BACTERIAL PATHOGENICITY

Mechanisms of chloride secretion induced by thermostable direct haemolysin of Vibrio parahaemolyticus in human colonic tissue and a human intestinal epithelial cell line

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Thermostable direct haemolysin (TDH) produced by Vibrio parahaemolyticus is thought to play an important role in the severe diarrhoea caused by this organism. This study investigated the enterotoxicity of TDH for human intestinal cells. Addition of TDH to the mucosal side of human colonic tissue in Ussing chambers caused increased short circuit currents (Isc), a process that was inhibited by 4,4′-diisothiocyanatostilbene-2,2′-disulphonic acid (DIDS), an inhibitor of Ca2+-activated chloride (Cl−) channels. With human colonic epithelial (Caco-2) cells, high Isc and intracellular Ca2+ concentrations ([Ca2+]i) were detected after the addition of TDH to the apical side of the cell monolayer. The Isc decreased with the addition of DIDS, but not with glybenclamide, 5-nitro-2-(3-phenylpropylamino) benzoic acid, or gadolinium chloride. No Isc increase with TDH was observed when the Cl− in the medium was replaced by gluconate or when Ca2+ was depleted. Similarly, TDH did not raise [Ca2+]i after depletion of extracellular Ca2+. R7, a mutant form of TDH, reduced the effects of TDH on Isc and [Ca2+]i, as did protein kinase C (PKC) inhibitors. Thus, TDH increases Cl− secretion in human colonic epithelial cells, apparently through mechanisms involving cell binding and Ca2+ influx, followed by elevation of [Ca2+]i associated with PKC phosphorylation.

Introduction

Vibrio parahaemolyticus is an important cause of gastro-enteritis. Clinically, the infection is characterised by diarrhoea and abdominal pain which generally subside after 7–10 days. However, the mechanisms underlying the diarrhoeic action of this pathogen are not well understood. Thermostable direct haemolysin (TDH) secreted from V. parahaemolyticus is considered to be a major virulence factor of this organism [1]. It has various biological activities including haemolytic activity, cardiototoxicity, mouse lethality and enterotoxicity [1–4]. Several reports have shown that TDH is able to induce intestinal secretion in animal models and that it is involved in the pathogenesis of diarrhoea induced by V. parahaemolyticus [5–7]. However, the precise mode of action of this toxin in the pathogenesis of intestinal disease has yet to be established. Huntley et al. [8] have shown that the intracellular Ca2+ concentration ([Ca2+]i) in erythrocytes is increased by TDH along with an increase in cation influx. TDH also induces chloride (Cl−)-dependent extracellular ion transport in rabbit ileum with Ca2+ as a second messenger [6]. On the other hand, addition of TDH to the apical side of T84 cells, a colonic crypt-like cell line, did not stimulate either Cl− secretion or an increase in [Ca2+]i [9].

It has been suggested that the haemolytic effect of TDH is initiated by binding to the erythrocyte surface and subsequent pore formation in the membrane, resulting in colloid osmotic lysis [10]. It was not known whether the binding of TDH to cell receptors had a significant effect on Isc in the human colon. Although some reports have suggested that GT1b is the possible receptor for TDH [11, 12], recent studies contradicted these findings [1, 13]. R7, a mutant form of TDH, was included in the present study. This mutant toxin has a single amino acid substitution of serine for

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glycine at residue 62, which markedly decreases its haemolytic activity, although it retains the ability to bind to erythrocytes and competes with native TDH for binding sites [14, 15]. The present study investigated the mechanism of action of TDH on ion transport in human colonic cells.

Materials and methods

**Human colon tissue**

Human colon tissue was obtained from eight patients who underwent elective abdominal surgery at Kobe Rosai Hospital between Dec. 1998 and April 1999. All the patients consented to the use of tissue for this study. The study was conducted in accordance with the Declaration of Helsinki and approved by the Human Ethics Committee of Kobe Rosai Hospital. The diagnosis that necessitated removal of large intestine in these patients was carcinoma. Tissue samples were taken from macroscopically normal areas distant from the cancer lesion. They were prepared immediately by cutting the surgically resected colon open along the mesenteric border and then transporting the tissue in ice-cold modified Ringer’s solution to the laboratory. The modified Ringer’s solution contained: 120 mM NaCl, 25 mM NaHCO3, 3.3 mM KH2PO4, 0.8 mM K2HPO4, 1.2 mM CaCl2 and 10 mM glucose. The pH of this solution was 7.4 when gassed with a mixture of O2 95% and CO2 5% at 37°C. Before mounting in the Ussing chamber, the specimens were prepared by dissecting the muscle layers with fine scissors and forceps.

**Cells**

Caco-2 cells were purchased from the American Type Culture Collection (Rockville, MD, USA). Caco-2 cells were derived originally from a human colon carcinoma and develop villus-like structures during growth to confluence. They were maintained in Eagle’s Minimum Essential Medium (MEM) supplemented with fetal bovine serum (FBS) 10%, gentamicin 100 U/ml and non-essential amino acids 1%. The media and supplements were from Gibco BRL (Gaithersburg, MD, USA). Cells were grown in 75-ml flasks at 37°C in air with CO2 5%, fed at 2-day intervals and passed weekly. Stock cells were trypsinised, suspended at 20 x 10^6 cells/ml in medium and seeded at confluent density on to 1.0 ml transwell inserts (Costar, Cambridge, MA, USA). After 3 days, 2 mM sodium butyrate (Sigma) was added. The cells on transwell inserts were used for the Ussing chamber experiments after culture for 6 days. Sodium butyrate is known to induce differentiation in many cells, including Caco-2 cells [16–18]. It occurs naturally in normal human colon and is used as an energy source by colonocytes [19]. Levels of butyrate in normal human faeces may be as high as 20 mM [20]. Caco-2 cells treated with butyrate have higher trans-epithelial resistances and greater sensitivity to trans-epithelial short circuit current (Isc) increases by TDH compared with nontreated cells (A. Takahashi and T. Honda, unpublished observations). Thus, butyrate-treated Caco-2 cells were used in this study to investigate the effects of TDH.

**Ussing chamber experiments**

For measurement of Isc, the bath solution contained modified Ringer’s solution, pH 7.4. To deplete Ca2+ from the apical cell surface, CaCl2 was omitted from the bath solution and 1 mM EGTA was added. Apical Cl− current was measured following permeabilisation of the basolateral membrane with nystatin 360 µg/ml for 15–30 min to establish a mucosa-to-serosa Cl− concentration gradient. Serosal NaCl was replaced by equimolar sodium gluconate and CaCl2 was increased to 4 mM to compensate for the Ca2+-buffering capacity of the gluconate ion [21]. The nystatin-induced pores provide electrical continuity without loss or alteration of cytoplasmic compounds necessary for the maintenance of the response to acetycholine and [Ca2+]i [22]. Transwell cell culture inserts were mounted in an Ussing chamber (laboratory made) and the tissues were continuously short-circuited. Trans-epithelial resistance was measured by applying a 5-mV pulse at 40–50-s intervals and the resistance was calculated by Ohm’s law. TDH (prepared as described below), 4,4’-diisothiocyanostilbene-2,2’-disulphonic acid (DIDS), glybenclamide, 5-nitro-2-(3-phenylpropylamino) benzoic acid (NPPB) and gadolinium chloride (all from Sigma) were added only to the mucosal bath solution at the concentrations indicated.

**Isolation of crude haemolysin**

Recombinant plasmids of pKK223-3 harbouring the structural genes of wild-type TDH (pT101) and mutant toxin R7 (pT102) were introduced into *Escherichia coli* JM109 by transformation. Transformed *E. coli* were cultivated at 37°C for 16 h with rotary shaking in Luria-Bertani broth (Bacto tryptone, Difco, 1%, yeast extract, Difco, 0.5% and NaCl 0.5%) containing ampicillin 100 µg/ml. The recombinant toxins were purified as reported previously [23] with minor modifications. Briefly, the harvested cells were treated with polyethylenimine (Wako Pure Chemicals, Osaka, Japan) 3000 U/ml in 10 mM phosphate-buffered saline (PBS; pH 7.2) to release the periplasmic components. The proteins were further purified through a series of chromatography columns. Fractions containing wild-type TDH and R7 were assayed by haemolysis on rabbit blood agar plates [24]. The purity of samples was examined by SDS-PAGE according to the method of Laemmli [25], in polyacrylamide 12% gels with 2 µg of protein per lane.

**Intracellular Ca2+**

The concentration of [Ca2+]i was determined by microfluorimetry with a fluorescent dye, 1,2-(5’-
carboxyoxazol-2'-y1)-6-aminobenzofuran-5-oxy)-2(2'
амино-3'-метилифенокси)бензол-Н,Н'-Н'-тетра-ацети
cid, пента-ацетоил метил эстер (Fura-2/AM, Mole
cular Probes, Eugene, OR, USA), at excitation
wavelengths of 340 and 380 nm and an emission
wavelength of 510 nm, with a specially designed
chamber and an ARGUS-50/CA fluorimeter system
(Hamamatsu Photonics, Japan). The cells were
cultured on glass coverslips (18 × 18 mm) for 5 days,
then loaded with Fura-2/AM (2 μM) for 30 min and
washed twice in PBS. The coverslips were then inserted
into the chamber of the fluorimeter and recordings were
taken within 30 min.

Statistical evaluations
The data were evaluated by the unpaired Student’s t test
and p < 0.05 was considered significant.

Other chemicals
Protein kinase C (PKC) inhibitors, calphostin C and
stauroporin, were purchased from Sigma. Inorganic
salts of guaranteed grade were purchased from Wako
Pure Chemicals.

Results
Purification of TDH and R7
Wild-type and mutant TDH (R7) synthesised in E. coli
JM109 and purified gave single bands on SDS-PAGE
(Fig. 1a), suggesting that the toxins were purified to
homogeneity. These samples were concentrated to
300 μg/ml by ultrafiltration through a PM10 mem
brane (Amicon) and stored in PBS at 4°C. TDH
displayed haemolytic activity on rabbit blood agar (Fig.
1b), while R7 did not, confirming an earlier report [15].

Effects of TDH on human colon
Addition of TDH caused an increase in lsc in human
colonic tissue when added on the mucosal side of
human colonic tissue in Ussing chambers (Fig. 2). The
lsc did not change when PBS was added. The high lsc
induced by TDH decreased when 100 μM DIDS, an
inhibitor of Ca2+-activated Cl− channels [26, 27], was
added. These results suggest that TDH increases Cl−
secretion by human colonic tissues.

Effects of TDH on a human colonic cell line
The mechanism of ion secretion was further investi
gated with human colonic epithelial (Caco-2) cells.
Fig. 3 shows that TDH increased the trans-epithelial
current when added to the apical side of the Caco-2
cell monolayer. When the Cl− in the bath solution was
substituted by gluconate on both the apical and
basolateral sides of the cells, there was no increase in
lsc irrespective of TDH addition (Fig. 3). This
indicates that the lsc stimulated by TDH is dependent
on extracellular Cl−. When Ca2+ was removed from
the bath solution by omission of CaCl2 and addition of
1 mM EGTA, the addition of TDH again caused no
change in lsc (Fig. 3). Thus, lsc changes are also
dependent on the extracellular Ca2+, suggesting that
the increase in lsc stimulated by TDH is generated by
Ca2+-activated Cl− channels.

The current increased in a dose-dependent manner
according to the concentration of TDH (Fig. 4a). Trans
epithelial resistance did not change with TDH concen
trations ranging from 0.01 to 10 μg/ml (Fig. 4b).
On the other hand, trans-epithelial resistance decreased
markedly at a TDH concentration of 50 μg/ml, making
it difficult to short-circuit the cell monolayers and
increasing the current measurement noise. As no
appreciable trans-epithelial resistance change was noted
with 10 μg of TDH/ml, this concentration was used for
subsequent experiments.

Effects of Cl− channel inhibitors
Four kinds of channel inhibitors were used to
investigate the hypothesis that the lsc increase
stimulated by TDH is generated by Ca2+-activated
Cl− channels. Fig. 5a shows that the lsc increase in

Fig. 1. (a) SDS-PAGE of purified preparations of wild
type TDH and mutant toxin R7. Lanes: 1, molecular
mass markers (from top to bottom, 97.4, 66.3, 30.0, 20.1,
14.4 kDa); 2, wild-type TDH; 3, R7. (b) Haemolytic
activity of (1) wild-type TDH and (2) R7 on rabbit blood
agar.

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Fig. 2. Effects of TDH 10 µg/ml and 100 µM DIDS on Isc of human colon tissue mounted in Ussing chambers. ●, TDH was added on the mucosal side of the tissue; after 20–25 min, DIDS was added to the mucosal side of the human colon tissue at the time indicated. ■, negative control (no TDH or DIDS added). Values are expressed as means and SD (n = 5). *Significant difference, p < 0.05 versus negative control.

Fig. 3. Effect of glucose and Ca²⁺ depletion on Isc in Caco-2 cell monolayers treated with TDH. ●, positive control (TDH challenge); ■, Cl⁻ in the bath solution of the Ussing chamber was replaced by gluconate; ▲, Ca²⁺ depletion (CaCl₂ was omitted from the bath solution and 1 mM EGTA was added). TDH 10 µg/ml was added on the apical side of the Caco-2 cells at the time indicated. ▼, negative control (no TDH added). Values are expressed as means and SD (n = 5). *Significant difference, p < 0.05 versus negative control.
Caco-2 monolayers stimulated by TDH was inhibited by DIDS (100 μM), an inhibitor of Ca²⁺-activated Cl⁻ channels [26, 27]. When Caco-2 cell samples were pre-treated with DIDS, TDH had no effect on Isc (Fig. 5a). Glybenclamide (300 μM), an inhibitor of cAMP-dependent Cl⁻ channels [28, 29], 100 μM NPPB, an inhibitor of Cl⁻ channels [26, 28] and gadolinium³⁺, an inhibitor of the stretch-activated channel [30, 31], had no effect on TDH-induced increases in Isc (Fig. 5c). These results are consistent with the conclusion that Isc changes produced by TDH are generated by Ca²⁺-activated Cl⁻ channels [32].

When the Cl⁻ from the apical side of the bath solution was replaced by gluconate and the basolateral cell membranes were permeabilised by treatment with nystatin, TDH caused an increase in Isc that again was inhibited when DIDS was added on the apical side (Fig. 5b). This indicates that the Ca²⁺-activated Cl⁻ channel in the apical side of the Caco-2 cell monolayers generates the Isc increases stimulated by TDH.

**Effects of R7 on Isc**

If binding of TDH to its receptor on Caco-2 cells is a necessary step in altering Isc, there would be no change in Isc if TDH was prevented from binding to its receptor. R7, a mutant form of TDH [15], was used to check this possibility. The presence of R7 by itself had no effect on Isc, but when cells were pre-treated with R7, the effects of TDH on Isc were prevented (Fig. 6).

**Effects of PKC inhibitors on Isc**

PKC inhibitors were also used to evaluate the changes in Isc caused by TDH (Fig. 7). Compared with the positive control, 1 μM calphostin C decreased the Isc by 69% and 0.01 μM staurosporin by 74% at 21 min (Fig. 7). Calphostin C and staurosporin were pre-loaded for 30 min. If pre-loaded for longer, trans-epithelial resistance decreased, making it difficult to measure the Isc.

**Changes in intracellular Ca²⁺ concentrations**

The intracellular Ca²⁺ concentration of Caco-2 cells increased in the presence of TDH (Fig. 8a) but not in the absence of extracellular Ca²⁺. Thus, the increase in [Ca²⁺]³ is due to an influx of Ca²⁺ from the extracellular medium. Pre-treatment of Caco-2 cells with mutant toxin R7 reduced the effects of TDH on Ca²⁺ influx (Fig. 8b). As already reported, R7 competes with TDH for binding sites [15], and the specific binding of TDH to its receptor was shown here to be necessary to increase [Ca²⁺]³. The increase in [Ca²⁺]³ caused by TDH was much less pronounced when calphostin C and staurosporin were added (Fig. 8c), suggesting a PKC-mediated increase of [Ca²⁺]³.

**Discussion**

The results show that TDH stimulated Isc currents in Caco-2 cells, a human colonic epithelial cell line, and

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*Fig. 4. Effect of TDH concentration on Isc and trans-epithelial resistance of Caco-2 cell monolayers. TDH was added to the basolateral side of Caco-2 cells mounted in Ussing chambers (n = 6). (a) Isc increase, compared with basal Isc. (b) Effect of TDH on trans-epithelial resistance. (Delta trans-epithelial resistance = trans-epithelial resistance at 20 min after TDH addition – trans-epithelial resistance before TDH addition).*
Fig. 5. Effect of inhibitors on Isc in Caco-2 cell monolayers in the presence of TDH. TDH 10 µg/ml was added on the apical side at the time indicated. (a) Isc traces showing effect of 100 µM DIDS added on the apical side at the time indicated. (b) Effects of TDH and DIDS on apical membrane Cl⁻ currents after the establishment of a basolateral-to-apical Cl⁻ gradient and permeabilisation of the basolateral membrane with nystatin. The illustration on the right represents the monolayers and indicates the direction of the ion gradient (arrow) and the permeabilised membrane (broken line). (c) Effect of Cl⁻ channel inhibitors, 100 µM DIDS, 300 µM glybenclamide, 100 µM NPPB and 500 µM gadolinium³⁵, on the ISc (14.2 ± 2.8 µA/cm²) stimulated by TDH 10 µg/ml. The Cl⁻ channel inhibitors were added to the apical side of the cell monolayers after stimulation with TDH for 10 min. The percentage decrease in ISc = (Inhibited ISc)/(Peak ISc − Basal ISc) × 100. Basal ISc, ISc before TDH addition; Peak ISc, the highest ISc during 10 min after TDH addition; Inhibited ISc, the lowest ISc during 10 min after addition of Cl⁻ channel inhibitors. Values are expressed as means and SD (n = 5).
these currents followed the activation of Cl\(^-\) channels. ISc increases caused by addition of TDH to the mucosal side of the human colonic tissue had the same characteristics as those observed with Caco-2 cells, suggesting that TDH may also stimulate Cl\(^-\) secretion in the human colon.

TDH is a pore-forming toxin creating a functional pore size of c. 2 nm in target membranes [10]. Thus, there is the possibility that Cl\(^-\) moves through TDH-formed pores. However, other evidence suggests that this is not the case: DIDS, calphostin C and staurosporin inhibited the TDH-induced Cl\(^-\) currents. If Cl\(^-\) was simply passing through TDH-formed pores, those inhibitors would have no inhibitory effect on the Cl\(^-\) currents.

Human colonic epithelial cells are reported to have several types of Cl\(^-\) secretion pathways [33]. It was not
clear which type of Cl− secretion pathway was activated by TDH, but the cystic fibrosis transmembrane conductance regulator (CFTR) is one of the major Cl− channels in Caco-2 cells and is one of the most important Cl− secretion pathways involved in human diarrhoea. It was possible, therefore, that CFTR was the target for TDH, especially as PKC inhibitors were found to block Cl− secretion induced by TDH and PKC is said to activate CFTR [34]. However, glybenclamide and NPPB, both of which are known to
be inhibitors of CFTR [28], had no effect on the Cl− currents stimulated by TDH (Fig. 5c), indicating that TDH effects were not mediated by CFTR.

The swelling of erythrocytes or Intestine 407 cells induced by TDH has been reported [10, 35]. If this type of cell swelling had occurred with Caco-2 cells, there would be the possibility that the stretch-activated channels may have been opened. Cell swelling was noted within 15 min of adding TDH (unpublished observation). However, gadolinium2+, an inhibitor of stretch-activated channels, had no effect on TDH-stimulated Cl− secretion and so these channels do not appear to be involved with TDH-induced Cl− secretion.

Other investigators have reported that, in rabbit ileum, Isc increases due to TDH depend on extracellular Cl−, as indicated by increased transient Isc currents [5, 6]. No self-inactivation of Isc was observed in the present work during the 30 min following the addition of TDH to the human colonic cells. These findings suggest that the Cl− currents induced by TDH are mediated by the Ca2+-activated Cl− channel, because there is evidence of [Ca2+]i dependency and DIDS, an inhibitor of the Ca2+-activated Cl− channel, reduced the Isc. It is also likely that the channels are located on the apical side of the cells (Fig. 5a and b).

There may be three steps for the stimulation of Cl− currents by TDH. First, TDH binds to its receptor on the epithelial cells. This is suggested by the inhibition of [Ca2+]i elevation and Cl− current by R7. R7 is a mutant form of TDH and inhibits the haemolytic activity of TDH through competitive binding to the receptor [14, 15]. Consequently, the effect of TDH on Cl− secretion is also dependent on the binding of TDH to its receptors. Second, TDH induces an influx of Ca2+ followed by an elevation of [Ca2+]i. When extracellular Ca2+ was depleted, there was no [Ca2+]i elevation, suggesting that the influx of Ca2+ was TDH-induced. No [Ca2+]i spike was observed in the present study, as is reported to occur in rabbit cell lines [6, 36]. Considering the pathway of Ca2+ influx, PKC inhibitors inhibited the Ca2+ influx stimulated by TDH. This suggests that TDH activates PKC, which is then followed by the elevation of [Ca2+]i. The increase in [Ca2+]i caused by TDH was reduced by calphostin C, while there was no increase at all with staurosporin. Calphostin C is a more specific inhibitor of PKC, whereas staurosporin also inhibits others kinases. An earlier study reported that PKC may be involved in the lysis of human erythrocytes by TDH [37]. Taken together, these findings suggest that PKC activation induced by TDH may be an important step for inducing the diarrhoea caused by _E. coli_ haemolyticus.

The third step is the stimulation of Cl− secretion mediated by [Ca2+]i elevation. When the [Ca2+]i elevation was suppressed by R7 or by depletion of the extracellular Ca2+ ions, no Cl− current increases were seen. Moreover, DIDS decreased the Cl− current without suppression of [Ca2+]i elevation (data not shown), pointing to the conclusion that increased Cl− currents were a secondary effect of increased [Ca2+]i.

In conclusion, it is proposed that TDH may induce diarrhoea (i.e., fluid secretion) in three steps: (i) binding to the receptor molecule (not yet identified) on colonic epithelial cells, (ii) elevation of [Ca2+]i associated with PKC activation, and (iii) activation of Ca2+-activated Cl− channels, resulting in Cl− secretion from the serosal to the mucosal side of the epithelial layer.

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