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Multiple System Atrophy: Role of Coenzyme Q10

D Mantle¹, Nadia Turton² and IR Hargreaves^{3*}

Abstract

Multiple system atrophy (MSA) is a progressive neurodegenerative disorder characterized by a variable combination of autonomic failure, Parkinsonism, and ataxia. There is currently no treatment available to halt or delay progression of this disorder. Biochemically, MSA is characterized by mitochondrial dysfunction, oxidative stress, and inflammation. In the present article we have therefore reviewed the potential role of coenzyme Q10 (CoQ10) in the pathogenesis and treatment of MSA, on the basis of its role in mitochondrial function, and its antioxidant and anti-inflammatory activities, as well as its reported depletion in blood and cerebellar tissue from MSA patients.

Keywords: Coenzyme Q10; Multiple system atrophy; Mitochondrial dysfunction; Oxidative stress.

Introduction

Multiple system atrophy (MSA) is a progressive neurodegenerative disorder characterized by a variable combination of autonomic failure, Parkinsonism, and ataxia [1]. As a consequence of the latter, MSA patients often suffer from genitourinary dysfunction and orthostatic hypotension [2]. With regard to treatment, L-dopa replacement therapy in MSA patients is less effective than in patients with Parkinson's disease (PD) [3]; paroxetine, a selective serotonin reuptake inhibitor has been shown

to provide some benefit in MSA patients [4]. There is currently no treatment to halt or delay the progression of MSA. The age of onset of MSA is typically around 55-60 years of age. MSA may be difficult to distinguish clinically from other disorders, particularly PD, especially in the early stages of the disease [5]. MSA is one of a group of disorders known as synucleinopathies, characterized by deposition of abnormal misfolded alpha-synuclein proteins in the central and

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peripheral nervous system [6]. In PD, the abnormal alpha-synuclein is deposited in neurons, whilst in MSA it forms glial cytoplasmic inclusions in oligodendrocytes. Histologically, selective atrophy and neuronal loss in striatonigral and olivopontocerebellar brain regions underlie the subdivision of MSA into Parkinsonian (MSA-P) and a cerebellar phenotype (MSA-C) [7]. Biochemically, MSA is characterized by depletion of coenzyme Q₁₀ (CoQ₁₀), which has a key role in cellular energy production. In some populations, particularly East Asian [8], the deficiency in CoQ₁₀ levels is in turn associated with abnormalities in the gene, COQ2 which encodes the enzyme, coenzyme-Q₂-polyprenyltransferase which is involved in the synthesis of CoQ₁₀ [9]. Notwithstanding the COQ2 phenotype, the reports of decreased plasma and cerebellum CoQ₁₀ status in MSA patients indicate evidence of impaired COQ biosynthesis, which in turn may contribute to the pathogenesis of MSA via mitochondrial dysfunction, oxidative stress, and inflammation. In the present review, we have therefore reviewed the potential role of CoQ₁₀ in the pathogenesis and treatment of MSA.

Coenzyme Q₁₀

CoQ₁₀ is an isoprenoid molecule that is synthesised by most cells of the body apart from red blood cells as its synthesis requires the presence of mitochondria [10,11]. CoQ₁₀ has a number of key functions cellular functions including its role as an electron carrier in the mitochondrial respiratory chain (MRC) as well as its role as a cellular antioxidant [10,11]. CoQ₁₀ has also been shown to directly regulate the expression of

more than 100 genes, including a number involved in inflammation [12]. Most of the body's daily requirement for CoQ₁₀ (estimated as 500mg) is provided via endogenous synthesis, with a relatively small proportion (5mg) obtained from the normal diet; optimal endogenous synthesis occurs at 20-25 years of age, followed by an ensuing decline, such that the production at 65-70 years is approximately 50% of that at 20-25 years [13,14]. The biosynthesis of CoQ₁₀ is a complex multi-step process [15] for which mutations in at least 10 genes that encode enzymes in the CoQ₁₀ biosynthetic pathway have been identified [11] which if impaired can result in deficit in endogenous CoQ₁₀ status, process relevant to the pathogenesis of MSA as outlined in the following sections of this article. With regard to the importance of CoQ₁₀ in MRC function and cellular energy supply, several lines of evidence point to impaired brain energy supply/mitochondrial dysfunction in MSA. These include the demonstration of reduced cerebral glucose metabolism in MSA patients via positron emission tomography [16], and reduced creatine phosphate levels/depleted cell energy metabolism quantified by phosphorus-31 nuclear magnetic resonance spectroscopy in MSA patients [17,18].

CoQ₁₀ depletion in MSA

A number of clinical studies have reported evidence of decreased CoQ₁₀ levels in plasma, CSF (cerebrospinal fluid) or cerebellar tissues of MSA patients. As noted in the Introduction, a deficiency in CoQ₁₀ levels may be associated with abnormalities in the COQ2 gene encoding the enzyme (coenzyme-Q₂-polyprenyltransferase) involved in the

synthesis of CoQ₁₀, although this is not the case for all MSA patients [19]. Abnormalities in genes encoding other enzymes in the CoQ₁₀ biosynthetic pathway have also been reported in some studies, including PDSS₁ (Decaprenyl-diphosphate synthase subunit 1), COQ₅ (methyltransferase), and COQ₇ (5-demethoxyubiquinone hydroxylase) [20]. Thus, in a series of 44 MSA patients, Mitsui et al [21] found a significant 30% decrease in the mean plasma CoQ₁₀ level of MSA patients compared to controls, regardless of patient COQ₂ genotype. Kasai et al [22] described a significant reduction in serum CoQ₁₀ levels, when related to cholesterol level (to account for the lipoprotein fraction of the blood), in 18 MSA patients (COQ₂ genotype not specified) compared to controls; the circulatory lipoproteins, LDL (low density lipoprotein) and VLDL (very low-density lipoprotein) cholesterol act as the main carriers for CoQ₁₀ in the blood. In a series of 40 patients with MSA (COQ₂ phenotype not specified), Du et al [23] found significantly reduced CoQ₁₀ levels in plasma compared to controls. Compta et al [24] reported also reported significantly reduced CoQ₁₀ levels in CSF samples from a series of 20 MSA patients (COQ₂ genotype not specified), compared to those in patients with related neurological disorders (PD, progressive supranuclear palsy) or controls. With regards to brain tissue, the cerebellum appears to be most affected by CoQ₁₀ depletion. It is of note that cerebellar ataxia is a characteristic of MSA, whilst levels of CoQ₁₀ in the human brain are reported to be lowest in the cerebellum, which may thus be selectively vulnerable to CoQ₁₀ deficiency. Barca et al [25] found CoQ₁₀ levels in post-mortem cerebellar tissue to be significantly decreased (by 40%) from a

cohort of 12 MSA patients (without COQ₂ mutations), compared to controls. Although none of the MSA patients had COQ₂ mutations, there were significant decrease in the protein levels of PDSS₁ and COQ₅ CoQ₁₀ biosynthetic enzymes. It is of note that CoQ₁₀ levels in both striatal and occipital cortical samples from these MSA patients were similar to the controls. Similarly, Schottlaender et al [26] reported a significant decrease in CoQ₁₀ levels in post-mortem cerebellum samples from a series of 20 MSA cases, compared to controls, although only by 3-5%. Hsiao et al [20] found reduced levels of ATP, associated with reduced expression of the COQ₂ and COQ₇ CoQ₁₀ biosynthetic enzymes, in disease-affected brain areas (principally cerebellum, as well as putamen) of MSA patients. Evidence of decreased MRC complex II-III activity has also been reported in the white matter of postmortem MSA patient brain samples which is thought to reflect the deficit in cerebral CoQ₁₀ status reported in this condition since the activity of this enzyme is dependent upon the endogenous level of this isoprenoid [27]. In the absence of a COQ₂ mutation the cause of CoQ₁₀ deficiency reported in MSA patients is uncertain but it may result from oxidative stress induced catabolism of CoQ₁₀ or the impairment of the enzymes in the biosynthetic pathway of the isoprenoid [26,27]. It is also of note that neurons cultured from MSA patients show evidence of autophagic impairment, as indicated by increased basal autophagy, reduced autophagic flux and reduced activity of the lysosomal enzymes, α -Mannosidase and β -Mannosidase [28]. Furthermore, that one of the functions of CoQ₁₀ is the maintenance of

normal lysosomal function via its role in maintaining the acidity of the organelle [29].

Effect of CoQ₁₀ supplementation in MSA

Studies on supplementation of CoQ₁₀ in MSA have been restricted to work in cell culture, or single patient case studies. Using neuronal cells cultured from MSA patients with and without the COQ2 mutation, Nakamoto et al [30] identified cellular dysfunction attributable to reduced CoQ₁₀ levels, which were in part resolved via administration of exogenous CoQ₁₀. In an MSA patient with the COQ2 mutation and in an advanced stage of the disease, Mitsui et al [31] reported high dose CoQ₁₀ supplementation (1200mg/day) improved brain energy metabolism (as measured by cerebral oxygen metabolic rate/positron emission tomography). There is a clear rationale for the involvement of CoQ₁₀ in the pathogenesis of MSA, and evidence from a number of clinical studies for depleted CoQ₁₀ levels in blood or brain tissue from MSA patients. To date there has been no randomised controlled trials of supplementary CoQ₁₀ in MSA, and this is now warranted. One issue which needs to be first resolved is the optimal formulation to enable supplementary CoQ₁₀ to cross blood-brain barrier and access the brain [32].

Safety of CoQ₁₀

The safety of CoQ₁₀ has been confirmed in more than 200 randomized controlled clinical studies reported in the peer-reviewed medical literature, as listed on Medline. In these studies, CoQ₁₀ supplementation has been used in the treatment of in a number of disorders with no serious adverse clinical effects being reported. However, very rarely,

individuals may experience mild gastrointestinal disturbance, although this is does not appear to be dose related [33]. The observed safe level (OSL) risk assessment method has indicated that the evidence of safety for CoQ₁₀ is very strong at doses of up to 1200 mg/day, although much higher levels have been used in some randomised controlled trials without adverse effects. Supplementation with CoQ₁₀ does not appear to affect the biosynthesis of endogenous CoQ₁₀ [33].

Importance of CoQ₁₀ supplement formulation

Bioavailability is defined as the proportion of an ingested substance that is absorbable from the digestive tract into the bloodstream. The bioavailability of CoQ₁₀ is low, typically of the order of 5%; this is a consequence of its chemical structure, i.e., it is a lipid soluble molecule consisting of a benzoquinone ring and a side chain comprising ten isoprenoid units. The bioavailability of CoQ₁₀ is in turn subject to the formulation of the supplement [34]. Supplemental CoQ₁₀ is manufactured via a procedure in which CoQ₁₀ crystals in polymorphic form are obtained as an end product of a yeast fermentation process. Since the human digestive tract is not capable of absorbing CoQ₁₀ in polymorphic crystalline form, it is important that supplements are formulated such that the CoQ₁₀ polymorphic crystals are transformed (via a thermal recrystallisation process) into an acicular form, which in turn is more readily dispersed into single CoQ₁₀ molecules in the digestive tract for subsequent absorption. In the absence of such crystal transformation, the bioavailability of supplemental CoQ₁₀ in

normal subjects is reduced by 75% [34]. In addition, because food supplements are not subject to the same strict quality standards as prescription-type medicines, it is important that CoQ10 supplements should be manufactured to pharmaceutical standards if they are to be used in clinical studies; furthermore, such CoQ10 supplements should be of proven bioavailability in human subjects, as documented in the peer-reviewed medical literature. In this regard, to date there is only one CoQ10 product (Myoquinon) that has received a marketing authorisation within the EU, for the adjuvant treatment of heart failure.

Conclusion

MSA is a progressive neurodegenerative disorder for which there is relatively little available in terms of conventional treatment. There is evidence from a number of clinical studies for a depletion of CoQ10 levels in relevant tissues from MSA patients (Figure 1), and there is a rationale for the involvement of CoQ10 in the pathogenesis of this disorder, based on its role in cellular energy metabolism, and its antioxidant and anti-inflammatory action.

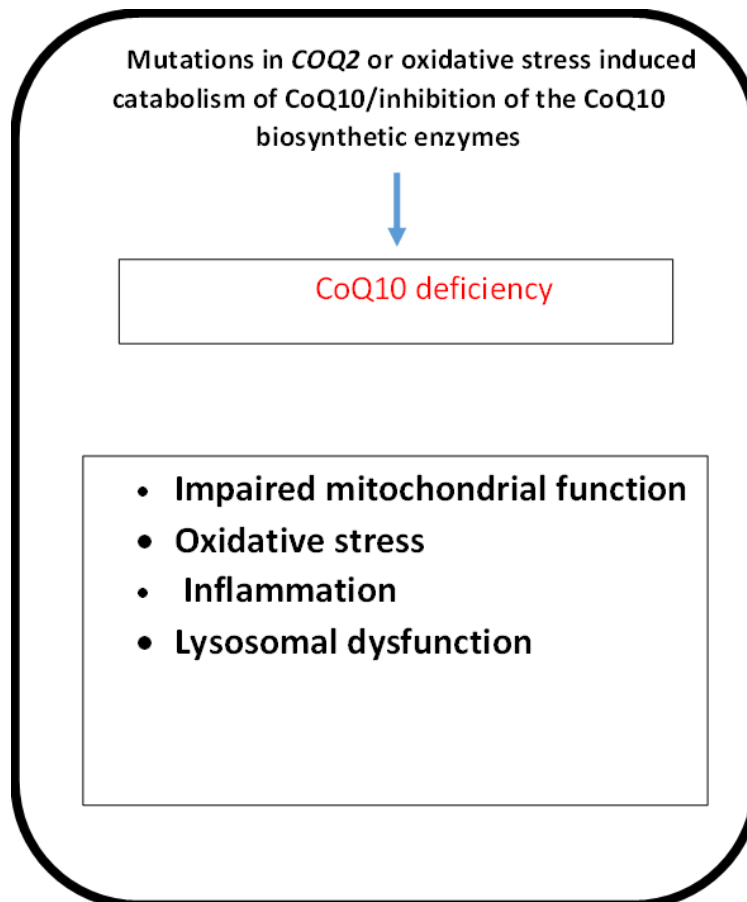


Figure 1: The potential causes of a CoQ10 deficiency in multiple system atrophy and its contribution to disease pathophysiology. COQ10: Coenzyme Q10.

What is now required is a clinical study to investigate the potential benefit of supplementing CoQ₁₀ in MSA patients. On the UMINCTR clinical trials registry, a randomised controlled study to investigate the efficacy of CoQ₁₀ in MSA patients is listed

as being underway (UMIN000031771), under the direction of Professor S. Tsuji of University of Tokyo Hospital, but no other information is currently available: (https://center6.umin.ac.jp/cgi-open-bin/ctr_e/ctr_view.cgi?recptno=R000036134)

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