

Effects of Therapeutic Plasma Exchange on the Endothelial Glycocalyx in Septic Shock

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Abstract

Background

Disruption of the endothelial glycocalyx (eGC) is observed in septic patients and its injury is associated with multiple-organ failure and inferior outcomes. Besides this biomarker function, increased blood concentrations of shedded eGC constituents might play a mechanistic role in septic organ failure. We hypothesized that therapeutic plasma exchange (TPE) against fresh frozen plasma might influence eGC related pathology.

Methods

We enrolled 20 norepinephrine dependent ($NE > 0.4\mu\text{g}/\text{kg}/\text{min}$) patients with early septic shock (onset $< 12\text{h}$). Sublingual assessment of the eGC via sublingual sidestream darkfield (SDF) imaging was performed. Plasma eGC degradation products such as heparan-sulfate (HS) and the eGC regulating enzymes, heparanase (Hpa)-1 and Hpa-2, were obtained before and after TPE. A 3D microfluidic flow assay was performed to examine the effect of TPE on eGC *ex vivo*. Results were compared to healthy controls.

Results

SDF demonstrated a marked decrease in eGC thickness in septic patients compared to healthy individuals ($p=0.001$). Circulating HS levels were increased more than six-fold compared to controls and decreased significantly following TPE (controls: 16.9 (8-18.6) vs. septic patients before TPE: 105.8 (30.8-143.4) $\mu\text{g}/\text{ml}$, $p<0.001$; vs. after TPE: 70.7 (36.9-109.5) $\mu\text{g}/\text{ml}$, $p<0.001$). The Hpa-2 /Hpa-1 ratio was markedly reduced in septic patients before TPE but normalized after TPE (controls: 13.6 (6.2-21.2) vs. septic patients at inclusion: 2.9 (2.1-5.7), $p=0.001$; vs. septic patients after TPE: 13.2 (11.2-31.8), $p<0.001$). *Ex vivo* stimulation of endothelial cells with serum from septic patients induced eGC damage that could be attenuated with serum post TPE.

Conclusions

Septic shock results in profound degradation of the eGC and an acquired deficiency of the protective regulator Hpa-2. TPE removed potentially injurious eGC degradation products and partially attenuated Hpa-2 deficiency.

Trial registration

clinicaltrials.gov NCT04231994, retrospectively registered 18 January 2020

Background

Sepsis is a life-threatening organ dysfunction caused by a dysregulated host response to infection. Septic shock features refractory volume resuscitation and serum lactate elevation (1), commonly ending in death (2). It has been recognized that global endothelial dysfunction, in particular breakdown of the vascular barrier, represents a cornerstone in the development of multi-organ failure in sepsis (3). The endothelial glycocalyx (eGC), a gel-like structure of glycosaminoglycans and proteoglycans covering the entire luminal surface of the endothelium, contributes to the maintenance of vascular hemostasis including tone and permeability as well as inflammation and coagulation (4). Disruption of this highly dynamic structure is observed early in sepsis, and the resultant eGC injury is strongly associated with later multi organ failure and inferior outcomes (5-7). Heparanase-1 (Hpa-1) is the enzyme primarily responsible for the injurious degradation of the major eGC component, heparan-sulfate (HS) and is upregulated in sepsis (8). By contrast Heparanase-2 (Hpa-2), a protein that has been described as a protective antagonist of Hpa-1 (9, 10), is suppressed in murine sepsis models (11), suggesting imbalance of eGC regulating proteins in sepsis. Furthermore, increased levels of shedded HS degradation products into the circulation are not only biomarkers of glycocalyx injury but also can act as disease mediators, namely the so-called *Damage associated molecular patterns* (DAMPs). DAMPs directly contribute to sepsis associated organ failures such as cardiomyopathy (12) and encephalopathy (13). Therapeutic measures against sepsis morbidity and mortality are limited to anti-infective drugs and organ support (14). So far, no specific intervention targeting endothelial dysfunction, including eGC degradation, exists to the present time. We recently showed that therapeutic plasma exchange (TPE) could serve as an adjunctive treatment strategy in early and severe septic shock (15). The positive effects (15) could be related to removal of deleterious components or replacement of protective plasma proteins consumed by the disease process (16, 17).

Here, we hypothesize that TPE against plasma from healthy donors might 1) remove products of eGC shedding that serve as important injurious DAMPs (e.g. HS) and 2) simultaneously compensate deficiency of protective Hpa-2 to attenuate dysbalance of eGC regulation enzymes. In this study, we therefore investigated the effect of a single TPE against FFPs on key constituents of the eGC as well its regulating enzymes in the blood of patients with early and severe septic shock. Additionally, quantitative sublingular sidestream darkfield (SDF) imaging *in vivo* as well as microvascular perfusion studies in an *ex vivo* endothelial microfluidic chip model, were undertaken to test our hypothesis.

Methods

Study population

This study was a post hoc analysis from a subset of patients included in both a single center non-randomized study (15) and a recently concluded randomized study (NCT04231994, accepted for publication, unpublished). Data and bio-samples were acquired from patients receiving TPE directly before and after the TPE procedure and results were further compared to healthy individuals used as controls. In total, we screened 1.427 patients submitted to our 14-bed medical ICU from July 2016 to March 2019 for the presence of sepsis per SEPSIS-3 definition (1). Of the 45 patients included in both

studies, we finally analyzed a subgroup of 20 patients, all of whom received additional TPE treatment and provided sufficient blood sample volumes for all further analysis steps (**Figure 1**). All patients were treated according to the 2016 Surviving Sepsis Campaign (SSC) guidelines. Patients were included based on: (i) septic shock with need for vasopressors <24 h prior to entry, and (ii) profound systemic hypotension requiring norepinephrine (NE) doses of > 0.4 µg/kg/min despite adequate intravenous fluid resuscitation (≥ 30 ml/kg bodyweight crystalloids). As non-inclusion criteria, we defined unavailability of TPE within first six hours after study inclusion, pregnancy or breast feeding, age <18 years, end-stage chronic disease, and presence of a directive to withhold life-sustaining treatment. The ethical committee of Hannover Medical School approved both study protocols (EK 2786-2015 and EK 8852_MPG_23b_2020) and written informed consent was obtained from participants or authorized representatives. The study was performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. Demographic and clinical data were obtained immediately at study inclusion before TPE.

TPE

Vascular access was established by venous insertion of an 11-French two-lumen hemodialysis catheter. TPE was performed in a singular treatment session against a fixed dose of 12 units of FFP. Anticoagulation during TPE was achieved by regional citrate infusion. In patients with acute kidney injury (AKI), hemodialysis was interrupted for the duration of TPE. Blood samples were drawn before and after TPE. NE dose was titrated every 10-15 min to maintain a mean arterial pressure (MAP) above 65mmHg.

Data and sample collection

Patient plasma and serum blood samples were acquired before and after TPE. For comparison we used plasma and serum from healthy human donors without preexisting serious medical conditions after written informed consent. No personal or identifying information were collected from study participants. All samples were stored at -80 degree Celsius until use. All personal patient data were anonymized before further analysis. Data were collected using electronic medical records including the patient data monitoring system (PDMS) m.life (Version 10.5.0.71, medisite GmbH, Berlin, Germany). Sequential Organ failure assessment (SOFA) scores were calculated according to the description by Vincent et al (18).

Assessment of the eGC thickness *in vivo*

The eGC thickness was assessed non-invasively using a SDF camera (CapiScope HVCS, KK Technology, Honiton, UK) coupled with the GlycoCheck™ software. The software automatically detects microvessels with diameters between 5 and 25 µm and records eGC thickness, determined by analysis of the dynamic lateral movement of red blood cells into the permeable part of the eGC layer expressed as the *Perfused boundary region* (PBR) (in µm). All measurements were performed at the time of blood sampling by observers experienced in the method as described before (6).

Enzyme-linked immunosorbent assays

ELISAs specific for Heparanase-1 (amsbio, #EA1340Hu) and Heparanase-2 (amsbio, #E5389Hu) were performed in plasma samples. All samples were measured using a Tecan absorbance microplate reader (Sunrise, #F039300) at 450nm. All measurements were performed in duplicates.

Glycosaminoglycan Isolation and Purification

The plasma samples were diluted 1:1 in 0.1 M K_2HPO_4 (pH 8.0) and then subjected to proteolysis with 100 μ g/ml proteinase K (Sigma-Aldrich, Darmstadt, Germany) at 56 °C for 24 h. Afterwards, the samples were heated at 90 °C for 10 min and filtrated on Ultrafree-MC filters (0.22 μ m membrane) at 12 000 g for 10 min. Filtrates were recovered, mixed with equal amounts of 1.5% sodium nitrate and 33% of acetic acid, and incubated at room temperature with gentle shaking for 1 h. The reaction was stopped by the addition of 12.5% ammonium sulfate (half of a total sample volume). Subsequently, the samples were transferred to the tubes containing saline and Triton X-100 (final concentration 1%), vigorously shaken at room temperature for 30 min and then cooled down to 4 °C using ice bath. Finally, the samples were supplemented with trichloroacetic acid to the final concentration of 10% at incubated at 4 °C for additional 10 min, followed by centrifugation at 12.000 g for 10 min and washing with chloroform. The aqua phase was dialyzed (3500 MWCO) against buffer containing 40 mM ammonium acetate and 3 mM $CaCl_2$ (pH 6.8) for 16h. The glycosaminoglycans were collected and either directly subjected to digestion or lyophilized.

Enzymatic Digestion of Glycosaminoglycans and Liquid chromatography – Mass spectrometry (LC-MS) Analysis

The glycosaminoglycans were digested with 0.1 U/ml chondroitin lyase ABC (Sigma-Aldrich, Darmstadt, Germany) in 40 mM ammonium acetate and 3 mM $CaCl_2$ (pH 6.8) at 37 °C overnight. The digestion products were recovered by centrifugal filtration (3500 MWCO) and freeze-dried for LC-MS analysis. Alternatively, glycosaminoglycans were treated with 1 U/ml of heparinase enzymes (Iduron, ALderley Edge, United Kingdom) at 30 °C for 10 h or with 60 U/ml hyaluronidase (Sigma-Aldrich) 37 °C for 6 h. Derivatization of unsaturated disaccharides with 2-Aminoacridone (AMAC) and LC-MS analysis were performed as previously described (19).

Microfluidic experiments

Microfluidic chips were fabricated of polydimethylsiloxan (PDMS) (Sylgard 184, Dow Corning) by replication of the polymeric master as described by our group previously (11). Naive human microvascular endothelial cell (HMEC-1) line (ATCC) were incubated under flow conditions (38.75 dyn/cm^2) for 5 days before the experiments. Cells were treated with MCDB131 medium supplemented with 20% patient (either collected before or directly after TPE) or control serum for 6 hours under flow conditions. Confocal microscopy was then performed using Leica TCS-SP2 AOBS confocal microscope (Leica Microsystems) at the Core Facility for Laser Microscopy at Hannover Medical School. All the images were taken with oil-immersed x63 objective, NA 1.4. Series of z-scans were processed and

quantified using ImageJ software. 3D reconstruction of the eGC structure was performed using Leica LasX software.

Statistical analysis

Data were presented as median with interquartile range (IQR). Two-tailed p values of less than 0.05 were considered to indicate statistical significance. Paired t-test or Wilcoxon-test (as appropriate) was utilized in order to compare longitudinal values before (pre) and after (post) TPE. Unpaired t-test and Mann-Whitney-test (for not normal distributed variables) were employed to compare unpaired values. We used GraphPad Prism 7 (Graph Pad, La Jolla, CA, USA) and SPSS Statistics Version 25 (SPSS Inc., Chicago, IL, USA) for data analysis and graph generation.

Results

Cohort characterization

Demographic and clinical details are summarized in **Table 1**. Eighty percent of the patients were men, and the median (IQR) age was 53 (34-59) years. Lungs and the abdomen were the most common sites of infection. A causative pathogen was identified in 65% of the cases. Gram negative and positive pathogens were most commonly identified and in 10% more than one pathogen was detected. All patients were treated with a combination of broad-spectrum antibiotics. Median (IQR) SOFA score was 18 (15-19). All patients were in severe shock indicated by high NE doses and lactate concentrations at study inclusion. Patients displayed signs of severe hyper-inflammation as indicated by high levels of C-reactive protein (CRP) and procalcitonin (PCT). Ninety percent were mechanical ventilated and had an oxygenation index (P_{aO_2} / FiO_2) of 130 (117-189). AKI with need for renal replacement therapy (RRT) was present in 65% of the patients at time of inclusion.

Assessment of endothelial glycocalyx thickness *in vivo*

We quantified the size of the individual patients' eGC in the sublingular microvasculature using an indirect surrogate termed PBR. The larger the PBR (i.e. the diameter where the blood cells move in a micro-vessel) the smaller the thickness of the eGC. We found (**Figure 2**) a marked decrease in the thickness of the eGC in septic patients compared to healthy individuals indicated by increased PBRs (Median (IQR) PBR for controls: 1.88 (1.82-1.93) μm vs. septic patients at inclusion: 2.18 (2.06-2.48) μm , $p=0.001$).

Effect of TPE on products of endothelial glycocalyx shedding

Three key constituents of the eGC were investigated in the patients' blood employing mass spectroscopy analysis (**Figure 3**). Chondroitin sulfate (CS) concentrations (**Figure 3A**) were increased at study inclusion compared to healthy controls and demonstrated a trend towards reduction following TPE (controls: 7.1 (6.3-7.7) $\mu\text{g/ml}$ vs. septic patients at inclusion: 9.3 (6.5-35.5) $\mu\text{g/ml}$, $p=0.005$; vs. septic patients after

TPE: 8.5 (6-30.8) $\mu\text{g/ml}$, $p=0.078$). HA (**Figure 3B**) was markedly increased in septic individuals and reduced by more than half following TPE (controls: 10.1 (5.8-17.4) ng/ml vs. septic patients at inclusion: 1476 (188.3-3834) ng/ml , $p<0.001$; vs. septic patients after TPE: 652.9 (146.1-1592) ng/ml , $p<0.001$). Comparable, HS (**Figure 3C**) concentrations were increased more than six times compared to controls and were decreased by about a third following a single TPE treatment (controls: 16.9 (8-18.6) $\mu\text{g/ml}$ vs. septic patients at inclusion: 105.8 (30.8-143.4) $\mu\text{g/ml}$, $p<0.001$; vs. septic patients after TPE: 70.7 (36.9-109.5) $\mu\text{g/ml}$, $p<0.001$).

Effect of TPE on regulating enzymes of the endothelial glycocalyx

The key glycocalyx sheddase Hpa-1 (**Figure 4A**) was decreased in septic shock patients compared to controls and increased following TPE (controls: 1.8 (1.2-2.7) ng/ml vs. septic patients at inclusion: 1 (0.9-1.3) ng/ml , $p<0.001$; vs. septic patients after TPE: 1.3 (1.2-1.7) ng/ml , $p<0.001$). Even more noticeable, the Hpa-1 counterpart, Hpa-2 (**Figure 4B**), was markedly reduced by 85% in septic patients compared to non-septic individuals and was substituted by TPE treatment reaching normal blood concentrations following TPE (controls: 16.7 (10.6-31.1) U/ml vs. septic patients at inclusion: 2.5 (2.2-5.9) U/ml , $p<0.001$; vs. septic patients after TPE: 19.7 (13.8-39.8) U/ml , $p<0.001$). Consequentially, the ratio of Hpa-2 to Hpa-1 (**Figure 4C**) concentration was markedly reduced in septic patients before TPE and normalized after TPE (controls: 13.6 (6.2-21.2) vs. septic patients at inclusion: 2.9 (2.1-5.7), $p=0.001$; vs. septic patients after TPE: 13.2 (11.2-31.8), $p<0.001$).

In-vitro recapitulation and verification

To demonstrate that the degradation of the eGC induced by septic serum might be attenuated following TPE treatment, we used a microfluidic chamber with cultured endothelial cells under flow over 3 days that synthesize an intact and stable eGC under *in vitro* conditions. After stimulation with serum from septic patients before and after TPE treatment or control serum, the eGC was visualized by confocal microscopy followed by computerized 3D reconstruction (**Figure 5A**). Its thickness is then quantified by analyzing the HS positive area. We found that stimulation with serum from patients with septic shock before TPE was sufficient to severely damage the eGC indicated by a markedly reduced HS positive area on the surface of endothelial cells (**Figure 5A**). The HS positive area (**Figure 5B**) was reduced by 37% compared to healthy controls ($p = 0.003$). Consistent with our hypothesis that TPE treatment replenishes the deficit in protective Hpa-2 in septic patients, we observed that loss of HS positive area on endothelial cells was attenuated following perfusion with serum collected from patients after receiving TPE (**Figure 5A**). Quantitative analysis demonstrated a trend towards higher HS surface areas when stimulation with serum collected pre- ($3.7\pm 1.4\%$) and after ($6.2\pm 3.7\%$) TPE were compared ($p = 0.086$ for pre vs. post-TPE, $p = 0.948$ for post-TPE vs. control, **Figure 5B**).

Discussion

We investigated the effects of early TPE on the eGC in septic shock. Patients included in this investigation experienced a severe form of septic shock as indicated by high NE requirement,

inflammatory markers and a high prevalence of multi-organ failure. We found that a single and early TPE had a profound effect on multiple different eGC related parameters in these patients and report several important findings.

First, we could confirm a profound decrease in eGC thickness indicating shedding of the eGC in septic patients compared to healthy controls by *in vivo* SDF measurement. PBR values in this cohort were in line with previous observations made in septic patients (20). Of note, median PBR values were exclusively found in a range that was previously demonstrated to correlate with a poor survival in sepsis patients, namely a value above 1.97 μm (21).

Second, three key constituents of the eGC, notably CS, HA and HS, were increased in the circulation of septic shock patients and could be eliminated by TPE. Among them, CS was only mildly increased, which is in line with previous observations (22) (19). In contrast, both HA and HS were substantially elevated in patients with sepsis. Considering the severity of septic shock in this cohort, these results reproduce previous observations that have closely correlated both HA and HS concentration to the severity of multi-organ dysfunction and mortality (6). Importantly, HA and HS, beyond being biomarkers of disease severity, have further been suggested to possess direct pathophysiological significance. HA causes amplification of the pro-inflammatory response through Toll-like receptor-4 (TLR4) (23, 24). HS aggravate systemic septic inflammatory reaction by increasing signaling through TLR4 (11, 25) and stabilization of interferon-gamma (26), potentially contributing to distant organ failure such as septic cardiomyopathy (12, 27). Additionally, septic encephalopathy may be aggravated by direct binding of HS to important protective neurotransmitters causing depletion of those within the central nervous system (13, 28). Here, we could demonstrate that TPE might be an effective tool to rapidly eliminate circulating HA and HS in septic patients.

Third, TPE attenuated an acquired dysbalance of essential eGC regulation enzymes. The process of eGC degradation leading to subsequent appearance of toxic shedding products in the patients' blood is closely regulated by specific enzymes. We investigated whether or not TPE could also affect these underlying regulatory enzymes. As HS is the most abundant constituent of the eGC and its role as a toxic DAMP has been described most extensively, we chose to focus on HS. Hpa-1 is primarily responsible for degradation of HS chains, and its enzymatic activity was increased in septic pulmonary (5) and renal (7) failure. While some previous reports found the concentration of Hpa-1 increased (12) in the blood of septic patients, others observed reduced blood concentrations of Hpa-1 (29). In our study, Hpa-1 concentrations were significantly reduced compared to healthy controls. Given the close binding of Hpa-1 within the HS rich layer eGC on inflammatory stimuli (30), one could speculate that a reduced Hpa-1 blood concentration might indicate an increased shift of Hpa-1 from the soluble compartment to the eGC layer leading to increased shedding of HS.

Previous observations found the protective antagonist, termed Hpa-2, to be depleted in septic mice blood and renal tissue (11). Here, we confirm these pre-clinical findings for the first time in septic patients. An analogous role of acquired Hpa-2 deficiency in critical ill Covid-19 patients has been recently reported by

our group (31). In the present study, TPE did not only replenish deficient Hpa-2 but completely corrected the dysbalanced ratio of protective Hpa-2 to injurious Hpa-1. We speculate that correcting the balance of regulating mediators of critical HS content might translate into improved eGC stability under septic conditions. This observation suggests that TPE might evolve its therapeutic potential in sepsis not only by removing injurious molecules but also by replacing consumed protective factors. A similar state-of-affairs has been demonstrated earlier for anti-coagulatory proteins (16, 17).

Finally, we applied a 3D *ex vivo* model using septic serum. This stimulus was sufficient to severely damage the eGC in a microfluidic chamber with cultured endothelial cells that synthesize an intact and stable eGC under *in vitro* conditions. Stimulation of this complex *ex vivo* cellular system with septic serum led to an acute degradation of HS. We suggest that this model represents an experimental correlate of the shedding exhibited by our patients. When we used serum from the same septic shock patients after TPE was performed, the eGC was protected in this *in-vitro* model.

Together, these observations suggest that TPE might reduce eGC shedding by rebalancing the homeostasis between Hpa-1/Hpa-2.

This study has important limitations, mainly its small sample size. In addition, the intervention was administered at a fixed dose, which precludes us from providing data on effects at different dosages or time frames. Given the post-hoc nature of this analysis, longitudinal assessment of glycocalyx related parameters was not possible. For instance, PBR was not analyzed in the following days when *de novo* synthesis might have generated novel glycocalyx sugars. The restoration of a hydrodynamically relevant glycocalyx layer *in vivo* requires about 7 days (32). It is therefore not to be expected that eGC thickness can improve within a short period of time.

Conclusions

In this prospective exploratory trial, severe septic shock was associated with increased eGC shedding and an acquired deficiency in protective Hpa-2. Early TPE treatment partially attenuated this imbalance by removing potentially injurious shedding products and by replacing the eGC stabilizing enzyme Hpa-2. Whether or not an appropriately powered randomized controlled trial TPE might improve outcome in septic patients remains to be determined.

Abbreviations

AKI = Acute kidney injury

BMI = Body mass index

CRP = C-reactive protein

CS = Chondroitin sulfate

DAMPs = Damage associated molecular patterns

eGC = endothelial Glycocalyx

HS = Heparan sulfate

Hpa-1 = Heparanase-1

Hpa-2 = Heparanase-2

FFP = Fresh frozen plasma

HA = Hyaluronic acid

LC-MS = Liquid chromatography – Mass spectrometry

MAP = Mean arterial pressure

NE = Norepinephrine

PBR – Perfused boundary region

PCT = Procalcitonin

RCT = Randomized controlled trial

RRT = Renal replacement therapy

SDF = Sublingual sidestream darkfield

SOFA = Sequential Organ Failure Assessment

TPE = Therapeutic plasma exchange

Declarations

Ethics approval and consent to participate

The ethical committee of Hannover Medical School approved protocols of both studies (EK 2786-2015 and EK 8852_MPG_23b_2020), and written informed consent was obtained from participants or authorized representatives. The study was performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

Consent of publication

Not applicable

Availability of data and material

The datasets used and analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interest.

Funding

No funding was received.

Authors contributions

KS collected clinical data from the PDMS, calculated statistics and generated the figures for publication. UCH, AS, MW and YK performed the laboratory experiments. BMWS was the leading nephrology consultant coordinating and performing the plasma-exchange on our unit. JJS, BS, HS and PAG recruited patients. KS, UCH, HS, CB, SD, HH and MMH interpreted data. KS and SD wrote the manuscript. SD and KS had the original idea for both trials and wrote the proposals. All authors read and approved the final manuscript.

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Tables

Table 1: Demographic and clinical characteristics at study inclusion	
Category	Median (IQR) / n (%)
Age - yr	53 (34-59)
Sex - no (%)	
male	16 (80)
female	4 (20)
BMI - kg/m ²	27.8 (21.9-32.6)
Sepsis onset - no (%)	
ambulatory	14 (70)
hospital acquired	6 (30)
Side of infection - no (%)	
lung	14 (70)
abdomen	3 (15)
urogenital	1 (5)
soft tissue	1 (5)
more than one	1 (5)
identified pathogen - no (%)	
gram+	3 (15)
gram-	6 (30)
fungi	1 (5)
viral	1 (5)
more than one	2 (10)
non identified	7 (35)
SOFA	18 (15-19)
Norepinephrine dose (µg/kg/min)	0.734 (0.564-1.206)
CRP (mg/l)	267 (151-325)
PCT (µg/l)	24 (9-99)
Lactate (mmol/l)	6.6 (2.6-11.3)
Mechanical ventilation - no (%)	18 (90)

Oxygenation index (PaO ₂ /FiO ₂)	130 (117-189)
Renal replacement therapy - no (%)	13 (65)

ABBREVIATIONS:

BMI – body mass index, SOFA - Sequential Organ Failure Assessment, CRP – C-reactive protein, PCT – procalcitonin

Figures

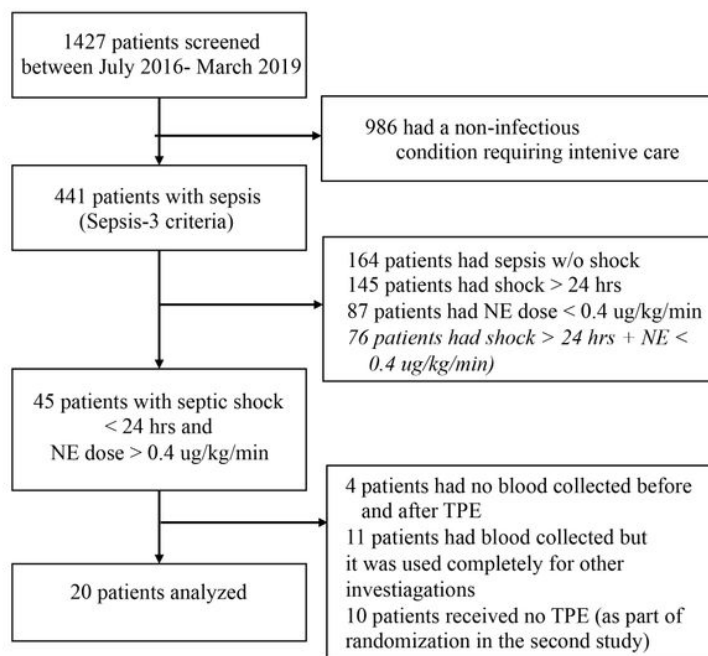


Figure 1

Flow chart of study participants. NE depicts norepinephrine and TPE therapeutic plasma exchange.

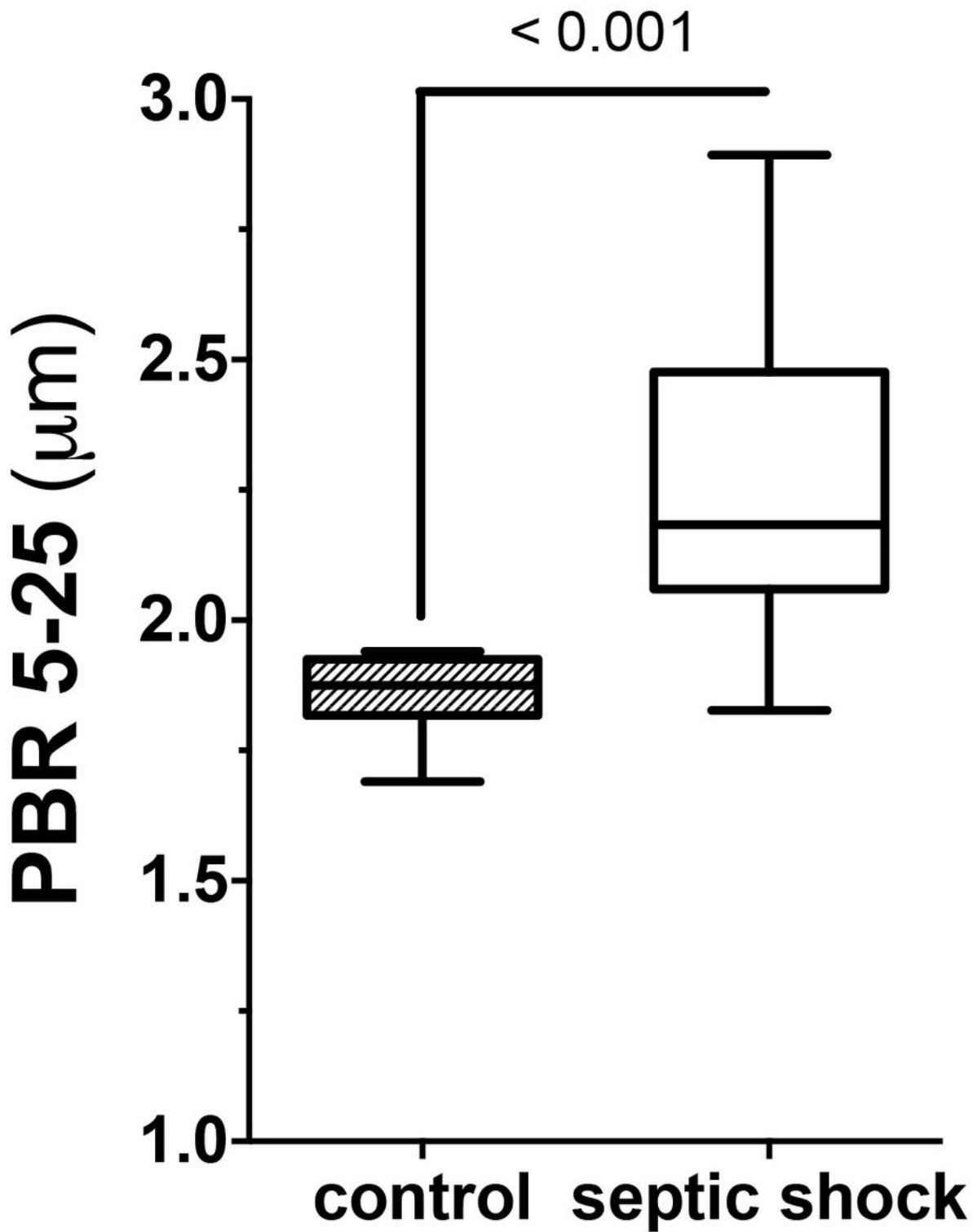


Figure 2

Injury to the endothelial glycocalyx (eGC) in-vivo. Sublingual dark field imaging in patients allows quantification of the eGC thickness as indicated by the Perfused Boundary Region (PBR). Box and whisker blots showing results for healthy controls (n=10) as well as patients with septic shock before (pre) (n=11) and directly after (post) (n=11) Therapeutic Plasma Exchange (TPE).

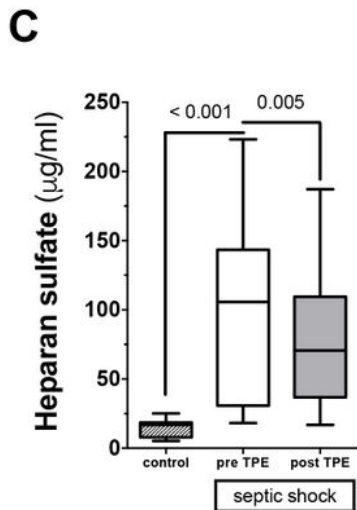
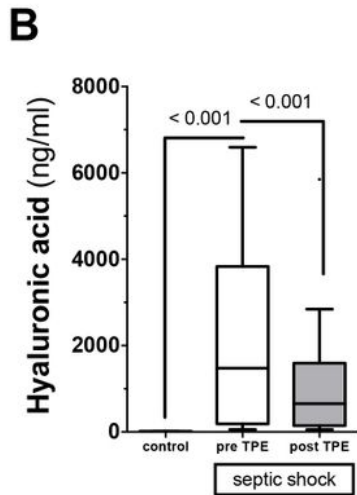
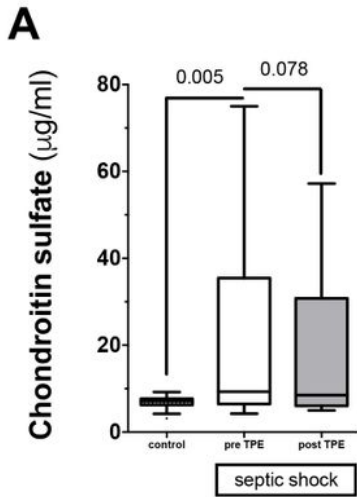


Figure 3

Effect of Therapeutic plasma exchange (TPE) on glyocalyx shedding products. Box and whisker blots showing blood concentrations of Hyaluronic acid (HA) (A), Chondroitin sulfate (CS) (B) and Heparan sulfate (HS) (C) for healthy controls (n=20) as well as patients with septic shock before (pre) (n=20) and directly after (post) (n=20) TPE.

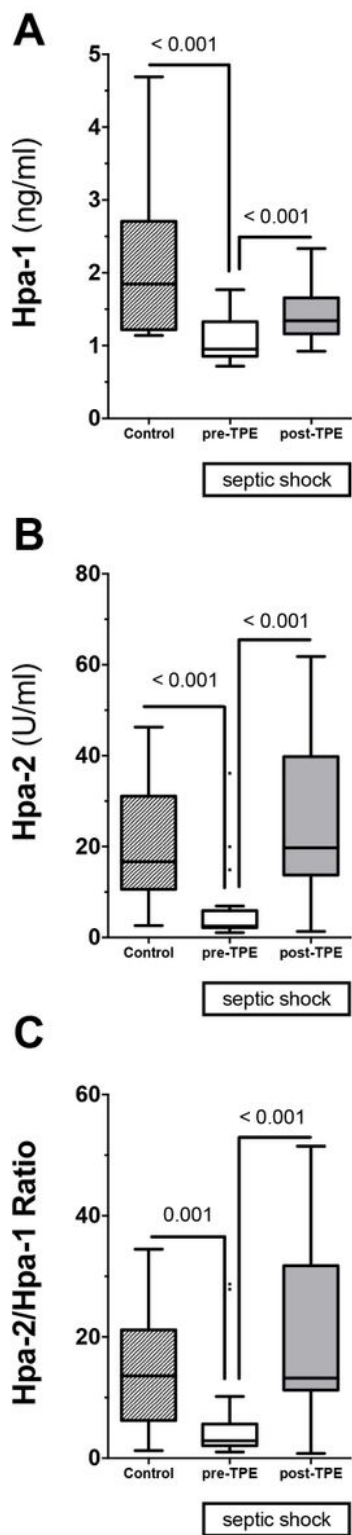


Figure 4

Effect of Therapeutic plasma exchange (TPE) on key regulating enzymes of the endothelial glycocalyx (eGC). Box and whisker blots showing blood concentrations of circulating Heparanase-1 (Hpa-1) (A), Heparanase-2 (Hpa-2) (B) as well as the ratio of Hpa-2 to Hpa-1 (C) for healthy controls (n=18) as well as patients with septic shock before (pre) (n=20) and directly after (post) (n=20) TPE.

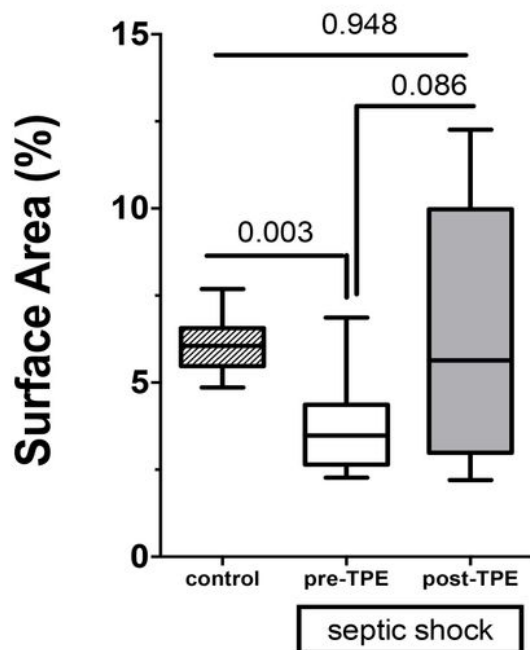
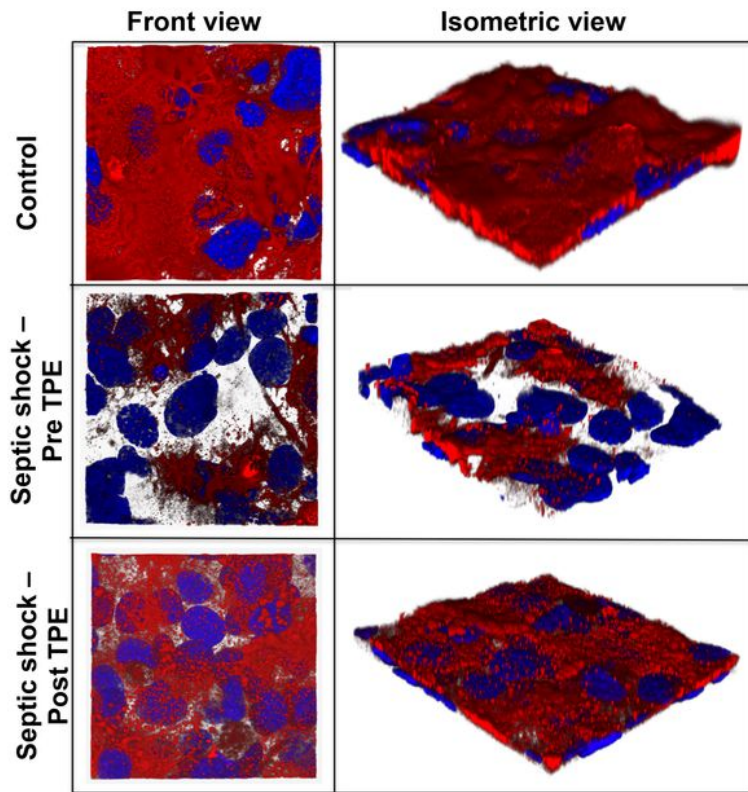


Figure 5

Ex vivo stimulation of 3D microvessels with septic serum before and after Therapeutic Plasma Exchange (TPE). Exemplary 3D reconstruction of the heparan sulfate (HS) layer images of naive endothelial cells in a microfluidic chip (HS in red, DAPI nuclei staining in blue) after perfusion with serum and incubation overnight of a septic patient both before and after TPE compared to a healthy control (A) and quantification of the HS positive surface area as box and whisker blots (B).