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Effect of GPVI-Fc in combination with standard antiplatelet drugs and of GPVI-Fc fused to CD39 on platelet thrombus formation

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Abbreviations and acronyms

ACS	acute coronary syndromes
ADP	adenosine diphosphate
ADAM	a disintegrin and metalloproteinase
AGEs	advanced glycation end products
AMP	adenosine monophosphate
ASA	acetylsalicylic acid
Ca^{2+}	calcium ion
CHO cells	Chinese hamster ovary cells
COL/ADP	collagen + adenosine diphosphate
COL/EPI	collagen + epinephrine
COX	cyclooxygenase
DAPT	dual antiplatelet therapy
Fc	fragment crystallizable region of IgG
FcRγ	Fc receptor γ-chain
GPO	glycine-proline-hydroxyproline
GP	glycoprotein
GPIIbIIIa	glycoprotein IIbIIIa
GPVI	glycoprotein VI
GPVI-Fc	recombinant dimeric GPVI-Fc fusion protein “revacept®”
Ig	immunoglobulin
ITAM	immunoreceptor tyrosine-based activation motif
MEA	multiple electrode aggregometry
Mg^{2+}	magnesium ion
MMPs	matrix metalloproteinases
NSTEMI	non ST-elevation acute coronary syndrome
P_i	inorganic phosphate
PCI	percutaneous coronary intervention
PFA-200	platelet function analyzer 200
PLCγ2	phospholipase Cγ2
STEMI	STelevation myocardial infarction
sCD39	soluble CD39

sGPVI	soluble GPVI
TxA_2	thromboxane A_2
UFH	unfractionated heparin

List of publications

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Introduction

Atherothrombosis and current standard antiplatelet therapy

Myocardial infarction and ischemic stroke are leading causes of mortality and morbidity worldwide [1]. A critical step precipitating these ischemic events is the erosion or rupture of atherosclerotic plaques that exposes thrombogenic material to the bloodstream [2, 3]. Atherosclerosis is a systemic disease characterized by intimal thickening due to cell and lipid accumulation leading to plaque formation and eventually plaque disruption [4, 5]. As a result of plaque rupture or erosion, platelets become activated, aggregate and form intravascular thrombi—a pathological process referred to as atherothrombosis [2-4]. In contrast, the physiological platelet activation during primary hemostasis is initiated in response to endothelial injury of the healthy vessel wall and prevents hemorrhage and blood loss [6]. Drug therapies aiming to prevent atherothrombotic events target platelet activation and aggregation and are commonly used to lower the vascular risk in patients suffering from coronary or cerebrovascular disease [7].

Antiplatelet therapy is generally conducted either as a single drug application of acetylsalicylic acid (ASA) alone or as dual anti-platelet therapy (DAPT) by combining the former with an antagonist of the ADP-receptor $P2Y_{12}$ [8-10]. ASA inhibits the formation of the prothrombotic thromboxane A_2 (TxA_2) by irreversible inhibition of the platelet cyclooxygenase I (COX I) [11]. The $P2Y_{12}$-receptor antagonists inhibit platelet activation by adenosine diphosphate (ADP). ADP is released from dense platelet granules at sites of platelet adhesion and aggregation accompanied by different cytokines and other biologically active substances [8, 11]. Released ADP then activates additional platelets via the $P2Y_{12}$- and $P2Y_1$-receptors and leads to further platelet aggregation and secretion via feedback amplification and, hence, to thrombus propagation [8]. The substances cangrelor and ticagrelor—the latter was used as a representative of the $P2Y_{12}$-receptor antagonists in the conducted studies—act as direct and reversible $P2Y_{12}$-receptor antagonist, while clopidogrel, prasugrel and ticlopidine irreversibly block the $P2Y_{12}$-receptor after being transformed into their active metabolite via hepatic metabolism [8, 11].

DAPT and heparin is the standard therapy in patients with acute coronary syndromes (ACS) and myocardial infarction undergoing percutaneous coronary intervention (PCI) [12-15]. In certain high risk patients undergoing PCI an even stronger antiplatelet medication with glycoprotein IIbIIIa (GPIIbIIIa) inhibitors can be indicated: GPIIbIIIa inhibitors such as abciximab, eptifibatide or tirofiban are then applied intravenously in addition to unfractionated heparin (UFH) and pretreatment with or without clopidogrel [8, 12-19]. By blocking the platelet integrin $\alpha_{IIb}\beta_3$, GPIIbIIIa inhibitors act as fibrinogen-receptor antagonists and thereby strongly inhibit platelet aggregation [11].

All mentioned drugs target and inhibit platelet activation and aggregation at the cost of an increased bleeding risk, ranking from minor bleeding to fatal intracranial bleeding [9, 10, 20, 21]. While the pathological thrombus formation is inhibited by these antiplatelet drugs, the physiological process of primary hemostasis that prevents hemorrhage and blood loss, is affected as well. Severe bleedings occur especially when drug combinations are applied [10]. However, the combination of antiplatelet drugs is more effective in preventing ischemic events compared to single drug therapy [9, 10]. Although the current standard antiplatelet therapies provide an improved treatment of cardio- and cerebrovascular diseases, atherothrombosis is still a problem [22]. On the other hand, an improvement or increase in the antithrombotic effect—for example by combining different antiplatelet drugs—can lead to an increased bleeding risk [10, 21, 22]. This explains the need and search for novel antiplatelet drugs that might complement or even replace the currently used antiplatelet therapies. Ideally, these novel drugs should have no or little effect on physiological hemostasis while effectively inhibiting the pathological thrombus formation found in atherothrombosis.

One of these novel strategies in antiplatelet therapy is the targeting of platelet glycoprotein VI (GPVI). GPVI, a 60-65 kDa type I transmembrane glycoprotein of the immunoglobulin superfamily, contains two immunoglobulin-like loops (D1 and D2) in its extracellular domains, which are crucial for collagen-binding [23, 24]. It is co-expressed on platelets with the Fc receptor γ-chain (FcRγ). The latter is crucial for surface expression of GPVI as well as for signaling through the receptor [25, 26]. GPVI associates with the Src family kinases Fyn and Lyn as well as with calmodulin [27, 28]. Ligand binding to GPVI leads to cross-linking and clustering of the receptor and activation of Fyn and Lyn which phosphorylate immunoreceptor tyrosine-based activation motifs (ITAM) within the cytoplasmic tail of FcRγ. The phosphorylated ITAMs in turn bind to the tandem SH2 domains of Syk leading to its activation [28]. These initial

signaling steps lead to the assemblance and phosphorylation of downstream adapters, the activation of phospholipase Cγ2 (PLCγ2) with the subsequent increase in cytosolic calcium and protein kinase C activation. The latter signals ultimately lead to activation of platelets [26, 29, 30].

GPVI is present on the platelet surface both as monomer and dimer [31, 32]. While the monomeric form predominates on resting platelets, the expression of the dimeric form on the platelet surface increases when platelets are stimulated [32]. Only the dimeric form of GPVI is important for platelet activation and aggregation as it shows high affinity binding to glycine-proline-hydroxyproline (GPO) sequence repeats in collagen fibers [24, 33-35]. The described process is crucial in plaque-induced thrombus formation [36].

The importance of GPVI in atherothrombosis

The main thrombogenic components of atherosclerotic plaques are collagen type I and III. [36, 37]. The interaction of platelet GPVI with these collagenous plaque components was shown to be crucial in plaque-induced platelet activation [36, 38]. Binding of GPVI to these collagen structures initiates platelet activation via the mentioned intracellular signaling: Shape change and adhesion of platelets are induced, followed by activation of fibrinogen receptors and secretion of the secondary platelet agonists TxA2 and ADP, subsequently leading to thrombus formation [7, 36]. The former is contrasted by the coordinated interaction via two platelet surface collagen receptors—GPVI and integrin $\alpha_2ß_1$—stimulated by collagen from healthy vessel walls [39]. The two collagen receptors play an important role in stable platelet adhesion to normal collagen, and upon collagen-interaction individual platelets appear to use either of them [39]. Hence, individual platelets become activated via GPVI either before or after integrin $\alpha_2ß_1$-mediated stable platelet adhesion. So, while both platelet collagen receptors are essential for platelet interaction with collagen from healthy vessel walls, GPVI alone is sufficient for platelet interaction with and activation by plaque-derived collagen [36].

The structure of the plaque-derived collagen differs greatly from the structure of collagen found in healthy vessel walls. This indicates that the interaction with and activation of platelets is influenced by aspects of the collagen structure [36, 40, 41]. Both enzymatic and non-enzymatic processes may be involved in the evolvement of these differences in collagen structure. Plaque-

collagen is known to be cleaved by proteolytic enzymes, primarily by specific matrix metalloproteinases (MMPs) that are overexpressed in atherosclerotic plaques due to inflammation [42-45]. The resulting small and diffuse cross-linked collagen fragments nevertheless retain their ability to activate platelet GPVI or might even have an increased capacity to activate platelets [36]. Further, adjacent collagen molecules become linked non-enzymatically by advanced glycation end products (AGEs) that accumulate during ageing and diabetes and provoke changes in the fibrillar collagen structure [46, 47]. These changes in collagen structure might explain why GPVI is responsible for plaque-induced platelet aggregation while the second platelet collagen receptor—the integrin $\alpha_2ß_1$—seems to play an only minor role in atherothrombosis [36, 48].

GPVI in hemostasis

Since GPVI plays an important role in platelet activation, it could be expected that its deficiency would have a severe impact on normal hemostasis [22]. However, patients with GPVI deficiency present an only mild bleeding tendency [26, 49-55]. GPVI deficiency is most frequently found in acquired immune thrombocytopenia: Patients commonly present mild to severe thrombocytopenia accompanied by a lack of collagen-induced platelet activation due to antibody-induced GPVI depletion [49-52]. In response to ligand binding, GPVI is proteolytically cleaved from the platelet surface mediated prominently by members of the a disintegrin and metalloproteinase (ADAM) family: ADAM10 and ADAM17. [56-62]. Activating as well as non-activating anti-GPVI antibodies, collagen and fibrin as well as inhibitors of GPVI-related signaling proteins–such as Syk, Src family kinases and calmodulin–lead to the release of soluble GPVI fragments [56, 57, 60, 63-65]. Patients with anti-GPVI auto-antibodies may also have thrombocytopenia which is explained by increased phagocytosis, sequestration and clearance of antibody-bound platelets [51]. Further, signaling through the FcRγ-chain seems to play an essential part in the signaling process leading to thrombocytopenia since mice bearing a mutant variant of the FcRγ-chain did not develop detectable thrombocytopenia [66]. In contrast, a normal platelet count is found in patients with congenital GPVI deficiency, and a compound heterozygous GPVI mutation was identified in two of these cases [53-55]. Bleeding tendency in all these patients were described as mild, although the acquired condition can bear the risk of severe bleeding complications if combined with thrombocytopenia [26].

These findings are confirmed by studies in GPVI deficient mice. In knock-out mice GPVI deficiency is obtained by gene knock-out of the genes coding for GPVI or FcRγ—since the co-receptor FcRγ is necessary for GPVI surface expression [25, 67, 68]. An acquired deficiency in GPVI in mice can also be induced via the injection of anti-GPVI antibodies leading to transient thrombocytopenia and GPVI depletion: The injection of rat anti-murine GPVI antibodies—termed JAQ1, JAQ2 and JAQ3 which are directed to different epitopes of GPVI—into mice resulted in a prolonged GPVI depletion in circulating murine platelets [63, 69, 70]. *In vitro* antibody treatment did not achieve the same depletion, and the existence of a pathway downstream of GPVI—leading to internalization and irreversible loss of murine GPVI—was proposed [58, 66]. Whether a similar internalization process occurs in human platelets treated with anti-GPVI antibodies *in vitro* or *in vivo* has not yet been established [58, 71]. However, anti-GPVI antibody treatment of human platelets can induce GPVI shedding *in vitro*, probably by metalloproteolysis [71]. As well as for patients with GPVI deficiency no serious hemorrhagic impact was observed in GPVI deficient mice. The longer bleeding time occasionally observed may be associated with modifier genes [72]. In summary, these observations indicate an only minor role of GPVI in normal hemostasis [22, 73].

GPVI as a target in antiplatelet therapy

Since GPVI is the most important collagen-receptor in atherothrombosis, while only being of minor importance in hemostasis, it is an ideal target in antiplatelet therapy [36, 74]. Targeting GPVI allows to preferentially inhibit atherosclerotic plaque-induced platelet aggregation while systemic bleeding tendencies are not likely to become severely altered and physiologic hemostasis should be preserved. Further, a good antithrombotic efficacy can be expected due to the early inhibition of platelet activation combined with an additional reduction in thrombin generation—probably by inhibiting its interaction with fibrin polymers [22, 75]. Furthermore, GPVI expression is restricted to platelets and megakaryocytes and its inhibition should have no effect on other cells [76, 77].

Of note, platelet GPVI expression varies dependent on the GPVI-genotype and is higher in patients with transient ischemic attack and stroke [78, 79]. Accordingly, patients with acute stroke and large artery disease presented elevated levels of plasma soluble GPVI (sGPVI) suggesting an association between metalloproteinase-mediated shedding of platelet GPVI and

atherothrombotic disease [62, 80]. In mice depletion of GPVI significantly reduced the infarct volume in acute experimental stroke without any increase in bleeding complications. The latter indicates both the involvement of GPVI in stroke development and a favorable safety profile concerning its inhibition [81].

An enhanced GPVI expression was further displayed in patients with ACS as an independent marker of myocardial ischemia [82]. Several studies indicate that allelic differences in GPVI alter platelet function and that polymorphic variations at the GPVI locus effect the susceptibility for myocardial infarction [83-85]. Possession of the C-allele of the GPVI T13254C polymorphism showed an association with coronary thrombosis [85]. An increased risk for myocardial infarction was further described for the GPVI 13254CC genotype [83]. These observations further indicate that GPVI might be an ideal therapeutic target when aiming to prevent cardio- and cerebrovascular events.

GPVI targeting strategies

The GPVI pathway may be targeted via different strategies. One approach is to inhibit the platelet GPVI-collagen-interaction. This can be achieved either by GPVI-mimics competing with platelet GPVI for collagen binding or by anti-GPVI antibodies blocking platelet GPVI—without effecting GPVI expression [74]. Since anti-GPVI-antibodies act systemically and inhibit GPVI on all circulating platelets, they are potent inhibitors of platelet aggregation and might increase bleeding tendencies as observed in some patients with anti-GPVI auto-antibodies [26, 86]. Some anti-GPVI antibodies like JAC-1 in mice induce platelet GPVI depletion [63, 87, 88]. This second strategy would most likely provide a prolonged antithrombotic effect [69, 89]. However, GPVI depletion might influence the platelet count and provoke thrombocytopenia [26, 69]. Its mechanism and the activation signals involved are so far only poorly characterized [89]. A third approach might be the use of signaling inhibitors such as kinase-targeting drugs to inhibit collagen-triggered platelet responses via the GPVI signaling pathway [89]. The lack of specificity presented by the targeted kinases might though lead to a wide range of possible adverse effects [89]. Hence, targeting the GPVI-collagen-interaction might be the most promising approach.

Advantages of GPVI targeting via GPVI-Fc

Inhibition of platelet GPVI binding to collagen can be achieved by the dimeric GPVI-Fc fusion protein revacept®—in the following referred to as GPVI-Fc [86, 90]. The soluble fusion protein, of approximately 150 kDa molecular mass, comprises two extracellular domains of human GPVI–each linked to the Fc of human IgG1 by a 3-amino acid linker sequencen—and the resulting dimere structure shows high affinity to collagen typ I and III [24, 33, 86, 90].

GPVI-Fc does not act systemically: it binds to vascular collagen only when it is exposed after atherosclerotic plaque rupture/erosion or injury of healthy vessels [86]. Further, GPVI-Fc did not increase bleeding in mice and humans. [90, 91]. In a phase 1 study a single intravenous GPVI-Fc application was shown to be safe and well tolerated without affecting hemostasis in healthy human volunteers [90]. Long-term application of GPVI-Fc in mice also attenuated atheroprogression by inhibiting GPVI-mediated platelet adhesion to atherosclerotic vessel walls [48, 92]. Additionally, prolonged GPVI-Fc-administration showed favorable effects on vascular remodeling after wire injury of murine carotid arteries [93]. Hence, GPVI-Fc administration might provide beneficial effects beyond short term application [90].

GPVI-Fc furthermore showed a more potent inhibition of platelet thrombus formation onto atherosclerotic plaques at high shear flow, as found in stenotic vessels, compared to arterial flow at lower shear rates [94]. The latter suggests—in addition to the lesion-focused mechanism of action of GPVI-Fc—a rather localized antithrombotic efficacy at stenotic atherosclerotic lesions that have a high risk to rupture [2, 94]. The possibility of a localized antiplatelet therapy at sites of plaque rupture and erosion combined with the absence of noticeable effects on hemostasis is the reason why in the dissertation GPVI-Fc was favored over anti-GPVI antibodies.

Objectives

I. GPVI-Fc in combination with standard antiplatelet drugs in plaque-induced thrombus formation *in vitro*

The primary purpose of this dissertation was to study the potential of GPVI-Fc as an adjunct to current standard antiplatelet therapy and to deduce its possible effect when applied on top of these drugs in clinical settings caused by atherothrombotic events—as found in myocardial infarction, ischemic stroke or PCI [95]. Toward that end, GPVI-Fc was combined with ASA, the $P2Y_{12}$-receptor-antagonist ticagrelor, alone or in combination (DAPT), or the anti-GPIIbIIIa antibody abciximab in an experimental setting mimicking atherosclerotic plaque-induced atherothrombosis *in vitro* [95].

Both static assays and dynamic experiments under arterial flow conditions were conducted comparing the different single drugs and their combinations [95]. GPVI-Fc or buffer control was added to blood from healthy human volunteers anticoagulated with hirudin—in order not to disturb the physiological blood concentrations of Ca^{2+} and Mg^{2+} both important in platelet adhesion and aggregation to collagen [95-97]. The blood contained additionally ASA, ticagrelor, both antiplatelet drugs, or abciximab alone or combined with ASA and/or ticagrelor [95]. Static platelet aggregation was determined by multiple electrode aggregometry (MEA) using the Multiplate® device. Dynamic experiments were performed to simulate platelet activation by plaque rupture or erosion: Blood was perfused over human atherosclerotic plaque homogenate at a shear rate of 600/s representing the approximate mean physiological wall shear rate of carotid and coronary arteries and, subsequently, platelet deposition to plaque-collagen was measured and analyzed via fluorescent microscopy [95, 98-100].

Effects on platelet aggregation were examined as well as effects on platelet adhesion. The latter was studied in the presence of the fibrinogen receptor antagonist abciximab, that is clinically used in PCI and blocks platelet aggregation [12, 19]. Stable and total platelet adhesion were compared since subsequent platelet aggregation—in the natural setting with undisturbed platelet fibrinogen receptor binding—may be determined rather by stable than by transient platelet adhesion to plaque-collagen [95]. Stable platelet adhesion was therefore measured after stopping blood flow and rinsing off rolling or loosely attached platelets [95]. *In vitro* bleeding

times for each drug or combination were further measured by the PFA-200 device simulating primary hemostasis *ex vivo* [95].

The results were published in the paper "*Recombinant GPVI-Fc added to single or dual anti-platelet therapy in vitro prevents plaque-induced platelet thrombus formation"* [95].

II. Enhancing the antithrombotic potential of GPVI-Fc by fusion to CD39

A second approach aimed at increasing the antithrombotic potential and therapeutic efficiency of GPVI-Fc [101]. To target both GPVI-mediated and ADP-enforced platelet aggregation GPVI-Fc was linked to the extracellular domain of the ecto-ADPase CD39 that splits prothrombotic extracellular ADP into AMP and P_i [101-103]. The enzyme is amongst others expressed by endothelial cells and is important to keep platelets non-activated while they pass through intact blood vessels [102]. Recombinant soluble CD39 (sCD39) might hence serve as an effective inhibitor of platelet reactivity by inhibiting ADP-mediated platelet recruitment without any direct effect on platelets [101, 103].

General CD39 activation has shown an increase in bleeding in different murine models—when applied intravenously as well as in CD39-transgenic mice [104, 105]. Since GPVI-Fc acts locally at sites of plaque rupture and erosion and is more potent at high shear flow found at stenoses, the linker molecule is expected to turn the systemic action of sCD39 into a localized action focused to the lesion site [94, 101]. Consequently, the effective doses of CD39 should be perceivably lower and systemic bleeding complications should be reduced compared to the application of sCD39 [101, 104, 106].

In conclusion, the bifunctional fusion protein GPVI-CD39 was designed as a lesion-directed dual antiplatelet therapy expected to lack systemic bleeding complications [101]. The cDNA coding for the fusion protein was established by gene synthesis: The extracellular domain of platelet GPVI and the Fc part of human IgG2 were connected by a 15-amino acid linker to the extracellular domain of human CD39 [101]. While the original GPVI-Fc revacept® comprises the Fc of human IgG1, the fusion protein is—for steric reasons—composed of the Fc derived from human IgG2 [86, 90, 101]. The Fc domain facilitates dimerization of the fusion molecule while the flexible amino acid linker enables proper folding of the CD39 domain [101]. Doxycycline-

inducible, stably transfected CHO cells successfully expressed the fusion protein which was subsequently purified from the cellular supernatant by protein G affinity chromatography [101].

The fusion molecule was evaluated regarding its inhibitory potential on collagen- and plaque-induced platelet thrombus formation *in vitro* and arterial thrombus formation after vascular injury in mice *in vivo* [101]. Effects on platelet aggregation under static conditions were analyzed by MEA in human blood using collagens from different sources as well as human atherosclerotic plaque material and the secondary agonist ADP [101]. To simulate plaque-induced atherothrombosis blood was perfused over atherosclerotic plaque homogenate at different shear rates: Shear rates of 600/s and 1500/s were chosen to represent the mean physiological wall shear rate in carotid and coronary arteries and the shear rate at mildly stenotic coronary lesions, respectively [98, 101, 107]. Furthermore, pulsatile flow conditions were applied to mimic the stop-and-go blood flow found in coronary arteries [101, 108, 109]. The antithrombotic effects of GPVI-CD39 was additionally studied *in vivo* in a murine vascular injury model monitoring the time to vessel-occlusion after local application of 15% ferric chloride onto the common carotid artery [101]. To estimate bleeding tendencies *in vitro* closure times were measured with the PFA-200 device after adding GPVI-CD39 to citrated blood [101]. Pharmacokinetics and *in vivo* bleeding time were further studied in mice to determine the hazard potential of GPVI-CD39, since effective doses of sCD39 provoked a higher bleeding risk in different animal models [101, 104, 105].

The obtained results were published in the paper "*ADPase CD39 Fused to Glycoprotein VI-Fc Boosts Local Antithrombotic Effects at Vascular Lesions"* [101]. The author's contribution as co-author consisted in the planning, realization, analysis and presentation of the static and flow experiments—represented in Figure 3 and Figure 4—as well as in the drafting of the respective paragraphs of the paper (methods and results).

Summary

The dimeric fusion protein GPVI-Fc acts as a lesion-focused antiplatelet drug. It binds to plaque-collagen and conceals binding sites for platelet GPVI [86, 90]. Consequently, it inhibits platelet GPVI-mediated platelet activation and aggregation and therefore thrombus formation. The main purpose of this dissertation was to study the potential of GPVI-Fc as a possible clinical adjunct to ASA, a $P2Y_{12}$-receptor-antagonist (ticagrelor), both (DAPT), or a GPIIbIIIa inhibitor (abciximab) in an experimental setting of plaque-induced atherothrombosis relevant for ischemic stroke, myocardial infarction or during PCI [95]. We investigated whether the addition of GPVI-Fc on top of these antiplatelet drugs *in vitro* could further suppress plaque-induced platelet thrombus formation without untoward effects on primary hemostasis [95].

Under static conditions, GPVI-Fc restrained plaque-induced platelet aggregation by 53 %, and enhanced platelet inhibition by ASA (51 %) and ticagrelor (64 %) to 66 % and 80 %, respectively [95]. Under arterial flow, GPVI-Fc reduced plaque-induced platelet aggregation by 57 %, and significantly increased platelet inhibition by ASA (28 %) and ticagrelor (47 %) to about 81 % each [95]. The triple combination of GPVI-Fc, ASA and ticagrelor resulted in a virtually complete inhibition of plaque-induced platelet aggregation (93 %) [95].

In conclusion, GPVI-Fc added on top of ASA, ticagrelor or both provided superior inhibition of plaque-induced platelet aggregation as compared to the respective drugs alone or in combination [95]. These findings were particularly pronounced under arterial flow conditions [95]. The latter might be due to the strong inhibition of platelet adhesion to plaque-collagen by GPVI-Fc under flow [95]. In contrast to ASA and ticagrelor, GPVI-Fc directly inhibits the platelet-collagen-interaction [95]. Furthermore, GPVI-Fc acts as a lesion-focused antiplatelet drug, whereas ASA and $P2Y_{12}$-receptor-antagonists act systemically and suppress TxA_2- or ADP-mediated activation in all circulating platelets [86, 94]. Probably due to this mechanism of action which is restricted to the collagen exposed after rupture or erosion of atherosclerotic lesions, GPVI-Fc seems safe concerning bleeding risks [95]. Indeed, when added on top of ASA or ticagrelor, GPVI-Fc did not alter the PFA-200 closure time [95]. The latter is in accordance with previous findings in mice *in vivo*: GPVI-Fc did not prolong tail bleeding time when combined with ASA or a $P2Y_{12}$-receptor-antagonist [91]. These results suggest that GPVI-Fc added to current single or dual antiplatelet therapy with ASA and/or $P2Y_{12}$-receptor-antagonists might provide a superior protection against acute atherothrombotic events while bleeding risks are not increased

[95]. This rationale is supported by the increased platelet GPVI-expression in patients with ACS or ischemic stroke [80, 82, 95].

In combination with the GPIIbIIIa antibody abciximab GPVI-Fc very strongly inhibited total (81 %) and stable (89 %) platelet adhesion to plaque under flow [95]. GPIIbIIIa inhibitors, which block platelet aggregation via fibrinogen-receptor-binding, are clinically used during PCI to prevent acute thrombotic complications and are known to increase bleeding risks [21, 110]. These findings suggest that the combination of GPIIbIIIa inhibitors with GPVI-Fc in patients could be harmful [95]. In conclusion, our study provides experimental evidence that the short-term addition of GPVI-Fc to ASA and/or $P2Y_{12}$-receptor-antagonists might provide a safe and superior anti-atherothrombotic protection during interventions and might replace the addition of GPIIbIIIa blockers [95].

To further enhance the antithrombotic potential of GPVI-Fc the recombinant fusion protein GPVI-CD39 was created and analyzed [101]. The fusion molecule efficiently degraded exogenous ADP and inhibited ADP-, collagen- and atherosclerotic plaque-induced platelet aggregation under static conditions as well as plaque-triggered thrombus formation under arterial flow [101]. The effect was dose and shear dependent: inhibition was more pronounced at high shear (1500/s) compared to low shear (600/s) [101]. GPVI-CD39 exhibited stronger potency than GPVI-Fc to inhibit aggregate formation when tested at concentrations of 150 nmol/L at continuous flow at a shear rate of 600/s [101]. The difference was larger and significant when pulsatile flow was applied [101].

GPVI-CD39 did not increase closure times in an *in vitro* assay simulating primary hemostasis using either COL/ADP or COL/EPI cartridges [101]. As expected, closure time increased significantly at higher GPVI-CD39 concentrations using P2Y cartridges—which allow for sensitive detection of P2Y antagonism—confirming effective inhibition of the secondary agonist ADP by the fusion molecule [101]. In a murine model of ferric chloride–induced carotid arterial thrombosis, GPVI-CD39 did not increase tail bleeding time *in vivo* while effectively delaying vascular thrombosis [101]. In accordance to previous data on sCD39 the respectively low concentrations of GPVI-CD39 applied suggest that the combination of CD39 with GPVI in a single molecule offers a favorable risk–benefit ratio when compared to sCD39 [101, 104, 106].

These findings suggest that the fusion protein GPVI-CD39 is an attractive strategy for lesion-directed antiplatelet therapy: It inhibits collagen-induced platelet adhesion and aggregation at sites of plaque rupture and erosion and subsequently local platelet recruitment by the released

ADP without relevantly increasing systemic bleeding [101]. This local enrichment of CD39 might, further, offer an attractive therapeutic option in arterial diseases since reduced CD39 activity was shown to be associated with disease progression in patients with peripheral arterial disease [101, 111]. In addition, the frequently applied $P2Y_{12}$-receptor antagonist clopidogrel and ticlopidine were shown to inhibit as prodrugs vascular CD39 activity *in vitro* [112]. Hence, short-term intravenous GPVI-CD39 administration might result beneficial especially in acute vascular syndromes and emergency conditions [101]. In conclusion, the GPVI-CD39 fusion protein might be an effective and safe molecule for the treatment of acute atherothrombotic events and should be further investigated in clinical trials [101].

Zusammenfassung

Das dimere Fusionsprotein GPVI-Fc entfaltet seine antithrombozytäre Wirkung an atherosklerotischen Gefäßläsionen. Hier bindet es an Plaquekollagen und verbirgt so Bindungsstellen für GPVI auf Thrombozyten [86]. Dies führt zur Hemmung der GPVI-vermittelten Thrombozyten-aktivierung und -aggregation und der Entstehung von Thromben. Das primäre Ziel dieser Dissertation lag in der Beantwortung der Frage, inwiefern GPVI-Fc als Zusatztherapie zu Acetylsalicylsäure (ASA), einem $P2Y_{12}$-Rezeptor-Antagonisten (wie beispielsweise Ticagrelor), dualer Thrombozytenaggregationshemmung (DAPT) oder einem GPIIbIIIa-Rezeptor-Antagonisten (wie beispielsweise Abciximab) klinisch sinnvoll sein könnte [95]. Die Durchführung der Versuche erfolgte *in vitro* in einem Modell der Plaque-induzierten Thrombozyten-aggregation, um die atherothrombotischen Ereignisse nach Ruptur oder Erosion atherosklerotischer Plaques – wie sie beim ischämischen Schlaganfall, beim Myokardinfarkt oder während perkutaner transluminaler Angioplastie auftreten – wiederzuspiegeln [95]. Untersucht wurde, ob sich durch Zusatz von GPVI-Fc eine zur bisherigen antithrombozytären Therapie zusätzliche Hemmung der Plaque-induzierten Thrombozytenaggregation – ohne negative Auswirkungen auf die primäre Hämostase – erreichen lässt [95].

Unter statischen Versuchsbedingungen bewirkte GPVI-Fc eine Reduktion der Plaque-induzierten Thrombozytenaggregation von 53 % sowie eine Steigerung der Hemmung durch ASA (51 %) und Ticagrelor (64 %) von 66 % beziehungsweise von 80 % [95]. Unter arteriellen Flussbedingungen hemmte GPVI-Fc die Plaque-induzierten Thrombozytenaggregation mit 57 %

und führte zu einer signifikanten Steigerung der Hemmung durch ASA (28 %) und Ticagrelor (47 %) auf jeweils etwa 81 % [95]. Die Dreifachkombination von GPVI-Fc, ASA and Ticagrelor bewirkte eine beinahe vollständige Hemmung der Plaque-induzierten Thrombozytenaggregation (93 %) [95].

Zusammenfassend bot die Zugabe von GPVI-Fc zu ASA, Ticagrelor oder beiden Aggregationshemmern eine überlegene Hemmung der Plaque-induzierten Thrombozyten-aggregation im Vergleich zu den jeweils einzelnen Medikamenten oder deren Kombination [95]. Dies war insbesondere unter arteriellen Flussbedingungen ausgeprägt [95]. Letzteres beruht möglicherweise auf der spezifischen Hemmung der Thrombozytenadhäsion an Plaquekollagen durch GPVI-Fc unter Flussbedingungen [95]. Denn im Gegensatz zu ASA und Ticagrelor hemmt GPVI-Fc die Thrombozyten-Kollagen-Interaktion direkt [95]. Darüber hinaus wirkt GPVI-Fc gezielt an Gefäßläsionen, während ASA und $P2Y_{12}$-Rezeptor-Antagonisten eine systemische Wirkung zeigen und die TxA_2- oder ADP-vermittelte Aktivierung aller zirkulierender Thrombozyten hemmen [86, 94]. Möglicherweise aufgrund dieses gezielten, auf das exponierte Kollagen an atherosklerotischen Gefäßläsionen begrenzten, Wirkmechanismus zeigt sich GPVI-Fc sicher hinsichtlich Blutungsrisiken [95]. Übereinstimmend führte der Zusatz von GPVI-Fc zu ASA oder Ticagrelor nicht zu einer Veränderung der PFA-Verschlußzeit [95]. Letzteres steht in Einklang mit früheren Ergebnissen *in vivo* in Mäusen: GPVI-Fc führte nicht zu einer verlängerten Blutungszeit nach Verletzung der Schwanzspitze – auch nicht in Kombination mit ASA oder $P2Y_{12}$-Rezeptor-Antagonisten [91]. Diese Ergebnisse legen nahe, dass der Zusatz von GPVI-Fc zur gängigen Thrombozytenaggregationshemmung mit ASA und/oder $P2Y_{12}$-Rezeptor-Antgonisten einen überlegenen Schutz vor akuten atherothrombotischen Ereignissen zu leisten vermag – ohne dabei eine Erhöhung des Blutungsrisikos zu bewirken [95]. Diese Argumentation wird ebenfalls gestützt durch das Vorliegen einer erhöhten GPVI-Expression bei Patienten mit ACS oder ischämischem Schlaganfall [80, 82, 95].

In Kombination mit dem GPIIbIIIa-Antikörper Abciximab führte GPVI-Fc zu einer sehr starken Hemmung der totalen (81 %) sowie der stabilen (89 %) Thrombozytenadhesion unter Fluss-bedingungen [95]. GPIIbIIIa-Hemmer blockieren die Fibrinogen-Rezeptor-vermittelte Thrombo-zytenaggregation und werden klinisch während perkutaner transluminaler Angioplastie zur Verhinderung akuter thrombotischer Komplikationen eingesetzt, wobei sie bekanntermaßen das Blutungsrisiko erhöhen [21, 110]. Die Ergebnisse legen nahe, dass die Kombination von GPIIbIIIa-Hemmern mit GPVI-Fc für Patienten von Nachteil sein könnte [95]. Die starke

Hemmung der Thrombozytenadhesion durch Kombination von GPVI-Fc und Abciximab deutet darauf hin, dass das gesteigerte Blutungsrisiko – welches nach Verabreichung von GPIIbIIIa-Hemmern beobachtet wurde – durch Zusatz von GPVI-Fc verstärkt werden könnte [95]. Zusammenfassend liefert die Untersuchung experimentellen Anhalt dafür, dass der kurzzeitige Zusatz von GPVI-Fc zu ASA und/oder $P2Y_{12}$-Rezeptor-Antagonisten einen sicheren und überlegeneren anti-atherothrombotischen Schutz während angioplastischer Eingriffe bieten könnte als die Zugabe von GPIIbIIIa-Hemmern [95].

Um das antithrombotische Potential von GPVI-Fc weiterzuentwickeln, wurde das rekombinante Fusionsprotein GPVI-CD39 entwickelt und analysiert [101]. Das Fusionsmolekül führte zu einem effizienten Abbau exogenen ADPs sowie zur Hemmung sowohl der ADP-, Kollagen- und Plaque-induzierten Thrombozytenaggregation unter statischen Bedingungen als auch der Plaque-induzierten Thrombusbildung unter arteriellen Flussbedingungen [101]. Der Effekt war scherraten- und dosisabhängig: Bei hoher Scherrate (1500/s) zeigte sich eine ausgeprägtere Hemmung im Vergleich zur niedrigeren Scherrate (600/s) [101]. GPVI-CD39 bewirkte eine stärkere Aggregationshemmung als GPVI-Fc bei einer Konzentration von 150 nmol/L und kontinuierlichem Fluss bei einer Scherrate von 600/s [101]. Dieser Unterschied war größer und signifikant unter pulsatilem Blutfluss [101].

GPVI-CD39 führte nicht zu einer Verlängerung der Verschlusszeit in einem *in vitro* Modell der primären Hämostase unter Verwendung von COL/ADP oder COL/EPI Testkartuschen [101]. Erwartungsgemäß zeigte sich eine signifikante Verlängerung der Blutungszeit bei höheren GPVI-CD39 Konzentrationen unter Verwendung von P2Y Testkartuschen [101]. Letztere erlauben einen sensitiven Nachweis eines P2Y Antagonismus und ihre Verwendung bestätigte eine effektive Hemmung des sekundären Agonisten ADP durch das Fusionsmolekül [101]. GPVI-CD39 verzögerte effektiv die Gefäßthrombosierung und führte nicht zu einer verlängerten Blutungszeit nach Verletzung der Schwanzspitze *in vivo* in einem Mausmodell der Eisenchlorid-induzierten Carotisarterien-Thrombose [101]. In Übereinstimmung zu früheren Ergebnissen zu sCD39 legen die vergleichsweise niedrigen GPVI-CD39 Konzentrationen nahe, dass die Kombination von CD39 und GPVI in einem Molekül ein günstigeres Risiko-Nutzen-Verhältnis bietet im Vergleich zu sCD30 [101, 104, 106].

Diese Ergebnisse zeigen, dass das rekombinante Fusionsprotein GPVI-CD39 eine attraktive Strategie für eine lokalisierte Thrombozytenaggregationshemmung an atherosklerotischen

Plaqueläsionen sein könnte: GPVI-CD39 hemmt die durch Plaque-Kollagen induzierte Thrombozytenadhesion und -aggregation und anschliessend lokal die durch sezerniertes ADP vermittelte Thrombozytenrekrutierung, ohne dabei eine Erhöhung der systemischen Blutungsneigung zu bewirken [101]. Eine solch lokale Anreicherung von CD39 könnte eine attraktive Therapieoption bei Patienten mit peripherer arterieller Verschlusskrankheit sein, da sich hier ein Zusammenhang zwischen reduzierter CD39 Aktivität und dem Fortschreiten der Erkrankung zeigte [101, 111]. Die diesen Patienten häufig verabreichten $P2Y_{12}$-Rezeptor Antagonisten Clopidogrel und Ticlopidine bewirken als prodrugs zudem eine Hemmung der vaskulären CD39-Aktivität *in vitro* [112]. Folglich könnte die kurzzeitige intravenöse Applikation von GPVI-CD39 besonders vorteilhaft sein bei akuten atherothombotischen Ereignissen sowie in Notfallsituationen [101]. Zusammenfassend bietet sich mit dem GPVI-CD39 Fusionsprotein ein vielversprechendes Molekül für die Behandlung akuter atherothrombotischer Ereignisse, welches in klinischen Studien weiter untersucht werden sollte [101].

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Publication I

Mojica Muñoz AK, Jamasbi J, Uhland K, Degen H, Münch G, Ungerer M, Megens R, Weber C, Lorenz R, Brandl R, Siess W. **Recombinant GPVI-Fc added to single or dual anti-platelet therapy in vitro prevents plaque-induced platelet thrombus formation**. *Thrombosis and Haemostasis*. 2017 Aug 1; 117(8):1651-1659. doi: 10.1160/TH16-11-0856. Epub 2017 Jun 1.

Publication II

ORIGINAL RESEARCH

American Heart Association | American Stroke Association

ADPase CD39 Fused to Glycoprotein VI-Fc Boosts Local Antithrombotic Effects at Vascular Lesions

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***Background*—**GPVI (Glycoprotein VI) is the essential platelet collagen receptor in atherothrombosis. Dimeric GPVI-Fc (Revacept) binds to GPVI binding sites on plaque collagen. As expected, it did not increase bleeding in clinical studies. GPVI-Fc is a potent inhibitor of atherosclerotic plaque-induced platelet aggregation at high shear flow, but its inhibition at low shear flow is limited. We sought to increase the platelet inhibitory potential by fusing GPVI-Fc to the ectonucleotidase CD39 (fusion protein GPVI-CD39), which inhibits local ADP accumulation at vascular plaques, and thus to create a lesion-directed dual antiplatelet therapy that is expected to lack systemic bleeding risks.

***Methods and Results*—**GPVI-CD39 effectively stimulated local ADP degradation and, compared with GPVI-Fc alone, led to significantly increased inhibition of ADP-, collagen-, and human plaque–induced platelet aggregation in Multiplate aggregometry and plaque-induced platelet thrombus formation under arterial flow conditions. GPVI-CD39 did not increase bleeding time in an in vitro assay simulating primary hemostasis. In a mouse model of ferric chloride–induced arterial thrombosis, GPVI-CD39 effectively delayed vascular thrombosis but did not increase tail bleeding time in vivo.

***Conclusions*—**GPVI-CD39 is a novel approach to increase local antithrombotic activity at sites of atherosclerotic plaque rupture or injury. It enhances GPVI-Fc–mediated platelet inhibition and presents a potentially effective and safe molecule for the treatment of acute atherothrombotic events, with a favorable risk–benefit ratio. **(*J Am Heart Assoc*. 2017;6:e005991. DOI: 10.1161/JAHA.117.005991.)**

Key Words: glycoprotein • platelet • thrombosis

Ischemic stroke is the most frequent disabling disease. Stroke and myocardial infarction are leading causes of death.[1] Frequently, the underlying alteration is the rupture or erosion of atherosclerotic plaques, leading to platelet adhesion and thrombus formation and to embolization, as observed in cerebral arteries.[2] Platelet adhesion and activation mediated by GPVI (glycoprotein VI) and dependent on collagen-bound von Willebrand factor play important roles in human plaque-triggered thrombus formation and subsequent development of cardiovascular syndromes such as stroke and could be a target for pharmacological inhibition of pathological thrombus formation.[3–6] The alternative collagen receptor, $\alpha 2\beta 1$-integrin, is not involved in plaque-induced platelet aggregation.[4,6] Targeting collagen-induced activation of GPVI should allow preferential inhibition of atherosclerotic plaque-induced thrombosis without affecting systemic hemostasis. GPVI expression is specifically observed in platelets and megakaryocytes.[7,8]

The interaction of GPVI with collagen can be inhibited competitively by a dimeric GPVI-Fc fusion protein (Revacept)[9,10] or by antibodies that have been developed to block GPVI.[11–13] Whereas anti-GPVI antibodies are systemic and potent inhibitors of plaque- and collagen-induced platelet aggregation in static and dynamic models, GPVI-Fc acts locally at the site of plaque rupture and is most effective under high shear flow.[12] Anti-GPVI antibodies

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Clinical Perspective

What Is New?

- Dimeric glycoprotein VI (GPVI-Fc; Revacept) binds to collagen in atherothrombosis, GPVI. GPVI-Fc is a potent inhibitor of atherosclerotic plaque-induced platelet aggregation at high shear flow, but its inhibition at low shear flow is limited.
- Fusing GPVI-Fc to the ectonucleotidase CD39, which inhibits local ADP accumulation at vascular plaques, creates a lesion-directed dual antiplatelet therapy that is expected to lack systemic bleeding risks.

What Are the Clinical Implications?

- The fusion of GPVI-Fc and CD39 potently reduces intravascular thrombus formation, adding to the therapeutic potency of GPVI-Fc.
- Further development should investigate optimal dosing to prepare clinical trials.

might increase bleeding propensity, as observed in some patients with anti-GPVI autoantibodies,[13] whereas GPVI-Fc does not interact directly with platelets, did not increase bleeding times in clinical studies, and thus may be safer.[10] Consequently, this drug circumvents important shortcomings of existing platelet inhibitors and antithrombotics, which all incur a moderately to greatly increased bleeding risk.[14,15]

Sites of platelet adhesion and aggregation are also characterized by local release of ADP, several cytokines, and other biologically active substances from these platelets.[16] Released ADP activates additional platelets and leads to further platelet aggregation and secretion and thrombus propagation.[16] The endothelial ecto-ADPase CD39 (ENTPDase1) degrades ADP to AMP and inorganic phosphate (Pi) and thus locally inactivates an important platelet stimulus that may cause occlusive thrombi.[17–19] Gayle et al developed a soluble form of CD39 that can inhibit platelet function in vitro[20] and in vivo.[17,21] Hence, the potential of each, soluble CD39 and soluble GPVI (GPVI-Fc) alone, to inhibit platelet function has been characterized appropriately. General, nonspecific CD39 activation, however, results in bleeding propensity in CD39-transgenic mice[22] and after systemic application of soluble CD39 in vivo.[23]

In this study, we combined soluble CD39 and GPVI-Fc to form a recombinant, bifunctional fusion protein (GPVI-CD39) and showed that this molecule potently inhibits collagen- and plaque-induced platelet thrombus formation in vitro and arterial thrombus formation after vascular injury in vivo. Tail bleeding time in mice was not prolonged. GPVI-CD39 can bind to vascular lesions locally and concentrate in plaques, which should allow for markedly lower effective doses than soluble CD39, thus minimizing its bleeding propensity.

Methods

Reagents and Antibodies

Standard laboratory chemicals were purchased from Carl Roth. Ham's F-12 growth medium, fetal bovine serum, PBS, and glutamine were from Biochrom. Blasticidin S was obtained from InvivoGen. Hygromycin B came from Carl Roth. ProCHO4 growth medium was from Lonza. All enzymes for cloning were bought from New England Biolabs. Doxycycline hydrochloride, ADP sodium salt, and ATP disodium salt hydrate were purchased from Sigma-Aldrich. Part of the recombinant hirudin was a kind gift from Prof. Christian P. Sommerhoff (University of Munich), and another part was purchased from Celgene. Collagen-related peptide was synthesized at AnaSpec and chemically cross-linked. DiOC6 (3,3′-dihexyloxacarbocyanine iodide) was from Life Technologies. midazolam (Dormicum; Roche) was purchased from Roche, and medetomidine (Dormitor; Pfizer) and fentanyl were both from Janssen-Cilag. Recombinant soluble human CD39 (solCD39) was obtained from R&D Systems. Goat–antihuman Fcγ and goat–antihuman IgG (H+L)-POD (peroxidase) were purchased from Jackson ImmunoResearch.

Cloning and Protein Production

GPVI-Fc was taken from existing stocks. The cDNA coding for the fusion protein (GPVI-CD39), consisting of the extracellular domain of platelet GPVI, Fc (partial hinge region, CH2 and CH3 domain) of human IgG2, and the extracellular domain of human CD39, which was connected by a 15-amino acid linker, was established by gene synthesis. For steric reasons, the sequence coding for the Fc part of human IgG2 was inserted into the GPVI-CD39 fusion protein, whereas the original GPVI-Fc (also termed Revacept, which is currently in clinical investigation) is composed of the Fc derived from human IgG1. The cDNA was cloned into the mammalian expression vector pcDNA5/FRT/TO using HindIII and BamHI sites. Flp-In-CHO cells (Life Technologies) that had been genetically modified to harbor the cDNA for a Tet repressor protein were stably transfected with the expression construct and pOG44 helper plasmid using Lipofectamine 2000 (Thermo Fisher Scientific) transfection reagent according to the instructions of the supplier (Life Technologies). Stable adherent cells were adapted to growth in suspension in the chemically defined growth medium ProCHO4 supplemented with 4 mmol/L glutamine, 600 μg/mL hygromycin B, and 20 μg/mL blasticidin S. Recombinant protein expression was induced in dense cultures by addition of 30 ng/mL doxycycline followed

by incubation at 31°C and 5% CO_2 for 6 to 7 days in a humidified atmosphere. The construct for the control protein was produced by gene synthesis, accordingly. Expression of Fc(IgG2) control proteins was performed in stably transfected Flp-In-CHO cells grown at 37°C, 5% CO_2 for 3 to 4 days in Ham's F-12 medium with 2% fetal bovine serum that had been depleted for bovine IgG in advance. Recombinant proteins were purified from cell culture supernatants using HiTrap Protein G HP affinity chromatography columns (VWR), according to the manufacturer's manual. All proteins were dialyzed against PBS. Purified GPVI-CD39 protein was separated in nonreducing and reducing sample buffer in a Tris-HEPES NH 4% to 20% gradient gel that was stained with Coomassie Brilliant Blue G250.

ADPase Activity

Various concentrations of GPVI-CD39 or solCD39 protein or plasma samples from the pharmacokinetic study diluted 1:500 to 1:2000 in assay buffer were incubated in 25 mmol/L Tris-HCl, 5 mmol/L $CaCl_2$, pH 7.5, with 200 μmol/L ADP in a total volume of 100 μL for 30 minutes or 5 minutes at 37°C. Enzymatically released Pi was detected using the Malachite Green phosphate detection kit, according to the supplier's manual (R&D Systems). A serial dilution of Pi standard was analyzed in parallel, which facilitates quantification of released Pi. Absorbance was measured at a wave length of 630 nm using a Tecan Infinite 200 ELISA reader. Enzymatic activity of purified protein was calculated taking incubation time and protein amount into account and expressed as units per milligram of protein.

Blood Collection

Blood was withdrawn from healthy volunteers who did not take any anticoagulative medication within the past 14 days with either recombinant hirudin (200 U/mL; 13 μg/mL) or citrate as anticoagulant. Informed consent was obtained, as approved by the local ethics committee. In total, 58 healthy volunteers were included into the study: Blood samples from 39 participants were taken for in vitro experiments using vascular agonists, and blood samples from 19 participants were used for experiments involving human plaque material.

Human Carotid Atherosclerotic Plaque Material

Atherosclerotic plaques were donated from patients undergoing endarterectomy for high-grade carotid artery stenosis.[24] Patients' informed consent was obtained, as approved by the ethics committee of the Faculty of Medicine of the University of Munich, in accordance with the Declaration of Helsinki. Plaque material from 10 patients was included. The carotid plaque tissue was processed and preserved, as described.[12] Plaque homogenates from 5 patients were mixed to obtain plaque pools that were kept in aliquots at −80°C. Plaque homogenates were used to stimulate platelets in blood under static conditions or coated onto glass coverslips for flow studies.[12]

Platelet Aggregation

The effect of GPVI-CD39 and control proteins on platelet aggregation was analyzed using the Multiplate (Roche) device.[25] 1:1 diluted hirudin-anticoagulated blood was preincubated with antagonist for 3 minutes in the test cell without stirring to avoid platelet preactivation.[26] Agonist was added, and samples were incubated for 6 minutes at 37°C with stirring. The following agonists were used: 6.5 μmol/L ADP, 12 μg/mL collagen isolated from rabbit aorta, 103 μg/mL collagen type I secreted by human fibroblasts (VitroCol; Advanced BioMatrix), or 333 μg/mL pooled human plaque homogenate. Platelet aggregation was measured in arbitrary units over the time period (arbitrary units×minutes; cumulative aggregation values).

Platelet Aggregation Under Flow Conditions

Glass coverslips were coated with pooled human plaque homogenates, as described,[12] and mounted into parallel plate flow chambers using sticky slides (0.1 Luer sticky slides; ibidi) previously blocked with 4% human serum albumin in PBS. The flow chamber was then mounted on the stage of a fluorescence microscope (TE2000-E; Nikon) within an incubation chamber (37°C). The flow chamber was rinsed with PBS and blocked with 4% human serum albumin in PBS and subsequently perfused with hirudin-anticoagulated human blood from healthy donors that had been preincubated for 10 minutes at 37°C with DiOC6 (1 μmol/L) to stain platelets and with an antagonist or control protein. Blood was perfused with continuous flow at shear rates of 600/s and 1500/s or with pulsatile flow (60 pulses/min, 0.5 seconds: shear rate 0/s; 0.5 seconds: shear rate 1000/s; resulting in a mean shear rate of about 600/s) using a withdrawal syringe pump. Fluorescence of adhering platelets and platelet aggregates was continuously recorded and quantified, as described in detail.[12]

In Vivo Thrombus Formation After Ferric Chloride Injury in Carotid Arteries

For examination of arterial thrombus formation in vivo, C57BL/6J wild-type mice aged 6 to 8 weeks were anesthetized by injection of midazolam (5 mg/kg body weight), medetomidine (0.5 mg/kg body weight), and fentanyl

(0.05 mg/kg body weight). In the ferric chloride model, 21 mice were studied.

The common carotid artery was dissected free, and the mice were injected intravenously 30 minutes before carotid injury with GPVI-CD39 (3 mg/kg body weight) or its control and with GP1bα-488 for platelet visualization. The carotid was exteriorized and injured by topical application of a filter paper saturated with 15% ferric chloride for 1 minute. Thrombus formation in arteries was monitored for 20 minutes or until complete occlusion (stop of blood flow for >1 minute). Digital films and images were recorded with a Nikon Eclipse intravital microscope and analyzed off-line.

Pharmacokinetic Analysis

Male and female wild-type C57BL/6J mice aged 12 to 22 weeks were used in this small-scale study. Nine mice were investigated. GPVI-CD39 or solCD39 was applied at a volume of 5 mL/kg into the right tail vein. At time points indicated in the figure7C, blood sampling was performed by incision of the left tail vein using 25 µL heparinized capillaries. Blood samples were recovered by centrifugation at 2400*g* for 10 minutes. The upper plasma phase was transferred to fresh tubes and stored frozen at −20°C.

Determination of Protein Concentration in Plasma Samples of Mice

The concentration of GPVI-CD39 or Fc control protein in plasma samples was determined by Fc-specific sandwich ELISA. Wells of a MaxiSorp 96-well plate (Thermo Fisher Scientific) were coated with 0.1 µg per well of goat–antihuman Fcγ antibody. Wells were washed 3 times with PBST (PBS and Tween-20) between incubations. After blocking with 3% skimmed milk in PBST, wells were incubated for 1 hour with 50 µL plasma from mice treated with GPVI-CD39 (1:200) or Fc (1:500) diluted in PBST. Wells were incubated for 1 hour with 100 µL of 80 ng/mL goat–antihuman IgG

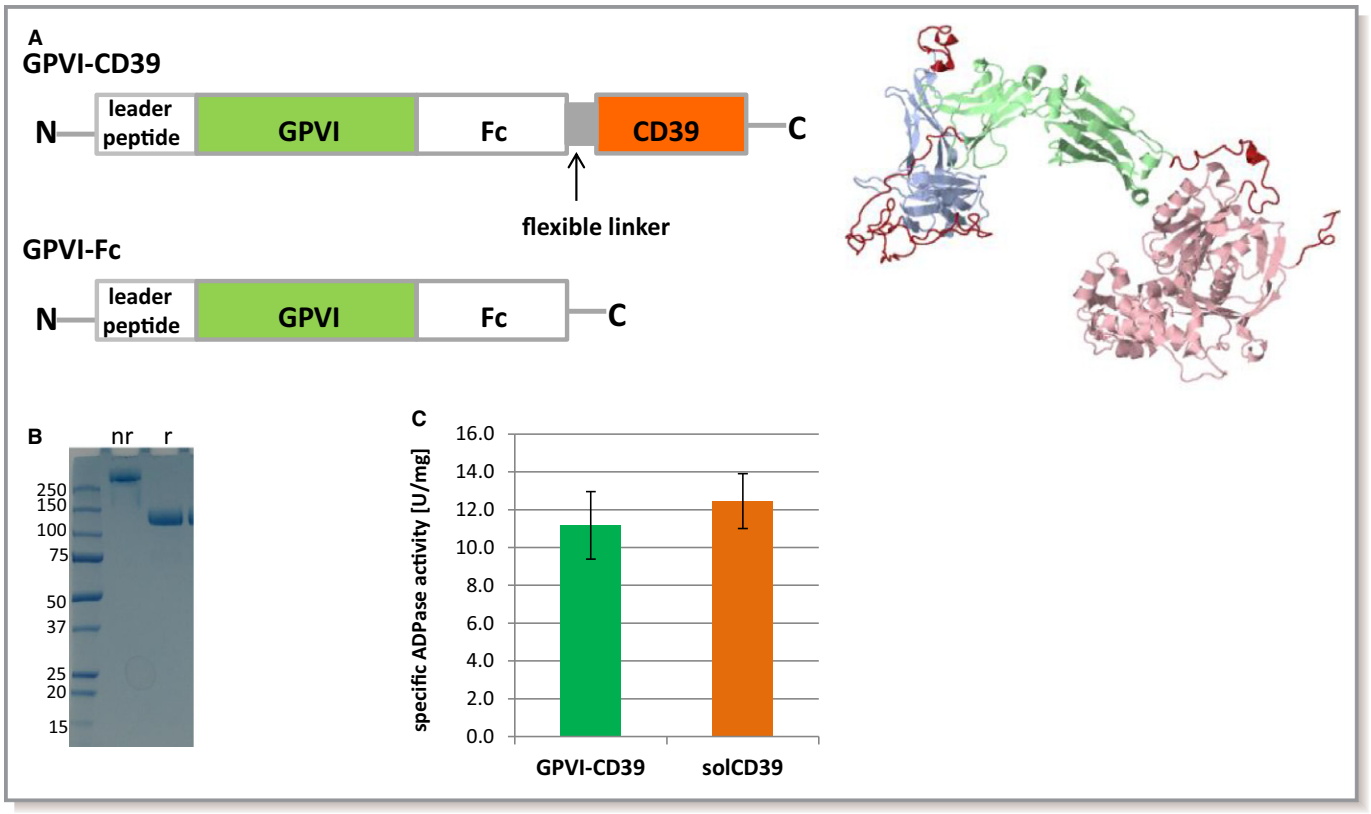

Figure 1. Structure scheme and biochemical characterization of bifunctional, recombinant GPVI-CD39 compared to GPVI-Fc. A, Structure (left panel) and putative 3D-modeling (right panel) of bifunctional, recombinant GPVI-CD39 compared with GPVI-Fc. The 3D model shows the extracellular GPVI domains in blue, the Fc part in green, and the CD39 domain in light red. The N-terminal leader peptides of each protein are cleaved before secretion of each protein. B, Coomassie staining of GPVI-CD39 as purified from supernatants of GPVI-CD39–expressing cells. C, Specific ADPase activity of recombinant GPVI-CD39 (333 nmol/L) in comparison to that of commercially available soluble CD39 (666 nmol/L; n=3, mean±SEM). Both specific activities were determined at other enzyme molarities and did not differ, as expected, because substrate concentrations were not limiting. GPVI indicates glycoprotein VI; GPVI-CD39, dimeric glycoprotein VI and CD39 fusion protein; GPVI-Fc, dimeric glycoprotein VI; nr, nonreducing conditions; r, reducing conditions.

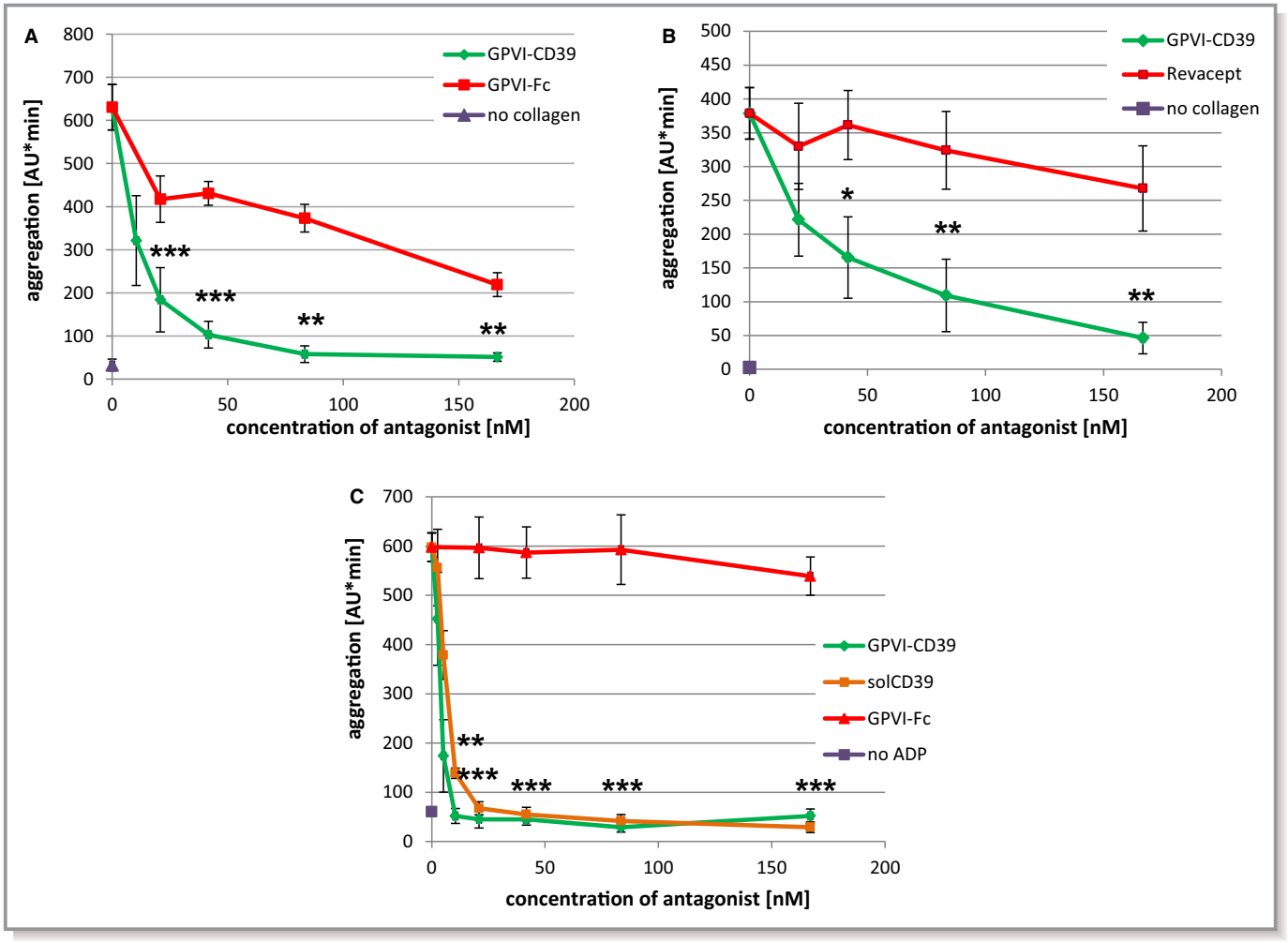

Figure 2. Effects of GPVI-CD39 and GPVI-Fc fusion proteins and of control proteins on static platelet aggregation in blood after stimulation with collagen or ADP. Platelet aggregation was determined by impedance aggregometry. Values are mean±SEM. A, Platelet aggregation after stimulation with 12 µg/mL collagen extracted from rabbit aorta. Preincubation with increasing concentrations of GPVI-CD39 reduces platelet aggregation more strongly than GPVI-Fc alone (n=5; $^{**}P<0.01$ and $^{***}P<0.001$, compared with GPVI-Fc). B, Platelet aggregation after stimulation with 103 µg/mL collagen from cultured human fibroblasts (VitroCol; Advanced BioMatrix), as determined by impedance aggregometry. Preincubation with increasing concentrations of GPVI-CD39 reduces platelet aggregation more strongly than GPVI-Fc alone (n=5; $^{*}P<0.05$ and $^{**}P<0.01$, compared with GPVI-Fc). C, Platelet aggregation after stimulation with 6.5 µmol/L ADP. Preincubation with increasing concentrations of either GPVI-CD39 (n=8) or of soluble CD39 markedly reduces ADP-induced platelet aggregation, whereas GPVI-Fc alone has no effect ($^{**}P<0.01$ and $^{***}P<0.001$). AU indicates arbitrary unit; GPVI-CD39, dimeric glycoprotein VI and CD39 fusion protein; GPVI-Fc, dimeric glycoprotein VI; solCD39, soluble CD39.

(H+L)-POD detection antibody. POD activity was visualized using 100 µl of Ultra TMB-ELISA substrate (Thermo Fisher Scientific), and signal intensities were read with a Tecan Infinite F200 ELISA reader.

Analysis of In Vivo Tail Bleeding Time in Mice

Test or control substances were applied into the tail vein of C57BL/6J mice. Animals were anesthetized by intraperitoneal injection of 0.5 mg/kg medetomidine, 5 mg/kg midazolam, and 0.05 mg/kg fentanyl. At 10 minutes after protein delivery, a blood sample of 20 µL was drawn for analysis of recombinant protein content and ADPase activity using a heparinized capillary. At 15 minutes after protein application, the distal 2 mm of the tail were cut off, and the tail was immediately immersed in prewarmed PBS (37°C) and time-monitored until bleeding stopped for at least 30 seconds. The process was standardized to yield comparable results over time, and results were reproducible. Animals were euthanized, and a final blood sample was stored for analysis.

Determination of In Vitro Closure Time

Citrated blood of healthy donors was mixed with antagonist in concentrations indicated in the figures 6 and added to Dade PFA collagen/epinephrine, Dade PFA collagen/ADP, or

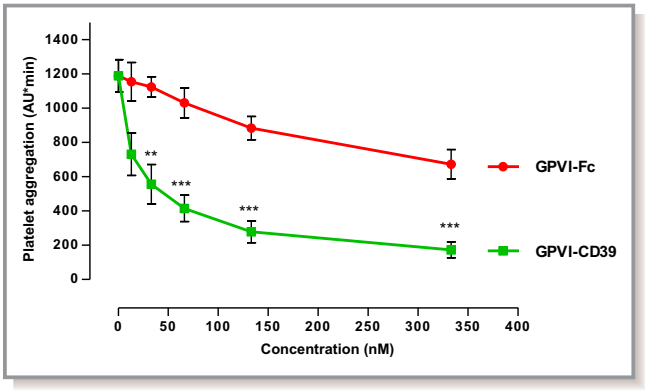

Figure 3. GPVI-CD39 inhibits static platelet aggregation in blood stimulated by human plaque more potently than GPVI-Fc. Blood samples were preincubated for 3 min with increasing concentrations of GPVI-CD39 or GPVI-Fc before stimulation with plaque homogenate (333 μg/mL) for 10 min. Values are mean ±SEM (n=8). ***P<0.001 by 2-way ANOVA for factor concentration and drug and secondary pairwise comparisons of isomolar GPVI-CD39 vs GPVI-Fc by Fisher least significant difference. The asterisks indicate significant differences between the 2 drugs at isomolar concentrations. In addition, direct-pair comparisons between isomolar drug concentrations by Student t testing resulted in the same significance levels. AU indicates augmented unit; GPVI-CD39, dimeric glycoprotein VI and CD39 fusion protein; GPVI-Fc, dimeric glycoprotein VI.

Innovance PFA P2Y test cartridges (Siemens Healthcare). Blood was aspirated under high shear conditions (>5000/s) through a capillary onto a membrane with a small aperture coated with substances that activate platelets and lead to closure of this aperture. The time until closure of this aperture is monitored and expressed as in vitro closure time with a maximum closure time of 300 seconds.

Statstical Analysis

Normal distribution of all analyzed parameters was verified and confirmed by Kolmogorov–Smirnov testing. Differences between ≥2 experimental groups were analyzed by ANOVA using SPSS software (version 19; IBM Corp), followed by Fisher least significant difference post hoc testing. Specifically, 2-way repeated-measures ANOVA was used as indicated. The Student t test with Bonferroni method was also used when absence of differences in ADPase activity was investigated.

Results

Description of GPVI-CD39 Protein and its Properties

To enhance the antithrombotic potential of GPVI-Fc, we created a fusion protein that combines the extracellular collagen binding domain of GPVI with the extracellular domain of CD39 harboring enzymatic ADPase activity (Figure 1A). The Fc domain in between facilitates dimerization of the molecule, as was confirmed by nonreducing polyacrylamide gel analysis (Figure 1B). A flexible linker of 15 amino acids facilitates proper folding of the CD39 domain. The protein was successfully expressed by doxycycline-inducible, stably transfected CHO cells and was purified from cellular supernatants by protein G affinity chromatography. At various concentrations, the fusion protein exhibited mean ADPase activity of 11.2±4.0 U/mg, which was similar to that of commercially available solCD39 (12.5±3 U/mg).[27] These results are shown in Figure 1C. Statistical comparison of GPVI-CD39 with solCD39 activities (equal amounts) yielded no significant difference by either Student t testing or ANOVA.

Effect of GPVI Fusion Proteins on Collagen-, ADP-, or Plaque-Induced Platelet Aggregation in Human Blood Under Static Conditions

The effect of GPVI-CD39 on collagen-induced aggregation of human platelets was analyzed in blood using collagens from different sources as well as human plaque material and the secondary agonist ADP. GPVI-CD39 exhibited a highly significant, dose-dependent inhibition of platelet aggregation induced by 12 μg/mL collagen isolated from rabbit aorta (Figure 2A). Similarly, using 103 μg/mL collagen secreted by human fibroblasts (VitroCol; mainly type I collagen) as agonist, GPVI-CD39 inhibited platelet aggregation significantly, whereas GPVI-Fc resulted in only minor inhibition at the same concentration (Figure 2B). Effective inhibition of ADP-induced platelet aggregation occurred by GPVI-CD39 as well as by equimolar concentrations of solCD39, using 6.5 μmol/L ADP, whereas GPVI-Fc lacking the CD39 component displayed no inhibitory effect (Figure 2C). Adding GPVI-CD39 to platelet aggregation triggered by human plaque material (333 μg/mL) also resulted in dose-dependent inhibition with an approximate IC_{50} value of 30 nmol/L (Figure 3). GPVI-Fc tested at the same concentrations was markedly and significantly less effective than GPVI-CD39.

Effect of GPVI Fusion Proteins on Plaque-Induced Platelet Aggregate Formation Under Flow Conditions

To mimic the situation found in arteries after human carotid plaque rupture in vivo, pooled human plaque homogenates from samples taken during carotid surgery were coated onto glass coverslips, and human blood was perfused in a parallel flow chamber over the coated surface at various arterial shear rates in the presence or absence of GPVI fusion proteins.

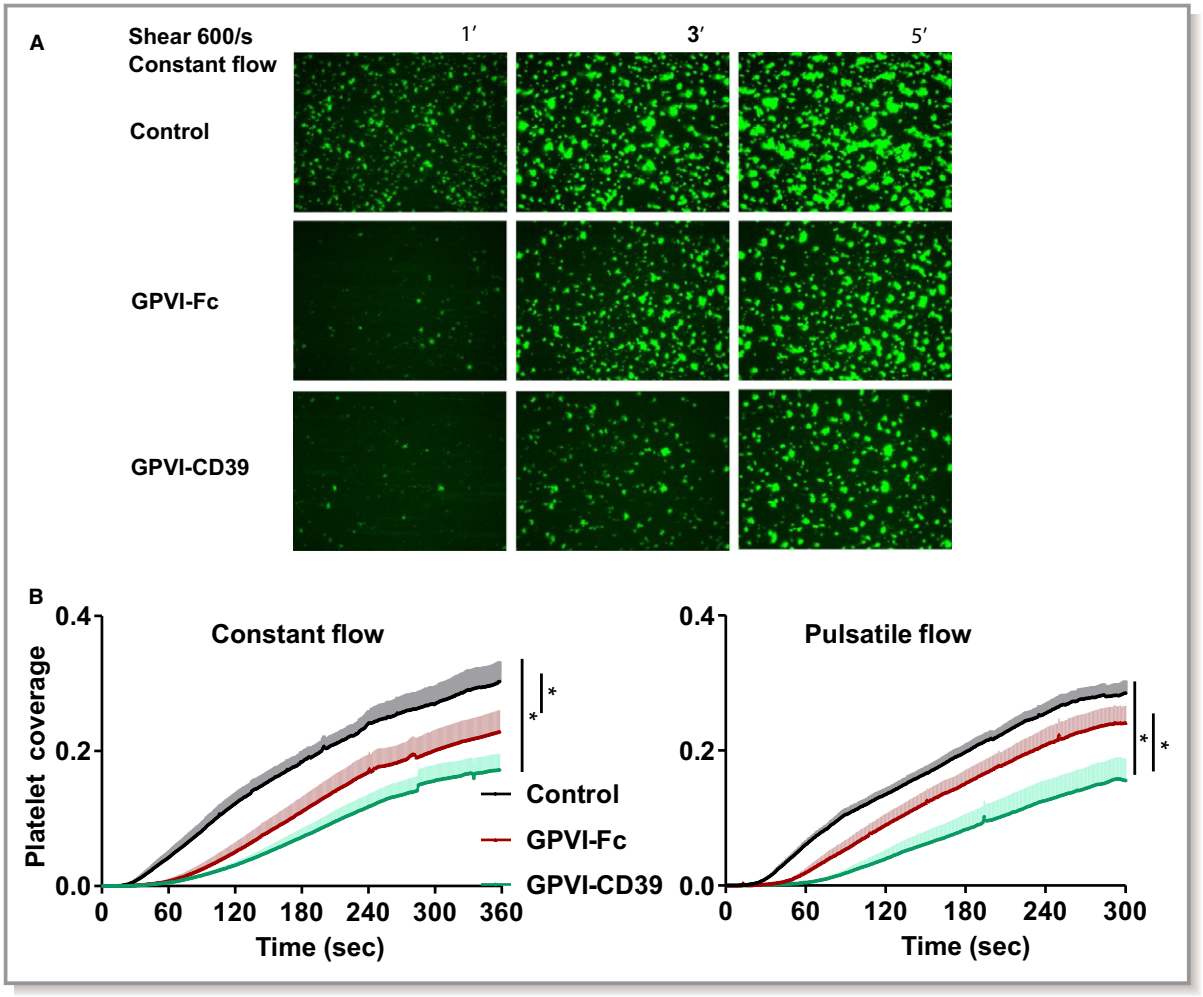

Figure 4. Effects of GPVI-CD39 and GPVI-Fc on plaque-induced platelet deposition from flowing blood at 2 arterial shear rates. A, Representative micrographs display platelet coverage of pooled plaque homogenate at different times after start of blood flow at 600/s. Blood was preincubated for 10 min with DiOC6 for platelet visualization in the absence (control) or presence of GPVI-CD39 (150 nmol/L) or GPVI-Fc (150 nmol/L). B, Effects of GPVI-Fc and GPVI-CD39 on the kinetics of platelet deposition onto human plaques from flowing blood at constant (shear rate 600/s) or pulsatile flow (60 pulses/min, mean shear rate 600/s). The binary fluorescent area fraction (1.0=total area) was quantified, as detailed in Methods. Values are mean±SEM of 8 experiments performed in parallel with the same blood donors. **P*<0.05, by repeated-measures ANOVA at 300 s and secondary pairwise comparison by Fisher least significant difference. Repeated measures refer to the comparison of aliquots from samples of each donor under different concurrent experimental conditions at the same time. C, Comparison of the effects of either 75 or 150 nmol/L GPVI-CD39 on plaque- induced platelet deposition from flowing blood at low and high arterial shear rates. Blood was preincubated with DiOC6 for platelet visualization in the absence (control) or presence of GPVI-CD39 (75 or 150 nmol/L) for 10 min at 37°C before start of flow at shear rates of 600/s or 1500/s. Values are mean±SEM (n=6). **P*<0.05 and ***P*<0.01 by repeated-measures ANOVA at 300 s and secondary pairwise comparison by Fisher least significant difference. DiOC6 indicates 3,3′-dihexyloxacarbocyanine iodide; GPVI-CD39, dimeric glycoprotein VI and CD39 fusion protein; GPVI-Fc, dimeric glycoprotein VI.

A shear rate of 600/s was selected to represent the mean physiological wall shear rates in carotid and coronary arteries, whereas a mean shear rate of ≈1500/s has been described to prevail in mildly stenotic coronary lesions.[28] In addition, pulsatile flow conditions were tested to simulate the stop-and-go blood flow in coronary arteries. GPVI-CD39 exhibited stronger potency than GPVI-Fc to inhibit aggregate formation when tested at concentrations of 150 nmol/L at continuous flow at a shear rate of 600/s (Figure 4A and 4B). The difference was larger and significant when pulsatile flow was applied (Figure 4B, right panel).

At the shear rate of 1500/s, the effects of GPVI-CD39 were more pronounced compared with its effects at the lower shear rate. GPVI-CD39 at 150 nmol/L led to nearly complete inhibition (−97%) of plaque-induced platelet aggregation.

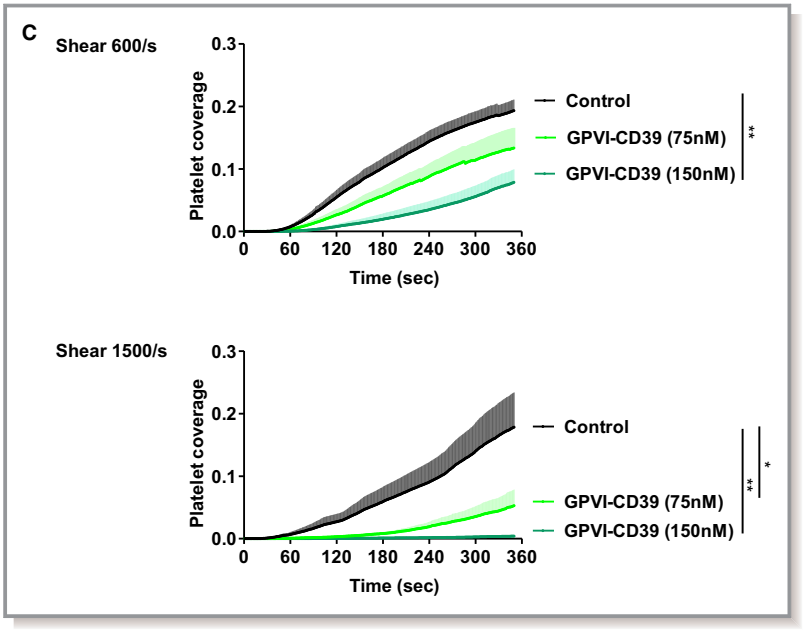

Figure 4. Continued.

GPVI-CD39 at 75 nmol/L still significantly inhibited plaque-induced platelet aggregation (Figure 4C).

Antithrombotic Effects of GPVI-CD39 In Vivo in a Ferric Chloride Model

To investigate the antithrombotic effects of GPVI-CD39 in vivo in mice, the common carotid artery was injured using 15% ferric chloride, and the time to occlusion of the vessel was monitored. In wild-type mice, the mean time to vessel occlusion was 480 seconds (not shown). Intravenous administration of either vehicle (NaCl) or 1.5 mg/kg (10 nmol/kg) GPVI-Fc resulted in similar occlusion times, whereas 3 mg/kg (10 nmol/kg) GPVI-CD39 significantly delayed vessel occlusion to 1083 seconds (Figure 5).

Assessment of Closure Times

The efficacy of GPVI-CD39 was also analyzed by measuring closure times in response to various agonists with a platelet function analyzer (Innovance PFA-200). Four different concentrations of GPVI-CD39 were tested, ranging from 21.7 to 217 nmol/L. Using either COL/ADP or COL/EPI cartridges, no significant increase in closure times of the aperture compared with the buffer control (PBS) was observed (Figure 6A and 6B). Using the COL/EPI cartridges, only acetylsalicylic acid, used as a positive control, inhibited the closure of the aperture completely over the analyzed time period. As expected, P2Y cartridges, which allow for sensitive detection of P2Y antagonism, showed a statistically significant increase in closure time using 47 to 217 nmol/L GPVI-CD39 but not with 21 nmol/L (Figure 6C). The prolongations with higher concentrations of GPVI-CD39 corresponded to those observed with 1.9 μmol/L of the $P2Y_{12}$ inhibitor ticagrelor (Figure 6C). These results confirmed effective inhibition of the secondary agonist ADP by GPVI-CD39.

Pharmacokinetic Analysis and Determination of In Vivo Bleeding Time in Mice

Because the application of effective doses of solCD39 in various animal models of thrombosis caused higher bleeding risks, the hazard potential of GPVI-CD39 was analyzed by measuring in vivo bleeding times in mice. To determine a proper time point after protein application for an in vivo bleeding study, a pharmacokinetic study of GPVI-CD39 plasma concentrations was performed. Mice were injected with 4 mg/kg GPVI-CD39 or 2 mg/kg solCD39; these doses relate to 26.6 nmol of the CD39 moieties of both agents.

Blood sampling was performed at intervals indicated in Figure 7A, and both the content of Fc-containing protein (GPVI-CD39) and ADPase activity in plasma were determined. At 5 minutes after protein application, a mean concentration of GPVI-CD39 of 95 μg/mL was detected. The solCD39 could not be analyzed because of the lack of an Fc portion. Concentration of the protein decreased rapidly in the course of 2 hours. After 48 hours, GPVI-CD39 was still detectable at a low concentration of 6 μg/mL.

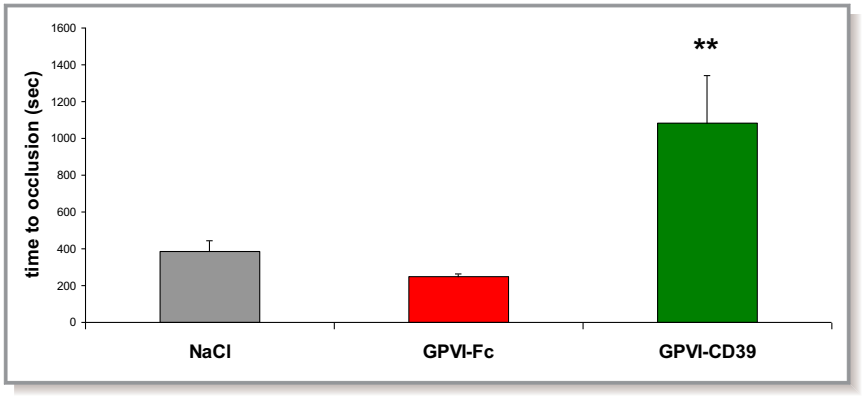

Figure 5. Effect on thrombus formation after ferric chloride injury: mean times to occlusion after administration of vehicle (NaCl), GPVI-Fc, or GPVI-CD39. Administration of 3 mg/kg (10 nmol/kg) GPVI-CD39 strongly delayed ferric chloride–induced thrombus formation in vivo compared with administration of 1.5 mg/kg (10 nmol/kg) GPVI-Fc or vehicle only. Mean values of 7 independent experiments are shown with SEM. $**P<0.01$ by ANOVA. GPVI-CD39 indicates dimeric glycoprotein VI and CD39 fusion protein; GPVI-Fc, dimeric glycoprotein VI.

ADPase activity was measured in the same plasma samples for solCD39 and was comparable to that of GPVI-CD39 (Figure 7B). ADPase activity diminished rapidly during the first 60 minutes but was still detectable at very low levels after 2 days.

The analysis of tail bleeding time 15 minutes after intravenous administration showed no differences for 4 mg/kg (13 nmol/kg) GPVI-CD39 compared with 2 mg/kg (13 nmol/kg) GPVI-Fc or vehicle or buffer controls (Figure 7C).

Discussion

In the present study, we generated a recombinant fusion protein consisting of a GPVI domain coupled to the ecto-ADPase CD39 that degrades prothrombotic extracellular ADP.[17,18] We found that this fusion molecule efficiently inhibits ADP-, collagen- and human plaque–induced platelet aggregation under static conditions and plaque-triggered platelet adhesion and thrombus formation under arterial flow at clinically relevant concentrations. In contrast, collagen/epinephrine-triggered closure times, as measured in an Innovance PFA-200 device, were unchanged because epinephrine is a sufficiently strong agonist. Moreover, GPVI-CD39 markedly delayed ferric chloride–induced thrombus formation in mice in vivo but did not prolong tail bleeding times in vivo at any doses.

Our findings imply that the fusion protein GPVI-CD39 is an attractive strategy for a lesion-directed dual antiplatelet therapy (inhibition of collagen- and ADP-induced platelet adhesion/aggregation) at sites of arterial vulnerability (eg plaque ruptures and erosions, stented lesions) but may not incur a relevant systemic bleeding risk. So far, dual antiplatelet therapy, which typically combines acetylsalicylic acid with an ADP receptor antagonist such as clopidogrel, is the standard therapy for patients with acute vascular lesions treated by coronary stenting, and its major limitation is increased bleeding risk.

The endothelial ecto-ADPase CD39/ENTPDase1 degrades ADP to AMP and Pi and thus inactivates an important agent that may cause occlusive thrombi.[17–19] Transgenic mice that overexpressed CD39 showed impaired platelet aggregation and resistance to thrombogenic stimuli but also markedly prolonged tail bleeding time that led to death when unchecked.[22] Similarly, these CD39-transgenic mice were also resistant to ferric chloride–induced thrombus formation,[27] and to myocardial injury.[29] CD39-transgenic pigs were also generated and underwent a model of myocardial ischemia-reperfusion injury by left anterior descending artery balloon inflation.[30] These pigs showed markedly reduced infarct sizes compared with wild-type controls. In contrast, $CD39^{-/-}$ knockout mice were characterized by increased cerebral infarct volumes and reduced postischemic cerebral perfusion.[31] These knockout mice also developed increased atherosclerotic plaque burden when cross-bred with apolipoprotein $E^{-/-}$ knockouts, with especially low CD39 expression in atheroprone regions.[32]

Gayle et al developed a soluble form of CD39 that can inhibit platelet function in vitro[20] and in vivo[18,21,31]: Administration of 4 mg/kg soluble CD39 led to clearly reduced infarct sizes and improved neurological function in experimental mouse stroke (whereas 1 mg/kg had no effects). In this study, bleeding time was prolonged only after administration of ≥8-mg/kg doses of solCD39 in mice. In addition,

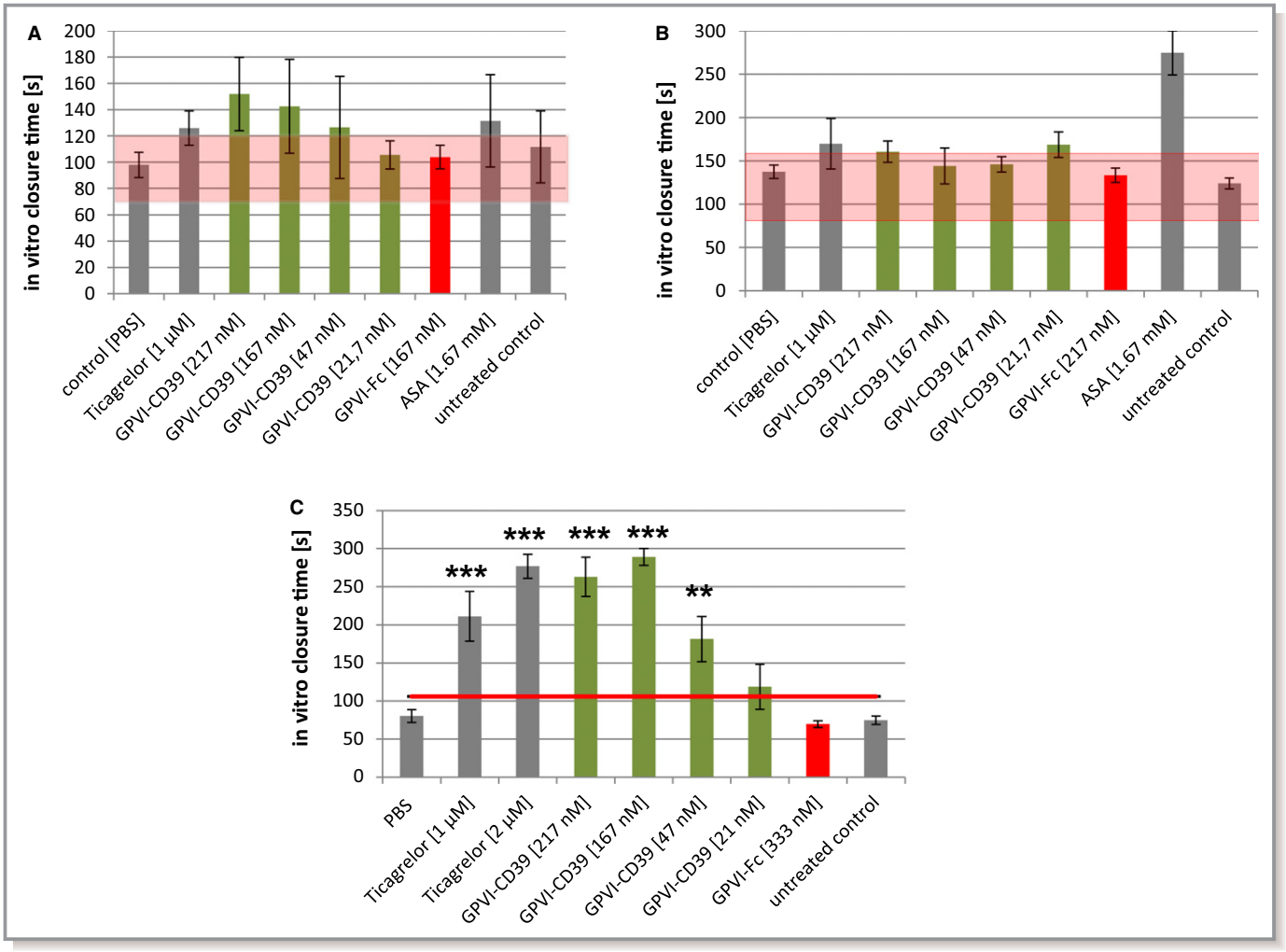

Figure 6. Effects on Innovance PFA-200 closure times of human blood ex vivo. A, Effects of ticagrelor, GPVI-CD39, GPVI-Fc, or ASA at the indicated concentrations on closure times in collagen/ADP cartridges (n=8 samples from independent donors). No significant differences between groups occurred. B, Effects of ticagrelor, GPVI-CD39, GPVI-Fc, or ASA at the indicated concentrations on closure times in collagen/epinephrine cartridges (n=8 samples from independent donors). No significant differences between results for GPVI-CD39 and GPVI-Fc occurred. Closure time was significantly (P=0.04) prolonged after addition of ASA compared with PBS only. C, Effects of ticagrelor, GPVI-CD39, GPVI-Fc at the indicated concentrations on closure times in specific P2Y cartridges (n=8 samples from independent donors; $^{**}P$<0.01 and $^{***}P$<0.001 vs PBS only). ASA indicates acetylsalicylic acid; GPVI-CD39, dimeric glycoprotein VI and CD39 fusion protein; GPVI-Fc, dimeric glycoprotein VI.

Hohmann et al reported markedly increased bleeding time after 8 mg/kg but not after 0.8 mg/kg[23]; however, this lower dose did not have a beneficial effect on occlusion time in a ferric chloride–induced carotid thrombosis model.[23] In pigs, 700 µg/kg solCD39 increased bleeding times but achieved only a nonsignificant trend to attenuate platelet and fibrin deposition after coronary balloon injury.[21]

In our study, we combined soluble forms of CD39 and GPVI-Fc to form a recombinant, bifunctional protein, GPVI-CD39, to investigate platelet-mediated thrombus formation. We showed previously that GPVI-Fc inhibits platelet-induced thrombus formation at sites of vascular injury.[9] Administration of GPVI-Fc improved myocardial ischemia [33] and cerebral infarction [34] without affecting bleeding time[35] and inhibited progression of atherosclerosis.[36] GPVI-Fc also inhibited collagen-induced aggregation in humans in a phase 1 study.[10]

The combination of GPVI-Fc with CD39 potentiates the antithrombotic effect of GPVI-Fc by blocking not only the primary platelet agonist collagen but also the secondary agonist ADP. Local platelet release of ADP is an important mediator of atherosclerotic plaque-stimulated platelet aggregation at static and flow conditions.[19] GPVI-coupled CD39 should concentrate specifically at collagen fibers within vascular lesions and atherosclerotic plaques and thus act at lower local concentrations in response to lower systemic concentrations than soluble recombinant CD39. Consequently, bleeding risk that results from recombinant CD39 should be minimized.[20,23]

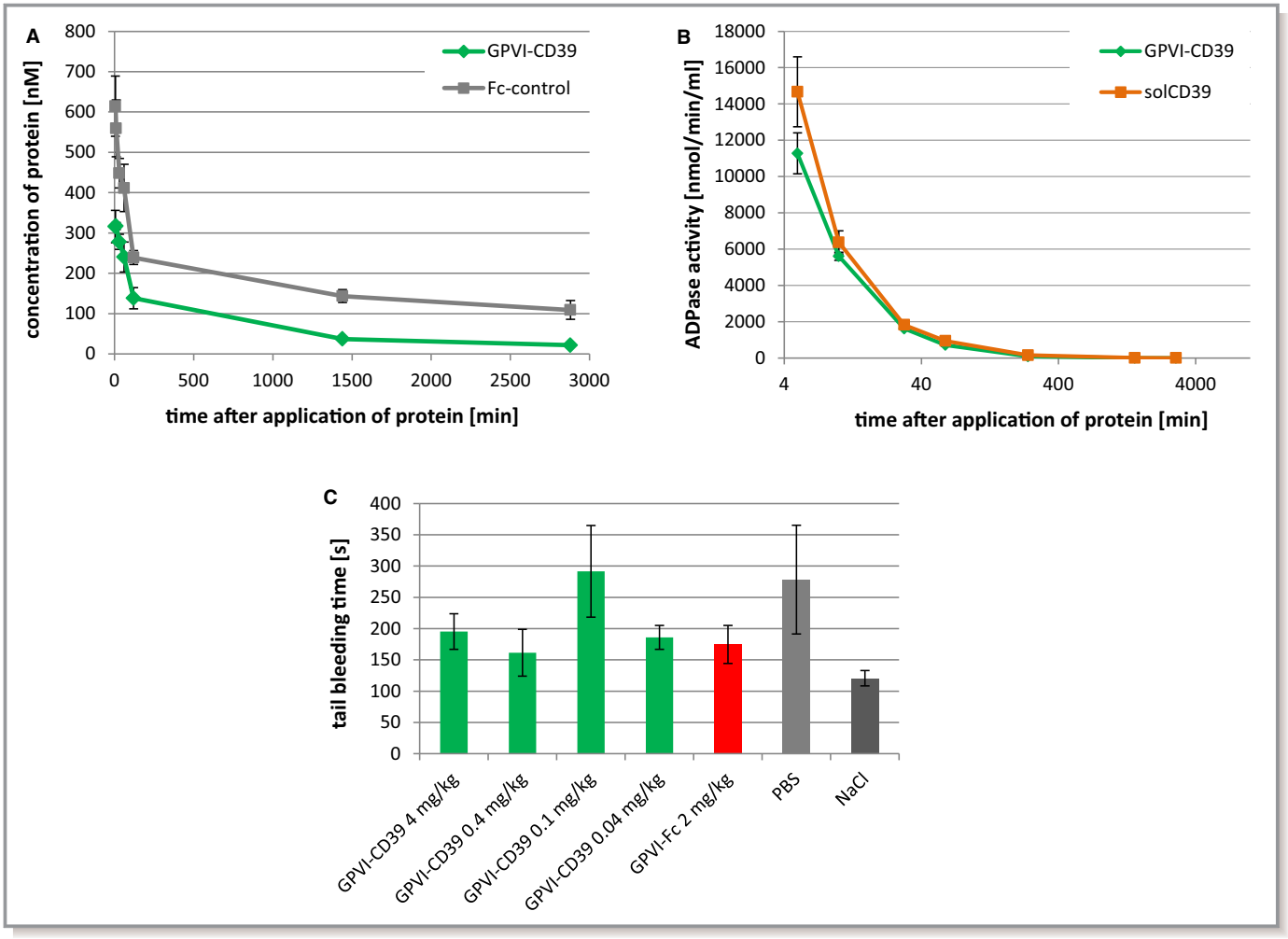

Figure 7. Pharmacokinetic and pharmacodynamic evaluation in mice in vivo; bleeding times in vivo. A, Plasma concentrations in mice up to 48 hours after administration of GPVI-CD39 or Fc control protein. Blood samples were taken at the indicated times after IV administration of 4 mg/kg (13 nmol/kg) GPVI-CD39, and plasma levels were detected by ELISA. Mean±SEM is shown.(n=3 animals). B, ADPase activities in mice up to 48 hours after administration of GPVI-CD39 or Fc controls. Blood samples were taken at the indicated times after IV administration of either 4 mg/kg GPVI-CD39 (13 nmol/kg, corresponding to 26 nmol/kg ADPase moieties) or 26 nmol/kg solCD39, and ADP turnover (mean±SEM) was measured by using a Malachite Green phosphate detection kit. Time is shown at a logarithmic scale to visualize decrease in activity during early time points (n=3 animals). C, Tail bleedings times. Tails were incised 15 minutes after IV administration of the indicated doses of GPVI-CD39, GPVI-Fc, or buffer, and tail bleeding times were determined. Mean values of 8 independent experiments are shown with SEM. No significant differences between groups occurred. GPVI-CD39 indicates dimeric glycoprotein VI and CD39 fusion protein; GPVI-Fc, dimeric glycoprotein VI; IV, intravenous; solCD39, soluble CD39.

Under flow, platelet inhibition by GPVI-CD39 was more pronounced than adding a full ex vivo dose of the ADP receptor inhibitor ticagrelor to GPVI-Fc: Comparing the results of the current study with those of our previous results,[37,38] 150 nmol/L GPVI-CD39 was equally effective in inhibiting plaque-induced platelet aggregation (81% inhibition) as the combination of 150 nmol/L GPVI-Fc with 3.82 µmol/L of the ADP receptor antagonist ticagrelor (79% inhibition). This comparison underscores the relative potency of the GPVI-CD39 fusion protein compared with existing antiplatelet drugs. Similar to previous reports on solCD39,[21,23] the fairly low dose of GPVI-CD39 used in this study had no effect on systemic bleeding times; however, GPVI-CD39 was fully effective in inhibiting arterial thrombosis in response to a ferric chloride challenge. This finding implies that the combination of CD39 with GPVI in a single molecule offers a favorable risk–benefit ratio.

The concept of a fusion protein has been developed in parallel with another interesting fusion concept, namely, the combination of CD39 with an activation-specific anti-GPIIb/IIIa single-chain antibody,[22,39] which also allowed reduction of the systemic doses of applied CD39 due to local enrichment. Both approaches are complementary insofar as this ScFvSCE5-CD39 fusion protein[23] targets growing thrombi, whereas the approach to use GPVI-CD39 focuses on local enrichment at high-risk arterial lesion before a full thrombus has evolved.

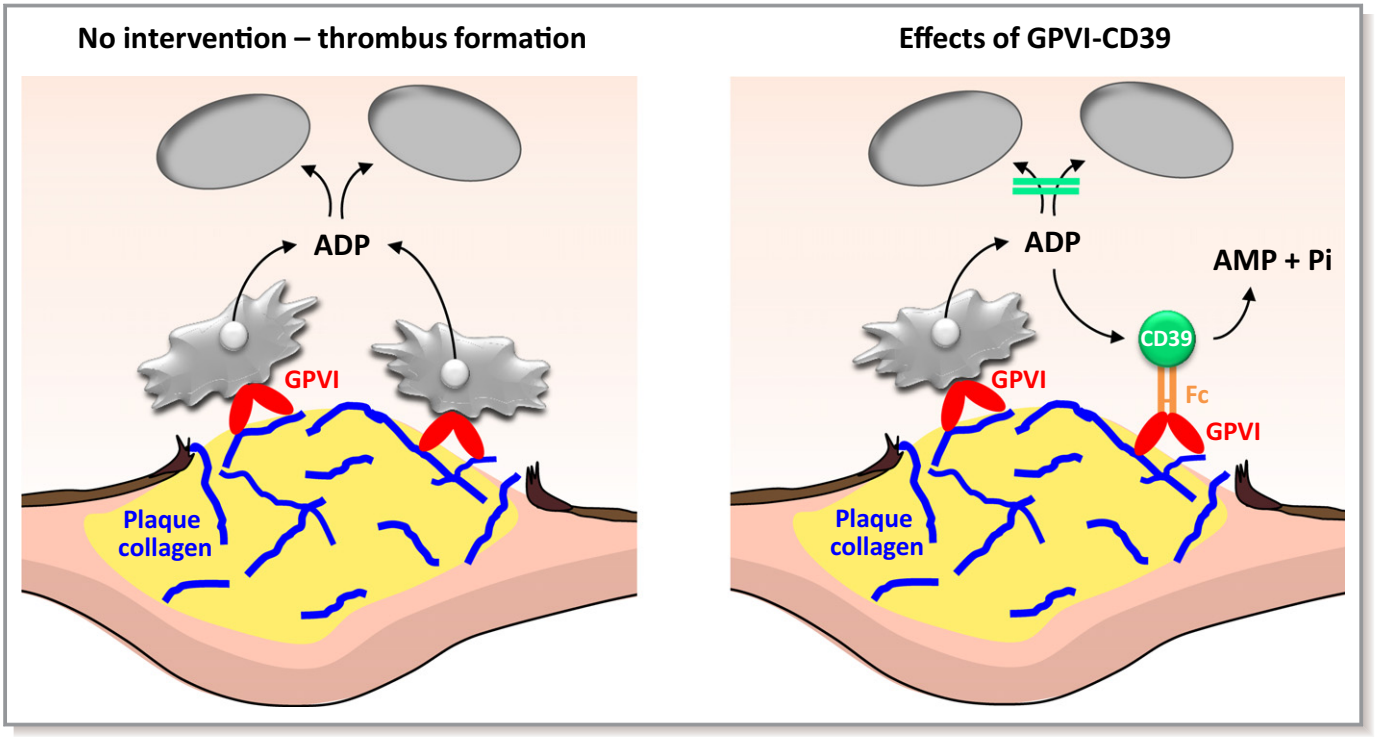

Figure 8. Mode of action of GPVI-CD39 at arterial plaques. GPVI indicates glycoprotein VI; GPVI-CD39 indicates dimeric glycoprotein VI and CD39 fusion protein; Pi, inorganic phosphate.

Such local enrichment of CD39 might provide an attractive alternative therapeutic option in arterial diseases. Reduced CD39 activity was recently shown to be associated with disease progression in patients with peripheral arterial disease.[40] However, the frequently used ADP receptor antagonist drug clopidogrel and ticlopidine further inhibit CD39 activity, especially at the beginning (the first few days) of the respective therapies,[41] so that in comparison, short-term rapid intravenous administration of GPVI-CD39 might be particularly beneficial for acute vascular syndromes and emergency conditions. A schematic overview of the mode of action of GPVI-CD39 is shown in Figure 8.

Generally, CD39 fusion proteins offer perspectives in several regards and indications.[42] CD39 has been proposed as an approach to widen the cardiovascular therapeutic window.[43] We demonstrated in this study that the antiatherosclerotic properties of blocking GPVI binding sites and promoting CD39 activity add up at the site of atherothrombosis when combined in a bifunctional molecule, but this fusion protein does not compromise systemic hemostasis.

Limitations of the Study

The antithrombotic effects of the fusion proteins have been studied in vivo in murine arterial thrombosis models and ex vivo in human atherothrombosis models but not in vivo in cardiovascular patients after plaque ruptures or erosions.

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Disclosures

Drs Degen, Münch, Holthoff, Fassbender and Ungerer are employees of the biotech company Advancecor. Meinrad Gawaz is a co-founder of Advancecor, owns shares of Advancecor and is Professor at the Cardiology Department of the University of Tübingen. He further received honoraria payments from Lilly, Bristol-Myers Squibb and Bayer-Schering and is also consultant for Bayer-Schering.

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