The spleen: another mystery about its function

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CONTINUING THE RECENT SERIES of articles on the pathogenesis of lipopolysaccharide (LPS)-induced fever (8, 9, 11–16, 21, 25, 26), a study by Feleder et al. (7) in this issue of the American Journal of Physiology-Regulatory, Integrative and Comparative Physiology reports a novel finding: an exaggeration of the febrile response to LPS in guinea pigs after splenectomy. The authors attribute this exaggeration to the observed increase in LPS uptake by Kupffer cells. They conjecture that the spleen naturally limits the fever response by inhibiting the avidity of Kupffer cells to LPS. The results of this elegant study are both clinically important and highly unexpected.

The clinical importance of these results stems from two facts. First, the spleen often must be removed surgically in several forms of hypersplenism and in abdominal trauma (4). Second, it has long been recognized that splenectomy increases the incidence of infection with the pneumococcus, other encapsulated bacteria, and organisms that are usually not pathogenic in humans (20). Infection after splenectomy often results in fulminant sepsis; the increased sensitivity to infection lasts for many years (4). Consequently, the prophylaxis (vaccination) and early recognition of infection are of great importance. Even a low-grade fever in an asplenic patient is an indication to search aggressively for infection, start antibacterial therapy, or both. Clinicians need to know whether and how the febrile response is modified by removal of the spleen. This is the question asked by Feleder et al. (7).

The answer their study provided does not agree readily with the existing literature. In addition to participating in specific immunity via the production of antibodies, the spleen is involved in nonspecific host-defense responses (reviewed in Refs. 4, 7). Due to its high content of phagocytes (~15% of the body’s population of “fixed” tissue macrophages) and direct connection to the bloodstream, the spleen has a role in the clearance of circulating microorganisms, particles, and some large molecules, such as LPS. Splenic macrophages take up ~3% of an intravenous dose of LPS (5). In endotoxemia, they become activated and produce inflammatory cytokines and lipid mediators (18, 24); some of these macrophages migrate to the liver, where they become Kupffer cells (see Ref. 18). The number of Kupffer cells in the liver changes little after splenectomy, with the exception of the acute (1–2 day) postoperative period, when it increases as a result of the intra-abdominal intervention (3). However, the LPS-induced increase in the number of Kupffer cells, which normally occurs due to the migration of splenic macrophages, is strongly inhibited by splenectomy (3). Likewise, splenectomy inhibits the responsiveness of Kupffer cells (3) and other macrophages (4) to inflammatory stimuli. Clearance of LPS is either unchanged (1) or slightly decelerated (19) after this surgery. Accordingly, most responses to LPS (from production of pyrogenic cytokines and other inflammatory mediators to hemocoagulation and hypotension) are either unchanged or inhibited after splenectomy (2, 18, 19).

The responses that are either unaffected or inhibited by splenectomy include the development of LPS tolerance (1, 10). Even the lethal activity of LPS is either unchanged (6) or decreased (1) by this surgery.

Hence, the literature data suggest that febrile responsiveness to LPS is likely to be unchanged or decreased, but not exaggerated, after splenectomy. This suggestion has been confirmed. In two experiments involving 82 rabbits, Greisman et al. (10) found that splenectomy does not affect the febrile response to systemic LPS. The same article reports the results of three patients who had undergone posttraumatic splenectomy 7–11 years earlier. No changes in their fever response to systemic LPS were found compared with six volunteers with intact spleens. In this context, the finding of Feleder et al. (7) of increased febrile responsiveness after splenectomy in guinea pigs is surprising.

In support of their finding, the authors cite clinical observations of frequent fevers in asplenic patients. Although such fevers are well recognized and agree with our own clinical practice, they can be explained by a variety of factors. For example, the association of splenectomy with a suppressed immune defense against infection (4) increases the frequency of infectious complications and, consequently, of infection-associated fevers. In the early postoperative period, an ischemic lesion to the pancreas can cause fevers (22). Although we have not seen signs of such a lesion in our patients, others consider it a common complication of splenectomy (22). The most frequent indication for the removal of spleen is lymphoproliferative conditions such as Hodgkin’s disease. Patients with these conditions develop fevers regardless of whether they have undergone a splenectomy (17). Last but not least, an attenuated development of pyrogenic tolerance (10) can also account for increased febrile responsiveness, because a nontolerant host responds to the same pyrogenic stimulus with a higher fever. This latter mechanism might have contributed to the results of some, but not all, experiments conducted by Feleder et al. (7),
who administered LPS to guinea pigs twice, 7 and 30 days after surgery.

Although the exaggeration of LPS fever in guinea pigs after splenectomy contradicts the earlier work by Greisman et al. (10) and is supported by little existing literature, the contradiction may reflect some of the multiple differences in the structure and function of the spleen across species (4). The unexpected multiple differences in the structure and function of the spleen after splenectomy contradicts the earlier work by who administered LPS to guinea pigs twice, 7 and 30 days after splenectomy.

REFERENCES