

Thematic Review Series: Phospholipases: Central Role in Lipid Signaling and Disease

Calcium-independent phospholipases A₂ and their roles in biological processes and diseases

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Abstract Among the family of phospholipases A₂ (PLA₂s) are the Ca²⁺-independent PLA₂s (iPLA₂s) and they are designated group VI iPLA₂s. In relation to secretory and cytosolic PLA₂s, the iPLA₂s are more recently described and details of their expression and roles in biological functions are rapidly emerging. The iPLA₂s or patatin-like phospholipases (PNPLAs) are intracellular enzymes that do not require Ca²⁺ for activity, and contain lipase (GX₂SG) and nucleotide-binding (GXGXXG) consensus sequences. Though nine PNPLAs have been recognized, PNPLA8 (membrane-associated iPLA₂γ) and PNPLA9 (cytosol-associated iPLA₂β) are the most widely studied and understood. The iPLA₂s manifest a variety of activities in addition to phospholipase, are ubiquitously expressed, and participate in a multitude of biological processes, including fat catabolism, cell differentiation, maintenance of mitochondrial integrity, phospholipid remodeling, cell proliferation, signal transduction, and cell death. As might be expected, increased or decreased expression of iPLA₂s can have profound effects on the metabolic state, CNS function, cardiovascular performance, and cell survival; therefore, dysregulation of iPLA₂s can be a critical factor in the development of many diseases. ■ This review is aimed at providing a general framework of the current understanding of the iPLA₂s and discussion of the potential mechanisms of action of the iPLA₂s and related involved lipid mediators.—Ramanadham, S., T. Ali, J. W. Ashley, R. N. Bone, W. D. Hancock, and X. Lei. **Calcium-independent phospholipases A₂ and their roles in biological processes and diseases.** *J. Lipid Res.* 2015. 56: 1643–1668.

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OVERVIEW OF THE GROUP VIA Ca²⁺-INDEPENDENT PHOSPHOLIPASES A₂

The Ca²⁺-independent phospholipases A₂ (iPLA₂s) are part of a diverse family of PLA₂s that hydrolyze the *sn*-2 substituent from membrane phospholipids to release a free fatty acid and a lysolipid (1, 2). These enzymes are ubiquitously expressed, and in contrast to secretory PLA₂s (sPLA₂s) and cytosolic PLA₂s (cPLA₂s), do not require Ca²⁺ for either translocation or activity. Some of the first descriptions of iPLA₂ activity were in the mid- to late-1980s with the identification of a plasmalogen-selective PLA₂ in

Abbreviations: AA, arachidonic acid; Ank, ankyrin; ATGL, adipose triglyceride lipase; BEL, bromoenol lactone; CGI-58, comparative gene identification-58; COX, cyclooxygenase; cPLA₂, cytosolic phospholipase A₂; CT, cytidyltransferase; ER, endoplasmic reticulum; FK, fluoroketone; FKGI18, fluoroketone-based inhibitor of iPLA₂β; GPx, glutathione peroxidase; INAD, infantile neuroaxonal dystrophy; iPLA₂, independent phospholipase A₂; iPLA₂β, cytosol-associated Ca²⁺-independent phospholipase A₂; iPLA₂β-KO, global iPLA₂β-null mice; iPLA₂γ, membrane-associated Ca²⁺-independent phospholipase A₂; LO, lipoxygenase; LPA, lysophosphatidic acid; LPC, lysophosphatidylcholine; NBIA, neurodegeneration with brain iron accumulation; NOD, non-obese diabetic; NSMase-2, neutral SMase-2; NTE, neuropathy target esterase; PAF, platelet-activating factor; PC, phosphatidylcholine; PE, phosphatidylethanolamine; PGE₂, prostaglandin E₂; PLA₂, phospholipase A₂; PNPLA, patatin-like phospholipase; PSA, prostate-specific antigen; RIP-iPLA₂β-Tg, mice which overexpress iPLA₂β only in β-cells; R-BEL, enantiomer of BEL selective for iPLA₂γ; ROS, reactive oxygen species; S-BEL, enantiomer of BEL selective for iPLA₂β; sPLA₂, secretory phospholipase A₂; SRE, sterol regulatory element; SREBP, sterol regulatory element-binding protein; Tg, transgenic.

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the cytosol of canine myocardium (3) that migrated with a molecular mass of 40 kDa. Analogous activity was subsequently described in insulinoma cells (4) and renal proximal tubules (5), as well as in a macrophage cell line (6). The Ca²⁺-independent PLA₂s are designated as group VI iPLA₂s (7, 8) and now include seven members, as described in **Table 1**: iPLA₂β (VIA-1 and -2), iPLA₂γ (VIB), iPLA₂δ (VIC), iPLA₂ε (VID), iPLA₂ζ (VIE), and iPLA₂η (VIF). Three others (iPLA₂φ, iPLA₂ι, and iPLA₂κ) have been recognized, but very little is known about them and they are not yet assigned to group VI (9, 10). Due to their shared homology with patatin, the iPLA₂s are included in the patatin-like protein family and are also referred to as PNPLAs. The iPLA₂s also share a consensus GX SXG catalytic motif contained within a patatin-like lipase domain. This review discusses the current understanding of the various iPLA₂s, starting with the less-described iPLA₂δ, iPLA₂ε, iPLA₂ζ, and iPLA₂η, followed by emerging reports relating to iPLA₂γ, and ending with the most widely examined, iPLA₂β.

iPLA₂δ

The group VIC iPLA₂δ (PNPLA6), also known as neuropathy target esterase (NTE), was recognized for manifesting iPLA₂ and lysophospholipase activities in 2002 (11). The gene for iPLA₂δ is located at chromosome 19p13.3-13.2, and encodes a protein containing 1,366 amino acids with a molecular mass of 146 kDa and an active site at S¹⁰⁰⁵. Expressed predominantly in neurons, iPLA₂δ localizes to the endoplasmic reticulum (ER) and Golgi apparatus (12), and its inhibition or deletion leads to axonal degeneration. It is in this context that NTE was discovered during studies for causes of organophosphorus ester-induced paralysis in the late 1960s (13, 14). Whereas conventional KO of NTE is embryonic lethal (15), conditional KO of NTE in the CNS leads to neurodegeneration (16, 17), suggesting loss of function as a causative factor in the development of neurological diseases. However, mutations in the catalytic site of NTE lead to hereditary spastic paraplegia (18, 19), a symptom of NTE-motor neuron disorder. Clinical manifestations of NTE-motor neuron disorder are only evident when mutations are carried by both alleles, suggesting that the neurodegeneration results from production of abnormal NTE, rather than due to reduction in NTE activity (20, 21).

Among the syndromes associated with mutations in PNPLA6 are: Gordon Holmes (22, 23) and Boucher-Neuhauser (23), characterized by early-onset ataxia and hypogonadism; Oliver-McFarlane (24), characterized by trichomegaly, congenital hypopituitarism, retinal degeneration, and choroidal atrophy; Laurence-Moon (24), characterized by progressive spinocerebellar ataxia and spastic paraplegia; and photoreceptor degeneration and childhood blindness (25). An NTE-related iPLA₂ (PNPLA7) awaits further characterization (9, 10).

iPLA₂ε

The group VID iPLA₂ε (PNPLA3), also referred to as adiponutrin, was described in 2001 (12). The gene for iPLA₂ε is located at chromosome 22q13.31 and encodes a protein containing 481 amino acids with a molecular mass of 52 kDa and an active site at S⁴⁷. PNPLA3 is mainly expressed in intracellular membrane fractions in hepatocytes (26) and was originally described as a nutritionally-regulated adipose-specific transcript in 3T3-L1 adipocytes (12). In addition to phospholipase activity, iPLA₂ε manifests TG lipase and acylglycerol transacylase activities (27), leading to the suggestion that it facilitates energy/lipid mobilization and storage in adipocytes. In this regard, iPLA₂ε correlates highly with the development and progression of nonalcoholic fatty liver disease and has been identified as a genetic determinant of liver fibrosis (28, 29). Whereas the WT *PNPLA3* exhibits lipolytic activity toward TGs, the rs738409 variant *PNPLA3*, where isoleucine¹⁴⁸ is replaced by methionine (L148M), reduces the access of substrates and activity of PNPLA3 toward glycerolipids. This leads to development of macrovesicular steatosis (26, 30), simple steatosis to steatohepatitis and progressive cirrhosis (31), and hepatic fibrinogenesis by a sterol regulatory element-binding protein (SREBP)-1c-PNPLA3 pathway (32). A greater impact of the L148M variant on hepatic lipid content is unmasked in the presence of other risk factors such as obesity (33), visceral adiposity (34), increased intake of sugars (35), omega-6 PUFAs (36), glucokinase regulatory protein gene variant (37), chronic hepatitis B (38), and hepatocellular carcinoma (39). In contrast to these reports, PNPLA3 has been reported to restore lipid homeostasis (40) by mediating acylation of lysophospholipids and hydrolyzing TGs in the liver in a direct manner or by regulation by cofactors (41, 42).

TABLE 1. Listing of the group VI family of iPLA₂s

Group VI PLA ₂ s	Described	Other Names	Chromosome	Amino Acids	kDa	Ank Repeats	Localization	Active Site
VIA-1, iPLA ₂ β	1994 (6)	PNPLA9	22q13.1	752	85	8	Cytosol	S ⁴⁶⁵
VIA-2, iPLA ₂ β	1999 (96)	PNPLA9	22q13.1	804	88	7	Cytosol	S ⁵¹⁹
VIB, iPLA ₂ γ	2000 (61, 62)	PNPLA8	7q31	782	90	0	Membrane	S ⁴⁸³
VIC, iPLA ₂ δ	2002 (11)	PNPLA6, NTE	19p13.3-13.2	1,366	146	0	Neurons (ER, Golgi)	S ¹⁰⁰⁵
VID, iPLA ₂ ε	2001 (12)	PNPLA3, adiponutrin	22q13.31	481	52	0	Liver adipocytes	S ⁴⁷
VIE, iPLA ₂ ζ	2004 (27, 43, 44)	PNPLA2, desnutrin, ATGL	11p15.5	504	55	0	White and brown adipocytes (lipid droplets)	S ⁴⁷
VIF, iPLA ₂ η	1994 (60)	PNPLA4, gene sequence-2 (GS2)	xp22.3	253	27	0	ubiquitous	S ⁴³

iPLA₂ζ

The group VIE iPLA₂ζ (PNPLA2), also known as TST2.2, desnutrin, and adipose TG lipase (ATGL), was described in 2004 (27, 43, 44). The gene for iPLA₂ζ is located at chromosome 11p15.5 and encodes a protein containing 504 amino acids with a molecular mass of 55 kDa and an active site at S⁴⁷. Similar to iPLA₂ε, iPLA₂ζ also exhibits TG lipase and acylglycerol transacylase activities (27). For optimal activity, ATGL requires the cofactor comparative gene identification-58 (CGI-58), which amplifies the hydrolase activity 20-fold (45). Mutations in CGI-58, as in Chanarin-Dorfman syndrome (46), lead to TGs in various tissues and decreases in both CGI-58 and ATGL have been reported to exacerbate myocardial steatosis and oxidative stress to promote cardiac apoptosis in a rodent T2D model (47). Analogously, ATGL deficiency in mice promotes tissue accumulation of lipids and leads to premature death due to cardiomyopathy, as a consequence of reductions in fatty acid oxidative gene expression, mitochondrial fatty acid oxidation, and reduced oxygen consumption (48). Macrophages with ATGL deficiency are more susceptible to ceramide-mediated mitochondrial dysfunction and programmed cell death (49). β-Cell-specific ATGL-deficiency has been demonstrated to lead to hyperglycemia due to impaired insulin secretion, as a consequence of increased islet TG content with lower fatty acid levels. These mice also have decreased expression of PPARδ genes that encode enzymes required in mitochondrial oxidation, and this is reflected by impaired mitochondrial respiration and ATP production needed for glucose-stimulated insulin secretion (50). While polymorphisms in *PNPLA2* are reported to highly correlate with T2D (51), the contribution of ATGL to insulin secretion and signaling has been challenged (52, 53). In addition to its links to CGI-58 and PPARδ, ATGL has been reported to interact with TNFα in adipocytes (54), estrogen receptor α (ERα) in bone marrow (55), fat-specific protein 27 (FSP27) in human adipocytes (56), sirtuin 1 (SIRT1) during β-adrenergic signaling (57), hepatic PPARα (58), AMPK during thermogenesis (59), and to be a candidate for transcriptional control by PPARγ-mediated signals (54).

iPLA₂η

The group VIF iPLA₂η (PNPLA4), also known as gene sequence-2 (GS2), was described in 1994 (60). The gene for iPLA₂η is located at xp22.3 and encodes a protein containing 253 amino acids with a molecular mass of 27 kDa and an active site at S⁴³. Similar to iPLA₂ε and iPLA₂ζ, iPLA₂η exhibits TG lipase and acylglycerol transacylase activities (27). Though expression of iPLA₂η in a variety of tissues (liver, brain, skeletal muscle, lung, placenta, kidney, and pancreas) was identified in 1994, and more recently in adipose tissue (27), to date, very little is known about its biology or its role in metabolic diseases. Similar to iPLA₂ε and iPLA₂ζ, iPLA₂η activation is proposed to contribute to regulation of anabolic and catabolic fluxes

of acyl equivalents in tissues. It has been suggested that the TG lipase activity of iPLA₂ε, iPLA₂ζ, and iPLA₂η play roles in serum fatty acid accumulations associated with metabolic syndrome and T2D. A related GS2-like iPLA₂ (PNPLA5) has yet to be characterized (9, 10).

iPLA₂γ

The group VIB iPLA₂γ (PNPLA8) genomic organization and mRNA sequence were first described in a variety of tissues (skeletal muscle, heart, placenta, brain, liver, and pancreas) in 2000 (61) and later in the same year in lymphocytes (62). The gene for iPLA₂γ is located at 7q31 and encodes a protein containing 782 amino acids with a molecular mass of 90 kDa and an active site at S⁴⁸³. Recognition of the similarity in the catalytic domain between human iPLA₂γ, cPLA₂, and plant PLA₂ patatin and conservation of sequence surrounding Asp⁶²⁷, and noting that substitution of alanine for either Ser⁴⁸³ of Asp⁶²⁷ caused loss of iPLA₂γ activity, led to the suggestion that the Ser-Asp dyad constitutes the active site in human iPLA₂γ (63). Initially recognized as membrane associated (61, 62), dual-competing subcellular localization signals have been identified in discrete isoforms of iPLA₂γ (64) that promote its accumulation and expression of activity in the peroxisomes and mitochondria (65), leading to the suggestion that iPLA₂γ plays a role in integration of lipid and energy metabolism. Further, iPLA₂ activity in the ER of rabbit and rat kidney (66) and ventricular myocyte membranes (67) has been demonstrated to be due to iPLA₂γ.

The iPLA₂γ protein contains four methionine residues that can act as potential translational initiation sites (60, 63) to generate the full-length (~88 kDa) and three truncated products (77, 74, and 63 kDa). Attempts at expression of the truncated products in HEK293 cells, however, led to the predominant expression of the 63 kDa product (68), the isoform reported earlier to be expressed in peroxisomes (64). Further examination of parental cells revealed that the 63 kDa isoform was much more abundant than the full-length iPLA₂γ in HEK293 and human colorectal cancer cell lines, HCA-7 and WiDr, while in human bronchial epithelial (BEAS-2B) and rat fibroblastic (3YI) cells, the full-length iPLA₂γ was the predominant isoform (68). These authors suggested that iPLA₂γ potentiates arachidonic acid (AA) release from various subclasses of phosphatidylethanolamine (PE) and phosphatidylcholine (PC) to increase prostaglandin E₂ (PGE₂) production via cyclooxygenase (COX)-1 and -2, and this contributes to cell growth and tumorigenesis. In contrast, comparative substrate preference studies revealed that unlike cPLA₂, which generates predominantly 1-palmitoyl lysophosphatidylcholine (LPC) and AA from 1-palmitoyl-2-arachidonoyl-*sn*-phosphatidylcholine hydrolysis, and iPLA₂β, which exhibits mixed PLA₁/PLA₂ activities and generates 1-palmitoyl LPC at an initial 3-fold rate greater than 2-arachidonoyl LPC, iPLA₂γ overexpressed in and purified from Sf9 cells hydrolyzed saturated and monounsaturated fatty acids at equal rates from the *sn*-1 or *sn*-2 position in diacyl PC substrates. However, it was less effective in releasing

PUFAs from the *sn*-2 position, as reflected by generation of 2-arachidonoyl LPC at a 10-fold faster rate than 1-palmitoyl LPC (69).

Understanding the role of iPLA₂γ-derived lipid signals has substantially advanced following the generation of mice with tissue-specific overexpression or global KO of iPLA₂γ. Cardiac-specific overexpression of iPLA₂γ presented multiple phenotypes that included reductions in myocardial phospholipid mass in fasted and fed states, accumulation of TGs with caloric restriction, acute fasting-induced hemodynamic dysfunction (that was accompanied by loosely packed and disorganized mitochondrial cristae), and elevated levels of 2-arachidonoyl-*sn*-glycero-3-phosphocholine and 2-docosahexaenoyl-*sn*-glycero-3-phosphocholine (65). These findings were associated with increased expression not of the full-length, but of the 70 and 63 kDa iPLA₂γ isoforms. Impairment in mitochondrial function is also evidenced in iPLA₂γ-null mice, which exhibit growth retardation, cold intolerance, and increased mortality due to aortic stress that were associated with decreased myocardial function and O₂ consumption (70). The iPLA₂γ-null mice also become resistant to Western diet-induced increases in body weight, adiposity, circulating levels of cholesterol, glucose, and insulin; and insulin resistance, and glucose intolerance (71). Ability to utilize fat and carbohydrates is also affected in these mice in association with severe impairment in skeletal muscle mitochondrial oxidation of fatty acids. Subsequent studies revealed that marked decreases in cardiolipin molecular species containing 22:6 were an underlying cause for the mitochondrial uncoupling evident in the iPLA₂γ-null mice (72). Similarly, hippocampal phospholipid metabolism was found to be severely compromised with iPLA₂γ-deficiency leading to a mitochondrial neurodegenerative disorder characterized by degenerating mitochondria, autophagy, and cognitive dysfunction, that was associated with alterations in the compositions and content of PCs, PEs, oxidized PEs, and ceramides and a shift in cardiolipins to shorter chain molecular species (73). Increased lipid peroxidation was also evident in the skeletal muscles of iPLA₂γ-null mice, which exhibited abnormal mitochondrial function, oxidative stress, growth retardation, and loss of skeletal muscle structure and function (74). These findings are consistent with a previous report of the protective effects of iPLA₂γ, deduced using a selective inhibitor of iPLA₂γ against oxidant-induced lipid peroxidation and necrosis of renal proximal tubular cells (75). In contrast to the earlier report in the heart (65), the full-length iPLA₂γ was the major isoform detected in the last two studies (74, 75).

The identification of iPLA₂γ in the mitochondria and ER paved the way for studies that demonstrated a protective role for iPLA₂γ against cell death. Utilizing knockdown protocols, global iPLA₂γ-null mouse model, or by selective inhibition with bromoenol lactone (BEL) (suicide substrate) of iPLA₂γ (*R*-BEL) versus iPLA₂β (*S*-BEL), several studies reported protective effects of iPLA₂γ against oxidant- and cytokine-induced cell death. Human astrocytes exposed to hydrogen peroxide or tert-butyl hydroperoxide

exhibited cell death, and pretreatment with *S*-BEL, but not *R*-BEL, amplified loss of ATP levels and cell necrosis (76). Similarly, knockdown of iPLA₂γ in renal proximal tubular cells resulted in increased susceptibility to oxidant-induced cell death, elevations in lipid peroxidation, and uncoupled oxygen consumption (77, 78). Analogous findings were reported in INS-1 insulinoma cells, where knockdown of iPLA₂γ promoted increases in cytokine- and oxidant-induced membrane peroxidation and apoptosis (79). Cytoprotective effects of iPLA₂γ were also demonstrated in glomerular epithelial cells, and these were attributed to iPLA₂γ-mediated upregulation of ER chaperones (80). A general conclusion derived from these studies is that the lack of iPLA₂γ decreases substrate availability for reacylation, leading to increases in lipid peroxidation. In apparent contrast to these reports, genetic ablation of iPLA₂γ or its inhibition with *R*-BEL attenuated calcium-, reactive oxygen species (ROS)-, or oxidized lipid-mediated increases in liver mitochondrial swelling, mitochondrial permeability transition pore opening, and cytochrome *c* release from mitochondria, which trigger the intrinsic apoptotic pathway (81, 82).

The more recent description of iPLA₂γ, to date, has limited wide studies of its role in clinical diseases, but a few reports suggest a role for iPLA₂γ in certain clinical-related disorders. Chagas' disease is caused by protozoan parasite *Trypanosoma cruzi*, which infects cardiac myocytes promoting release of inflammatory mediators such as eicosanoids. Inhibition of iPLA₂γ attenuated AA and PGE₂ release and platelet-activating factor (PAF) production from HL-1 cardiac myocytes infected with *T. cruzi* (83), and these effects were alleviated by pretreatment with *R*-BEL. Consistent with a protective role of iPLA₂γ in this process, the survival rates were lowered and tissue parasitism amplified in *T. cruzi*-infected iPLA₂γ-null mice, suggesting that iPLA₂γ activity affords protection against acute state cardiomyopathy in Chagas' disease (83). In contrast, iPLA₂γ-deficiency has been shown to increase bleeding time and provide resistance to thromboembolism (84), raising the possibility of targeting iPLA₂γ for antithrombotic drug development. To date, the only reported clinical manifestation relating to iPLA₂γ is a report that its absence is associated with myocardial dysfunction, cognitive defects, and mitochondrial degeneration (85) in a case study that closely parallels the phenotype in iPLA₂γ-null mice (73).

iPLA₂β

The group VIA iPLA₂β (PNPLA9) is the most widely described of the iPLA₂s and expression of its activity was first described in P388D1 macrophage-like cells in 1994 (6) and later shown to be the same enzyme (86) as that cloned from Chinese hamster ovary cells in 1997 (86–88). Unlike cPLA₂, which exhibits preference for hydrolysis of AA from the *sn*-2 position (89), the iPLA₂s demonstrate no substrate specificity and manifest PLA₂/PLA₁, lysophospholipase (90, 91), transacylase (27, 91), and thioesterase (92, 93) activities. The extensively studied iPLA₂β was

cloned from hamster (87), mouse (86), and rat (94), and they represent species homologs that are 85 kDa proteins (752 amino acids) with a serine lipase consensus sequence (GTSGT), preceded by eight N-terminal ankyrin (Ank) repeats (87, 94).

A homologous 88 kDa iPLA₂β was cloned from human lymphocyte lines and testis (95) that contains a 54-amino acid insert interrupting the eighth Ank repeat. Subsequent analyses with human pancreatic islet mRNA identified cDNA species that encoded two distinct 85 kDa (VIA-1) and 88 kDa (VIA-2) human iPLA₂β isoforms (96). Analogous transcripts were also identified in human promonocytic U937 cells. The human iPLA₂β gene resides on chromosome 22 in region q13.1 and contains 16 exons in the VIA-2 transcript. Exon 8 is not present in the VIA-1 transcript, indicating that it arises by an exon-skipping mechanism of alternative splicing.

Additional alternate splicing events generate iPLA₂β variants that differ in their subcellular localization, catalytic activity, and likely cellular function (95). Splice variants (Ank-1 and Ank-2) encode premature stop codons due to alternatively spliced exon 10a. The proteins encoded by these splice variants, VIA Ank-1 (53 kDa, ~479 amino acids) and VIA Ank-2 (47 kDa, ~427 amino acids), terminate after the seventh Ank repeat domain and before the active site, whereas VIA-3 (~70 kDa, 640 amino acids) terminates just after the lipase active site. Two additional active iPLA₂β isoforms have been recognized to arise from proteolytic cleavage: a ~63 kDa isoform (VIA-4, 623 amino acids) arising from caspase-3-catalyzed cleavage at the N terminal (97, 98) and a ~70 kDa (VIA-5, ~640 amino acids) isoform arising from C-terminal cleavage (99). Proteomic analyses by mass spectrometry further reveal that the iPLA₂β is a candidate for numerous truncations at the N-terminal end (100, 101), but the activities and biological roles manifested by these products have not yet been discerned.

Basic characteristics of iPLA₂β

In addition to the Ank repeats, the iPLA₂β protein contains an ATP binding consensus motif (GGGVKG), an N-terminal caspase-3 cleavage site (DVTD), and a putative bipartite nuclear localization sequence (KREFGEHTKMT-DVKKPK). Though under basal conditions iPLA₂β is predominantly localized in the cytosol (102), translocation of iPLA₂β to the Golgi, ER, mitochondria, and nucleus is evident under stimulatory conditions (98, 100, 103–110). The iPLA₂β and iPLA₂γ share signature ATP binding motif, serine lipase site, and a region of 9 amino acids (627–635 in iPLA₂γ), whose biological significance is not known, but otherwise lack any additional homology (61, 87).

Modulation of iPLA₂β

Oligomerization. A unique distinction between iPLA₂β and other PLA₂s is the presence of a variable number of Ank repeats in iPLA₂β, which are absent in other PLA₂s. Several lines of study suggest that the Ank regions confer iPLA₂β protein activity. The active form of iPLA₂β appears to be an oligomer of interacting protein subunits, as supported

by radiation inactivation and gel filtration chromatography analyses that reveal association of the 85 kDa iPLA₂β activity with an apparent molecular mass of 250–350 kDa (6, 87, 111). This has led to the speculation that the active form of iPLA₂β is an oligomer of 85 kDa subunits and that the subunits associate with each other via their Ank repeat regions (87), similar to the involvement of Ank repeats in other protein-protein interactions (112). Consistent with this possibility are the observations that iPLA₂β deletion mutants lacking the Ank repeat domain, but retaining the catalytic domain, are catalytically inactive (87) and that activity of the full-length protein is reduced when it is coexpressed with truncated iPLA₂β-like proteins that retain the Ank repeat domain, but lack the catalytic domain (95). In the long isoform of human iPLA₂, a proline-rich insert interrupts the last iPLA₂β Ank repeat with some similarities to the Smad4 domain that mediates interactions with signaling partners (113). This raises the possibility that the proline-rich insert in human iPLA₂β allows it to interact with proteins not recognized by the short isoform of iPLA₂β.

Oxidation. It has been suggested that iPLA₂β inactivation can occur by a mechanism involving oxidation of sulfhydryl groups within the iPLA₂β (78). Subsequently, oligomerization of iPLA₂β in INS-1 cells in response to oxidative stress was demonstrated (114). Oxidant-induced oligomerization alters the subcellular localization of iPLA₂β and results in reduced release of AA, suggesting inhibition of iPLA₂β catalytic activity. These nonproductive oligomers are DTT-sensitive and therefore likely generated through intermolecular disulfide bonds. Like iPLA₂β, iPLA₂γ activity is suppressed by oxidants, but restored when oxidant-inhibited enzyme is treated with a reducing agent (78, 115).

Together, these studies indicate that iPLA₂β monomers are capable of assembling into both productive and nonproductive oligomers. The productive oligomerization is mediated through the N-terminal Ank repeat domain, while inactive oligomers are formed through intramolecular disulfide bonds.

Activation. The iPLA₂β protein contains a consensus nucleotide-binding motif (GGGVKG) that is homologous to those of protein kinases (61, 116). This feature mediates regulation and stabilization of iPLA₂β activity by ATP (6, 91, 117, 118), which is independent of enzyme phosphorylation (6, 117, 118). Also contained in iPLA₂β are a C-terminal 1-9-14 calmodulin-binding motif (IRKQGQGNKVKK LSI) and a calmodulin-binding peptide (AWSEMVGIQYFR) (106, 116, 119). These facilitate formation of a signaling complex between iPLA₂β and CaMKIIβ and enhancement of both activities is evident upon their association (120). This has been offered as one explanation of why Ca²⁺ store depletion activates iPLA₂ (121) and may occur in vascular myocytes (90), pancreatic islet β-cells (122), and human granulocytes (123). Ca²⁺ store depletion also activates hydrolysis of arachidonate from phospholipids in differentiated human U937 promonocytic cells by a mechanism that

does not require a rise in cytosolic $[Ca^{2+}]$ (124). The iPLA₂β protein also contains a consensus sequence site for caspase-3-mediated cleavage within the first Ank repeat (125). The truncated product manifests higher activity (125) and localizes to the nucleus under high glucose stimulation and prolonged stress (98, 107), suggesting that it may amplify hydrolysis of nuclear membrane phospholipids and lead to nuclear membrane lysis, or that the iPLA₂β and/or iPLA₂β-derived products accumulate in an environment that can potentially participate in transcriptional induction of favorable and unfavorable genes.

Gene induction. The iPLA₂β gene contains a sterol regulatory element (SRE) (126). Under stressful conditions SREBPs are processed to mature forms of SREBPs (127–135), which translocate to the nucleus and bind to SRE. This leads to induction of iPLA₂β transcription and protein expression, which are suppressed in the presence of a dominant negative form of SREBP-1 (136–138). Intriguingly, the iPLA₂β gene exhibits remarkable cross-species homology in the promoter region, which contains putative consensus sequences for a number of stress-related transcriptional factors, suggesting that the iPLA₂β gene is a candidate for modulation during periods of stress. Confirmation of iPLA₂β induction by these stress-related transcriptional factors will lead to a better understanding of the role of iPLA₂β in stress responses and disease manifestation.

iPLA₂β inactivation. Inhibitors of iPLA₂β include arachidonyl trifluoromethyl ketone (AACOCF₃), methyl arachidonyl fluorophosphonate, and palmitoyl trifluoromethyl ketone (PACOCF₃), which are sometimes used for “selective” inhibition of cPLA₂ (139–141). While siRNAs directed at iPLA₂β and, now available, iPLA₂β-KO and iPLA₂β-Tg mice (142–144) have provided insight into biological processes impacted by iPLA₂β, the majority of studies to assess the role of the iPLA₂β isoform have utilized a selective inhibitor of iPLA₂ (145). This inhibitor, (E)-6-(bromomethylene) tetrahydro-3-(1-naphthalenyl)-2H-pyran-2-one, was synthesized in 1991 and was originally designated as a haloenol lactone substrate (146), but is now referred to as BEL. The BEL compound is an irreversible inhibitor that selectively targets iPLA₂ enzymes and has little or no effect on cPLA₂ or sPLA₂ activity at concentrations that inhibit iPLA₂β or iPLA₂γ (27, 146, 147). Over the years, BEL has been used to discern the involvement of iPLA₂ in biological processes and, to date, is still considered the only available specific irreversible inhibitor of iPLA₂. Because the *S*- and *R*-enantiomers of BEL exhibit selective inhibition of iPLA₂β and iPLA₂γ, respectively (148), comparison of outcomes using racemic and enantiomers of BEL facilitates distinction of effects due to the β versus the γ isoform. Studies of the mechanism of inhibition reveal that the binding of BEL to iPLA₂β leads to generation of a diffusible bromoketomethyl acid, which promotes covalent modification of cysteine residues and not the active site serine of iPLA₂β (139, 146, 149, 150). In the presence of DTT, C651 was the only cysteine residue that was modified by BEL, leading to the suggestion

that DTT protects iPLA₂β from inactivation by BEL. However, using different isolation protocols and higher iPLA₂β-specific activity, an additional interaction between C651 and active site serine, S465, was suggested to account for substantial BEL-mediated inhibition (151). While the use of BEL continues to enhance our knowledge of iPLA₂β-mediated effects, its irreversible inhibitory profile, potential cytotoxicity (152, 153), and several examples of inhibition of nonPLA₂ enzymes (11, 27, 152, 154, 155) render it unfeasible for *in vivo* iPLA₂ inhibition.

To improve selectivity and reduce toxicity, other compounds are being developed and fluoroketone (FK)-based inhibitors are proving to be as potent as BEL, while being more selective for iPLA₂β and also exhibiting reversible inhibitory kinetics (1, 156, 157). Because FK inhibitors target serine active sites, they could potentially also inhibit cPLA₂s. However, modification of the FK group along with addition of a hydrophobic terminus, connected by a medium-length carbon chain to mimic the fatty acid chain, conferred selectivity of the FK compounds for iPLA₂ versus sPLA₂ or cPLA₂ (157), and earlier generation FK compounds (FKGK11 and FKGK2) were found to be beneficial in an experimental autoimmune encephalomyelitis animal model of multiple sclerosis (158). Subsequently, the FK-based inhibitor of iPLA₂β (FKGK18) was found to be 7-fold more potent than FKGK11 toward iPLA₂β; 195 and >455 times more potent for iPLA₂β than for group IVA cPLA₂ and group V sPLA₂, respectively (159); and effective in cell-based studies (160) and in countering T1D (161). Recently developed and awaiting characterization is an even more selective inhibitor (GK187) of iPLA₂β (162). On-going deuterium exchange mass spectrometry and molecular dynamics analyses suggest that FKGK inhibitor binding to iPLA₂β causes changes in the loops surrounding the active site of iPLA₂β in the catalytic domain, blocking access to phospholipid substrates and reducing solvent accessibility (163). As the development of chemical inhibitors continues, newer structurally dissimilar and smaller compounds (164) with even greater selectivity for iPLA₂β are forthcoming, as described at the 6th International Conference on PLA₂s in 2015 (Kokotos et al., unpublished observations).

Proposed roles for iPLA₂β

Membrane remodeling. One of the earliest proposed functions for iPLA₂β was a “housekeeping” role that involves generation of lysophospholipid acceptors for incorporation of AA into phospholipids, based on experiments involving inhibition of iPLA₂β activity in P388D1 cells with BEL or with an antisense oligonucleotide (165, 166). Inhibition of iPLA₂β activity in P388D1 cells suppressed (~60%) incorporation of [³H]AA into phospholipids while reducing (~60%) [³H]LPC levels in [³H]choline-labeled P388D1 cells. However, [³H]palmitic acid incorporation was only slightly reduced. This is thought to represent the mechanism whereby iPLA₂β inhibition reduces incorporation of [³H]AA into P388D1 cell phospholipids. Such incorporation reflects a deacylation/reacylation cycle (167) of phospholipid remodeling rather than *de novo* synthesis (168), and the level of LPC acceptors is thought to limit

the rate of [³H]AA incorporation into P388D1 cell PC (165, 166).

A second housekeeping function for iPLA₂β is suggested from studies with CTP:PC cytidyltransferase (CT)-overexpressing Chinese hamster ovary cells (169). CT catalyzes the rate-limiting step in PC biosynthesis via the Kennedy pathway, and cells overexpressing CT exhibit increased rates of PC biosynthesis and degradation and little net change in PC accumulation (169). Immunoreactive iPLA₂β protein and activity increase in the CT overexpressors and the increased PC degradation is prevented by BEL, suggesting that iPLA₂β is upregulated in response to CT overexpression (169). In general, this could represent an important role for iPLA₂β in cell biology because PC biosynthesis is involved in regulation of cell cycle and apoptosis (170).

More recently, in a study examining the effects of lipotoxicity in β-cells, the monolysocardiolipin content was reported to correlate with iPLA₂β expression level (171). The authors suggested that iPLA₂β contributed to cardiolipin remodeling by excising oxidized PUFA residues from cardiolipin to yield monolysocardiolipin species for reacylation with unoxidized C18:2-CoA to regenerate the native cardiolipin structure and function. This facilitated stabilization of association of cytochrome *c* with mitochondrial membranes and decreasing its appearance in the cytosol, thereby reducing ROS-mediated apoptosis. The authors concluded that participation of iPLA₂β in such an excision-reacylation mechanism of repair of oxidized phospholipids represents a special case of the originally proposed function of the enzyme in phospholipid remodeling.

Cell proliferation. Studies utilizing chemical inhibition or genetic modification protocols reveal a positive correlation between maintenance of iPLA₂β activity and cell proliferation. In the presence of BEL, human promonocytic U937 (172) and ovarian carcinoma (173) cells exhibit a decreased rate of proliferation and this is rescued in Caco-2 (174) and endothelial (175) cells by addition of AA. Consistently, knockdown of iPLA₂β suppresses and overexpression of iPLA₂β accelerates proliferation of insulinoma cells (176, 177). Further, while proliferation of vascular smooth muscle cells from iPLA₂-null mice is severely reduced, it is reversed upon addition of AA or PGE₂ (178). Other studies suggest that iPLA₂β is required for cell cycle progression, through both p53-dependent and -independent mechanisms (173, 175, 179–181). The molecular mechanism whereby iPLA₂β promotes cell cycle progression and proliferation remains unclear, but is likely to be related to bioactive lipid mediators that are generated by the enzyme. For example, the products of iPLA₂β activity may activate genes involved in cell division (87, 173, 182, 183). Arachidonate and eicosanoids have been linked to iPLA₂β-dependent proliferation (174, 175). Ovarian cancer cells produce lysophosphatidic acid (LPA) in an iPLA₂β-dependent manner, and this potent mitogen acts in an autocrine fashion to induce proliferation and migration (173, 182). These observations imply that regulation of

iPLA₂β activity may need to be considered in the context of countering tumorigenesis.

Bone formation. AA and its metabolites are important mediators of bone remodeling. The 5-lipoxygenase (LO) products, leukotrienes and 5-HETE, function as negative modulators of bone formation by inhibiting osteoblast differentiation and bone formation (184). In contrast, PGE₂ enhances bone formation and mass by increasing osteoblast replication and differentiation and/or by inhibiting osteoclastic resorption (185–188), although high concentrations of PGE₂ can stimulate bone resorption (189). Dietary supplementation with AA promotes increases in bone mass and volume (190, 191), reflecting a beneficial role of eicosanoids in bone formation. iPLA₂β-null female mice exhibit an age-related low bone/high bone adiposity phenotype that is independent of changes in estradiol levels (192). Osteoblasts and adipocytes share a common mesenchymal stem cell origin, and treatment of WT bone marrow stromal cells with BEL recapitulates the in vivo phenotype in promoting differentiation of the cells in favor of adipocytes away from osteoblasts (192). The higher adiposity in the bone marrow would be expected to compromise bone integrity, as in osteoporosis or diabetes, and this indeed is evidenced in the iPLA₂β-null mice, as reflected by increased fragility and decreased strength of their bones (192). These findings suggest that iPLA₂β-derived lipids play a critical role in deciding the fate of stem cells toward becoming osteoblasts or adipocytes, and raise the possibility that cell differentiation may be modulated by differential iPLA₂β activation.

Male fertility. Disruptions in PLA₂ are often associated with impairment in normal reproduction. For instance, deficiency in sPLA₂-III, which is expressed in proximal epididymal epithelium, causes defects in sperm maturation and impairment in the ability of the spermatozoa to fertilize intact eggs (193). These were associated with a compromised shift in acyl groups from oleic acid, linoleic acid, and AA to docosapentaenoic and docosahexaenoic acids during epididymal transit. Another sPLA₂ (group X) expressed in the acrosome of spermatozoa is released in an active form during capacitation through spontaneous acrosome reaction. Deficiency in sPLA₂-X promoted lower rates of spontaneous acrosome reaction and decreased in vitro fertilization efficiency (194). In contrast, only the females are affected by cPLA₂ deficiency and they exhibit problems with ovulation, oocyte transport, and oocyte implantation (195). Consistent with this, female patients experiencing decreased implantation rates in in vitro fertilization have reduced cPLA₂α expression and PGE₂ levels (196). Similar to absences in sPLA₂s, male mice with homozygous iPLA₂β gene disruption have impaired reproductive ability that is marked by reduced sperm motility and ability to fertilize mouse oocytes (143). Analogous phenotype is exhibited in WT spermatozoa treated with BEL. Based on earlier reports of involvement of LPC in acrosome reaction (197–199) and induction of capacitation (200), it was suggested that LPC levels are decreased

due to reduction in hydrolysis of spermatozoa membrane phospholipids in the absence of iPLA₂β. Females deficient in iPLA₂β, however, do not appear to suffer any adverse fertility consequences (143).

iPLA₂β and islet β-cells

The continued description of activity and related biochemistry of a Ca²⁺-iPLA₂ in myocardium in the early 1990s coincided with observations that fuel secretagogue-stimulated accumulations in AA in islet β-cells occurred, in part, in the absence of Ca²⁺. This led to the first description of a similar Ca²⁺-iPLA₂ activity in pancreatic islet β-cells (102) that resided predominantly in islet β-cells, with very little such activity in islet nonβ-cells. This was followed by the first demonstration of a functional role for iPLA₂β activity in a biological process, where activation of iPLA₂β was a requisite for optimal glucose-stimulated insulin secretion from islet β-cells (201, 202), and implicated a signaling role for iPLA₂β. In contrast to reports using P338D1 cells, findings utilizing multiple approaches in a variety of β-cell models indicated that the iPLA₂β did not serve a membrane remodeling role, but rather, it had a signaling role in β-cells (105, 142, 144, 176, 177, 203–205). Further, the failure of iPLA₂β manipulations to modulate membrane remodeling in native macrophages (206) suggested that the housekeeping role of iPLA₂β may be cell-specific and is predominant in the macrophage-like cell line P338D1. However, the demonstration of iPLA₂β activity protecting β-cells against lipotoxicity by preserving cardiolipin content (171) raises the possibility that iPLA₂β may manifest an organelle- and stimuli-specific protective/remodeling role in β-cells.

Glucose-stimulated insulin secretion. The β-cell is the primary sensor of glucose and when circulating levels of glucose rise, it is transported into the β-cell where it undergoes glycolytic metabolism (207–210). During this process, ATP is generated and its binding to plasma membrane ATP-sensitive potassium (K_{ATP}) channels leads to inactivation of the channels and membrane depolarization (211–214). This activates voltage-operated Ca²⁺ channels promoting Ca²⁺ influx and a rise in cytosol [Ca²⁺] (215–219), which is a critical signal of insulin release from secretory granules (215–217, 220). It has been recognized for a long time that fuel secretagogues, such as glucose, also induce hydrolysis of membrane phospholipids leading to accumulations in inositol 1,4,5-trisphosphate, free AA, and AA metabolites (221–225). AA, at concentrations that accumulate following stimulation with glucose, induces a rise in β-cell cytosolic Ca²⁺ concentrations, due in part to Ca²⁺ influx and Ca²⁺ release from intracellular (i.e., ER) stores (170, 202, 222, 226, 227). Whereas activation of phosphoinositide-phospholipase C requires Ca²⁺ (221), a component of the accumulation of AA and its metabolites do not (170). This led to the hypothesis that a Ca²⁺-independent phospholipase activity may be manifested in β-cells that is activated upon glucose stimulation, and the resulting generation of AA serves to amplify the Ca²⁺ signal necessary for optimal insulin secretion. Utilization of various

insulinoma cell lines, rodent and human islets, molecular biological protocols, and genetically-modified mice, collectively, provided a mechanism by which stimulation of β-cells increases hydrolysis of AA from β-cell membrane phospholipids, in parallel with insulin secretion, in an iPLA₂β-dependent manner (4, 105, 177, 201, 203, 204). Chemical inhibition, siRNA knockdown, or genetic ablation of iPLA₂β activity attenuated glucose-stimulated insulin secretion, while the opposite was evident with increased expression of β-cell iPLA₂β (99, 111, 142, 144, 176, 201, 203–205). As shown earlier in myocardial studies (87, 118), the predominant lipid pools that serve as substrates for iPLA₂β in β-cells are plasmalogens, and their abundance is decreased within minutes of glucose stimulation (4, 203, 204). Interestingly, islet β-cell membranes are enriched in AA, in particular, plasmenylethanolamine molecular species that contain AA (4, 204). The presence of such a membrane phospholipid composition lends itself to accumulations in AA in the β-cells upon activation of β-cell iPLA₂β. Modulation of the islet β-cell-delayed rectifier potassium channel, Kv2.1, by AA amplifies Ca²⁺ influx into the β-cells and enhances glucose-stimulated insulin secretion (142, 228). While AA itself manifests biological activity, the accompanying lysolipids and metabolites of AA, or eicosanoids, significantly impact various cellular processes to promote a multitude of effects (229, 230).

Pancreatic islets also express Ca²⁺-dependent PLA₂s that are involved in the insulin secretory process. The cPLA₂ is much more abundant in human islets than rodent islets, but very little is expressed in insulinoma cells (147, 231–235). cPLA₂ is activated by influx of Ca²⁺ into the cell (232) and is subject to glucose-mediated phosphorylation (235). A variety of sPLA₂s (1B, IIC, IIF, XIIA/B) have also been described in whole pancreas (236), islets (233, 234, 237), and in β-cell secretory granules (234, 238, 239) from which sPLA₂-1B is co-released with insulin (236). When observations from these studies are taken together, a sequential participation of PLA₂s in the insulin secretory process is suggested. Activation of iPLA₂β following glucose stimulation amplifies the Ca²⁺ signal within the β-cell to promote insulin secretion, which can be returned to basal levels by inhibition of iPLA₂β (201, 204). Activation of cPLA₂ due to accumulations in intracellular Ca²⁺ may then serve to maintain insulin secretion and inhibition of cPLA₂ appears to reduce secretion only 50% (233). The role of sPLA₂ may reside in its ability to enhance the ability of plasma membranes to bind secretory granules (238, 240–242), though a role for sPLA₂ in inactivating the K_{ATP} channels has also been described (237). In view of expression of membrane receptors for sPLA₂ in β-cells (238, 243, 244), the role of sPLA₂s in β-cells may be to serve as feedback modulators to maintain/amplify insulin secretion.

iPLA₂β and β-cell death and T1D

Among the roles ascribed to iPLA₂β, its contribution to apoptosis was initially recognized in studies performed by Kudo's group (97, 125). Their work with human leukemic monocyte lymphoma U937 cells revealed that activation of iPLA₂β, as opposed to cPLA₂, enhanced cell death and

that iPLA₂β undergoes caspase-3 (apoptosis executioner)-catalyzed cleavage to generate a more active shorter isoform of iPLA₂β. During the same period, Polonsky's group reported that ER stress-induced death of insulinoma cells occurs independently of Ca²⁺ and is mediated by a metabolite of AA (245). Intriguingly, while short-term (minutes) stimulation of iPLA₂β in β-cells has a beneficial effect of enhancing glucose-stimulated insulin secretion (4, 105, 177, 201, 203, 204), long-term (hours) exposures to pro-inflammatory cytokines, hyperglycemia, and ER stress induce iPLA₂β at the message, protein, and activity levels in β-cells (98, 136–138, 246) and lead to deleterious consequences that ultimately cause β-cell death (98, 103, 104, 136–138, 246). β-Cell apoptosis is a critical contributor to the onset and progression of diabetes and it is in this context that our group has focused on iPLA₂β biology to understand the underlying molecular mechanisms by which iPLA₂β-derived lipids promote β-cell death during T1D development, and our current understanding is illustrated in Fig. 1.

iPLA₂β and sphingolipids. Stress stimuli induce the intrinsic (mitochondrial) apoptotic pathway, which is mitigated by suppressing iPLA₂β expression/activity (103, 104, 136, 138, 246). Intriguingly, the primary lipid signals promoting mitochondrial decompensation were ceramides, derived through hydrolysis of sphingomyelins by neutral sphingomyelinase-2 (NSMase-2) (103, 104). Ceramides are part of the sphingolipid family and act as lipid messengers that can suppress cell growth and induce apoptosis (247–249), and as expected, inhibition or knockdown of NSMase-2-mitigated ceramide accumulation (103, 104, 137). Unexpectedly, inhibition, knockdown, or iPLA₂β deficiency attenuated, and iPLA₂β overexpression exacerbated, NSMase-2 induction and ceramide accumulation (103, 104, 136, 138, 246). These findings indicated that NSMase-2-catalyzed ceramide accumulations during β-cell

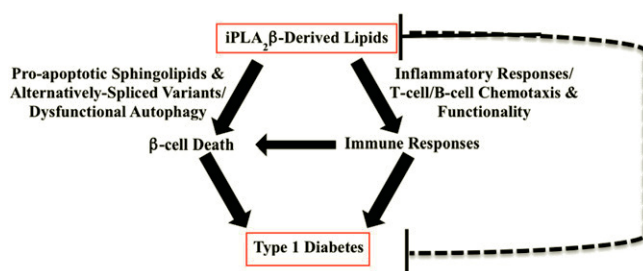


Fig. 1. Proposed roles for iPLA₂β-derived lipid signals in promoting β-cell death leading to T1D. Our collection of studies reveal that iPLA₂β activation is associated with processes that lead to β-cell apoptosis. The bioactive lipids (and their metabolites), derived from iPLA₂β-catalyzed hydrolysis of membrane phospholipids, are proposed to trigger: *a*) generation of pro-apoptotic sphingolipids, pro-apoptotic variants of apoptotic factors, and autophagy dysfunction to promote β-cell death; and *b*) inflammatory responses, immune cell functionality, and chemotaxis to promote immune responses, which serve to amplify the β-cell death process. We suggest that these effects of iPLA₂β-derived lipids, working in concert, contribute to the onset and progression of β-cell death, which eventually leads to the development of T1D.

apoptosis occur via an iPLA₂β-dependent mechanism. A recent report suggests that iPLA₂β-derived AA stimulates p38 MAPK and that this may serve as an additional intervening modulator of iPLA₂β-mediated increase in ceramide accumulations in β-cells (250).

iPLA₂β and alternate splicing. β-Cell apoptosis due to ER stress and pro-inflammatory cytokines is mediated through the intrinsic pathway, which is dependent on mitochondrial dysfunction and activation of caspase-9 (103, 104, 136, 138, 246, 251). The intrinsic apoptosis pathway is regulated by members of the Bcl-2 family of proteins that can be pro- or anti-apoptotic, depending on the spectrum of Bcl-2 homology domains that they contain. Among the anti-apoptotic Bcl-2 family members is Bcl-x(L), which associates with mitochondrial membranes and prevents their permeabilization, an early step in the intrinsic apoptosis pathway (252, 253). Overexpression of Bcl-x(L) has been correlated with increased survival of a variety of cells and tissues (254), including islet β-cells (255–257). Bcl-x(L)-null β-cells are hypersensitive to pro-apoptotic stimuli and reduced expression of Bcl-x(L) protein correlates with β-cell apoptosis in response to immunosuppressive drugs or high glucose (255–258). Conversely, overexpression of exogenous Bcl-x(L) protects β-cells from pro-inflammatory cytokine- and thapsigargin-induced apoptosis (258, 259).

Modulation of Bcl-x(L) expression is a complex mechanism consisting of both transcriptional and posttranscriptional processes and often leads to generation of both pro- and anti-apoptotic proteins from a single pre-mRNA (254, 260). Bcl-x(L) is the most abundant variant of the Bcl-x pre-mRNA, but other species can be generated at the expense of the mature mRNA encoding this anti-apoptotic protein (254). To date, Bcl-x RNA splicing has not been investigated in the β-cell, especially in the context of β-cell apoptosis and diabetes mellitus. We find that increased expression of iPLA₂β in β-cells is associated with a lower ratio of Bcl-x(L) to Bcl-x(s), while the opposite is true with iPLA₂β inhibition or deficiency (261). Lipidomic analyses by mass spectrometry revealed that the ratio of Bcl-x(L)/x(s) was directly proportional to the ratio of 5-HETE to EPA, suggesting that prolonged iPLA₂β activation in β-cells promotes generation of lipids, AA- and nonAA-derived, away from 5-HETE, thus disfavoring generation of the anti-apoptotic Bcl-x(L) variant. These findings raise the possibility that among the mechanisms by which iPLA₂β promotes β-cell apoptosis is one in which its activation triggers alternate splicing events favoring apoptotic processes. Of note, β-cell death due to direct activation of the mitochondrial apoptotic pathway by staurosporine is mitigated by iPLA₂β activity and this was related to preservation of repair mechanisms to sustain mitochondrial membrane components, such as cardiolipins (262, 263).

iPLA₂β and immune responses. β-Cell subcellular membranes are enriched in AA-containing phospholipids (144, 203, 204) and iPLA₂β activation leads to hydrolysis of AA, which can be metabolized by COX and LO enzymes to

generate eicosanoids (97, 125, 245, 264). These bioactive lipids act as paracrine and autocrine factors and greatly contribute to inflammation (264–266) and autoimmune diseases (267–274). PGE₂ has been reported to reduce debris clearance (275), and apoptotic clearance defects in non-obese diabetic (NOD) macrophages and dendritic cells are attributed to high PGE₂ levels (276, 277). It might be speculated that suppression of PGE₂ or other COX/LO-derived metabolite (278) generation can prevent the spread of β -cell apoptosis. Further, lysolipids and eicosanoids act as “chemoattractants” (230, 279–281), and increased generation of these could promote migration of immune cells toward the islet and subsequent infiltration, raising the possibility that in vivo inhibition of iPLA₂ β could mitigate immune responses leading to T1D. Autoimmune insulinitis is marked by degradation of the islet basement membrane, which presents a physical barrier to infiltrating leukocytes (282). Remarkably, the abundance of infiltrating cells is significantly reduced in NOD mice treated with FKGGK18 (161).

It is well-established that pancreatic islet β -cells are subject to pro-inflammatory cytokine-induced apoptosis during the pathogenesis of T1D (283). Our group has observed that in addition to inducing iPLA₂ β , pro-inflammatory cytokines promote ER stress, LPC generation, caspase-3 activation, and β -cell apoptosis and these outcomes were prevented following inhibition of iPLA₂ β with S-BEL (136). Further, addition of the cytokines to islets overexpressing iPLA₂ β resulted in exacerbated ER stress and β -cell apoptosis, which were blunted in islets devoid of iPLA₂ β (136). Taken together, these findings provided evidence of iPLA₂ β participation in β -cell apoptosis due to pro-inflammatory cytokines. This prompted further investigation of the role of iPLA₂ β in the pathogenesis in the NOD mouse, a model of spontaneous autoimmune-mediated T1D (161). In this study, we found that following administration of iPLA₂ β -selective inhibitor FKGGK18, NOD mice had significantly reduced incidence of diabetes and reduced insulinitis, higher circulating insulin, and preservation of β -cell mass (161). Additionally, FKGGK18 reduced TNF α production from CD4⁺ T-cells and antibodies from B-cells, independent of iPLA₂ γ activation, suggesting modulation of immune cell responses by iPLA₂ β or iPLA₂ β -derived products (161). Furthermore, adoptive transfer of diabetes by CD4⁺ T-cells to immunodeficient and nondiabetogenic NOD.*scid* mice was mitigated by FKGGK18 pretreatment and TNF α production from CD4⁺ T-cells was reduced by inhibitors of COX and 12-LO (161). These observations suggest that modulation of immune cell function may be a mechanism by which iPLA₂ β and iPLA₂ β -derived lipid signals participate in autoimmune-mediated β -cell death. In support of involvement of iPLA₂ β -derived lipid signals is the recent observation that 12-LO products contribute to pro-inflammatory cytokine-mediated β -cell dysfunction and apoptosis (284).

iPLA₂ β and autophagy. Whereas apoptosis is a well-studied process in β -cells, autophagy in β -cells has not received significant attention. Autophagy is a constitutively

active process of cellular degradation in all cell types and is regarded as a generally protective process to prolong cell survival. However, under increased stress, dysregulation of autophagy can lead to cell death (285). In view of evidence linking ceramides with autophagy (286, 287) and our collective observations that ceramide generation can occur via an iPLA₂ β -mediated mechanism, we addressed the possibility that iPLA₂ β expression modulates β -cell autophagy (246). We found that thapsigargin-induced ER stress promoted a greater conversion of LC3-I to LC3-II, reflecting activation of the autophagic response in islets from RIP-iPLA₂ β -Tg mice relative to islets from age-matched WT mice. In contrast, LC3-II generation was decreased in islets deficient in iPLA₂ β . Thapsigargin is thought to specifically block fusion of autophagosomes with lysosomes (288) and in the presence of inhibitors of autolysosomal activity, LC3-II accumulations in the RIP-iPLA₂ β -Tg and iPLA₂ β -KO mice are similar to their corresponding WT groups. Interestingly, inhibition of NSMase-2 in the presence of thapsigargin had minimal effect in WT islets, but modestly reduced LC3-II flux in the Tg. These findings suggest that differential iPLA₂ β activation can impact β -cell autophagy and that the most likely point of effect is beyond the induction step, in part, mediated by NSMase-2.

While this was the first demonstration of a link between iPLA₂ β and autophagy, it has been reported that mice deficient in iPLA₂ γ had enlarged hippocampal mitochondria, and that their degeneration led to an increase in autophagy (73). Those authors concluded that iPLA₂ γ -deficiency decreased mitochondrial membrane remodeling, resulting in loss of membrane potential and subsequent mitochondrial dysfunction leading to cognitive dysfunction and increased autophagy in the hippocampus. However, more detailed studies are needed to identify the precise location of iPLA₂ β impact on the autophagic responses in β -cells.

iPLA₂ β and diseases

Neurodegenerative. PLA₂s, including iPLA₂ β , are widely expressed in different regions of the brain (289–291), and iPLA₂ β immunoreactivity has been reported to be predominant in the cytosol and of less abundance in the nuclear fraction (292), suggesting a role for the enzyme and its products in nuclear signaling. iPLA₂ β has been purified from rat brain cytosol (293) and identified in dendrites and neurons, microglia, Purkinje cells, and astrocytes (290, 294–296), suggesting that it also participates in neuronal signaling. Advances in lipidomic analyses, coupled with kinetic studies in rodents and positron emission tomography protocols in humans, reveal that the turnover of AA in the brain is associated with cPLA₂ and COX-2 activities, whereas that of DHA (22:6n-3) was related to iPLA₂ β and COX-1 activities (297). This is consistent with the reports that in contrast to the islets, which are enriched in AA-containing glycerophospholipids, the most prominent *sn*-2 substituent in brain glycerophospholipids is DHA (297, 298), and iPLA₂ β -deficiency results in reduced DHA metabolism and content in the brain (299). Considering

its ubiquitous expression in the brain, dysregulation of iPLA₂β, as opposed to or in association with other PLA₂s, has been recognized to play critical roles in a variety of neurological disorders.

SCHIZOPHRENIA. Magnetic resonance spectroscopy studies reveal a higher than normal turnover of brain membrane phospholipids in patients with schizophrenia (300, 301). Whereas serum Ca²⁺-dependent PLA₂ activity appears to be unchanged, iPLA₂β is significantly higher in patient sera relative to control subjects (300). Consistent with these findings, iPLA₂β activity was increased (nearly 45%) in the temporal cortex of patients and proposed to be a causative factor in abnormal fatty acid metabolism and oxidative stress in schizophrenia (302). The increased breakdown in membrane phospholipids due to higher increases in iPLA₂β activity, may be reflected by alterations in neuronal membrane properties leading to hypodopaminergic (303). In contrast, Ca²⁺-dependent PLA₂ activity was decreased in the patients with schizophrenia (302). Another report suggests that increases in serum iPLA₂β activity are only evident in first-episode or acute early phase schizophrenia, and not apparent at chronic stages or in patients experiencing multi-episode schizophrenia (304). Brain samples from epilepsy patients with schizophreniform symptoms also express higher iPLA₂β activity (305). Genetic studies to identify PLA₂ polymorphisms associated with schizophrenia are, however, unclear. While allelic association between *PLA2G6* gene polymorphism has been reported, in the absence of similar links to *PLA2G1A* or *PLA2G1A-D* (sPLA₂s), *PLA2G1A-C* (cPLA₂), *PNPLA3* (iPLA₂ε), or *PNPLA8* (iPLA₂γ) genes (306, 307), others have reported potential association between schizophrenia and *PLA2G1A* (303) and *PLA2G1C* (308).

ALZHEIMER'S DISEASE. This disease is characterized by the polymerization of amyloid β and especially tau proteins, leading to the formation of senile plaques and neurofibrillary tangles, and such polymerization is stimulated by AA and other unsaturated fatty acids (309). All groups of PLA₂s have been proposed to play a role in the development of Alzheimer's disease, which is a leading cause of dementia in the elderly. For instance, sPLA₂s (IIA, V, IVA) are thought to be involved in neuronal death, sPLA₂s (III and X) with neurogenesis, and cPLA₂ and iPLA₂ in both neuronal death and neurogenesis (304). A frontal variant of Alzheimer's disease, in which there is a high occurrence of neurofibrillary tangles in the frontal cortex, is accompanied by a decrease in iPLA₂, but not cPLA₂, activity in the dorsolateral prefrontal cortex (310). This report suggests that this may be a compensatory response to accelerated phospholipid metabolism early in the disorder. Consistently, the predominant PLA₂ activity in rodent hippocampal slices was reported to be manifested by iPLA₂ and to be essential for synaptic plasticity, as reflected in iPLA₂ inhibition studies (311). This was later confirmed in whole animal studies (141), leading to the suggestion that reductions in cPLA₂ and iPLA₂ activities can have adverse effects on memory in patients with Alzheimer's (312). These studies, however, did not distinguish which iPLA₂ (β or γ) isoform activity was critical for the dementia associated

with Alzheimer's. However, a more recent report suggests that the early-onset, but not the later-onset, fronto-temporal type of dementia may be linked to *PLA2G6* mutations (313). Further, sPLA₂, cPLA₂, and iPLA₂ activities were reported to be reduced in serum from patients with bipolar disorders, who have a 5-fold increased risk for developing Alzheimer's disease (314).

PARKINSON'S DISEASE. Selective degeneration of dopaminergic neurons in the substantia nigra has been suggested to be related to low activity of phospholipid catabolic/anabolic enzymes, which may promote the oxidative membrane damage associated with Parkinson's disease that begins at 15–30 years of age (315). Many recessive loci have been linked to Parkinson's disease; however, they all do not associate with the disease. Homozygosity mapping and mutational analyses over the past 5 years reveals a complicated connection with mutations in the *PLA2G6* gene at the *PARK14* locus. Initially recognized in adult-onset parkinsonism (316), *PLA2G6* gene mutations are now linked to levodopa-responsive parkinsonism with severe impairments in swallowing, dystonia, and pyramidal weakness (317, 318), and to autosomal early-onset parkinsonism (313, 318–322). However, studies among Asian populations are conflicting, where a link between *PLA2G6* mutations and Parkinson's disease was reported in Singapore (323), but not in China (324, 325) or Japan (326).

INAD AND NBIA. Infantile neuroaxonal dystrophy (INAD) and neurodegeneration with brain iron accumulation (NBIA) are two additional autosomal recessive neurodegenerative diseases, which begin within 1–2 years of life and are characterized by widespread neurodegeneration that includes psychomotor regression, spasticity, and optic atrophy. INAD is characterized by the presence of axonal spheroids throughout the central and peripheral systems. NBIA patients are a subset of INAD patients with brain iron accumulation and they feature idiopathic neurodegeneration. A potential link between INAD and *PLA2G6* mutations was first reported in two unrelated Bedouin Israeli kindreds (327) and in a 2-year-old boy with psychomotor regression (328), and the pathogenesis is thought to begin prior to birth (329). The accompanying clinical INAD symptoms were found to recapitulate in subsequently generated global iPLA₂β-null mice (330, 331). Screening of DNA from human patients with INAD and NBIA identified 80% of INAD and 20% of NBIA patients with mutations in the *PLA2G6* gene, and neuropathologic changes that were analogous to those associated with Parkinson's and Alzheimer's diseases (332, 333). Studies using iPLA₂β-null mice suggest degeneration of mitochondrial inner membranes and presynaptic membranes (334), reductions in capacitative Ca²⁺ entry in astrocytes (335), point mutation in the Ank repeat producing an inactive iPLA₂β protein (336), and neuro-inflammation and Purkinje cell loss (337) as potential underlying mechanisms that lead to pathogenesis in neurodegenerative disorders associated with brain iron accumulations such as INAD, NBIA (338), Karak syndrome (339), and Parkinson's and Alzheimer's diseases accompanied by iron accumulations. In this regard, it should be noted that common

mutations and combination of mutations in *PLA2G6*-associated neurodegeneration may be associated with Parkinson's and Alzheimer's diseases in the absence or presence of iron accumulations (316, 339–347).

OTHER ROLES IN THE CNS. Additional evidence of iPLA₂β involvement in neurodegenerative disorder include: association of a subset of Shindler's disease in infants with *PLA2G6* mutations (348); elevations in iPLA₂β in patients with bipolar I disorder and a history of psychosis (349); neuro-inflammation and associated neuropathology with motor dysfunction in later life due to iPLA₂β-deficiency (350); and roles for iPLA₂β during early beneficial stages of myelin breakdown following peripheral nerve injury (351) and detrimental demyelination due to spinal cord injury (352), brain endothelial cell migration and proliferation (353), antidepressant-like effects of maprotiline (354), and pro-oxidative signaling related to ethanol-induced neurotoxicity (355).

Cancers. The ability of iPLA₂β to promote cell proliferation becomes prominent in the context of tumorigenesis. Several *in vitro* studies reveal higher expression of iPLA₂β in stimulated immortal cell lines and that chemical inhibition or siRNAs targeted against iPLA₂β reduces proliferation and promotes apoptosis of the cells (97, 108, 125, 356–364). Subsequent studies targeting specific cancers suggest that iPLA₂β promotes cancer cell growth via signal transduction pathways involving epidermal growth factor receptors, MAPKs, E3 ubiquitin-protein ligase mdm2, tumor suppressor protein p53, and cell cycle regulator p21 (365–367). In addition, there is increasing support for a role of iPLA₂β and iPLA₂β-derived LPA in promoting cancer cell proliferation and metastasis.

OVARIAN. A significant number of studies have explored the impact of PLA₂ activation in the context of ovarian cancer development. A potential involvement of cPLA₂ and iPLA₂ activities was recognized in women with endometrial dysfunction, who had a 4-fold increase in PLA₂ activity (368). Studies with ovarian carcinoma cells demonstrated a role for iPLA₂β, but not for cPLA₂, in promoting S and G2/M cell cycle phases, that was independent of p53 (173). BEL prevented these effects, but they were rescued with addition of LPA, and knockdown of iPLA₂β inhibited cell proliferation in culture and tumorigenicity of cancer cell lines in nude mice. Consistent with these findings, tumorigenesis and ascites formation associated with the epithelial ovarian cancer cell line ID8 administration were reduced by nearly 50% in iPLA₂β-null mice, as were the levels of LPA and LPC (370). Such inhibition was elevated to 95% when ID8 cells in which iPLA₂β was knocked down were used, suggesting the importance of iPLA₂β activity in host and tumor cells for cancer progression. Further, LPA, but not LPC, enhanced *in vivo* ascites formation and tumorigenesis in the iPLA₂β-null mice. Similar inhibition of cell adhesion, migration, and invasion of epithelial ovarian cancer cells was demonstrated with a structurally dissimilar iPLA₂β inhibitor, FKGI1 (371), confirming a role for iPLA₂β in these processes. In contrast, reports using nonselective (372) and selective PLA₂ inhibitors combined

with targeted genetic knockdowns (373) suggest that both cPLA₂ and iPLA₂β activities contribute to elevations in LPA and to ovarian cancer development.

OTHER CANCERS. Presently, there are limited numbers of studies linking iPLA₂β activity to development of other cancers; however, this area has experienced growth over the past 5 years. Comparison of LNCaP prostate cancer cells with normal prostate epithelial RWPE-1 cells revealed decreased expression of inhibitory Ank-iPLA₂β, but increases in expression (VIA-1 and -2) and activity of iPLA₂β in the cancer cells. Both inhibition of iPLA₂β with BEL and iPLA₂β knockdown reduced prostate-specific antigen (PSA) secretion from and apoptosis of the cancer cells (374). Exogenous PSA rescued inhibition of apoptosis by BEL, suggesting that iPLA₂β modulates PSA secretion, which in turn provides an autocrine survival function. Inhibition of iPLA₂β, but not iPLA₂γ, in p53-positive LNCaP cells was also found to be associated with activation of p38 and induction of reactive species, which leads to cell cycle arrest and cytostasis (375). Lung tumor growth in an *in vivo* allograft model is promoted by PRDX6, which is a bifunctional protein with glutathione peroxidase (GPx) and iPLA₂β activities (376). Nude mice bearing PRDX6-overexpressing lung cancer cells exhibited increases in tumor size and weight and increased expression of both GPx and iPLA₂β, and these outcomes were inhibited when a mutant PRDX6 was used, suggesting that PRDX6 promotes lung tumor growth via GPx and iPLA₂β. Occurrence of breast cancer is often accompanied by metastasis to the lung and injection of E0771 breast cancer cells in the mouse mammary pads resulted in an 11-fold higher number of breast cancer cells in WT lungs, relative to lungs from iPLA₂β-null mice (377). Further, production of thrombin-stimulated platelet-activating factor in lung endothelial cells was increased in the WT lungs and absent in the iPLA₂β-null mice. Taken together with the finding that inhibition of iPLA₂β, but not iPLA₂γ, prevented increases in PAF in WT cells suggests that iPLA₂β modulation of PAF production is a factor in cancer cell metastasis. Consistent with these findings, cigarette smoke extract increased PAF accumulations and increased cell motility in MDA-MB-231 breast tumor cells, and these effects were mitigated by iPLA₂β inhibition (378). Recently, unicortin, a member of the corticotrophin-releasing factor family, was shown to promote hepatic cancer cell line migration by upregulating cPLA₂ and suppress migration by downregulating iPLA₂β at the transcriptional level (379). Polymorphisms in *PLA2G6* have also been linked to increased risks for colorectal (380) and invasive cutaneous melanoma (381, 382).

Cardiovascular. The myocardial 40 kDa iPLA₂, described as a plasmalogen-selective PLA₂ (3, 118), was inhibited by BEL (146), stabilized by ATP (117), and formed an oligomeric regulatory complex with phosphofructokinase (384). From the collection of related studies, it can be ascertained that iPLA₂β activation in the heart may be beneficial and also detrimental (265, 385, 386). For instance, increases in membrane-iPLA₂ (387) and mitochondrial-iPLA₂ (388) activities were associated with irreversible cell damage

during myocardial ischemia and reperfusion; cardiomyopathy associated with HIV infection may involve an iPLA₂ signaling pathway (389); and iPLA₂β activation contributing to arrhythmogenic conduction slowing due to ischemia in diabetic hearts (390) have been reported. In contrast, iPLA₂ activation or its preference for plasmalogens was evident during global ischemia (391). However, iPLA₂ activation facilitated incorporation of 18:2 into (18:2)₄-cardiolipin to maintain mitochondrial bioenergetics during heart failure (392), protected against oxidant-induced cardiotoxicity (393), and contributed to cardiac endothelial cell production of PGI₂, which manifests protective effects in the heart (394). In Barth syndrome, a metabolic disorder caused by mutations in the mitochondrial transacylase tafazzin that is characterized with disturbances in cardiolipin abundance and molecular species, cardiolipin deacylation by iPLA₂β, but not iPLA₂γ, is thought to play a role (395, 396). There remains some uncertainty about which iPLA₂ isoform is expressed in the myocardium, with both iPLA₂γ (385) and iPLA₂β (265) reported to be the predominant isoform, and their relative contribution to myocardial PLA₂ activity.

iPLA₂β has also been implicated in activation of store-operated Ca²⁺-channels and Ca²⁺ release-activated Ca²⁺-channels in a variety of cells, and it has been suggested that an endogenous calcium influx factor activates iPLA₂β when applied to cell homogenates (397–399). In this context, inhibition of iPLA₂β reduces endothelial agonist-induced intracellular Ca²⁺ release and extracellular Ca²⁺ influx, suggesting that iPLA₂β is an important mediator of vascular relaxation (400).

Inflammatory and autoimmune. iPLA₂β activity has been reported in many components of the immune system, including macrophages (6, 401–404), monocytes (405), neutrophils (406, 407), mast cells (408), and T-cells and

B-cells (409). Much like different immune cells can have differing roles within the immune system; iPLA₂β can have cell-specific roles. Among its proposed roles in macrophages, iPLA₂β has been implicated in playing a major role in free fatty acid accumulation in macrophages (165, 410–412) leading to apoptosis. iPLA₂β, but not cPLA₂, has also been reported to promote macrophage proliferation (413). Interestingly, this phenomenon may be cell-specific, as transfection of a kidney cell line with iPLA₂β reduced cell proliferation (125), whereas, mature T- and B-lymphocytes do not express iPLA₂β and inhibition of iPLA₂β in immature T- and B-cells reduces cell viability and proliferation (409). Altered proliferation may work in tandem with increased apoptosis due to iPLA₂β-derived free fatty acids. Further, iPLA₂β-derived LPC during apoptosis has been reported to promote binding of IgM antibodies to dying cells and promote their clearance (414). Thus, iPLA₂β-derived free fatty acids may have both proliferative and apoptotic effects dependent on the specific cell system and/or stimuli.

More clearly evidenced, however, is the contribution of iPLA₂β in macrophage adhesion during inflammation. The iPLA₂β is required for maintenance of macrophage spreading and adhesion (415). Further, adhesion of macrophages is coupled by iPLA₂β-mediated AA release and 12/15-LO activity on receptors for macrophages within the extracellular matrix, contributing to inflammation by increasing macrophage retention at inflammation sites (416). Interestingly, the lack of iPLA₂β resulted in macrophage buildup late after nerve injury, suggesting iPLA₂β is involved in late state macrophage clearance (351). In support of this phenomenon, macrophage phagocytosis was blunted in iPLA₂β-depleted cells and increased by overexpression of iPLA₂β (417). Furthermore, chemical inhibition of iPLA₂β resulted in decreased macrophage IgG-mediated phagocytosis, which was associated

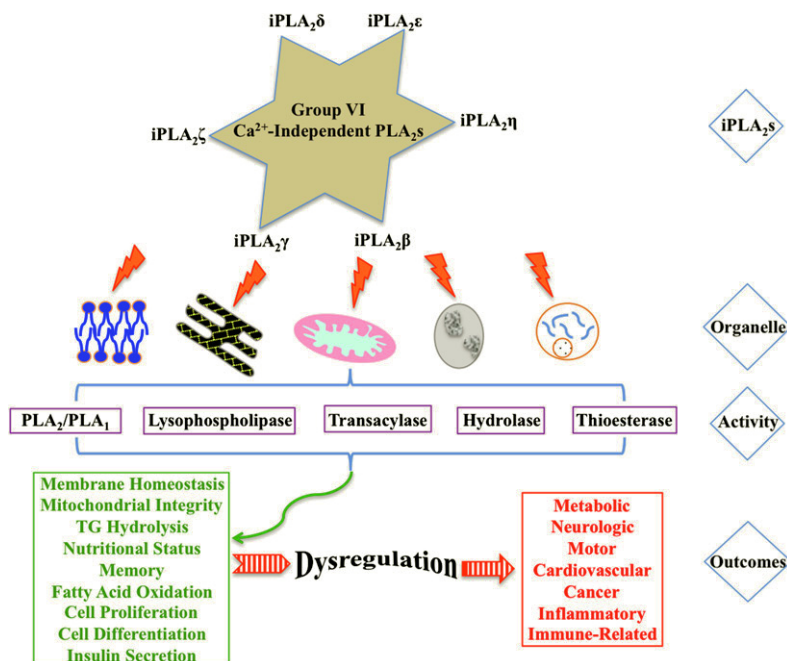


Fig. 2. Biological roles and consequences of iPLA₂ activation. The different isoforms of iPLA₂ (δ, ε, ζ, η, γ, and β) manifest cell/organelle-specific roles by expressing a variety of activities at the plasma membrane, ER, mitochondria, peroxisomes, and nucleus. The outcomes can be homeostatic and beneficial under normal conditions, but when the expression and/or activity are dysregulated (increased or decreased), they can be detrimental and lead to a variety of disorders. While the illustration describes the involvement of iPLA₂s, it might be expected that cPLA₂s and sPLA₂s, in a cell/organelle-specific manner, participate in a sequential manner or in concert with the iPLA₂s to produce the various outcomes.

with decreased AA release from the macrophages (418, 419). Thus, iPLA₂β likely influences macrophage activity, translocation, and attachment to the site of inflammation, and clearance of debris and apoptotic cells at the end of inflammation.


As might be expected, products derived from iPLA₂β activation can participate in inflammatory responses, which are also triggered during development of autoimmune diseases. Several factors, including ER stress (420, 421), ROS (422, 423), and NF-κB (424, 425), contribute to inflammatory diseases (i.e., autoimmune, metabolic, cancers, rheumatoid arthritis). NADPH oxidases generate ROS and cytokines induce it in a 12-LO product-dependent manner (230). ROS induce iPLA₂β (82, 426–432) and ROS generation is increased in neutrophils by iPLA₂β activation (433) and reduced in macrophages with iPLA₂β deficiency (434). Various stresses activate NF-κB (435–438), and iPLA₂β likely modulates NF-κB via ROS generation (439). ROS subsequently induce the chemoattractant, MCP-1 (434), raising the possibility that there is crosstalk between NF-κB and iPLA₂β. Further, chemotaxis in response to MCP-1 requires iPLA₂β activation (440). It has been suggested that iPLA₂β activity drives the initial inflammatory response through synthesis of PGE₂, LTB₄, and IL-1β, and that sPLA₂s and cPLA₂ are activated during the resolution phase (441).

The development of FK reversible inhibitors is facilitating testing the impact of PLA₂s in autoimmune diseases. Comparisons of earlier generation FKVK11 (iPLA₂) and FKVK2 (strong pan) with cPLA₂ inhibition in an experimental autoimmune encephalomyelitis animal model of multiple sclerosis revealed that cPLA₂ was involved in early onset, iPLA₂β-deficiency in the onset and progression, and sPLA₂ in later remission stages of experimental autoimmune encephalomyelitis (158).

Metabolic. Studies in iPLA₂β-null mice revealed that while fasting and fed blood glucose are unchanged from WT mice, iPLA₂β-null mice develop more severe hyperglycemia than WT mice after administration of multiple low doses of streptozotocin (144). This led to the suggestion that iPLA₂β results in an impaired ability to compensate for metabolic stresses. Consistent with this, high-fat diet exacerbates glucose tolerance in the iPLA₂β-null mice, relative to WT mice. However, in spite of a global iPLA₂β-deficiency, these mice do not develop dyslipidemia in response to high-fat diet (442).

CONCLUDING COMMENTS

In addition to the above-discussed iPLA₂s, other smaller mass isoforms with different substrate preferences and susceptibility to BEL have been reported in the kidney (443, 444) and rat parotid gland (445). It is likely that continued studies will reveal additional novel iPLA₂ activities that are products of different genes or are generated via alternate splicing or proteolytic cleavage of the currently identified isoforms. Regardless, it is clear that

the iPLA₂s participate in numerous biological processes and that modulation of their cell and/or organelle-specific expression or activity can have profound beneficial or detrimental consequences on membrane integrity and signal transduction. As global and tissue-specific iPLA₂-KO or Tg models continue to be developed, so will our understanding of the specific roles of iPLA₂s in vivo. Studies incorporating genetic analyses will no doubt aid in identifying further associations between diseases and polymorphisms in the iPLA₂ genes. While the focus of this review is on iPLA₂s, it is readily apparent that cPLA₂s and sPLA₂s may act sequentially or in concert with iPLA₂s in a cell/organelle-specific manner to produce relevant effects, and this should be a consideration in further exploration of the roles of PLA₂ in biological processes. Over the past decade, important links between iPLA₂ dysregulation and various diseases have come to the forefront, as illustrated in **Fig. 2**, and with continued studies of this family of PLA₂s, a greater understanding of the importance of iPLA₂-derived lipid signaling in disease development can be attained and this will facilitate identification of novel pathways that can potentially be targeted for drug therapy. Herein, every attempt was made to provide a comprehensive current understanding of iPLA₂s and omission of any relevant citations was unintentional. Readers interested in further elaboration of the areas addressed here are directed to other reviews (1, 153, 289, 291, 365–367, 447–451). 

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