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Sepsis-Induced Apoptosis Causes Progressive Profound Depletion of B and CD4⁺ T Lymphocytes in Humans

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Patients with sepsis have impaired host defenses that contribute to the lethality of the disorder. Recent work implicates lymphocyte apoptosis as a potential factor in the immunosuppression of sepsis. If lymphocyte apoptosis is an important mechanism, specific subsets of lymphocytes may be more vulnerable. A prospective study of lymphocyte cell typing and apoptosis was conducted in spleens from 27 patients with sepsis and 25 patients with trauma. Spleens from 16 critically ill nonseptic (3 prospective and 13 retrospective) patients were also evaluated. Immunohistochemical staining showed a caspase-9-mediated profound progressive loss of B and CD4 T helper cells in sepsis. Interestingly, sepsis did not decrease CD8 T or NK cells. Although there was no overall effect on lymphocytes from critically ill nonseptic patients (considered as a group), certain individual patients did exhibit significant loss of B and CD4 T cells. The loss of B and CD4 T cells in sepsis is especially significant because it occurs during life-threatening infection, a state in which massive lymphocyte clonal expansion should exist. Mitochondria-dependent lymphocyte apoptosis may contribute to the immunosuppression in sepsis by decreasing the number of immune effector cells. Similar loss of lymphocytes may be occurring in critically ill patients with other disorders. The Journal of Immunology, 2001, 166: 6952–6963.

Sepsis and the resultant multiple organ failure that it induces are the most common causes of death in many intensive care units. The CDC currently estimates that >500,000 people develop sepsis and 200,000 die annually in the U.S. alone (1). Sepsis is now the 12th most common cause of death in America (1). A current hypothesis is that sepsis represents a state of uncontrolled activation of the inflammatory cascade resulting in cell and organ injury (2, 3). A recent consensus panel definition of sepsis as “the systemic inflammatory response syndrome due to infection” (4) reflects the concept that sepsis is the result of an uncontrolled inflammatory cascade. Because of this hypothesis, a major focus of sepsis research has been the development of antiinflammatory therapies, e.g., corticosteroids, anti-endotoxin Abs, anti-cytokine Abs, anti-platelet-activating factor, etc. The surprising failure of antiinflammatory strategies (with the possible recent exception of activated protein C (5)) has led to a rethinking of the concept of sepsis as a disorder due to unbridled inflammation (6, 7).

Recent studies in animal models of sepsis as well as in patients who died of sepsis and multiple organ failure have shown that sepsis induces extensive loss of lymphocytes via apoptosis (8–11). Because lymphocytes produce proinflammatory cytokines and activate macrophages, loss of lymphocytes may be beneficial to survival by down-regulating the excessive inflammatory response (10, 12). Alternatively, loss of lymphocytes in sepsis may be detrimental by impairing the ability of the immune system to combat pathogens (10, 12). In support of the concept that lymphocyte apoptosis is detrimental to host survival are a number of studies showing that patients with sepsis are immunologically impaired. Patients with sepsis become anergic, i.e., have no response to skin testing with Ags derived from microbes to which previous exposure would be expected (positive controls) (13, 14). There is also indirect evidence for an immunodeficient state in patients with sepsis. Studies show that trauma patients develop a decrease in circulating lymphocytes that is maximal at day 3. The lowest number of lymphocytes occurred in those trauma patients who developed infection or death (15). Furthermore, intensive care patients who develop a decreased lymphocyte count for >3 days are at a greatly increased risk of nosocomial sepsis (16).

Importantly, animal studies show that prevention of lymphocyte apoptosis either by overexression of the antiapoptotic protein Bcl-2 or by administration of drugs that prevent activation of caspases (proteases that are activated in response to proapoptotic stimuli) improve survival in sepsis (17). To gain insight into the potential impact of lymphocyte apoptosis in sepsis, it is essential to determine both the extent of loss and type of lymphocytes that are being affected in the disorder. In the present study, the effect of sepsis on the various lymphocyte subsets, i.e., B cells, CD4 T cells, CD8 cytotoxic cells, and NK cells, was investigated. Defects in these lymphocyte subsets impair specific aspects of the host immune response and predispose to various pathogens. In addition to sepsis, other noxious stimuli such as ischemia/reperfusion or hypoxia can induce apoptosis (18). Therefore, nonseptic patients who were critically ill were also examined. Finally, we examined the role of active caspase-9 in lymphocyte apoptosis in sepsis. Apoptosis can proceed by two mechanistically distinct pathways, i.e., a receptor-mediated pathway that proceeds by activation of caspase-8 or a mitochondrial pathway that proceeds by caspase-9 (18, 19). Knowledge of the precise pathway of apoptosis will help identify stimuli that trigger cell death in sepsis and may allow for a more rational therapeutic approach.
Materials and Methods

Spleen sampling in patients with sepsis

The method of obtaining spleen samples was described previously (10) and is discussed briefly. Spleen samples were obtained from 24 septic patients rapidly postmortem, whereas spleen samples were obtained intraoperatively from 3 patients with sepsis during a procedure to remove spleens with abscess formation. In the spleen samples obtained postmortem, a protocol for immediate tissue sampling allowed for tissue harvesting in the intensive care unit as soon as informed consent could be obtained from next of kin. The spleen sample was placed in 10% buffered formalin for 24 h. Before paraffin embedding and sectioning, the length of time between onset of death and tissue sampling ranged from 15 min to 6 h, with the vast majority obtained between 30 and 90 min (10). In the three patients with sepsis whose spleens were removed intraoperatively, the sample was obtained from a grossly normal appearing section of the spleen that was not directly contiguous with the site of infection. Microscopic examination was used to confirm the lack of infectious organisms and abscess formation in the spleen samples obtained intraoperatively. Three other septic patients were excluded from the study because they were taking chronic high doses of immunosuppressive medication, i.e., corticosteroids and/or cyclosporin. Four patients with sepsis who were being treated with corticosteroids were included in the study (see Table I). Two of these four patients had corticosteroids initiated in the 24-36 h preceding their death. Low physiologic doses of corticosteroids were used in the other two (see Table I).

The protocol for tissue sampling was approved by the Human Studies Committee at Washington University School of Medicine.

Criteria of sepsis

Patients were classified as septic based on one of the three following criteria: 1) positive blood, abdominal fluid, or tissue cultures for bacteria or fungi (see Table I); 2) intraoperative evidence of infection, e.g., perforated intestine, kidney, and muscle from patients dying of sepsis and multiple organ failure (10). As reported, spleen and colon were the two organs exhibiting the greatest degree of cell death, with apoptosis being the overriding mechanism of death in these organs (10). The aim of the current study was to characterize the immunologic status of septic patients by determining the extent of lymphocyte depletion and by identifying cell phenotypes that might be preferentially affected by apoptosis. In addition to immunohistochemical methods, flow cytometry was used to detect apoptosis and to corroborate immunohistochemical findings.

Spleen sampling in patients with trauma

Due to the inability of obtaining normal human spleens, patients with blunt or penetrating abdominal trauma necessitating a splenectomy were used as a control population for comparison with the patients with sepsis. None of the trauma patients had significant comorbidities or was taking immunosuppressive medication; presumably, findings from this group are representative of those of a normal population. Spleens were removed rapidly after injury (usually within 3–8 h); therefore, values for the lymphocyte subsets should reflect those of a normal spleen.

Immunohistochemical staining for cell surface markers

An abbreviated description of the methods is provided. The complete description of immunohistochemical staining protocols is available on the website: http://elysium.wustl.edu/rhlab/.

Anti-human CD3, CD8, and CD20 Abs were prediluted by the manufacturer and applied to sections. Next, HRP polymer (Dako EnVision) was added, and slides were developed with 3,3'-diaminobenzidine tetrahydrochloride (DAB).

Incubation with mouse anti-human NK cell-like Ab, diluted 1:75 in PBS, was done for 1 h after blocking with 10% rabbit serum in PBS. Slides were rinsed, incubated with a biotinylated rabbit anti-mouse IgM, rinsed, and incubated with an avidin-biotin peroxidase complex (VectorStain ABC Elite; Vector). For CD4, primary Ab was diluted 1:75 and incubated for 1 h. After rinsing, secondary Ab (biotinyl-horse anti-mouse IgG; Vector) was added. Slides were rinsed, incubated with ABC, and developed with DAB.

Evaluation and image analysis of immunohistochemical stains

Slides were examined in a blinded fashion at 2× magnification to include as much of the tissue specimen for study as possible. Images were obtained using a Nikon (Melville, NY) COOLPIX 900 digital camera.

B cells and lymphoid follicles.

The area of the spleen positively stained for B cells (CD20) was calculated using Image Pro (Media Cybernetics, Silver Spring, MD). Because expansion of B cell zones in splenic white pulp occurs in response to antigenic challenge, the number and area of the lymphoid follicles (which comprise the white pulp) are indications of the immunologic response/competence of the host. The number of lymphoid follicles was calculated and expressed per square centimeter of the spleen sample. The total area of the sample (red and white pulp) occupied by CD20-positive lymphoid tissue was also calculated.

CD45, CD8, CD3, and NK cells.

The area of the spleen staining positive for CD4, CD8, CD3, or NK cells was calculated using Metamorph (Universal Imaging, West Chester, PA).

Immunohistochemical staining for active caspase-9

The affinity-purified rabbit anti-active caspase-9 Ab was a gift from Dr. Donald Nicholson (Merck Frosst Labs, Point Claire, Quebec, Canada). Briefly, tissues were deparaffinized, rehydrated, incubated in 3% H2O2, and rinsed. Ag retrieval was done in 0.1 M citrate buffer (pH 6.0) which was brought to a boil in a microwave oven. The tissues were blocked with a nonimmune serum (Zymed, San Francisco, CA). Primary Ab was diluted 1:1000 in PBS and incubated for 1 h at 37°C. Secondary Ab was added (Zymed). After incubation and washes, streptavidin complex was added (Zymed). Tissues were developed with metal-enhanced DAB (Pierce, Rockford, IL).

Flow cytometry of splenocytes from patients with sepsis or trauma

In addition to immunohistochemistry, spleens from five septic and six trauma patients were examined by flow cytometry (20, 21). Two of the five spleens included in the septic group were obtained intraoperatively during splenectomy; the three remaining spleens were obtained postmortem. Spleens from the six trauma patients were obtained intraoperatively. At the time of tissue harvesting, a small piece of spleen (~250–500 mg) was placed in PBS containing glutamine (2 mM), glucose (10 mM), and 1% H&E, hematoxylin and eosin.

3 Abbreviations used in this paper: DAB, 3,3'-diaminobenzidine tetrahydrochloride; H&E, hematoxylin and eosin.
Table I. Profiles of patients with sepsis

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age (yr)/Gender</th>
<th>Diagnosis</th>
<th>No. of Days in ICU*</th>
<th>No. of Days Septic</th>
<th>Absolute Lymphocyte Countb</th>
<th>Comorbidities</th>
<th>Inotropes</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>50/M</td>
<td>Necrotic bowel (cucumber, peritonitis)</td>
<td>6</td>
<td>7</td>
<td>1.0</td>
<td>Chronic renal failure on hemodialysis</td>
<td>Yes Lactic acidosis</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>28/M</td>
<td>Peritonitis, cardiac arrest with axon injury</td>
<td>5</td>
<td>3</td>
<td>1.0</td>
<td>Pancreatitis; chronic renal failure s/p membranous glomerulonephritis</td>
<td>Yes P. aeruginosa in peritoneal fluid</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>50/M</td>
<td>Peritonitis</td>
<td>11</td>
<td>11</td>
<td>5.5</td>
<td>Hepatitis C, cirrhosis</td>
<td>Yes Hepatorenal syndrome developed terminally</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>49/M</td>
<td>Thigh abscess, aspiration pneumonia</td>
<td>16</td>
<td>16</td>
<td>0.9</td>
<td>Non-insulin-dependent diabetes</td>
<td>Yes Enterococci and yeast in wound culture</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>53/M</td>
<td>Community pneumonia</td>
<td>1</td>
<td>1</td>
<td>0.4</td>
<td>Alcoholic</td>
<td>Yes Blood cultures (+) for Streptococcus pneumoniae, malnourished</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>80/F</td>
<td>Perforated colon from malignancy, peritonitis</td>
<td>27</td>
<td>27</td>
<td>1.4</td>
<td>None</td>
<td>Yes Blood cultures (+) for Candida tauralopsis; nosocomial bacterial pneumonia</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>52/F</td>
<td>Intraabdominal abscess secondary to diverticulitis</td>
<td>Multiple admissions</td>
<td>77</td>
<td>1.0</td>
<td>Sepsis-induced diabetes</td>
<td>Yes Citrobacter freundii and Enterococcus faecium in peritoneal fluid</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>63/M</td>
<td>Ischemic bowel, septic shock</td>
<td>4</td>
<td>4</td>
<td>0.8</td>
<td>Valvular heart disease</td>
<td>Yes Replacement aortic and mitral valve 1 mo prior</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>92/M</td>
<td>Nosocomial pneumonia s/p repair aortic aneurysm</td>
<td>12</td>
<td>6</td>
<td>0.5</td>
<td>Emphysema</td>
<td>No Developed renal failure requiring dialysis</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>77/F</td>
<td>PseudOMEMBRANOUS COLITIS, nosocomial pneumonia</td>
<td>15</td>
<td>4</td>
<td>0.7</td>
<td>Previous inferior MI; old stroke</td>
<td>No s/p resection of gastric carcinoma; malnourished</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>80/M</td>
<td>Peritonitis, gastrointestinal bleeding</td>
<td>4</td>
<td>4</td>
<td>0.6</td>
<td>Pancreatic cancer, COPD</td>
<td>Yes Blood cultures (+) for Enterococcus faecalis; malnourished</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>60/M</td>
<td>Cellulitis</td>
<td>5</td>
<td>5</td>
<td>0.2</td>
<td>Crohn’s disease, insulin-dependent diabetes, chronic steroids</td>
<td>Yes Blood cultures (+) for β-hemolytic streptococci; hydrocortisone 50 mg q8h</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>45/M</td>
<td>Community pneumonia, aspiration, bronchopneumonia</td>
<td>19</td>
<td>19</td>
<td>1.9</td>
<td>Alcoholic liver disease</td>
<td>Yes Haemophilus influenzae pneumonia</td>
<td></td>
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<tr>
<td>14</td>
<td>49/F</td>
<td>Acute bilateral bronchopneumonia</td>
<td>3</td>
<td>3</td>
<td>N.A.</td>
<td>Transferred from outside hospital for worsening respiratory failure</td>
<td>Yes Methylprednisolone 60 mg tid for cerebrovascular accident started 24 h before death; acute MI</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>82/M</td>
<td>Nosocomial pneumonia s/p repair leaking aortic aneurysm</td>
<td>23</td>
<td>10</td>
<td>0.8</td>
<td>None</td>
<td>Yes Serratia marcescens; pneumonia; developed renal failure requiring dialysis</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>38/F</td>
<td>Intraabdominal abscesses secondary to perforated colon cancer</td>
<td>9</td>
<td>9</td>
<td>0.3</td>
<td>None</td>
<td>Yes Spleenic abscess, peritoneal fluid (+) for P. aeruginosa</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>18/M</td>
<td>Peritonitis/pneumonia after blunt abdominal trauma with right colon injury</td>
<td>34</td>
<td>32</td>
<td>0.3</td>
<td>None</td>
<td>Yes Spleenic abscess, P. aeruginosa and Aspergillus fumigatus in wound</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>60/M</td>
<td>Intraabdominal abscess, bile leak from hepatic resection for colon metastasis</td>
<td>31</td>
<td>31</td>
<td>1.9</td>
<td>None</td>
<td>Yes Intraabdominal abscess, Candida albicans and Acinetobacter baumannii in blood</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>81/M</td>
<td>Nosocomial pneumonia after MVA with pulmonary contusion and femur fracture</td>
<td>7</td>
<td>3</td>
<td>0.6</td>
<td>None</td>
<td>Yes Jehovah’s Witness who refused blood, hematocrit of 15%</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>75/M</td>
<td>Endocarditis and sepsis</td>
<td>Multiple admissions</td>
<td>20</td>
<td>0.5</td>
<td>Valvular heart disease</td>
<td>Yes Candida parapsilosis spleenic abscess, sepsis after cardiac surgery for aortic valve repair</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>51/M</td>
<td>Necrotizing fasciitis after abdominal surgery for dehiscence</td>
<td>3</td>
<td>4</td>
<td>0.5</td>
<td>None</td>
<td>Yes Gas gangrene</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>83/F</td>
<td>Ischemic bowel with peritonitis, secondary anastomosis leak</td>
<td>3</td>
<td>3</td>
<td>0.4</td>
<td>None</td>
<td>No Peritoneal fluid (+) for Gran-positive cocci and Bacteroides fragilis</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>60/F</td>
<td>Bilateral bronchopneumonia</td>
<td>5</td>
<td>5</td>
<td>0.3</td>
<td>SLE, recurrent pneumonias</td>
<td>Yes Hydrocortisone 25 mg tid, on chronic steroids, Staphylococcus aureus; malnourished</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>85/F</td>
<td>MVA with perforated intestine, long bone fractures, cardiac contusion</td>
<td>8</td>
<td>8</td>
<td>0.9</td>
<td>None</td>
<td>Yes Escherichia coli and mixed organisms in peritoneal fluid</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>71/F</td>
<td>Nosocomial pneumonia</td>
<td>Multiple admissions</td>
<td>24</td>
<td>1.0</td>
<td>COPD</td>
<td>Yes Blood cultures (+) for pneumococci and Acinetobacter; malnourished</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>74/F</td>
<td>Ischemic bowel</td>
<td>3</td>
<td>3</td>
<td>0.2</td>
<td>None</td>
<td>No History of mesenteric ischemia</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>73/F</td>
<td>Urosepsis</td>
<td>2</td>
<td>2</td>
<td>0.3</td>
<td>None</td>
<td>Yes Found at home; likely sick for additional days, hydrocortisone 20 mg tid started 24 h before demise</td>
<td></td>
</tr>
</tbody>
</table>

* ICU, intensive care unit; MVA, motor vehicle accident; COPD, chronic obstructive lung disease; SLE, systemic lupus erythematosus; MI, myocardial infarct; NA, not available; (+), positive; q8h, every 8 h; tid, three times a day; s/p, surgical procedure.

b Lower limit of absolute lymphocyte count at Barnes Jewish Hospital is 1.2 k/mm³.
Profiles of critically ill nonseptic patients

Pressure of urine, and/or norepinephrine) was needed to maintain mean arterial pressure of 60 mm Hg and/or vasopressor therapy (dopamine, phenylephrine, and/or norepinephrine) was needed to maintain mean arterial pressure of 60 mm Hg. (The time period immediately before the procedure providing that the splenocytes had been dissociated and stored at 4–8°C in appropriate enriched buffer as described above (our unpublished observations). Apoptosis was quantified using a commercially available fluorescein-labeled annexin V/propidium iodide kit (Apoptosis Detection Kit; R&D Systems, Minneapolis, MN) as described previously (20, 21). The various lymphocyte phenotypes were identified using fluorescently labeled mAbs directed against lymphocyte surface markers (PharMingen, San Diego, CA): B cells, CD20; CD4 T cells; CD8 T cells; CD3 T cells; NK cells.

Statistical analysis

Data are means ± SEM. Data were analyzed with a statistical software program, Prism (GraphPad Software, San Diego, CA). Data involving two groups only were analyzed by Student’s t test, whereas data involving more than two groups were analyzed using one-way ANOVA with Tukey’s multiple comparison test. Significance was accepted at p < 0.05.

Results

Patient profiles and intensive care unit course

Pertinent clinical and laboratory findings for the septic and critically ill nonseptic patients are presented in Tables I and II, respectively. With two exceptions (septic patient 16 and critically ill nonseptic patient 10), the patients died. Twenty-three of the 27 septic patients and 11 of 16 critically ill nonseptic patients had a persistently low absolute lymphocyte count (data not shown). Values for the lowest absolute lymphocyte count of the patients during the 48 h preceding spleen harvesting are presented in Tables I and II. Twenty-two of the 26 septic patients and 11 of 16 critically ill nonseptic patients had an absolute lymphocyte count of <1200/mm³ (the lower limit of normal at Barnes Jewish Hospital) (Tables I and II).

Immunohistochemical staining

B cells (CD20). Several parameters were used to evaluate the effect of the disorders on B cells: 1) the total area of spleen (red and white pulp) occupied by B cells was determined; 2) the area of the spleen occupied by lymphoid follicles and the number of lymphoid follicles per cm² of spleen were calculated. These two determinations provide complementary data on the effect of sepsis or critical illness on B cells.

Evaluation of spleens from septic patients showed a marked loss of B cells compared with spleens from both trauma patients and critically ill nonseptic patients (Figs. 1–3; Table III). In many cases, spleens from septic patients could be distinguished from spleens from trauma patients by gross visual examination, i.e., with the naked eye, of the microscopic slide (Fig. 1). There was a marked loss in the number and size of dark stained foci representing the lymphoid follicles (Fig. 1). Microscopic examination confirmed the gross visual examination and demonstrated a 43% decrease in area of lymphoid follicles (white pulp) and a 38% decrease in total B cell area (red and white pulp) in septic vs trauma patients (Figs. 2 and 3 and Table III).

Although there was no statistical difference in either the area of lymphoid follicles or the total B cell area in critically ill nonseptic vs trauma patients (Figs. 3 and Table III), there were individual critically ill nonseptic patients who did demonstrate obvious decreases in B cells (Fig. 4B).

In reviewing results of B cell staining, it was apparent that patients who had been septic for prolonged periods had a greater loss of B cells. Furthermore, it seemed logical that the severity of lymphocyte loss might be related to duration of sepsis. To assess this possibility, patients were divided into two groups, i.e., those who

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age (yr)/ Gender</th>
<th>Diagnosis</th>
<th>No. of Days in ICU</th>
<th>Absolute Lymphocyte Count</th>
<th>Comorbidities</th>
<th>Inotropes</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>80/M</td>
<td>Cardiac arrest and shock after pneumonectomy</td>
<td>3</td>
<td>1.0</td>
<td>COPD and lung cancer</td>
<td>Yes</td>
<td>Developed shock; liver and renal failure</td>
</tr>
<tr>
<td>2</td>
<td>83/F</td>
<td>Cardiac arrest with hypoxic encephalopathy after repair of humeral fracture</td>
<td>2</td>
<td>0.2</td>
<td>CHF and diabetes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>74/M</td>
<td>Heart failure after MI and cardiac surgery</td>
<td>2</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>64/M</td>
<td>Heart failure after MI; arhythmia</td>
<td>8</td>
<td>0.5</td>
<td>CASHD, COPD, diabetes</td>
<td>Yes</td>
<td>Intraaortic balloon pump, respiratory failure, ileus</td>
</tr>
<tr>
<td>5</td>
<td>46/F</td>
<td>Cardiac arrest with hypoxic encephalopathy</td>
<td>4</td>
<td>0.5</td>
<td>CRF on dialysis, diabetes, CASHD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>37/M</td>
<td>Massive pulmonary embolism, DKA</td>
<td>1</td>
<td>1.1</td>
<td>Diabetes</td>
<td>Yes</td>
<td>Severe acidosis</td>
</tr>
<tr>
<td>7</td>
<td>32/F</td>
<td>Cardiac arrest with hypoxic encephalopathy</td>
<td>2</td>
<td>1.3</td>
<td>Diabetes, depression on lithium</td>
<td>Yes</td>
<td>Acute renal failure</td>
</tr>
<tr>
<td>8</td>
<td>77/F</td>
<td>Massive pulmonary embolus</td>
<td>2</td>
<td>1.5</td>
<td>CHF, Parkinson’s</td>
<td>Yes</td>
<td>Cardiogenic shock, renal failure</td>
</tr>
<tr>
<td>9</td>
<td>67/M</td>
<td>MI</td>
<td>3</td>
<td>1.4</td>
<td>CASHD</td>
<td>Yes</td>
<td>Intraaortic balloon pump</td>
</tr>
<tr>
<td>10</td>
<td>60/M</td>
<td>Pancreatitis, portal hypertension</td>
<td>1</td>
<td>0.5</td>
<td>Alcohol abuse, MI</td>
<td>Yes</td>
<td>Gastrointestinal bleeding</td>
</tr>
<tr>
<td>11</td>
<td>42/M</td>
<td>Massive gastrointestinal bleeding</td>
<td>1</td>
<td>0.2</td>
<td>Glomerular nephritis, alcohol abuse</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>80/F</td>
<td>Cardiac arrest with anoxic injury after orthopedic surgery</td>
<td>3</td>
<td>0.7</td>
<td></td>
<td>No</td>
<td>Pedestrian injury with ankle and humerus fracture</td>
</tr>
<tr>
<td>13</td>
<td>69/F</td>
<td>Cardiac arrest after aspiration</td>
<td>2</td>
<td>1.3</td>
<td>MI</td>
<td>Yes</td>
<td>Developed renal failure</td>
</tr>
<tr>
<td>14</td>
<td>52/M</td>
<td>MI and shock</td>
<td>7</td>
<td>0.7</td>
<td></td>
<td>Yes</td>
<td>Developed renal failure requiring dialysis</td>
</tr>
<tr>
<td>15</td>
<td>61/F</td>
<td>Pulmonary emboli and hemorrhage s/p hysterectomy</td>
<td>3</td>
<td>0.8</td>
<td>Previous pulmonary emboli</td>
<td>Yes</td>
<td>Renal failure</td>
</tr>
<tr>
<td>16</td>
<td>83/M</td>
<td>Massive gastrointestinal bleeding</td>
<td>2</td>
<td>0.6</td>
<td></td>
<td>Yes</td>
<td>Cerebrovascular disease</td>
</tr>
</tbody>
</table>

* ICU, Intensive care unit; COPD, chronic obstruction lung disease; CHF, congestive heart failure; CASHD, coronary atherosclerotic heart disease; CRF, chronic renal failure; DKA, diabetic ketoacidosis; MI, myocardial infarct; s/p, surgical procedure.

a Lower limit of absolute lymphocyte count at Barnes Jewish Hospital is 1.2 k/mm³.
FIGURE 1. Unmagnified view of six microscope slides stained for B cells (CD20) from trauma patients (A–C) and septic patients (D–F). The dark staining regions are concentrations of B cells in lymphoid follicles visible to the naked eye. Note the dramatic decrease in the size and number of lymphoid follicles in the septic patients vs the trauma patients. D, E, and F are septic patients 7, 9, and 17, respectively, in Table I. The spleen from patient 17 was removed intraoperatively.

FIGURE 2. Immunohistochemical staining for B cells (CD20) in a lymphoid follicle. ×200. Trauma patients (A and B) have considerably larger follicles and many more B cells than the septic patients (C and D). C and D are septic patients 17 and 20, respectively, in Table I.
were septic for <7 days and those who were septic for 7 or more days. All 4 patients on corticosteroids were in the group of patients who were septic for <7 days (see Table I). As shown in Fig. 5A, there was a more profound loss in B cells with increased duration of sepsis; compared with trauma patients, there was a 25% and a 52% decrease in B cell area in patients with sepsis for <7 days and ≥7 days, respectively (p < 0.05 and p < 0.001, respectively). The decrease in B cell area at ≥7 days was greater than the decrease in B cell area at <7 days, p < 0.05 (Fig. 5A). In addition to the decrease in total B cell area, sepsis caused a quantitatively similar progressive decrease in the area of lymphoid follicles (Fig. 5A). Finally, the number of lymphoid follicles was decreased in patients with sepsis by ~40% compared with trauma patients, and this difference did not change with duration of sepsis, i.e., 101.6 ± 6.9 and 61.6 ± 11.6 lymphoid follicles/cm² for trauma patients, patients with sepsis for <7 days, and patients with sepsis for ≥7 days, respectively (p < 0.01 and p < 0.05, respectively).

**CD4 T cells.** Similar to the findings with B cells, sepsis caused a significant loss in CD4 T cells which were decreased by 40% compared with trauma patients (Figs. 6, C and D, and 7 and Table III). The loss in CD4 T cells also was examined for the effect of duration of sepsis. Compared with trauma patients, there was a 34% and a 46% decrease in CD4 T cells in patients with sepsis for <7 days and ≥7 days, respectively (Fig. 5B; p < 0.001 for both). However, there was no difference in percentage area of CD4 T cells in patients in sepsis for <7 vs ≥7 days (Fig. 5B).

There was no difference in CD4 T cells in critically ill nonseptic patients vs trauma patients (Table III). Similar to the B cell data, individual critically ill nonseptic patients exhibited markedly decreased CD4 T cell staining (Fig. 4, C and D).

**CD8 T cells and NK cells.** In contrast to the decrease in B cells and CD4 T cells, septic patients had a 60% increase in CD8 T cells compared with trauma patients (p < 0.05) (Table III). Similarly, critically ill nonseptic patients had a 130% increase in CD8 T cells vs trauma, (p < 0.05). There was a 44% increase in NK cells in septic vs trauma patients, but this difference did not achieve significance (p > 0.05) (Table III). Interestingly, the CD8:CD4 ratio, a measure of immune status, was decreased from 3:1 in trauma patients to 1:1 in septic patients (p < 0.01 (Table III)).

**CD3 T cells.** The CD3 surface marker is associated with the TCR in both CD4 and CD8 T cells. In spleen, therefore, CD3 staining can be used to corroborate CD4 and CD8 immunohistochemical findings, because the number of CD3-positive T cells is an approximation of the sum of CD4 and CD8 T cells. In the present study, the sum of the areas of CD4 and CD8 approximately equaled the area of CD3 in all three groups of patients (Fig. 7 and Table III). Patients with sepsis had a 35% decrease in the CD3 area compared with the critically ill nonseptic patients (Fig. 7; p < 0.05).

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**Table III. Percent area of splenic lymphocyte subtypes determined via immunohistochemistry**

<table>
<thead>
<tr>
<th></th>
<th>CD20 (B cells)</th>
<th>Lymphoid Follicle</th>
<th>CD4 (T cell subset)</th>
<th>CD8 (T cell subset)</th>
<th>CD3 (T cells)</th>
<th>NK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma (n = 25–26)</td>
<td>13.8 ± 0.9</td>
<td>10.9 ± 1.0</td>
<td>3.1 ± 0.1</td>
<td>1.0 ± 0.2</td>
<td>4.4 ± 0.4</td>
<td>1.1 ± 0.2</td>
</tr>
<tr>
<td>Critically ill nonseptic (n = 15–16)</td>
<td>12.4 ± 1.5</td>
<td>11.2 ± 1.4</td>
<td>3.0 ± 0.4</td>
<td>2.3 ± 0.3a</td>
<td>5.3 ± 0.6</td>
<td>1.2 ± 0.2</td>
</tr>
<tr>
<td>Septic (n = 25–27)</td>
<td>8.5 ± 0.7†</td>
<td>6.2 ± 0.7†</td>
<td>1.8 ± 0.2†</td>
<td>1.6 ± 0.1a</td>
<td>3.4 ± 0.2†</td>
<td>1.7 ± 0.2</td>
</tr>
<tr>
<td>% Change in trauma vs critically ill nonseptic</td>
<td>10 ↓</td>
<td>4 ↑</td>
<td>3 ↓</td>
<td>130 ↑</td>
<td>20 ↑</td>
<td>6 ↑</td>
</tr>
<tr>
<td>% Change in septic vs trauma</td>
<td>38 ↓</td>
<td>43 ↓</td>
<td>40 ↓</td>
<td>60 ↑</td>
<td>23 ↓</td>
<td>44 ↑</td>
</tr>
</tbody>
</table>

a, p < 0.05 vs trauma; †, p < 0.05 vs critically ill nonseptic.
Lymphocyte cell typing and quantitation of apoptosis by flow cytometry

No spleens were available from critically ill nonseptic patients; therefore, only septic and trauma patients were compared. The findings from flow cytometry closely paralleled the results from the immunohistochemical staining studies. There was a 42% loss in B cells and a 45% loss in CD4 T cells in septic patients compared with trauma patients, \( p < 0.001 \) and \( p < 0.01 \), respectively (Fig. 10A). In contrast to the decrease in CD4 T cells and B cells, there was a 57% increase in NK cells in patients with sepsis vs those with trauma, \( p < 0.02 \). There was no difference in the percentage of CD8 T cells in septic vs trauma patients, \( p < 0.003 \).

Annexin V and propidium iodide staining revealed apoptosis in 4% of lymphocytes in trauma patients compared with 12% in septic patients, \( p < 0.002 \) (Figs. 10B and 11).

Discussion

Perhaps the most significant finding in the present study is the remarkable degree of loss of B cells and CD4 T cells in spleens of septic patients. The loss in splenic lymphocytes was associated with a significant and often profound decrease in circulating lymphocytes in 22 of the 26 septic patients. In spleens, the loss of B cells (which are concentrated in large lymphoid follicles) was so prominent that, in some cases, it was readily detected by gross visual examination of the microscopic slides by the naked eye (Fig. 1). During infection, B cells do not migrate to the site of pathogens but rather proliferate in spleen and other organized lymphoid tissues and release Abs that are transported to the focus of disease (22, 23). Therefore, the decrease in B cells observed in the spleens of septic patients has particular importance. The loss in CD4 T cells in septic patients was also striking (Fig. 6). The loss in lymphocytes (both B cells and CD4 T cells) is even more significant considering that it occurs in the context of overwhelming infection, a condition in which massive clonal expansion of B and T lymphocytes should be occurring.

A hallmark of sepsis is immunosuppression that is characterized by loss of delayed-type hypersensitivity, failure to eradicate a primary infection, and propensity to acquire new secondary infections (2, 3). The documented loss in CD4 T and B cells (rather than the anticipated increase in lymphocytes) may be contributing to the immunosuppression by decreasing the number of immune cells available to combat infection. In addition to causing a decrease in the

FIGURE 4. Immunohistochemical stain for splenic B and T cells in critically ill nonseptic patients, showing that some critically ill nonseptic patients had normal lymphocytes whereas other critically ill nonseptic patients had lymphocyte depletion. A, Robust follicle stained for B cells (CD20); B, follicle that is relatively depleted of B cells. \( \times 200 \). C, Normal CD4 T cells; D, decreased density of CD4 T cells. \( \times 400 \). A, B, C, and D represent patients 12, 4, 14, and 15, respectively, in Table II.
number of immune effector cells, lymphocyte apoptosis may contribute to immunosuppression by other mechanisms as well. Recent research has shown that apoptotic cells actively suppress the inflammatory response (24–26). Voll et al. (24) demonstrated that addition of apoptotic lymphocytes to endotoxin-stimulated PBMC caused a shift from secretion of proinflammatory cytokines (TNF-α, IL-1β, and IL-12) to antiinflammatory cytokines (IL-10). Barker et al. (25) showed that macrophages that ingested apoptotic cells had increased

![Figure 5](http://www.jimmunol.org/)

**FIGURE 5.** A, Comparison between septic and trauma for lymphoid follicles and total B cell area based on the duration of sepsis. Patients who were septic for <7 days had smaller lymphoid follicle area and smaller B cell area; *, p < 0.05. Patients who were septic for >7 days had an even smaller lymphoid follicle area and a B cell area that was less than the areas for trauma patient (+, p < 0.001) and also less than the areas for the patients septic for <7 days (+, p < 0.05). B, Effect of the duration of sepsis on CD4 T cell area. Both groups of septic patients, i.e., patients who were septic for <7 days and patients who were septic for >7 days had less area of spleen occupied by CD4 T cells (+, p < 0.001), but they were not different from each other.

![Figure 6](http://www.jimmunol.org/)

**FIGURE 6.** Immunohistochemical staining for splenic CD4 T cells. The T cell-rich periarteriolar zone is demonstrated in the trauma patient (A, ×200; B, ×400 magnification of the same patient) and the septic patients (C, ×200; D, ×400). C and D, Septic patients 6 and 25, respectively, in Table I. Note the decreased number of CD4 T cells in septic vs trauma patients.
production of TGF-β1, a potent immunosuppressant and antiinflammatory cytokine. Fadok et al. (26) reported that uptake of apoptotic vs necrotic cells caused the macrophage to respond in an antiinflammatory or proinflammatory manner, respectively.

Critically ill nonseptic patients

Although the critically ill nonseptic patients considered as a group did not demonstrate loss of lymphocytes compared with the control population (trauma patients), it was clear that certain individual critically ill nonseptic patients did have significant loss of lymphocytes (Fig. 4, A and B). The increase in active caspase-9 in critically ill nonseptic patients relative to trauma patients demonstrates that apoptosis of lymphocytes is occurring and will result in cell loss. It is likely that studies examining larger numbers of these patients would disclose subsets of critically ill nonseptic patients, e.g., liver failure, renal failure, congestive heart failure, who did have loss of lymphocytes that are comparable to that in the septic patients. As indicated in septic patients (Fig. 5), it is likely that the longer the duration of illness in the critically ill nonseptic patient, the more likely there is to be loss of lymphocytes. In this regard, the critically ill nonseptic patient who had the most extensive loss of B cells (Fig. 4) was also the patient who had the longest stay in the intensive care unit before death (8 days).

Although both critically ill nonseptic and septic patients had comparable increases in the number of cells that were positive for active caspase-9, many spleens of septic patients had a decreased number of lymphocytes in the lymphoid follicle; i.e., there was a decreased density of cells per unit area (see Fig. 9B). This finding of depletion of splenic lymphocytes per unit area was reported previously (10). It is likely that many of the lymphocytes of septic patients had already undergone caspase-9-mediated apoptosis, and this may have been a factor in the lack of difference in septic vs critically ill nonseptic patients. Studies from our laboratory show that there is a marked decrease in active caspase-9-positive cells in patients who were septic for prolonged periods of time vs patients who were septic for brief periods (data not shown).

**Lymphocyte apoptosis: a key pathophysiologic mechanism in sepsis?**

The present results establish an association between decreased lymphocytes and sepsis but do not establish causality between lymphocyte apoptosis and outcome in patients with sepsis. However, a growing body of animal studies supports the hypothesis that
Active Caspase 9

TRAUMA

SEPTIC

A

B

C

D

FIGURE 9. Immunohistochemical stain for active caspase-9 in spleen. The trauma patient had a single cell positive for active caspase-9 (identified by arrow), $\times 400$. The septic patients had numerous cells positive for active caspase-9 cells (brown staining); A and B, $\times 400$; C and D, $\times 600$. Many of the cells that are positive for active caspase-9 also exhibit the characteristic features of apoptosis, i.e., condensed and or fragmented nuclei. In C, macrophages have ingested apoptotic lymphocyte fragments that are positive for active caspase-9. A, Septic patient 19; B, septic patient 13; C and D, septic patient 26 (Table I).

a major pathophysiologic mechanism in sepsis is lymphocyte apoptosis (8–11, 27). Recently, Braun et al. (28) showed that administration of caspase inhibitors, drugs that block apoptosis, provided excellent neuroprotection in a rabbit model of pneumococcal meningitis. Ayala et al. (29) reported that septic mice deficient in FasL<sup>gld</sup> had decreased mucosal B lymphocyte apoptosis and improved survival compared with controls. Our laboratory has reported that prevention of lymphocyte apoptosis by a variety of compounds that inhibit caspases improves survival in a peritonitis animal model of sepsis (17, 20, 30). In addition to the efficacy of caspase inhibitors, mice in which the antiapoptotic protein Bcl-2 is overexpressed in T or B lymphocytes have decreased blood bacterial counts and improved survival in sepsis (17, 20, 30). Furthermore, adoptive transfer of T cells that overexpress Bcl-2 into nontransgenic mice improves survival in sepsis (30). Finally, caspase inhibition has also been reported to improve survival in an endotoxin model as well (31). Considered together, these studies provide strong supporting evidence in animal models that loss of lymphocytes in sepsis is a central pathogenic event.

Ischemia/reperfusion injury and other potential variables in sepsis-induced apoptosis

There are numerous metabolic and physiologic changes in critically ill patients that may be confounding factors in the sepsis-induced lymphocyte apoptosis. For example, the majority of patients with severe sepsis have episodes of ischemia/reperfusion injury and, in the
present study, 23 of the 27 septic patients required vasopressor therapy to maintain an adequate mean arterial blood pressure (Table I). Animal studies and some human data indicate that ischemia/ reperfusion injury can induce apoptosis in the gastrointestinal tract (32), heart (33), kidney (34), and brain (35). Four of the patients with sepsis were receiving corticosteroids (see Table I). It is possible that the corticosteroids contributed to lymphocyte apoptosis. However, the dose of corticosteroids in two of four septic patients (patients 23 and 27) was low (20–25 mg hydrocortisone every 8 h) and much less than can be produced by the body under severe stress. Furthermore, it is significant that all four of the septic patients receiving corticosteroids were in the group of patients who had sepsis for >7 days. These patients had less loss of B cells and CD4+ T cells than patients who were septic for >7 days.

Pathways of lymphocyte apoptosis in sepsis

There are two major pathways involved in initiation of apoptosis, i.e., a receptor initiated caspase-8-mediated pathway and a mitochondrial-initiated caspase-9-mediated pathway (18, 19). Activation of caspase-8 or caspase-9 subsequently leads to activation of caspase-3, an effector caspase that is in the final common pathway of the cell death program. Caspase-8 can be activated by a number of ligands including TNF and Fas (18, 36). The mitochondrial-mediated pathway can be activated by a diverse number of stimuli including, e.g., reactive oxygen species (36). Understanding the particular pathway of sepsis-induced apoptosis is important because it provides insight into potential factors responsible for initiating cell suicide and may allow for a more targeted therapy. The present studies showing activated caspase-9 in apoptotic lymphocytes of septic patients supports a mitochondrial-mediated pathway. Although demonstrating that caspase-9 is activated provides supporting evidence for a mitochondrial-initiated pathway, it is not conclusive proof because of recent studies which show that, in some instances, there is “cross-talk” between the various caspasases (19, 36). However, a great deal of data in animal models of sepsis are consistent with the concept that sepsis-induced lymphocyte apoptosis proceeds by the mitochondria-initiated pathway. Sepsis-induced thymocyte and splenocyte apoptosis is not blocked in BclR-deficient mice (21) or in TNF p55 or TNF p75 receptor-deficient mice (our unpublished observations). Although controversial, most recent studies show that Bcl-2 inhibits the mitochondrial but not the receptor-mediated apoptosis pathway (19). Therefore, the published studies noting that overexpression of Bcl-2 in T or B cells prevents lymphocyte apoptosis in sepsis (17, 20) is also consistent with a mitochondrial-mediated death pathway in the disorder.

Other potential mechanisms of immunosuppression in sepsis

Although we speculate that sepsis-induced lymphocyte apoptosis is a central pathogenic event, it is possible that other mechanisms are involved in the immunosuppression that characterizes the disorder (7, 37). A large body of studies indicates that critically ill patients with trauma are anergic and have multiple defects in immune function (11, 37–41). Pellegrini et al. (39) demonstrated that T cells from trauma patients underwent apoptosis at an accelerated rate compared with normal volunteers. However, T cell anergy did not appear to correlate with lymphocyte apoptosis (39). Lederer et al. (38) and Wichman et al. (40) have shown that major injury and sepsis induce increased production of IL-10, a counterinflammatory cytokine that impairs resistance to infection and/or decreases the ability to combat infection. Puyana et al. (41) reported that both Th1- and Th2-type lymphokines are depressed in posttrauma anergy. Lyons et al. (42) noted that major injury induced increased production of IL-10 and thereby impaired resistance to infection. Thus, lymphocyte apoptosis may be only one of the many factors that are involved in compromising host defense.

Limitations and alternative hypotheses

The major focus of the present study was to determine the effect of sepsis on the various lymphocyte phenotypes. The best way to determine whether sepsis is having an effect is to compare spleens from a “normal” population. Because it is not possible to obtain spleens from healthy normal persons, we elected to use spleens removed acutely from patients who had no comorbidities but who had trauma to the spleen necessitating a splenectomy. Other than the fact that their spleens were acutely fractured and bleeding, the cellular composition and architecture should be normal (except for the area of injury).

A possible concern is whether the relatively longer delay in spleen fixation in septic patients vs trauma patients (15-min to 6-h delay in septic patients vs 5- to 30-min delay in trauma patients; see Materials and Methods) could be responsible for some of the experimental differences. Data suggest that the differences in time of spleen fixation did not play a role in the results. Previous work from our laboratory did compare spleens of septic patients to spleens obtained from a group of patients after sudden cardiovascular death and whose tissues were not obtained until 3–12 h post-mortem (10). Microscopic examination of H&E tissue sections from these control spleens showed normal splenic architecture, no lymphocyte depletion, and little evidence of apoptosis (10). In a previous study, we showed that immunohistochemical staining for active caspase-3, a key cell death protease, was also significantly less in spleens from control vs septic patients (10). In the present study, we demonstrated that active caspase-9 was not effected by delay in tissue fixation (see Results on caspase-9). Also, in the present study, spleens removed intraoperatively from three septic patients (and formalin fixed immediately) exhibited some of the most remarkable loss of lymphocytes (Fig. 1F). Finally, the changes in lymphocyte phenotypes observed in spleens from septic
patients were not observed in critically ill nonseptic patients even though the delay in spleen fixation was longer in the latter group.

A final limitation concerns interpretation of the effect of lymphocyte apoptosis on host survival in septic patients. Although we speculate that loss of lymphocytes is detrimental to survival in septic patients because of the resultant immunosuppression, it is possible that lymphocyte apoptosis may have beneficial effects (12). Apoptosis of lymphocytes may lead to decreased production of proinflammatory cytokines, which induce or contribute to the systemic inflammatory response syndrome and organ injury in sepsis. A recent study of Pseudomonas aeruginosa pneumonia showed that apoptosis of lung epithelial cells (lymphocyte apoptosis was not evaluated) helped to limit the spread of the infection systemically and was essential for survival (43).

The present results show that sepsis rather than inducing lymphocyte proliferation causes a profound and progressive decrease in B cells and CD4 T cells. It is possible that this loss in B cells and CD4 T lymphocytes impairs the ability of the patient to eradicate the infection and predisposes to other invading pathogens. If immunosuppression resulting from loss of lymphocytes is determined to be a key factor in patient survival in sepsis, therapy with caspase inhibitors (which have shown remarkable success in clinically relevant animal models of sepsis) (17, 30) may represent a novel approach in the treatment of this highly lethal disorder.

References