Oxidative stress in bone remodeling: role of antioxidants

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Summary

ROS are highly reactive molecules which consist of a number of diverse chemical species, including radical and non-radical oxygen species. Oxidative stress occurs as a result of an overproduction of ROS not balanced by an adequate level of antioxidants. The natural antioxidants are: thiol compounds among which GSH is the most representative, and non-thiol compounds such as polyphenols, vitamins and also various enzymes. Many diseases have been linked to oxidative stress including bone diseases among which one of the most important is the osteoporosis. The redox state changes are also related to the bone remodeling process which allows the continuous bone regeneration through the coordinated action of bone cells: osteoclasts, osteoblasts and osteocytes. Changes in ROS and/or antioxidant systems seem to be involved in the pathogenesis of bone loss. ROS induce the apoptosis of osteoblasts and osteocytes, and this favours osteoclastogenesis and inhibits the mineralization and osteogenesis. Excessive osteocyte apoptosis correlates with oxidative stress causing an imbalance in favor of osteoclastogenesis which leads to increased turnover of bone remodeling and bone loss. Antioxidants either directly or by counteracting the action of oxidants contribute to activate the differentiation of osteoblasts, mineralization process and the reduction of osteoclast activity. In fact, a marked decrease in plasma antioxidants was found in aged or osteoporotic women. Some evidence shows a link among nutrients, antioxidant intake and bone health. Recent data demonstrate the antioxidant properties of various nutrients and their influence on bone metabolism. Polyphenols and anthocyanins are the most abundant antioxidants in the diet, and nutritional approaches to antioxidant strategies, in animals or selected groups of patients with osteoporosis or inflammatory bone diseases, suggest the antioxidant use in anti-resorptive therapies for the treatment and prevention of bone loss.

KEY WORDS: oxidative stress; antioxidants; bone remodeling; osteoporosis; antioxidant nutrient treatment.

Introduction

The physiological intracellular redox state depends on the ratio between the levels of pro-oxidants, oxidizing agents (reactive oxygen species, ROS) and antioxidants (1, 2). ROS are highly reactive molecules, which consist of a number of diverse chemical species, including radical and non-radical oxygen species such as superoxide anion (O₂⁻), hydroxyl radical (OH⁻) and hydrogen peroxide (H₂O₂). ROS, considered as the ‘primary’ ROS, can further interact with other molecules in order to generate ‘secondary’ ROS which are more aggressive, and they act either directly or prevalently through enzyme or metal-catalysed processes. ROS are produced during normal metabolism following the activation of various enzymes such as NADPH oxidase (membrane enzyme), superoxide dismutase (cytoplasmic enzyme) and various mitochondrial oxidases (3). Indeed, a controlled increase of ROS level and in particular of H₂O₂ may have an important role in the transmission of intracellular signaling which regulate many fundamental cellular processes such as proliferation, differentiation, apoptosis, repair processes and inflammation (5, 6).

The natural antioxidants are: thiol compounds among which the most important and represented in animals is the glutathione (GSH, γ-glutamyl-cysteinyl-glycine), non-thiol compounds such as polyphenols, predominantly contained in various plants, vitamins such as ascorbic acid, alfa-tocopherol and vitamin A, as well as various enzymes capable to eliminate ROS such as catalase, and enzymes that use GSH as substrate (GSH-reductase, GSH-peroxidase etc.) (3). GSH, present in concentrations of 2-10 mM within cells, is the primary determinant of the cellular redox environment (7) and exists mainly as the biologically active reduced-thiol form. The oxidation of GSH to GSSG and subsequent decrease in the GSH/GSSG ratio is often associated with oxidative stress. Thus, the GSH/GSSG ratio is a simple and useful indicator of cellular redox status (8, 9). De novo GSH synthesis, GSSG reduction, and exogenous GSH uptake are crucial in the maintenance of cellular redox homeostasis, and GSH seems to be involved in signaling
pathways being able to regulate the activity of transcription factors and protein through reactions of glutathionilation (2, 10, 11). Other thiol antioxidants are: Thioredoxin, Glutaredoxin, Cysteine (Cys) and the reduced form of Lipoic Acid (LA), dihydrolipoic acid (DHLA): the first two have catalatic-redox-active cysteines and catalyze the reduction of protein mixed disulfides (3). Cys is the most abundant low-molecular thiols in extracellular fluids with concentrations ranging from 40 μM to 8-10 μM (12), and DHLA contains two thiol groups and is produced in almost every cell in small amounts. In vivo Cys and DHLA act directly on ROS and RNS (Reactive Nitrogen Species) as scavengers and by regeneration of other antioxidants such as vitamin C, E and GSH (13-15).

The physiological redox state is maintained in equilibrium by various factors and mechanisms that regulate the activity of ROS-producing enzymes and antioxidants. Oxidative stress occurs as a result of an overproduction of ROS not balanced by adequate levels of antioxidants (1, 2). This can be determined by both physiological events, such as aging and hormonal changes (decrease of estrogen) (16-19) and pathological events related to the production of inflammatory cytokines involved in many pathological processes, exogenous and endogenous toxins, radiation exposure and drug therapies (2, 6, 20).

Oxidative stress generates a cellular damage due to lipid oxidation, structural alteration of the membranes, oxidation of proteins and nucleic acids; the damage may extend to the organs and become systemic (21). Many diseases have been linked to oxidative stress including bone diseases among which one of the most important is the osteoporosis.

Oxidative stress in postmenopausal osteoporosis, due to estrogen deficiency, has been related to the activation of NADPH oxidase and/or decreased synthesis of antioxidant enzymes and GSH levels (17, 18, 22, 23). Oxidative stress, in the elderly osteoporosis and in the secondary osteoporosis due to intestinal chronic diseases (IBD), is due to decrease of GSH levels and defensive antioxidant abilities (19, 20, 24) related also to reduced intestinal absorption of antioxidants contained in food. In osteoporosis secondary to bone inflammatory processes and prolonged therapy with steroidal anti-inflammatory drugs, oxidative stress is mainly due to the activation of enzymes which produce ROS (25, 26).

Oxidative stress in bone remodeling

The redox state changes are also related to the bone remodeling process which allows the continuous bone regeneration (25, 27). In fact, bone is a dynamic tissue that continuously renews itself throughout life by the coordinated action of the three major types of bone cells: osteoclasts, osteoblasts and osteocytes (28, 29). The remodeling process is the result of interactions between these cells and multiple molecular agents, including hormones, growth factors and cytokines. It is a physiological process that follows a time sequence lasting approximately six months wherein osteoclasts eliminate old or damaged bone tissue which is subsequently replaced with new bone tissue formed by osteoblasts, while the osteocytes function in the transduction of signals necessary to sustain mechanical loads. Recently, new data support the central regulatory role of osteocytes in bone remodeling and thus in viability and functionality of bone, maintaining normal levels of mineralization and repair.
maintenance of balance between bone resorption and formation. Increased levels of this ratio are correlated to increased turnover of bone remodeling due to increased resorption rate without adequate and proper bone formation; this event has been related to the pathogenesis of various skeletal diseases, including various form of osteoporosis and bone diseases secondary to inflammation (31, 32, 48). The expression of RANKL and OPG is regulated by various hormones and cytokines, but a fundamental event in the initiation and regulation of the bone formation and remodeling is the apoptosis of osteoblasts and osteocytes (27, 32).

Experimental data show that excessive apoptosis of osteocytes is correlated to an increased oxidative status causing an imbalance in favor of osteoclastogenesis (15, 50-52). There are few data on the molecular mechanisms that regulate these processes, but many studies are currently focused on the regulatory activities of the osteocytes. These cells constitute 90% of the bone cell population and are embedded in the bone matrix. They have a morphology similar to neuronal cells with a central body and dendritic extensions thanks to which they communicate with each other, with other bone cells, with blood capillaries and nerve endings. They are mechanosensory cells (30, 41) and under physiological conditions, following a microdamage or other physical and hormonal signals, such as estrogen deficiency, mature osteocytes undergo apoptosis, and some data show that this is related to oxidative stress (42, 50, 51). Indeed, apoptotic osteocytes induce lining cells to retract from the bone surface to form a suitable environment for the recruitment and activation of mature osteoclasts through formation and release of RANKL (32, 53). They also produce high levels of sclerostin and DKK1 which block OPG synthesis and release by Wnt/βcatenin pathway inhibition both in osteocytes and osteoblasts (30-32, 42). This event increases RANKL/OPG ratio promoting osteoclast activity, osteoblast apoptosis and bone degradation. Indeed, a microfracture can determine the breaking of the dendritic filaments and therefore the connections with other cells and blood vessels. This causes a deficient intake of O₂, nutrients, hormones and factors essential for their viability inducing metabolic alterations, oxidative stress and osteocyte apoptosis which initiates the remodeling process and bone resorption (34, 41, 42, 52, 54).

Under physiological conditions, after the phase of bone resorption, in response to factors released from the bone matrix, the recruitment of osteoblast precursors and their differentiation into mature, bone-synthesizing cells occur. However, an excessive oxidative stress induces an abnormal apoptosis of osteocytes resulting in an imbalance of the
remodeling process with consequent altered and deficient bone formation, as occurs in aging, glucocorticoid treatment, osteoporosis and other bone diseases related to oxidative stress (17, 26, 31, 55-57). Differently, vital osteocytes produce high levels of OPG and this contributes to the differentiation of osteoblasts and mineralization process (32, 50).

Antioxidants in bone remodeling and in bone loss

In vivo and in vitro data have shown that thiol and non-thiol antioxidants, directly and/or counteracting the effect of oxidants contribute to activation of osteoblast differentiation, mineralization process and reduction of osteoclast activity. All these antioxidants act as direct scavengers of ROS, but they also maintain high levels of GSH, in fact, together with GSH-reductase they contribute to the elimination of GSSG formed in the reduction reactions, maintaining normal levels of GSH/GSSG and the intracellular redox state (8, 14, 47). Some studies relate antioxidants to bone metabolism, in fact a marked decrease in plasma antioxidants was found in aged or osteoporotic rats and in aged or osteoporotic women (17, 19, 38). The loss of antioxidant leads to accelerated bone loss through the activation of a tumour necrosis factor alpha (TNFα)-dependent signalling pathway (18), and the administration of antioxidants such as vitamin C, E, N-acetylcysteine (NAC) and LA, has beneficial effects in individuals with osteoporosis (56-59). Administration of NAC or ascorbate in ovariectomized mice abolishes ovariectomy-induced bone loss, while l-buthionine-(S,R)-sulfoximine (BSO), a specific inhibitor of glutathione synthesis, causes substantial bone loss (49). LA has also beneficial effects in the maintenance of a healthy bone structure in rat ovariectomy and inflammation-mediated osteoporosis (60). Other data demonstrate that the administration of vitamin E is able to maintain bone mineral density in elderly men (39), and it promotes healing of osteoporotic fracture in ovariectomized rats inducing the bone regeneration (61). However, few studies have been performed on the direct action of antioxidants on bone cell activity. As regards thiol antioxidants some data have been obtained by using NAC, GSH and LA, a cysteine analogue drug with many therapeutic applications, has a protective role in controlling oxidative stress against many cells including osteoblasts, and stimulates osteoblastic differentiation of mouse calvarial cells (8, 14, 47, 62). Other studies report that NAC inhibits oxidative stress induced apoptosis of osteoblastic cells, and this is mediated by GSH (63, 64), moreover, NAC prevents osteoclast formation, NF-κB activation and TNF-α expression involved in osteoclast activation (49). Indeed, GSH is involved in osteoclast and osteoclast differentiation as well as in osteoporosis and other bone diseases (14, 17, 65).

Data reported in human osteoblastic-like SaOS-2 cells, which represent a valuable model system for studying osteoblast functions and mineralization process, demonstrate that GSH and NAC increase alkaline phosphatase (ALP) activity and other osteogenic markers, such as RUNX2 and osteocalcin, during the differentiation of these cells in mature osteoblasts (8). These antioxidants are able to restore osteoblastic mineralization due to oxidative stress induced both by GSH depletion, obtained by BSO (8) and by H2O2 treatment in bone marrow stromal cells isolated from rat femur (62). LA is also able to inhibit TNFα induced apoptosis of human bone marrow stromal cells in which JNK and NFKB are involved (66). It has also been demonstrated that high levels of GSH/GSSG ratio are important for osteoblast differentiation and mineralization process (8). Indeed, GSH redox state has been reported to play an important role in the differentiation and phenotype expression of some cell types including osteoblasts and osteoclasts (67). Moreover, GSH and NAC in SaOS-2 cells decrease RANKL/OPG levels, while, increase calcium levels and mineralization process (8). Therefore, these antioxidants promote bone formation and have an anti-osteoclastogenic action. LA also suppresses osteoclastogenesis in hBMSC by directly inhibiting RANKL-RANK mediated signals (13). Recent data have demonstrated the ability of GSH, NAC and LA to prevent osteocyte apoptosis and the increase of sclerostin and RANKL/OPG ratio levels induced by oxidative stress (15). This study is performed in a murine osteocyte-like cell line, MLO-Y4, which has similar phenotype and many characteristics of mature osteocytes and constitute a model to study osteocyte viability and apoptosis in response to microdamage and bone diseases (41, 52). This study was accomplished by inducing oxidative stress via starvation that, in part, mimics what happens following a microdamage at the level of osteocytes (34, 41, 42, 52, 54). Antioxidants and ROS mediate starvation-induced apoptosis and OPG expression by JNK signalling; whereas they regulate RANKL and sclerostin expression by both JNK and ERK1/2 activity (15). Moreover, it has been demonstrated that catalase, used as antioxidant, is able to inhibit the activation of TRAP-positive multinucleated giant cells induced by H2O2 treatment in cultures of primary human marrow cells (36). Other antioxidants inhibit TRAP, k-catepsin and protease activity in osteoclast cell lines (68, 69). In Figure 2 the effects of antioxidants against the action of oxidative stress at the molecular and cellular level are summarized. At the molecular level they prevent RANKL and sclerostin increase and OPG decrease, inhibiting the enhancement of the RANKL / OPG ratio in osteoblasts and osteocytes. Moreover, they inhibit the increase of bone acid phosphatase and protease activity which degrade the bone matrix in osteoclasts and induce alkaline phosphatase and matrix protein synthesis in osteoblasts. At the cellular level they counteract the excessive apoptosis of osteoblasts and osteocytes and reduce the differentiation and activity of osteoclasts.

Role of nutrients containing antioxidants in treatment and prevention of bone loss

Given the important role of ROS and oxidative stress in bone turnover, there is a considerable interest in the use of antioxidants in potential treatments for osteoporosis and bone inflammatory diseases. Different experimental protocols have been studied using either pharmacological or nutritional approaches. As regards nutritional approaches, epidemiological studies have provided evidence of a link between nutrient, antioxidant intake and bone health, and have led to investigations of the antioxidant properties of nutrients and their influence on bone metabolism. Polyphenols and anthocyanins are the most abundant antioxidants in the diet and are widespread constituents of fruits, vegetables, cereals, dry legumes, chocolate, tea, coffee and wine. Experimental studies in animals or cultured cell lines have supported roles for polyphenols in the preven-
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Figure 2 - Effect of antioxidants on bone cells at molecular and cellular level in bone resorption. Antioxidants inhibit and prevent oxidative stress and affect various enzymes, proteins and cytokines involved in bone remodeling.

Oxidative stress in bone remodeling: role of antioxidants (70). Recent data demonstrate that nutritional approaches to antioxidant strategies in bone cells and/or in animals or selected groups of pa-
tients with osteoporosis or inflammatory bone diseases, could be useful for the treatment and prevention of bone loss. In particular, as regards resveratrol, this increases bone mineral density and bone ALP in ovariectomized and old rats (72). Similarly, dietary supplementation with green tea or Hypericum perforatum or blueberry, containing various types of polyphenols, attenuates trabecular bone loss, prevents loss of collagen in bone matrix, inhibits senescence pathways in osteoblastic cells and prevents osteoporosis in ovariectomized rats (73-76). Tea drinking is also associated with beneficial effects in maintaining bone density in old women and in menopausal women (77, 78). Other data show that green tea polyphenols mitigate bone loss of female rats with chronic inflammation (79), and blueberry extracts have protective effects in acute inflammation and collagen-induced arthritis in the rats (80). Interesting is the protective effect of dietary supplementation of Hypericum perforatum against the oxidative stress and the bone mass loss obtained in rats subjected to forced swimming, in this case it has been shown how antioxidants can induce beneficial effects when oxidative stress and active bone resorption is caused by excessive physical activity (81). Finally, it has been demonstrated in young rats that blueberry phenolic component promotes bone growth activating canonical Want signalling, and diets enriched with blueberries increase bone density mass through suppression of RANKL in stromal cells (82, 83). Indeed, it is note that accumulation of bone mineral during childhood and adolescence is a determining factor for the cost of osteoporosis in aging and in post-menopausal period (84, 85), and various data indicate that daily consumption of fruits or vegetables may be important in increasing the bone mass peak (86, 87).

Conclusions

In this review, it has been shown that changes in intracellular redox state occur during the physiological bone remodeling and that oxidative stress induces important alterations of the differentiation process and activity of bone cells including also the osteocytes. It is highlighted the regulatory role of osteocytes in bone remodeling process and that oxidative stress, related to many diseases including osteoporosis, promotes osteoclast resorption and bone loss through an excessive apoptosis of osteocytes. This is due to RANK signalling activation by increasing RANKL expression with the consequent increase of RANKL/OPG ratio and inhibition of osteoblastic activation and mineralization process. Many in vitro and in vivo experiments demonstrate that these events are regulated by redox-sensitive signalling pathways in which are involved MAPKs, β-catenin and NF-kB activity. On the contrary, antioxidants have an important role in maintaining a normal bone remodeling process and protecting bone health; in fact, they prevent and/or reduce inflammatory state and bone loss by inhibiting osteocyte apoptosis and mitigating osteoclast activity, consequently, they increase osteoblast activity and induce osteogenesis. Clinical studies show a positive correlation between low levels of antioxidants and bone loss, and this is also related to an increase of markers of bone resorption. Among the biological antioxidants the most important is GSH and different antioxidants act as direct ROS scavengers but also maintaining high levels of intracellular GSH. Moreover, various studies demonstrate also the important role of nutrient antioxidants in bone health, both in young people, in order to favour the formation of optimal peak bone mass, and in the elderly and in menopausal women in order to prevent bone loss, often associated to bone fracture, morbidity and mortality. Indeed, it has been proposed antioxidant use in anti-resorption therapies considering also that they are able to reduce the activity of osteoclasts without determining their destruction which can be important when it is need not only to reduce bone resorption but also to restore physiological bone remodeling. In fact, the anti-resorptive drugs, which are very powerful drugs, currently in use bisphosphonates and the antibody to RANKL, denosumab, block resorption factors, but at the same time reduce the vitality of osteoclasts and promote their apoptosis, breaking the two-way communication between these and osteoblasts, and enabling the restoration of a normal remodeling process (88). Thereafter, it could be interesting to design new therapeutic approaches which include antioxidant treatments for bone diseases related to oxidative stress and bone loss. Indeed, these could act on the redox balance in bone cells and on redox regulated factors and processes involved in bone turnover. However, further studies are needed to clarify the cellular and molecular mechanisms underlying the relationship among oxidative stress, antioxidants and bone metabolism.

Disclosure

All Authors declare that they have no conflicts of interest.

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