jo2 agonistic anti-Fas antibody or recombinant Fas ligand to them. Fas-induced rapid fulminant hepatocyte apoptosis was partially ameliorated in Bak knockout mice but not in Bax knockout mice, and was completely abolished in double knockout mice 3 hours after Jo2 injection. Importantly, at 6 hours, double knockout mice displayed severe liver injury associated with repression of XIAP, activation of caspase-3/7 and oligonucleosomal DNA breaks in the liver, without evidence of mitochondrial disruption or cytochrome c–dependent caspase-9 activation. This liver injury was not ameliorated in a cyclophilin D knockout background nor by administration of necrostatin-1, but was completely inhibited by administration of a caspase inhibitor after Bid cleavage. Conclusion: Whereas either Bak or Bax is critically required for rapid execution of Fas-mediated massive apoptosis in the liver, delayed onset of mitochondria-independent, caspase-dependent apoptosis develops even in the absence of both. The present study unveils an extrinsic pathway of apoptosis, like that in type I cells, which serves as a backup system even in type II cells. (HEPATOLOGY **2011;54:240-251**)

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Fas, also called APO-1 and CD95, is one of the death receptors that are potent inducers of apoptosis and constitutively expressed by every cell type in the liver.[1] Dysregulation of Fas-mediated apoptosis is involved in several liver diseases.[2] In the liver of patients with chronic hepatitis C, Fas is overexpressed in correlation with the degree of hepatitis, and Fas ligand can be detected in liver-infiltrating mononuclear cells.[3,4] Fas is also strongly expressed in the livers of patients with chronic hepatitis B, autoimmune hepatitis, and nonalcoholic steatohepatitis.[4,5] Moreover, in the liver of patients with fulminant hepatitis, Fas is up-regulated with strong detection of Fas ligand.[6] In mice, injection of Jo2 agonistic anti-Fas antibody leads

Abbreviations: ALT, alanine aminotransferase; CypD, cyclophilin D; DISC, death-inducing signaling complex; DKO, double knockout; DMSO, dimethylsulfoxide; IAP, inhibition of apoptosis protein; KO, knockout; PARP, poly(adenosine diphosphate ribose) polymerase; RIP, receptor-interacting protein; TUNEL, terminal deoxynucleotidyl transferase–mediated deoxyuridine triphosphate nick-end labeling; WT, wild-type.

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**These authors contributed equally to this work.*

to massive hepatocyte apoptosis and lethality, suggesting that the hepatocyte is one of the most sensitive cell types to Fas stimulation.[7] This model is considered to at least partly mimic human fulminant liver failure.

Fas, upon ligation by Fas ligand, activates caspase-8 through the recruitment of Fas-associated protein with a death domain and formation of the death-inducing signaling complex (DISC).[1,2] Whereas activated caspase-8 directly activates effector caspases such as caspase-3 and caspase-7 through the so-called extrinsic pathway, leading to apoptosis in type I cells, it activates caspase-3/7 through the mitochondrial pathway in type II cells. In type II cells, activated caspase-8 cleaves the BH3-only protein Bid into its truncated form, which in turn directly or indirectly activates and homo-oligomerizes Bak and/or Bax to form pores at the mitochondrial outer membrane, leading to the release of cytochrome c. After being released, cytochrome c assembles with Apaf-1 to form apoptosomes which promote self-cleavage of procaspase-9 followed by activation of caspase-3/7 to cleave a variety of cellular substrates such as poly(adenosine diphosphate ribose) polymerase (PARP) and finally to execute apoptosis.[8,9] Hepatocytes are considered to be typical type II cells, because Bid knockout (KO) mice were reported to be resistant to hepatocyte apoptosis upon Fas activation.[10,11] Although Bak and Bax are crucial gateways to apoptosis of the mitochondrial pathway, little information is available about their significance in hepatocyte apoptosis because most traditional Bak/Bax double knockout (DKO) mice ($bak^{-/-}$ $bax^{-/-}$) die perinatally.[12]

In the present study, we tried to address this issue by generating hepatocyte-specific Bak/Bax DKO mice. We demonstrate that either Bak or Bax is required and sufficient to induce Fas-mediated early-onset hepatocyte apoptosis and lethal liver injury. Importantly, even if deficient in both Bak and Bax, Bak/Bax DKO mice still develop delayed-onset caspase-dependent massive hepatocyte apoptosis, suggesting that the mitochondria-independent pathway of apoptosis, as observed in type I cells, works as a backup system when the mitochondrial pathway of apoptosis in the liver is absent. This study is the first to demonstrate the significant but limited role of Bak and Bax in executing Fas-induced apoptosis in the liver.

Materials and Methods

Mice. Heterozygous Alb-Cre transgenic mice expressing Cre recombinase gene under the promoter of the albumin gene were described.[13] We purchased Bak KO mice ($bak^{-/-}$), Bax KO mice ($bax^{-/-}$), and Bak KO mice carrying the *bax* gene flanked by 2 *lox*P sites ($bak^{-/-}$ $bax^{flox/flox}$) from the Jackson Laboratory (Bar Harbor, ME). Traditional cyclophilin D (CypD) KO mice have been described.[14] All mice strains that we used were created from a mixed background (C57BL/6 and 129). We generated hepatocyte-specific Bak/Bax DKO mice ($bak^{-/-}$ $bax^{flox/flox}$ *Alb-Cre*) or hepatocyte-specific CypD/Bak/Bax triple KO mice ($cypd^{-/-}$ $bak^{-/-}$ $bax^{flox/flox}$ *Alb-Cre*) by mating the strains. Mice were injected intraperitoneally with 1.5 or 0.5 mg/kg Jo2 anti-Fas antibody (BD Bioscience, Franklin Lakes, NJ) or intravenously with 0.25 mg/kg recombinant Fas ligand (Alexis Biochemicals, San Diego, CA) cross-linked with 0.5 mg/kg anti-Flag M2 antibody (Sigma-Aldrich, St. Louis, MO) to induce apoptosis. In some experiments, mice were intraperitoneally injected with 2 mg/kg necrostatin-1 (Sigma-Aldrich) or 40 mg/kg Q-VD-Oph (R&D Systems, Minneapolis, MN). They were maintained in a specific pathogen-free facility and treated with humane care with approval from the Animal Care and Use Committee of Osaka University Medical School.

Apoptosis Assay. Measurement of serum alanine aminotransferase (ALT) levels, hematoxylin and eosin staining, and terminal deoxynucleotidyl transferase–mediated deoxyuridine triphosphate nick-end labeling (TUNEL) of liver sections have been described.[15] Analysis of cytochrome c release from isolated mitochondria have also been described.[16] To detect DNA fragmentation, 1.5 μg DNA extracted from 30 mg liver tissue by Maxwell16 (Promega, Madison, WI) was incubated with 0.5 μg RNase A (Qiagen, Tokyo, Japan) and separated by way of electrophoresis on a 1.5% agarose gel.

Western Blot Analysis. For western immunoblotting, the following antibodies were used: anti–full-length Bid, anti–Cox IV, anti–cleaved caspase-3, anti–caspase-7, anti–caspase-8, anti–caspase-9, anti-PARP, anti-Bax, anti-cIAP1, and anti-XIAP antibodies were

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obtained from Cell Signaling Technology (Beverly, MA); anti-Bax and anti-cIAP2 antibodies were obtained from Millipore (Billerica, MA); anti-Bid antibody, which detects truncated Bid, was generously provided by Xiao-Ming Yin (Indiana University School of Medicine, Indianapolis, IN)[17]; and anti–β-actin antibody was obtained from Sigma-Aldrich. For isolation of the mitochondria-rich fraction, a Mitochondrial Isolation Kit (Thermo Scientific, Rockford, IL) was used. The isolation of hepatocytes from whole liver has been described.[13]

Detection of Bax Oligomerization. Liver tissue was lysed with HCN buffer (25 mM 4-(2-hydroxyethyl)-1-piperazine ethanesulfonic acid, 300 mM NaCl, 2% CHAPS, protease inhibitor cocktail, phosphatase inhibitor cocktail, 100 μM BOC-Asp(OMe)CH2F [MP Biomedicals, Solon, OH]; pH 7.5). After the liver lysate was sonicated and centrifuged, the supernatant was collected and the concentration was adjusted. For cross-linking, 100 μL of the lysate was incubated with 5 μL 100 mM bis(maleimido)hexane (Thermo Scientific) and 5 μL 100 mM BS^3 (Thermo Scientific) for 30 minutes at room temperature as described.[18] After quenching the cross-linkers by way of incubation with 12 μL 1 M Tris-HCl (pH 7.5) for 15 minutes at room temperature, the lysate was boiled with sample buffer followed by western blot analysis for Bax.

Electron Microscopy. Livers were fixed by perfusion of phosphate-buffered saline with 2.5% glutaraldehyde solution buffered at pH 7.4 with 0.1 M Millonig's phosphate, postfixed in 1% osmium tetroxide solution at 4°C for 1 hour, dehydrated in graded concentrations of ethanol, and embedded in Quetol 812 epoxy resin (Nisshin EM, Tokyo, Japan). Ultrathin sections (80 nm) cut on ultramicrotome were stained with uranyl acetate and lead citrate and examined with an H-7650 electron microscope (Hitachi Ltd., Tokyo, Japan) at 80 kV.

Statistical Analysis. Data are presented as the mean ± SE. Differences between two groups were determined using the Mann-Whitney U test for unpaired observations. The survival curves were estimated using the Kaplan-Meier method and were tested by way of log-rank test. $P < 0.05$ was considered statistically significant.

Results

Bak Deficiency Partially Ameliorates Fas-Induced Hepatocellular Apoptosis but Fails to Prevent Animal Death. First, to examine the significance of Bak in hepatocellular apoptosis induced by Fas stimulation, Bak KO mice ($bak^{-/-}$) and wild-type (WT) littermates ($bak^{+/+}$) were intraperitoneally injected with 1.5 mg/kg Jo2 anti-Fas antibody and analyzed 3 hours later. Consistent with previous reports,[10,19] WT mice showed severe elevation of serum ALT levels with massive hepatocellular apoptosis (Fig. 1A,B). Bak KO mice also developed liver injury, but the levels of serum ALT and the number of TUNEL-positive hepatocytes were significantly lower in Bak KO mice than in WT mice (Fig. 1A-C). Western blotting for cleaved caspase-3, caspase-7, and PARP revealed that activation of effector caspases were partially inhibited in KO livers compared with WT livers (Fig. 1D). Cleavage of procaspase-9, which is initiated by mitochondrial release of cytochrome c, was also suppressed in Bak KO livers compared with WT liver (Fig. 1D). The cleaved form of caspase-8, a direct downstream target of Fas activation, was detected in both mice, but its levels were reduced in Bak KO mice compared with WT mice (Fig. 1D). This reduction may be explained by the lesser activation of caspase-3/7, because it has been reported that caspase-3/7 could activate caspase-8 through an amplification loop during apoptosis.[20] Collectively, these findings demonstrated that Bak deficiency partially ameliorated Fas-induced hepatocellular apoptosis associated with reduced cleavage of caspase-9, caspase-3/7, and PARP. We then compared survival of mice after Jo2 injection but found that Bak KO mice also rapidly died with kinetics similar to those of WT mice, suggesting that partial amelioration of hepatocellular apoptosis induced by Bak deficiency did not lead to survival benefit under our experimental conditions (Fig. 1E). Because Bax residing in the cytosol moves to the mitochondria upon activation, where it undergoes oligomerization,[21] we analyzed its translocation and oligomerization in the liver at 3 hours after Jo2 injection. Western blot analysis revealed that the levels of Bax expression clearly increased in the mitochondrial fraction in both WT livers and Bak KO livers (Fig. 1F). Signals for the Bax dimer were also detected in both livers (Fig. 1F). These findings indicate that Bax is also activated after Fas stimulation, raising the possibility of its involvement in hepatocellular apoptosis.

Bax Deficiency Fails to Ameliorate Fas-Induced Hepatocellular Apoptosis. Next, to examine the significance of Bax in hepatocellular apoptosis induced by Fas stimulation, Bax KO mice ($bax^{-/-}$) and WT littermates ($bax^{+/+}$) were injected with Jo2 and examined 3 hours later. There was no significant difference in the levels of serum ALT or the number of TUNEL-positive hepatocytes between the two groups (Fig. 2A-C), which is consistent with a previous report.[22] The levels of the cleaved forms of caspase-8, -9, -3, -7, and

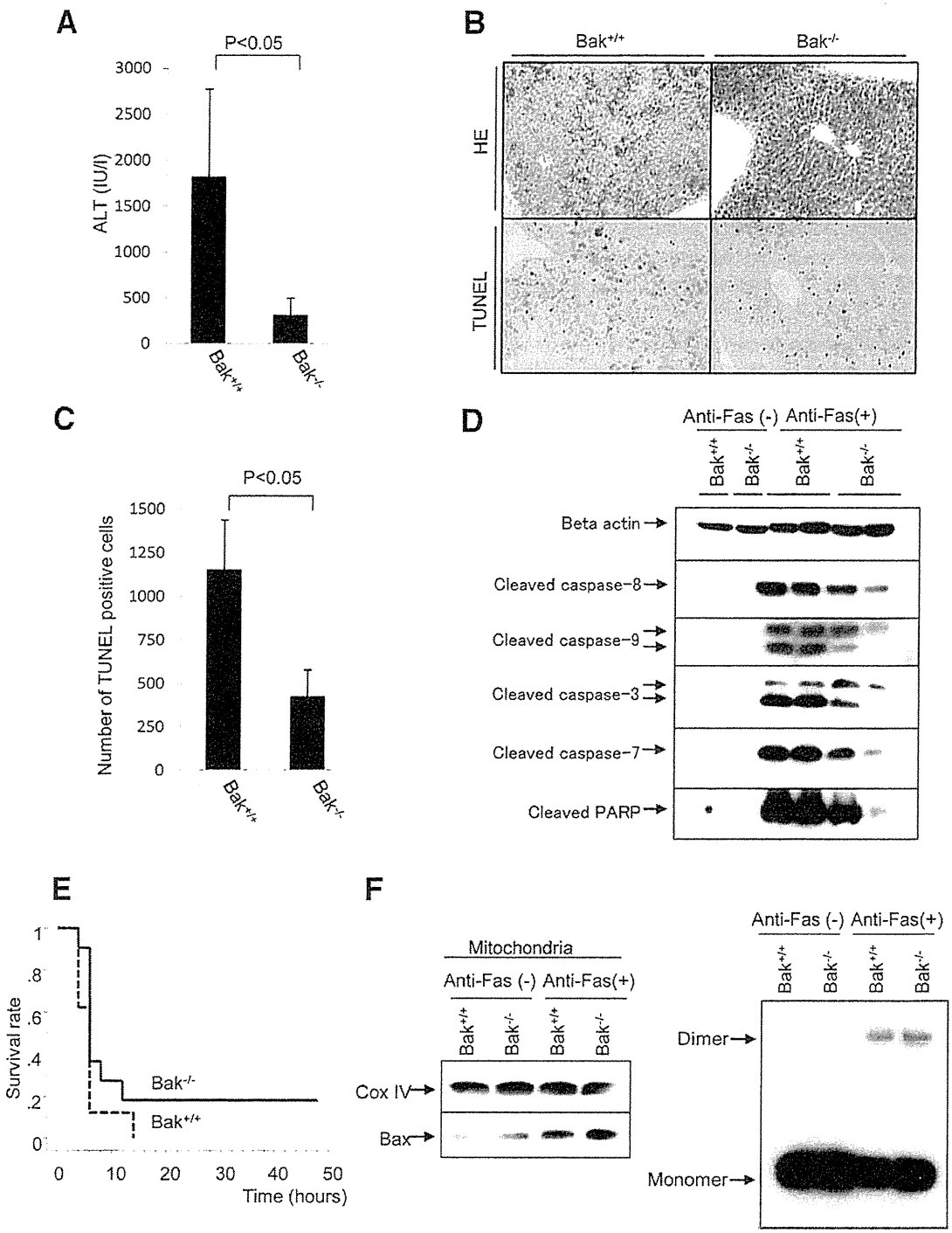

Fig. 1. Bak KO mice are partially resistant to Fas-induced hepatocellular apoptosis. Bak KO mice ($Bak^{-/-}$) or control WT littermates ($Bak^{+/+}$) were analyzed at 3 hours after intraperitoneal injection of 1.5 mg/kg Jo2 anti-Fas antibody. (A) Serum ALT levels (n = 10 or 11, respectively). (B) Hematoxylin and eosin (HE) and TUNEL staining of the liver sections. (C) Number of TUNEL-positive cells (n = 8 or 9, respectively). (D) Western blot analysis for the expressions of cleaved caspase-8, 9, -3, -7 and PARP. (E) Bak KO mice or control WT littermates were intraperitoneally injected with 1.5 mg/kg Jo2 anti-Fas antibody (n = 8 or 11, respectively). Survival rates after Jo2 injection are shown. (F) Bak KO mice or control WT littermates were analyzed 3 hours after intraperitoneal injection of Jo2 anti-Fas antibody (1.5 mg/kg) or vehicle. Left: Western blot analysis of the mitochondrial fraction of the liver for the expression of Bax. Right: Western blot analysis for the expression of Bax monomer and dimer in the liver.

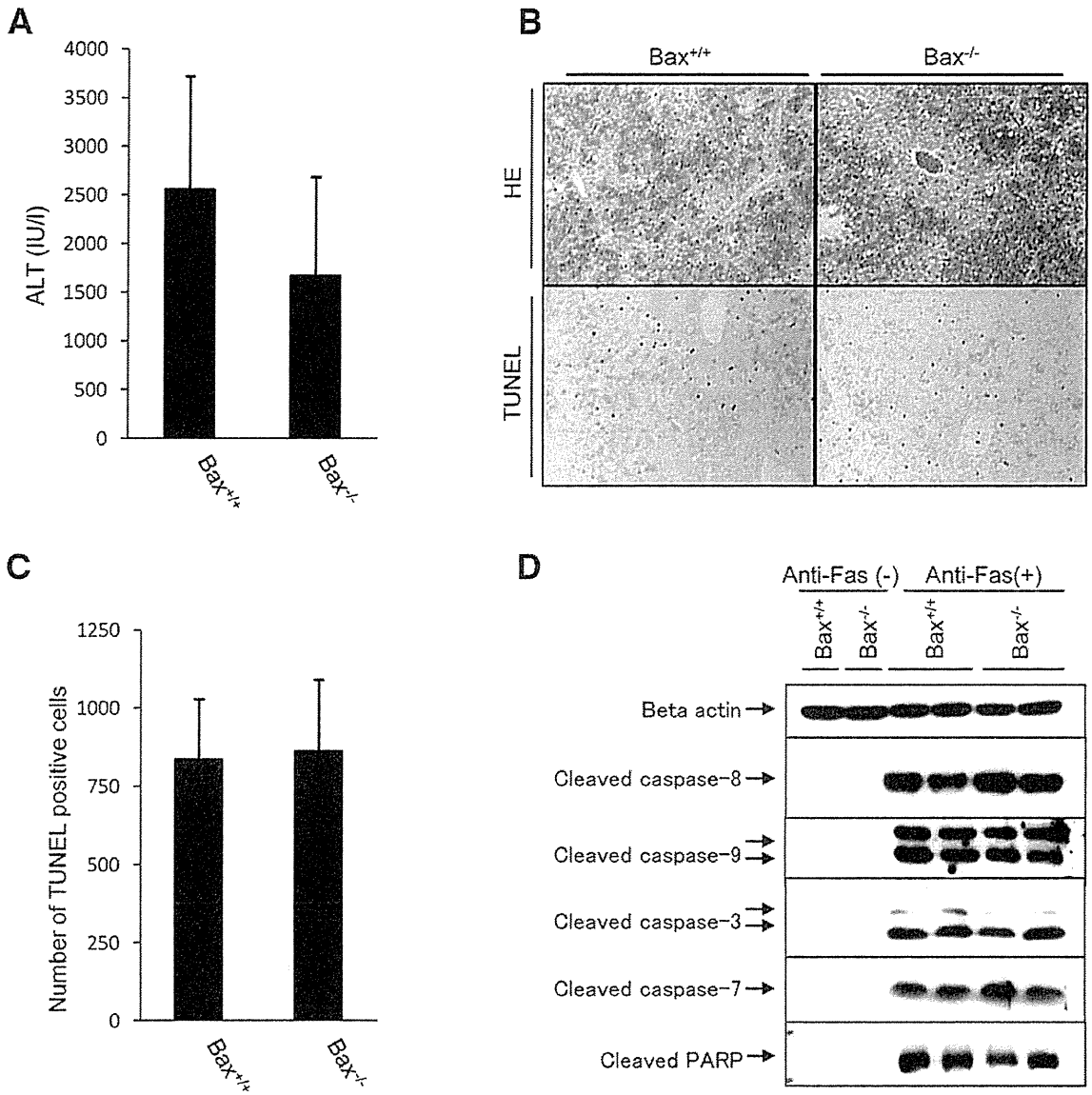

Fig. 2. Bax KO mice are not resistant to Fas-induced hepatocellular apoptosis. Bax KO mice ($Bax^{-/-}$) or control WT littermates ($Bax^{+/+}$) were analyzed 3 hours after intraperitoneal injection of Jo2 anti-Fas antibody (1.5 mg/kg). (A) Serum ALT levels (n = 11 per group). (B) Hematoxylin and eosin (HE) and TUNEL staining of the liver sections. (C) Number of TUNEL-positive cells (n = 8 per group). (D) Western blot analysis for the expressions of cleaved caspase-8, -9, -3, -7, and PARP.

PARP in Bax KO livers did not differ from those of WT livers (Fig. 2D). These findings demonstrate that, in contrast to Bak deficiency, Bax deficiency was not able to inhibit Fas-induced hepatocellular apoptosis.

Bax Deficiency Completely Blocks Fas-Induced Early-Onset Hepatocellular Apoptosis in a Bak-Deficient Background. To examine the impact of Bax in a Bak-deficient background, hepatocyte-specific Bak/Bax DKO mice (*bak*$^{-/-}$ *bax*$^{flox/flox}$ *Alb-Cre*) and Bak KO mice (*bak*$^{-/-}$ *bax*$^{flox/flox}$), which served as control littermates of this mating, were injected with Jo2 and analyzed 3 hours later. We confirmed the hepatocyte-specific defects of Bax protein in Bak/Bax DKO mice by way of western blot analysis (Fig. 3A). The serum ALT levels of Bak/Bax DKO mice were in the normal range and were significantly lower than those of Bak KO mice (Fig. 3B). Liver histology and TUNEL staining did not show evidence of hepatocyte apoptosis in Bak/Bax DKO livers, in contrast to Bak KO livers (Fig. 3C,D). Taken together, these results indicate that Bak and Bax are basically redundant molecules for execution of hepatocellular apoptosis induced by Fas

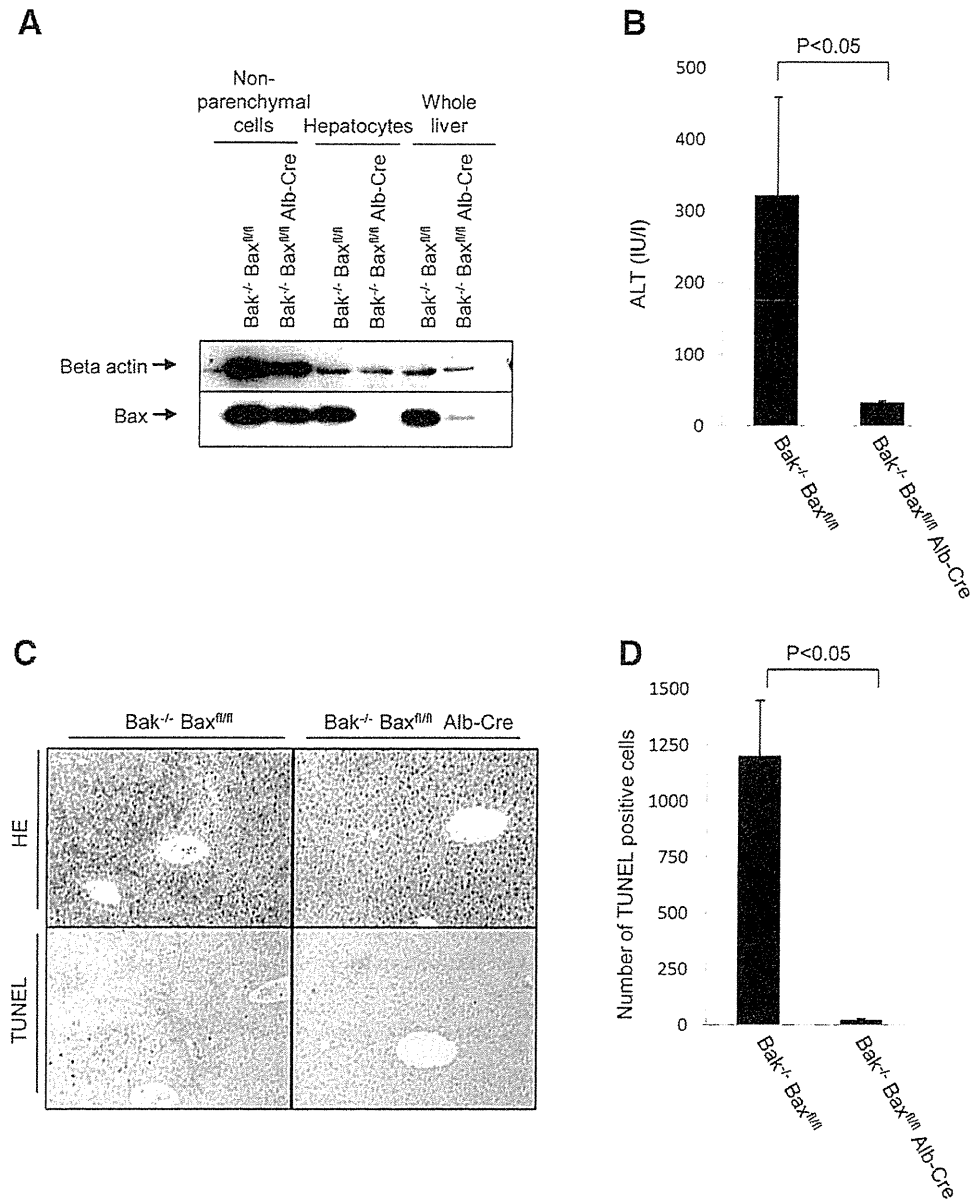

Fig. 3. Bak/Bax DKO mice are fully resistant to Fas-induced hepatocellular apoptosis in early phase. (A) Western blot analysis of the indicated fraction of the liver for the expressions of Bax. (B-D) Bak/Bax DKO mice ($Bak^{-/-}$ $Bax^{fl/fl}$ Alb-Cre) or control Bak KO littermates ($Bak^{-/-}$ $Bax^{fl/fl}$) were analyzed 3 hours after intraperitoneal injection of Jo2 anti-Fas antibody (1.5 mg/kg). (B) Serum ALT levels (n = 10 per group). (C) Hematoxylin and eosin (HE) and TUNEL staining of the liver sections. (D) Number of TUNEL-positive cells (n = 9 per group).

activation, although the former appears to be clearly required for full-blown apoptosis in vivo.

Fas Stimulation Leads to Late-Onset Hepatocellular Death Even in Bak/Bax Deficiency with Moderate Caspase-3/7 Activation Without Mitochondrial Disruption. To examine whether the inhibition of Fas-induced rapid liver injury in Bak/Bax deficiency is a durable effect, we analyzed the survival rate after Jo2 injection. The survival rate of Bak/Bax DKO mice was significantly higher than that of Bak KO mice, but approximately half of the Bak/Bax DKO mice died within 12 hours (Fig. 4A). To examine the cause of this late-onset lethality, we analyzed the serum ALT levels and liver tissue 6 hours after Jo2 injection. Unexpectedly, the serum ALT levels were highly elevated in Bak/Bax DKO mice (Fig. 4B). Liver histology revealed many hepatocytes with cellular shrinkage and scattered regions of sinusoidal hemorrhage (Fig. 4C), indicating that Bak/Bax DKO mice still developed severe liver injury at this time point. TUNEL staining

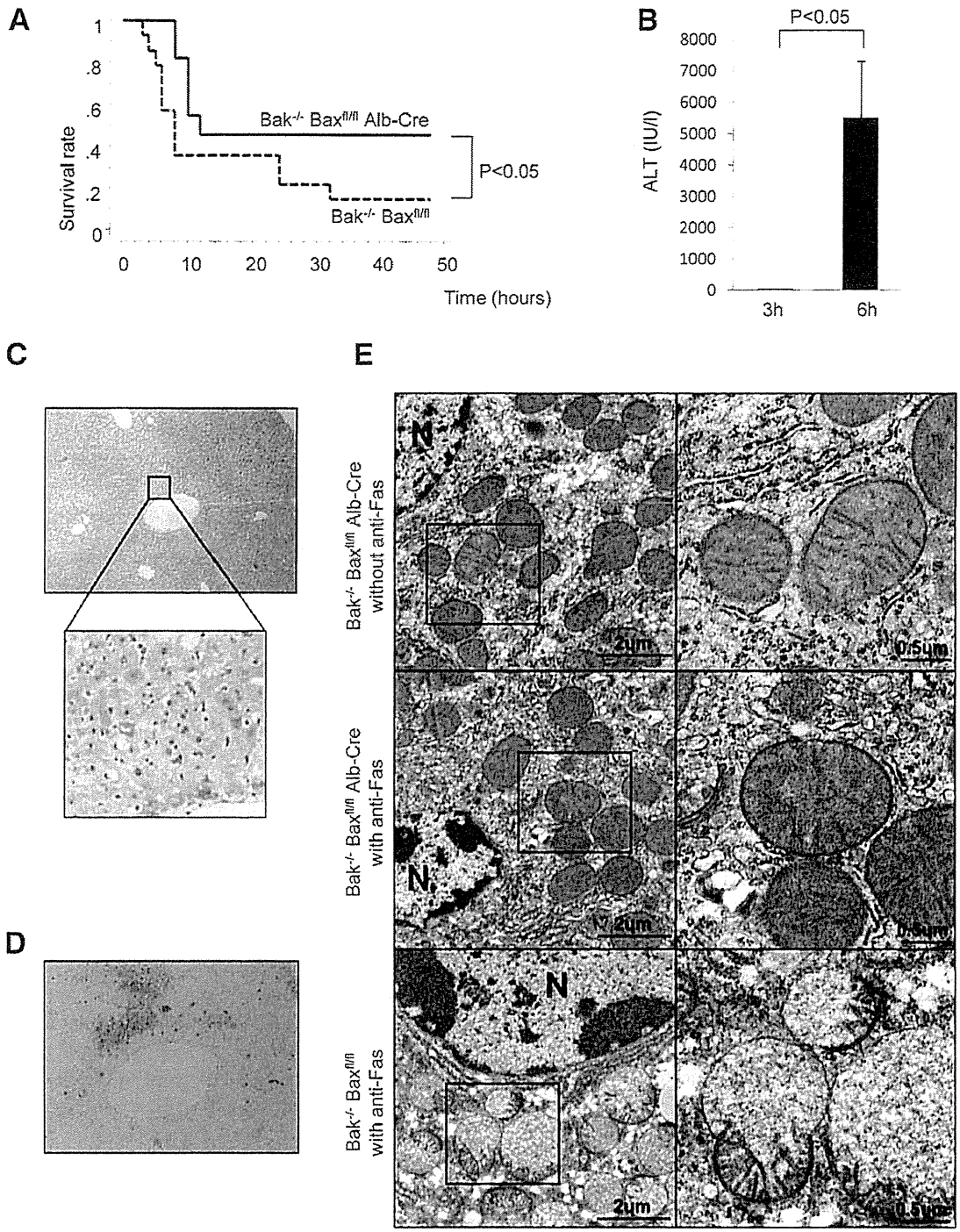

Fig. 4. Bak/Bax DKO mice develop late-onset severe liver injury upon Fas stimulation. Bak/Bax DKO mice ($Bak^{-/-}$ $Bax^{fl/fl}$ Alb-Cre) or control Bak KO littermates ($Bak^{-/-}$ $Bax^{fl/fl}$) were intraperitoneally injected with 1.5 mg/kg Jo2 anti-Fas antibody. (A) Survival rate after Jo2 injection (n = 11 per group). (B) Serum ALT levels of Bak/Bax DKO mice. (C, D) Hematoxylin and eosin (C) and TUNEL (D) staining of the liver sections of Bak/Bax DKO mice 6 hours after Jo2 injection. Representative photomicrographs are shown. (E) Representative electron microscopy photomicrographs of the livers of Bak/Bax DKO mice before and 6 hours after Jo2 anti-Fas injection (1.5 mg/kg) and control Bak KO mice 2 hours after Jo2 anti-Fas injection (1.5 mg/kg). Right panels are enlarged images of the square area of each left panel. N, nucleus.

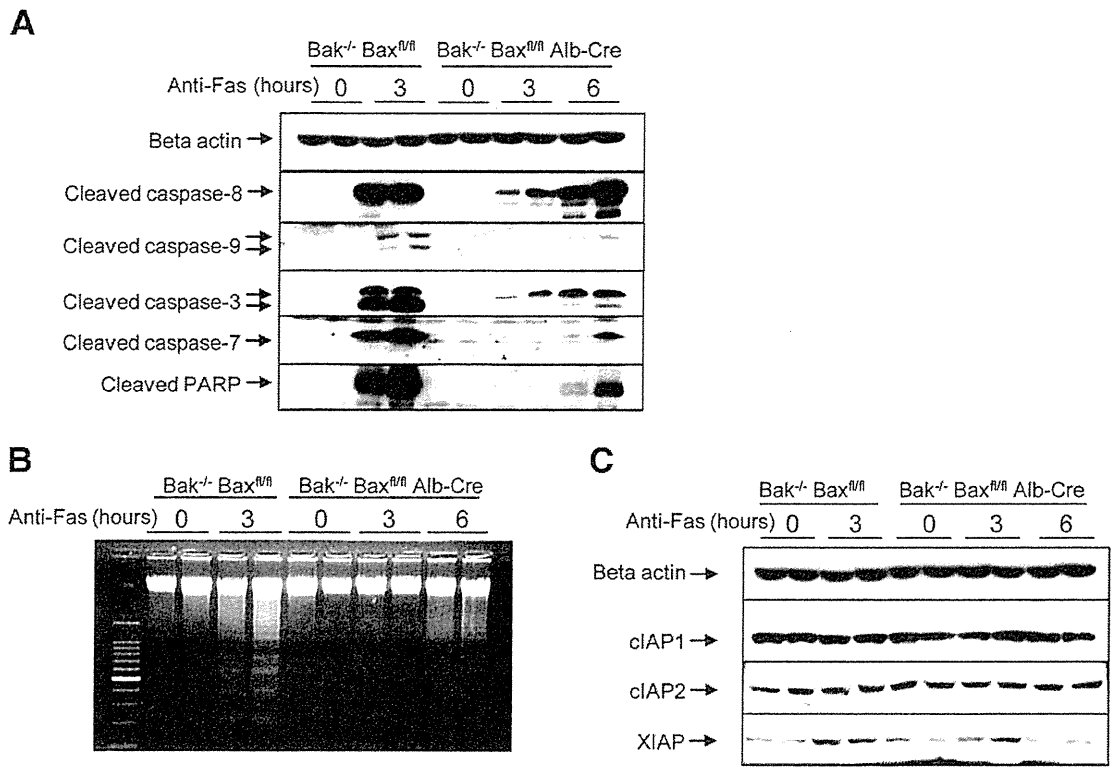

Fig. 5. Fas-mediated hepatocellular death in Bak/Bax DKO mice is associated with caspase-3/7 activation and oligonucleosomal DNA breaks. Bak/Bax DKO mice ($Bak^{-/-}$ $Bax^{fl/fl}$ Alb-Cre) or control Bak KO littermates ($Bak^{-/-}$ $Bax^{fl/fl}$) were intraperitoneally injected with Jo2 anti-Fas antibody (1.5 mg/kg). (A) Western blot analysis for expression of cleaved caspase-8, -9, -3, -7, and PARP. (B) DNA laddering of the liver. (C) Western blot analysis for expression of IAP family proteins.

revealed many TUNEL-positive hepatocytes in the liver sections. Of importance, electron microscopic analysis revealed mitochondrial alterations (such as disruption of the membrane and herniation of the matrix) in hepatocytes of Bak KO mice but not in hepatocytes of Bak/Bax DKO mice with chromatin condensation (Fig. 4E). Because some reports showed that hepatocytes act like type I cells with a high dose of Jo2 anti-Fas antibody and that anti-Fas antibody does not always reliably mimic the action of the physiological Fas ligand,[23,24] we also injected 0.5 mg/kg Jo2 or recombinant Fas ligand into Bak/Bax DKO mice. Similarly, both injected mice showed severe elevation of serum ALT levels and severe hepatitis with many TUNEL-positive cells at 6 hours (Supporting Figs. 1 and 2).

To examine the kinetics of caspase activation and apoptosis in the liver after Jo2 administration, we performed western blot analysis for caspase activation and agarose gel electrophoresis for DNA laddering. All signals for cleaved forms of caspase-3, caspase-7, and PARP in the liver were clearly detected at 6 hours in Bak/Bax DKO mice, although they were weaker than those at 3 hours in control Bak KO littermates (Fig. 5A). Regarding the cleaved form of caspase-9, two bands were detected at 3 hours in Bak KO liver, but not in Bak/Bax DKO liver. Previous research established that procaspase-9 has two sites for cleavage upon activation: both Asp353 and Asp368 sites are autoprocessed by caspase-9 activation after cytochrome c release, whereas the Asp368 site is preferentially processed over the Asp358 site by caspase-3.[25] In our western blot analysis, the slow migrating species corresponding to the fragment cleaved at Asp368, but not the rapid migrating species corresponding to that at Asp353, was weakly detected at 6 hours in Bak/Bax DKO liver. This indicated that caspase-3–mediated cleavage of procaspase-9 takes place without evidence of cytochrome c–induced autoprocessing of procaspase-9. Agarose gel electrophoresis clearly detected oligonucleosomal DNA laddering at 6 hours in Bak/Bax DKO livers, similar to our observation at 3 hours in control Bak KO livers (Fig. 5B). Collectively, these morphological and biochemical data support the idea that hepatocellular death occurring at 6 hours in the Bak/Bax DKO liver seems to involve apoptosis.

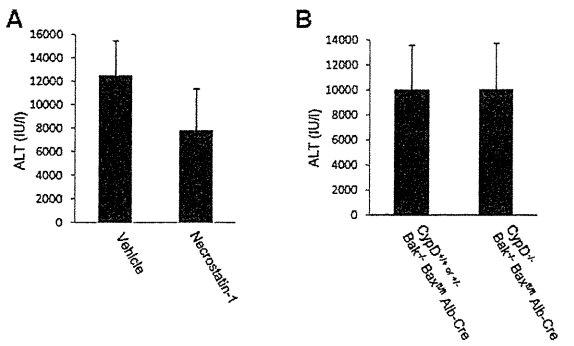

Fig. 6. Fas-induced hepatocellular death in Bak/Bax DKO mice is independent of RIP kinase and/or CypD. (A) Bak/Bax DKO mice ($Bak^{-/-}$ $Bax^{fl/fl}$ Cre) were intraperitoneally injected with 2 mg/kg necrostatin-1 in vehicle containing 0.2% dimethylsulfoxide or vehicle alone at 2 hours after injection of 1.5 mg/kg Jo2 anti-Fas antibody. Serum ALT levels at 6 hours after Jo2 injection are shown (n = 8 per group). (B) $CypD^{+/+ \text{ or } +/-}$ mice in a Bak/Bax-deficient background ($CypD^{+/+ \text{ or } +/-}$ $Bak^{-/-}$ $Bax^{fl/fl}$ Alb-Cre) or control $CypD^{-/-}$ littermates ($CypD^{-/-}$ $Bak^{-/-}$ $Bax^{fl/fl}$ Alb-Cre) were intraperitoneally injected with 1.5 mg/kg Jo2 anti-Fas antibody. Serum ALT levels at 6 hours after injection are shown (n = 7 per group or 8 per group, respectively).

To examine the underlying mechanisms by which caspase-3/7 was increasingly activated from 3 to 6 hours in Bak/Bax DKO mice, we analyzed the expression of inhibition of apoptosis proteins (IAPs), which can block cleavage of procaspase-3, -7, and -9.[26] The expression levels of cIAP1 and cIAP2 were not changed in the liver after Jo2 injection (Fig. 5C, Supporting Fig. 3). In contrast, the expression levels of XIAP were up-regulated in the livers of both Bak KO and Bak/Bax DKO mice at 3 hours after Jo2 injection, as in WT mice (Fig. 5C, Supporting Fig. 3), which is consistent with previous reports.[27] However, this up-regulation disappeared from the livers of Bak/Bax DKO mice at 6 hours. Repression of XIAP overexpression might explain why weak activation of capsase-3/7 gradually increased from 3 to 6 hours in the Bak/Bax DKO liver.

Cell Death with Bak/Bax Deficiency Is Not Dependent on a Necrotic Pathway. Fas activation was reported to induce not only caspase-dependent apoptosis but also caspase-independent necrosis, which is required for receptor-interacting protein (RIP) kinase.[28] To exclude the possibility of this necrotic cell death in the Bak/Bax DKO liver, we first examined the effect of necrostatin-1, which specifically inhibits RIP kinase to protect against necrotic cell death caused by death-domain receptor stimulation.[2,29] Bak/Bax DKO mice were injected with 2 mg/kg necrostatin-1 at 2 hours after or 1 hour before Jo2 injection. The ALT levels at 6 hours after Fas stimulation were clearly elevated without a significant difference between the necrostatin-1 injection group and the vehicle injection group (Fig. 6A and Supporting Fig. 4). We next examined the effect of CypD, which is a key molecule of mitochondrial permeability transition generated by Ca^{2+} overload and/or oxidative stress leading to necrotic cell death.[14,30] We injected Jo2 into $CypD^{-/-}$ mice with a Bak/Bax-deficient background (*cypd*$^{-/-}$ *bak*$^{-/-}$ *bax*$^{flox/flox}$ *Alb-Cre*) or control $CypD^{+/+ \text{ or } +/-}$ littermates (*cypd*$^{+/+ \text{ or } +/-}$ *bak*$^{-/-}$ *bax*$^{flox/flox}$ *Alb-Cre*). The ALT levels of CypD/Bak/Bax triple KO mice upon Fas stimulation were the same as those of control mice (Fig. 6B). These results indicate that liver injury in Bak/Bax deficiency induced by Fas stimulation was not dependent on the necrotic pathway, at least that mediated by RIP kinase and/or CypD.

Late-Onset Cell Death in Bak/Bax Deficiency Is Completely Dependent on Caspase. Although cell death observed in Bak/Bax DKO mice appears to be apoptosis, the question arose of whether relatively weak caspase-3/7 activity compared with that observed in Bak KO mice is sufficient for inducing liver injury 6 hours after Fas simulation. To this end, Bak/Bax DKO mice were given 40 mg/kg Q-VD-Oph, a potent broad spectrum caspase inhibitor,[31] 2 hours after injection of Jo2. Western blot analysis revealed the existence of truncated Bid and cleaved caspase-8 in the liver 2 hours after Jo2 injection, demonstrating that caspase-8 had already been activated by this point (Fig. 7A). Administration of the caspase inhibitor at 2 hours completely blocked the elevation of serum ALT levels and hepatocellular apoptosis, as evidenced by liver histology and TUNEL staining 6 hours after Jo2 injection (Fig. 7B-D). Finally, we tried to analyze the survival rate of Bak/Bax DKO mice and control Bak KO mice when therapeutically injected with the caspase inhibitor 2 hours after Jo2 injection. None of the Bak/Bax DKO mice showed lethal liver injury upon Jo2 injection, whereas half of the Bak KO mice died from severe liver injury (Fig. 7E). These findings suggest that Fas-induced liver injury in Bak/Bax deficiency was dependent on caspase activity, which could be fully negated by the caspase inhibitor. On the other hand, caspase activation in Bak KO mice was too high to be negated by the same dose of the caspase inhibitor.

Discussion

In the present study, we demonstrate that Bak KO, but not Bax KO, provides partial resistance to Fas-induced hepatocellular apoptosis in vivo. We demonstrated previously that Bak KO mice, but not Bax KO

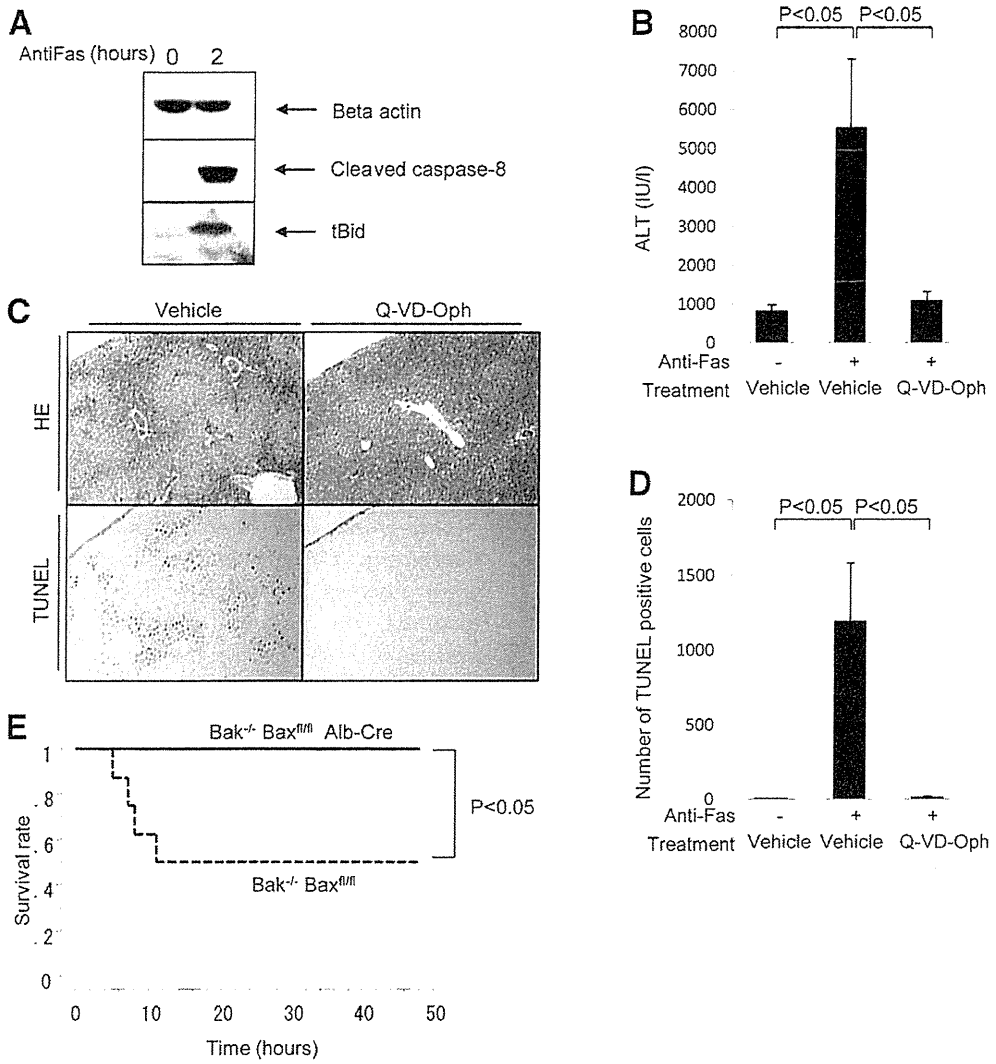

Fig. 7. Hepatocellular death in Bak/Bax DKO mice is dependent on caspase activation. (A) Bak/Bax DKO mice were analyzed before and 2 hours after intraperitoneal injection of Jo2 anti-Fas antibody (1.5 mg/kg). Western blot analysis of the liver for the expression of cleaved caspase-8 and truncated Bid (tBid). (B-D) Bak/Bax DKO mice were intraperitoneally administered 40 mg/kg Q-VD-Oph in 10 mL/kg dimethylsulfoxide (DMSO) or DMSO alone, as a vehicle, 2 hours after injection of 1.5 mg/kg Jo2 anti-Fas antibody and analyzed at 6 hours. (B) Serum ALT levels (n = 6 or 7 per group, respectively). (C) Hematoxylin and eosin (HE) and TUNEL staining of the liver sections. (D) Number of TUNEL-positive cells (n = 6 or 7 per group, respectively). Because intraperitoneal injection of DMSO leads to injury at the surface layer of the liver, TUNEL positivity close to the surface layer was excluded from the cell count. (E) Bak/Bax DKO mice ($Bak^{-/-}$ $Bax^{fl/fl}$ Alb-Cre) or control Bak KO littermates ($Bak^{-/-}$ $Bax^{fl/fl}$) were given 40 mg/kg Q-VD-Oph intraperitoneally in 10 mL/kg DMSO or DMSO alone at 2 hours after injection of 1.5 mg/kg anti-Fas antibody. The disease-free survival rate of lethal liver injury after Jo2 injection is shown (n = 8 per group).

mice, showed resistance to apoptosis induced by Bcl-xL deficiency, which depended mainly on Bid activation.[16] Research has shown that Fas induces apoptosis in hepatocytes through the Bid pathway,[10,11] and the present study also demonstrates that Bid becomes truncated in the liver upon anti-Fas injection. Therefore, truncated Bid may preferentially activate Bak rather than Bax in the liver. However, the present study also reveals that, in the absence of Bak, Bax plays an essential role in mediating the early onset of hepatocellular apoptosis. The most important finding of this study is that Bak/Bax deficiency failed to protect against the late onset of liver injury after Jo2 anti-Fas injection as well as Fas agonist injection. Wei et al.,[32] in their historical paper establishing the importance of Bak and Bax in the mitochondrial pathway of apoptosis, reported that hepatocytes were protected from Jo2-induced apoptosis in traditional Bak/Bax DKO mice ($bak^{-/-}$ $bax^{-/-}$). Because perinatal lethality occurs with most traditional Bak/Bax DKO mice,

they could only analyze three animals, which did not enable detailed analysis of cell death due to Jo2 stimulation. The present study is the first to (1) thoroughly examine the impact of Bak and Bax in the liver using conditional KO mice and (2) demonstrate that Bak/Bax deficiency can protect against Fas-induced severe injury in the early phase but not in the late phase.

The late onset of liver injury observed in Bak/Bax DKO appeared to be apoptosis based on biochemical and morphological observations, including caspase activation, oligonucleosomal DNA breaks and, most importantly, identification of cell death with caspase dependency. In addition, the well-established necrotic pathway mediated by RIP kinase and/or CypD was not involved. However, the difference from apoptosis observed in Bak KO mice was the absence of mitochondrial alteration or cytochrome c–dependent caspase-9 processing in Bak/Bax DKO mice. We also confirmed that Bak/Bax-deficient mitochondria were not capable of releasing cytochrome c in the presence of truncated Bid (Supporting Fig. 5). These data support the idea that activation of the mitochondrial pathway of apoptosis is fully dependent on either Bak or Bax even in the late phase, indicating at the same time that late onset of apoptosis takes place through an extrinsic pathway rather than the mitochondrial pathway.

Although hepatocytes are generally considered to be type II cells, recent work has shown that the requirement of the mitochondrial pathway may be overcome through changes induced by in vitro culture conditions[33,34] or the strength of Fas stimulation.[23] Schüngel et al.[23] demonstrated that hepatocytes act as type II cells with a low-dose Jo2 injection (0.5 mg/kg) and act as type I cells with an extremely high-dose Jo2 injection (5 mg/kg). This agrees with the generally accepted idea that type I cells exhibit strong activation of DISC and caspase-8, which itself is sufficient to induce apoptosis, whereas type II cells exhibit weak activation and therefore require amplification of the apoptosis signal through the mitochondrial loop. In the present study, we used 1.5 mg/kg or 0.5 mg/kg Jo2 antibody, which could be considered relatively low doses, and found that hepatocytes act like type II cells in WT mice or Bak/Bax single KO mice but act like type I cells in Bak/Bax DKO mice. The present study therefore demonstrates that hepatocytes can act as type I cells in the absence of Bak and Bax independent of the strength of DISC formation or signals from microenvironments.

The question arises of why hepatocytes can act as type I cells where the levels of DISC formation or caspase-8 activation may be insufficient to induce activation of downstream caspases. Recently, Jost et al.[27] reported a discriminating role of XIAP between type I and type II cells; in type II cells, the levels of XIAP expression increased after Fas stimulation but decreased in type I cells. In agreement with this report, XIAP expression was up-regulated at 3 hours in both Bak KO and Bak/Bax DKO livers. Interestingly, this XIAP up-regulation disappeared at 6 hours after Jo2 injection in Bak/Bax DKO mice. Because XIAP is a potent inactivator of caspase-3, -7, and -9 processing, repression of XIAP may be one reason why hepatocytes can act as type I cells at this time point.

Previous studies have reported that liver endothelial cells express Fas receptor and have suggested that apoptosis of these cells may participate in the liver damage in mice receiving Jo2 antibody, especially in the case of high-dose administration.[35] However, we did not find liver injury in the sinusoidal hemorrhage in Bak/Bax DKO mice at 3 hours after Jo2 injection, which is the time point when Bak KO mice developed it (Fig. 3C). Together with the fact that Bax, but not Bak, was active in liver nonparenchymal cells in our Bak/Bax DKO mice, as was the case in Bak KO mice (Fig. 3A), we speculate that Bak-deficient sinusoidal cells could not contribute much to liver injury at 3 hours after Jo2 injection (1.5 or 0.5 mg/kg).

Recently, a pan-caspase inhibitor was reported to reduce hepatic damage in liver transplant recipients and patients with chronic hepatitis C in clinical trials.[36,37] For treatment of fulminant liver injury, caspase inhibitors seem to be attractive drugs. However, the present study demonstrates that Fas-induced apoptotic signals could be efficiently amplified through the mitochondrial pathway, leading to high lethality even if caspase inhibitor was administered 2 hours after Jo2 injection. In contrast, administration of the same dose of the caspase inhibitor was able to fully block hepatocyte apoptosis and lethality in Bak/Bax DKO mice. From a clinical point of view, when using caspase inhibitors to prevent fulminant liver failure, concomitant inactivation of the mitochondrial amplification loop may be required.

In conclusion, the extrinsic pathway of apoptosis exists in hepatocytes and causes late onset of lethal liver failure in the absence of Bak and Bax independent of the strength of Fas ligation. This pathway could be therapeutically intervened through the use of caspase inhibitors, presumably due to low levels of DISC formation and subsequent weak activation of effector caspases in hepatocytes. The present study unveils the entire framework of the Fas-mediated signaling

pathway in hepatocytes, placing the mitochondrial pathway of apoptosis as a potent loop for amplifying activation of the caspase cascade to execute complete and rapid cell death in hepatocytes.

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BH3-only Activator Proteins Bid and Bim Are Dispensable for Bak/Bax-dependent Thrombocyte Apoptosis Induced by Bcl-xL Deficiency

MOLECULAR REQUISITES FOR THE MITOCHONDRIAL PATHWAY TO APOPTOSIS IN PLATELETS[S]

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A pivotal step in the mitochondrial pathway of apoptosis is activation of Bak and Bax, although the molecular mechanism remains controversial. To examine whether mitochondrial apoptosis can be induced by just a lack of antiapoptotic Bcl-2-like proteins or requires direct activators of the BH3-only proteins including Bid and Bim, we studied the molecular requisites for platelet apoptosis induced by Bcl-xL deficiency. Severe thrombocytopenia induced by thrombocyte-specific Bcl-xL knock-out was fully rescued in a Bak and Bax double knock-out background but not with single knock-out of either one. In sharp contrast, deficiency of either Bid, Bim, or both did not alleviate thrombocytopenia in Bcl-xL knock-out mice. An *in vitro* study revealed that ABT-737, a Bad mimetic, induced platelet apoptosis in association with a conformational change of the amino terminus, translocation from the cytosol to mitochondria, and homo-oligomerization of Bax. ABT-737-induced Bax activation and apoptosis were also observed in Bid/Bim-deficient platelets. Human platelets, upon storage, underwent spontaneous apoptosis with a gradual decline of Bcl-xL expression despite a decrease in Bid and Bim expression. Apoptosis was attenuated in Bak/Bax-deficient or Bcl-xL-overexpressing platelets but not in Bid/Bim-deficient platelets upon storage. In conclusion, platelet lifespan is regulated by a fine balance between anti- and proapoptotic multidomain Bcl-2 family proteins. Despite residing in platelets, BH3-only activator proteins Bid and Bim are dispensable for Bax activation and mitochondrial apoptosis.

Platelets are unique blood cells that do not have a nucleus but contain mitochondria and have the daily job of handling hemostasis and thrombosis (1). They are produced from megakaryocytes and once released into circulation can function for about 10 days in humans and 4–5 days in mice (2). They are then thought to be destroyed by the reticuloendothelial system. Regarding the mechanism that controls their lifespan, several studies have observed a decrease in mitochondrial membrane potential, caspase activation, and phosphatidylserine exposure in platelets, leading to the conclusion that platelets undergo apoptotic cell death (3–5). It has been demonstrated that platelets contain several apoptosis-related proteins such as Bcl-2 family proteins and a variety of caspase family proteins (3–7). Recently, Mason *et al.* (8) reported that knock-out of a single allele of the *bcl-x* gene results in mild thrombocytopenia, which is ameliorated in a Bak knock-out background. We have also reported previously that thrombocyte-specific homozygous Bcl-xL knock-out mice show marked thrombocytopenia (9). These findings established the critical role of Bcl-2 family proteins in regulating platelet apoptosis and lifespan. Platelets may be the simplest model for the study of Bcl-2 biology with physiological relevance because they neither perform *de novo* protein synthesis nor undergo proliferation.

The proapoptotic multidomain Bcl-2 family proteins Bak and Bax serve as effector molecules for the mitochondrial pathway of apoptosis. Upon activation, they form pores by homo-oligomerization at the mitochondrial outer membrane through which apoptogenic factors such as cytochrome *c* are released into the cytosol (10). Currently, three models for regulation of Bak/Bax-dependent mitochondrial apoptosis by Bcl-2 family proteins have been proposed (11–15). One, referred to as the indirect model or displacement model, argues that Bak and Bax are constitutively active and are neutralized by binding to at least one or more antiapoptotic members of the multidomain Bcl-2 family proteins including Bcl-2, Bcl-xL, Mcl-1, Bcl-w, and Bfl-1/A1. BH3[3]-only proteins such as Bad, Bid, Bim, Noxa, and Puma bind to the antiapoptotic Bcl-2 proteins to unleash Bak and Bax (15). The second model, referred to as the direct model, argues that Bak and Bax are inactive by default and require activator proteins to function. Among BH3-only proteins, Bid and Bim are classified as activator proteins with the others

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[3] The abbreviations used are: BH3, Bcl-2 homology domain 3; Pf4, platelet factor 4; MTS, 3-(4,5-dimethylthiazol-2-yl)-5-(3-carboxymethoxyphenyl)-2-(4-sulfophenyl)-2*H*-tetrazolium.

classified as sensitizer proteins because only Bid and Bim have been demonstrated to directly activate Bak and Bax (16, 17). In this model, Bid and Bim are sequestered by the antiapoptotic Bcl-2 family proteins, and the sensitizer BH3-only proteins bind to the antiapoptotic Bcl-2 proteins to liberate Bid and Bim so they can directly engage Bak and Bax (14). The third model, referred to as the embedded together model, argues that BH3-only activator proteins can recruit not only Bax but also antiapoptotic Bcl-2 proteins to mitochondrial membranes. Although membrane-bound Bax can form oligomers, membrane-bound antiapoptotic Bcl-2 proteins function as a dominant-negative Bax by competitively binding to Bax (12, 18).

In the physiological setting, genetic studies have revealed a functional relationship between BH3-only activator proteins and multidomain Bcl-2 family proteins. For instance, fatal polycystic kidney disease and lymphopenia caused by loss of Bcl-2 are ameliorated in a Bim knock-out background (19). Similarly, we reported previously that spontaneous hepatocyte apoptosis caused by hepatocyte-specific deficiency of Bcl-xL or Mcl-1 is alleviated by Bid deficiency (20, 21). These studies indicated that Bid or Bim is apparently involved in apoptotic phenotypes induced by lack of an antiapoptotic Bcl-2 family protein. However, it had not been established whether or not these direct activators are required for Bak/Bax activation, leading to mitochondrial apoptosis.

In the present study, we explored the molecular requisites for platelet apoptosis induced by Bcl-xL deficiency. We observed complete recovery from severe thrombocytopenia in Bcl-xL knock-out mice with a Bak and Bax double knock-out background, confirming that Bcl-xL deficiency causes apoptotic cell death through a Bak/Bax-dependent mitochondrial apoptosis machinery. Deficiency of either Bid, Bim, or both did not alleviate thrombocytopenia in Bcl-xL knock-out mice. An *in vitro* study revealed that pharmacological inhibition of antiapoptotic Bcl-2 family proteins sufficiently activated Bax protein to cause apoptosis even in Bid/Bim-deficient platelets. Our current study indicates that Bak/Bax can be activated by neutralization of antiapoptotic Bcl-2 family proteins for the execution of apoptotic cell death without involvement of the BH3-only direct activator proteins Bid and Bim in specific cellular contexts.

EXPERIMENTAL PROCEDURES

Mice—Mice carrying a *bcl-x* gene with two *lox*P sequences at the promoter region and a second intron ($bcl\text{-}x^{flox/flox}$) (22) and heterozygous *pf4-Cre* transgenic mice expressing the Cre recombinase gene under the regulation of the promoter of the platelet factor 4 gene (23) have been described previously. Thrombocyte-specific Bcl-xL knock-out mice ($bcl\text{-}x^{flox/flox}$ *pf4-Cre*) (9) and systemic Bid knock-out mice (24) also have been described previously. We purchased C57BL/6J mice from Charles River (Osaka, Japan) and systemic Bim knock-out mice, systemic Bak knock-out mice, systemic Bax knock-out mice, and conditional Bak/Bax double knock-out mice ($bak^{-/-}bax^{flox/flox}$) from The Jackson Laboratory (Bar Harbor, ME). We generated thrombocyte-specific Bcl-xL/Bid double knock-out mice ($bid^{-/-}bcl\text{-}x^{flox/flox}$ *pf4-Cre*), Bcl-xL/Bim double knock-out mice ($bim^{-/-}bcl\text{-}x^{flox/flox}$ *pf4-Cre*), Bcl-xL/Bid/Bim triple knock-out mice ($bid^{-/-}bim^{-/-}bcl\text{-}x^{flox/flox}$ *pf4-Cre*), Bcl-xL/Bak double knock-out mice ($bak^{-/-}bcl\text{-}x^{flox/flox}$ *pf4-Cre*), Bcl-xL/Bax double knock-out mice ($bax^{-/-}bcl\text{-}x^{flox/flox}$ *pf4-Cre*), Bcl-xL/Bak/Bax triple knock-out mice ($bak^{-/-}bax^{flox/flox}$ $bcl\text{-}x^{flox/flox}$ *pf4-Cre*), and Bak/Bax double knock-out mice ($bak^{-/-}bax^{flox/flox}$ *pf4-Cre*) by mating the strains. We also generated systemic Bid/Bim double knock-out mice ($bid^{-/-}bim^{-/-}$) by mating the strains. Heterozygous *HA-hBcl-xL* transgenic mice expressing human Bcl-xL gene under the regulation of the CAG promoter were generated according to a procedure described previously (25) using a hemagglutinin-tagged human bcl-xL expression plasmid, $pcDNA_3HAbcl\text{-}xL$ (26). Mice were maintained in a specific pathogen-free facility and treated with humane care under approval from the Animal Care and Use Committee of Osaka University Medical School.

Hematological Analyses—Blood was collected from the inferior vena cava of mice. Complete blood cell counts were determined using an automated cell counter (Sysmex, Kobe, Japan).

Platelet Isolation, Storage, and Preparation of Lysates—Platelets were isolated as described previously (9). Briefly, whole blood collected from mice or healthy donors was mixed with ¼ volume of citrate-phosphate-dextrose (Sigma-Aldrich). Platelet-rich plasma was obtained by centrifugation at 100 × *g* for 15 min at room temperature without braking. To avoid mechanical aggregation of platelets by centrifugation, platelet-rich plasma was incubated with 1 μM prostaglandin E_1 (Sigma-Aldrich) and 1 unit/ml apyrase (Sigma-Aldrich) (27). Next, platelets were isolated by centrifugation at 200 × *g* at room temperature for 15 min. Washed platelets were resuspended in modified Tyrode's buffer (5 mM HEPES, 137 mM NaCl, 2.7 mM KCl, 0.4 mM $NaH_2PO_4 \cdot 2H_2O$, 2.8 mM dextrose, pH 7.4) and left standing for 30 min before use. In some experiments, platelet-rich plasma or platelet suspension was stored under continuous gentle agitation in an incubator at 25 °C for the indicated time. For preparation of cell lysates, the platelet pellet was obtained by centrifugation at 200 × *g* at room temperature for 10 min after incubation with 1 μM prostaglandin E_1 (Sigma-Aldrich) for 10 min and lysed in lysis buffer (1% Nonidet P-40, 0.5% sodium deoxycholate, 0.1% sodium dodecyl sulfate, 1× protease inhibitor mixture (Nacalai Tesque, Kyoto, Japan), 1× phosphatase inhibitor mixture (Nacalai Tesque), phosphate-buffered saline, pH 7.4) unless otherwise indicated. The platelet lysates were cleared by centrifugation at 10,000 × *g* at 4 °C for 15 min. Protein concentrations were determined using a bicinchoninic acid protein assay kit (Pierce). We confirmed that incubation with prostaglandin E_1 did not affect the caspase-3/7 activity of isolated platelet supernatant (data not shown).

In Vitro ABT-737 Experiment—ABT-737, provided by Abbott Laboratories (Abbott Park, IL), was dissolved with DMSO. Platelets were treated with 10 μM ABT-737 or DMSO for the indicated times.

3-(4,5-Dimethylthiazol-2-yl)-5-(3-carboxymethoxyphenyl)-2-(4-sulfophenyl)-2H-tetrazolium (MTS) Assay—The MTS assay is a colorimetric assay for measuring the ability of living cells to reduce the uncolored MTS substrate to purple formazan. In platelets, this activity is directly related to cellular viability (4, 5). The MTS assay was performed with a cell proliferation kit (CellTiter 96 AQ_{ueous}, Promega, Tokyo, Japan) according to the manufacturer's protocol. Upon addition of

MTS solution, the reaction plate was incubated at 37 °C for 4 h, and then the absorbance was read at 490 nm with a plate reader (Bio-Rad).

Caspase-3/7 Activity—Serum or platelet supernatant caspase-3/7 activity was measured with a luminescent substrate assay for caspase-3 and caspase-7 (Caspase-Glo assay, Promega) according to the manufacturer's protocol.

Western Blot Analysis—Equal amounts of protein lysates were electrophoretically separated using SDS-PAGE and transferred onto PVDF membrane unless otherwise indicated. For immunodetection, the following antibodies were used: rabbit polyclonal antibody to Bcl-xL (Santa Cruz Biotechnology, Santa Cruz, CA), rabbit polyclonal antibody to Bid, rabbit polyclonal antibody to Bax, rabbit polyclonal antibody to cleaved caspase-3, rabbit polyclonal antibody to Bim, rabbit polyclonal antibody to Puma, rabbit polyclonal antibody to Bcl-2, rabbit polyclonal antibody to Bcl-w, rabbit polyclonal antibody to cytochrome c oxidase IV (Cell Signaling Technology, Beverly, MA), rabbit polyclonal antibody to Bak, rabbit polyclonal antibody to Bax (Millipore, Billerica, MA), rabbit polyclonal antibody to GAPDH (Trevigen, Gaithersburg, MD), rabbit polyclonal antibody to Bim (Assay Designs, Ann Arbor, MI), and mouse monoclonal antibody to β-actin (Sigma-Aldrich).

Isolation of Mitochondria-rich and Cytosolic Fractions—Platelet homogenates were prepared by repeated freeze-and-thaw methods (28). Briefly, platelets in isolation buffer (225 mM mannitol, 75 mM sucrose, 0.1 mM EGTA, 1 mg/ml fatty acid-free BSA, 10 mM HEPES-KOH, 1× proteinase inhibitor mixture, 1× phosphatase inhibitor mixture, pH 7.4) were frozen in liquid nitrogen for 1 min and then thawed at 37 °C for 3 min. This freeze-and-thaw sequence was repeated for two more cycles, and then the samples were centrifuged at 700 × *g* for 10 min at 4 °C. The supernatant was further centrifuged at 15,000 × *g* for 10 min at 4 °C. The pellet was regarded as the mitochondria-rich fraction, and the supernatant was the cytosolic fraction.

Immunoprecipitation—Platelets (1.0×10^8) were lysed in HNC buffer (25 mM HEPES/Na, 300 mM NaCl, 2% CHAPS, 1× protease inhibitor mixture, 1× phosphatase inhibitor mixture, pH 7.5) and immunoprecipitated using mouse monoclonal antibody to Bax (clone 6A7) (Abcam, Cambridge, MA) with an immunoprecipitation kit (Dynabeads Protein G, Invitrogen). Control immunoprecipitations were performed using mouse control IgG (Abcam).

Detection of Bax Oligomerization—Bax oligomerization was detected as described previously (29). Briefly, 5.0×10^7 platelets were lysed with HNC buffer. Next, ~50 mg of platelet lysates was incubated with 5 mM bismaleimidohexane (Pierce) and 5 mM bis(sulfosuccinimidyl) suberate (Pierce) for 30 min at room temperature. To quench cross-linkers, the lysates were incubated with 100 mM Tris-HCl, pH 7.5 for 15 min at room temperature. Bax oligomers were detected by Western blot using rabbit polyclonal antibody to Bax (Cell Signaling Technology).

Statistical Analysis—All data are expressed as mean ± S.D. Statistical analyses were performed by unpaired Student's *t* test or by one-way analysis of variance. When analyses of variance were applied, differences in the mean values among the groups were examined by Scheffe post hoc correction. $p < 0.01$ was considered statistically significant.

RESULTS

Thrombocytopenia Induced by Bcl-xL Deficiency Is Dependent on Proapoptotic Effector Proteins Bax and Bak—Previous research has reported that the mild thrombocytopenia caused by heterozygous Bcl-xL knock-out is prevented in a Bak knock-out background (8). We therefore first examined whether the severe thrombocytopenia seen in the thrombocyte-specific homozygous Bcl-xL knock-out mice (9) could also be prevented by loss of Bak. Bcl-xL and Bak double knock-out mice were generated by mating thrombocyte-specific Bcl-xL knock-out mice and systemic Bak knock-out mice. Bcl-xL and Bak double knock-out mice were born at the expected Mendelian frequency, but unexpectedly, their platelet count did not show any difference from that of the thrombocyte-specific Bcl-xL knock-out mice (Fig. 1*A*). Among Bcl-2 family proteins, not only Bak but Bax is also a well recognized proapoptotic effector protein. Therefore, we next generated Bcl-xL and Bax double knock-out mice by mating thrombocyte-specific Bcl-xL knock-out mice and systemic Bax knock-out mice. Bcl-xL and Bax double knock-out mice were also born at the expected Mendelian frequency, and their platelet count also was not different from that of the thrombocyte-specific Bcl-xL knock-out mice (Fig. 1*B*). To investigate whether the Bak/Bax-dependent mitochondrial apoptotic pathway is actually involved in thrombocytopenia caused by Bcl-xL deficiency, we generated Bcl-xL, Bak, and Bax triple knock-out mice by mating Bcl-xL and Bak double knock-out mice with thrombocyte-specific Bax knock-out mice because systemic Bak and Bax double knock-out mice usually die as neonates (30). Triple knock-out mice were born at the expected Mendelian frequency and did not show any protein expression of Bcl-xL, Bak, and Bax in their platelets on examination by Western blotting (Fig. 1*C*). The platelet count of the triple knock-out mice was almost normal and not significantly different from that of systemic Bak knock-out mice, which served as a control for this mating (Fig. 1*D*). These findings clearly demonstrated that the severe thrombocytopenia induced by thrombocyte-specific Bcl-xL knock-out was fully dependent on Bak/Bax. Serum caspase-3/7 activity, monitored by specific cleavage of the Ac-DEVD-*p*-nitroanilide substrate, was significantly higher in thrombocyte-specific Bcl-xL knock-out mice than control littermates (Fig. 1*E*), suggesting platelet apoptosis in the knock-out mice. Caspase activation in the Bcl-xL knock-out mice was not alleviated in a Bak knock-out background (Fig. 1*E*) but was diminished with a Bak and Bax double knock-out background (Fig. 1*F*), suggesting that Bcl-xL deficiency caused platelet apoptosis through a Bak/Bax-dependent mitochondrial pathway. These results also implied that either Bak or Bax was sufficient to induce apoptosis in Bcl-xL-deficient platelets.

ABT-737 Treatment Provokes Bak/Bax-dependent Apoptosis in Platelets—To investigate the molecular mechanisms of Bak/Bax-dependent platelet apoptosis provoked by a lack of anti-apoptotic Bcl-2 proteins, we conducted an *in vitro* study using ABT-737, a Bad mimetic, which antagonizes the antiapoptotic function of Bcl-xL, Bcl-2, and Bcl-w by binding to the hydro-