CLINICAL STUDY

Serum activin A and follistatin in disorders of spermatogenesis in men

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Abstract

Objective: Inhibin, activin and follistatin are glycoprotein hormones produced by the gonads. Recent studies have shown that inhibin B is the predominant form of inhibin in the circulation in men. The objective of this study was to investigate circulating levels of activin A and follistatin in disorders of spermatogenesis in men and their relationship with FSH and inhibin B.

Design and method: Serum from five different groups of men was prospectively collected and stored at −20 °C. The groups were men with: (i) proven fertility (controls) n = 20, (ii) primary testicular failure n = 15, (iii) obstructive azoospermia n = 10, (iv) oligospermia n = 10 and (v) miscellaneous sperm dysfunction n = 40. WHO criteria (1992) were used for semen characteris- tisation. Serum concentrations of ‘total’ activin A, follistatin, FSH and inhibin B were measured using specific two-site enzyme immunoassays.

Results: Activin A levels were significantly lower than in the controls in the obstructive azoospermia group and higher in the miscellaneous sperm dysfunction group. Serum follistatin levels did not significantly vary in any group compared with the controls. Circulating levels of FSH were higher than in the controls in the primary testicular failure and obstructive azoospermic group. Levels of inhibin B were lower than in the controls in all disorders of spermatogenesis studied.

Conclusion: This study demonstrates that activin A and follistatin are in the circulation in males and activin A levels are significantly lower in obstructive azoospermia and higher in miscellaneous sperm dysfunction than in controls. The mechanism involved in altering the levels of activin A in these conditions is not clear. However, high follistatin:activin A molar ratios (>2.5) in all groups suggests that all activin A in the circulation is bound to follistatin in males.

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Introduction

Inhibins are gonadal glycoprotein hormones consisting of alpha and beta subunits linked by disulphide bridges. Inhibin A is an α–βA dimer and inhibin B is an α–βB dimer. Activins are homodimers of beta subunits linked by disulphide bridges. Activin A is a βA–βA dimer, activin AB is a βA–βB dimer and activin B is a βB–βB dimer. Follistatin is a single chain glycoprotein.

Inhibins, activins and follistatin have been implicated in the endocrine regulation of pituitary follicle-stimulating hormone (FSH). Inhibins and follistatin have an inhibitory effect on pituitary FSH secretion, while activins have a stimulatory effect. Follistatin is also a high-affinity activin-binding protein that regulates the bio-availability of activins.

Development of specific enzyme immunoassays (EIAs) for inhibin A (1, 2), inhibin B (3), activin A (4), activin AB (5) and follistatin (6) has facilitated the measurement of different molecular forms of inhibins, activins and follistatin. Recent studies have shown that inhibin B is the major circulating form of inhibin in men, while inhibin A is not detected in male serum. In a previous study, close negative correlation was found between inhibin B and FSH concentrations in semen donors, infertile men and men with elevated FSH, but not in a group of healthy volunteers (7).

In males, there is evidence for the presence of inhibin/activin subunits in the Leydig and Sertoli cells. Inhibin B is also measurable in seminal plasma, and may reflect the functional state of the seminiferous epithelium (8). Several groups have studied the relationship between inhibin B and FSH in normal men and in men with disorders of spermatogenesis (7–15). There are no studies reporting levels of activin A and follistatin in male circulation and in disorders of
spermatogenesis. In most systems activins have the opposite biological function to that of inhibins. We proposed to explore the possible endocrine role of activin A in the pituitary–gonadal axis of men. Therefore, the objective of this study was to investigate circulating levels of activin A and follistatin in disorders of spermatogenesis in men and their relationship with FSH and inhibin B.

Materials and methods

Patient groups

WHO (1992) criteria were used for normal semen characterisation (27). All groups of men had a semen analysis. Semen analysis was carried out manually by one person for all research patients. Group 1 were normal control men, subjects with proven fertility (n = 20); group 2 were patients with primary testicular failure, i.e. they had both azoospermia and bilateral small testes with raised FSH (n = 15); group 3 had obstructive azoospermia, i.e. normal testes and normal FSH with radiologically demonstrated bilateral obstruction (n = 10); group 4 had oligospermia, i.e. decreased sperm number (n = 10) and normal FSH; group 5 had miscellaneous sperm dysfunction, i.e. normal testes, normal FSH and normal sperm number or decreased sperm number with decreased sperm motility (n = 40). The ages of the patients are shown in Table 1.

Hormone assays

‘Total’ activin A Serum concentrations of ‘total’ activin A were measured using an EIA specific for ‘total’ activin A as described in detail elsewhere (3). An in-house standard preparation (partially purified human follicular fluid) was standardised against rh activin A (Genentech, San Francisco, CA, USA) and used as the assay standard. The mean intra- and interassay CV values were 6.5 and 7.7% respectively.

Follistatin Serum concentrations of ‘total’ follistatin 288 (FS288) were measured in duplicates as previously described (6). Follistatin standard used in the assays was affinity purified (from human follicular fluid) and standardised against rh follistatin. The minimum detection limit of the assay for rh follistatin standard was 20 pg/ml. The mean intra- and interassay CV values were <10%. The assay cross-reacts 9.9% with FS315.

Inhibin B Serum concentrations of dimeric inhibin B were measured in 100 μl duplicates using an EIA as described in detail elsewhere (3). An in-house standard preparation (partially purified human follicular fluid) was standardised against rh inhibin B (Genentech) and was used as the assay standard. Minimum detection limit of the assay for rh inhibin B was 15 pg/ml. The mean intra- and interassay CV values were 6.2 and 7.2% respectively.

FSH Serum concentrations of FSH were measured using an Immulite-chemiluminescent assay kit (Diagnostic Products Ltd, Los Angeles, CA, USA). The mean intra- and interassay CV values were <10%. The detection range was 0.1–170 mIU/ml.

Statistical analysis

Results given in the text are means ± s.e.m. Data were log transformed to obtain a normal distribution. Unpaired Student’s t-tests were carried out to compare the controls with the different groups. Correlation analysis was carried out controlling for age to study the relationship between different hormones measured. Statistical Package for Social Sciences (SPSS) was used for the analysis.

Results

Serum activin A

‘Total’ activin A concentrations in control men ranged from 85 to 240 pg/ml with a mean of 150 ± 8 pg/ml. Activin A levels were significantly lower than in the controls in the obstructive azoospermia group (62.2 ± 5.8, P < 0.001) and higher in the miscellaneous sperm dysfunction group (201.6 ± 5.5, P < 0.01). However, serum activin A did not vary significantly from the controls in the other groups (Fig. 1).

Serum follistatin

Follistatin levels ranged from 443 to 1591 pg/ml in the control group and the levels did not significantly vary in any group compared with these controls (Fig. 2).

Follistatin:activin A ratio

The mean follistatin:activin A molar ratios for the controls (3.4 ± 0.3), primary testicular failure (4.2 ± 0.4), obstructive azoospermia (19.8 ± 1.3), oligospermia (3.6 ± 0.4) and miscellaneous sperm
Levels in any group did not significantly vary from those in controls.

Levels were significantly lower in men with primary testicular failure than in the controls in men with primary testicular failure (P < 0.001), obstructive azoospermia (P < 0.01), oligospermia (P < 0.05), and miscellaneous sperm dysfunction (P = 0.01).

Serum inhibin B

Serum concentrations of inhibin B in control men ranged from 200 to 892 pg/ml with a mean of 393.8 ± 37.7 pg/ml. Circulating levels of inhibin B were significantly lower than in the controls in men with primary testicular failure (65.5 ± 19.3 pg/ml; P < 0.001), obstructive azoospermia (224.1 ± 40.4 pg/ml; P < 0.01), oligospermia (266.2 ± 13.0 pg/ml; P < 0.05), and miscellaneous sperm dysfunction (277.2 ± 18.9 pg/ml; P = 0.01) (Fig. 3).

Serum FSH

Circulating levels of FSH were higher than in the controls (2.73 ± 0.22 mIU/ml) in men with primary testicular failure (19.90 ± 2.65 mIU/ml; P < 0.001), obstructive azoospermia (4.84 ± 0.83 mIU/ml, P < 0.05), oligospermia (4.89 ± 0.90 mIU/ml, NS) and miscellaneous sperm dysfunction (4.64 ± 0.73 mIU/ml, NS) (Fig. 4).

Relationship between FSH, inhibin B, activin A and follistatin

Activin A and follistatin did not significantly correlate with FSH in any group. Interestingly, follistatin had a significant negative correlation with inhibin B (r = −0.74, P < 0.01) in the primary testicular failure group and a positive correlation with inhibin B (r = 0.74, P = 0.02) in the obstructive azoospermic group. Serum follistatin did not significantly correlate with levels of activin A in any group.

Serum inhibin B had a significant correlation with FSH levels in the primary testicular failure (r = −0.67, 0.01, oligospermia (•) and miscellaneous sperm dysfunction (△). Levels in any group did not significantly vary from those in controls.

Figure 1 Scatter plot of serum ‘total’ activin A measurement in controls (○), primary testicular failure (●), obstructive azoospermia (○), oligospermia (●) and miscellaneous sperm dysfunction (△). Levels were significantly lower (P < 0.001) than in the controls in the obstructive azoospermia group, and higher (P < 0.01) in the miscellaneous sperm dysfunction group.

Figure 2 Scatter plot of serum ‘total’ follistatin measurement in controls (○), primary testicular failure (●), obstructive azoospermia (○), oligospermia (●) and miscellaneous sperm dysfunction (△). Levels in any group did not significantly vary from those in controls.

Figure 3 Scatter plot of serum inhibin B measurement in controls (○), primary testicular failure (●), obstructive azoospermia (○), oligospermia (●) and miscellaneous sperm dysfunction (△). Levels were significantly lower than in the controls in men with primary testicular failure (P < 0.001), obstructive azoospermia (P < 0.01), oligospermia (P < 0.05), and miscellaneous sperm dysfunction (P = 0.01).

Figure 4 Scatter plot of serum FSH measurement in controls (○), primary testicular failure (●), obstructive azoospermia (○), oligospermia (●) and miscellaneous sperm dysfunction (△). Levels were significantly higher than in the controls in men with primary testicular failure (P < 0.001) and obstructive azoospermia (P < 0.05).
and miscellaneous sperm dysfunction ($r = -0.56$, $P < 0.001$) groups.

**Discussion**

Activin/inhibin subunits are expressed in the testis early in fetal development and inhibin is present in the circulation in the neonate and during childhood (16). In the adult, inhibin and activin subunits can be identified within both the Sertoli and Leydig cell populations and a paracrine role for these peptides in the regulation of gonadal function has been proposed (17, 18). Epididymis has been also reported as a site of activin subunit expression and protein production in men (19). Activin subunits are also detectable immuno-histochemically in the testis, and activin A in seminal plasma disappears after vasectomy, suggesting an epididemal/testicular origin. Follistatin has been detected in both Sertoli and Leydig cells, and is secreted into seminal plasma (8).

Inhibin B in the male circulation is inversely correlated with FSH, as evidenced by a number of studies (7, 9–15). Testosterone treatment suppresses levels of FSH, luteinising hormone and inhibin B. Inhibin B levels recovered slowly after treatment was discontinued, returning to the pre-treatment level weeks later than FSH, but concurrently with the return of spermatogenesis, at which time the inverse relationship with FSH was restored (20). Inhibin B levels in healthy men fall slowly but progressively with ageing (21), mirroring a gradual rise in FSH, and consistent with the decreased levels of sperm production and serum testosterone seen in elderly men. In this study there was no significant difference in age between the different groups of men (Table 1). Therefore, the relationship between activin A and age in men is unclear.

While inhibin B has received most attention in clinical studies of testicular function in health and disease, activin A is also present in the seminal plasma (8) and may reflect spermatogenic competence. In the present study we have measured circulating levels of activin A and follistatin in a number of clinically defined groups of fertile and infertile males, and investigated the inter-relationship between these peptides, inhibin B and FSH.

Levels of activin A were lower in the obstructive azoospermic group and higher in the miscellaneous sperm dysfunction group. Follistatin did not appear to reflect spermatogenic failure, with levels of follistatin in the groups of infertile males not differing from controls. FS315 is reported to be the major follistatin form in the human circulation (22). The follistatin assay used in this study essentially detects FS288 and considerably cross-reacts with FS315 (9.9%), suggesting that levels of follistatin could be much higher (up to 9-fold) in these samples. In this study, follistatin:activin A molar ratios in all groups of the male serum are $>2$ suggesting that there is no ‘free’ activin A available to exert an endocrine effect on the pituitary. However, there may be other molecular forms of activins and inhibins that could be bound to follistatin, indicating the possibility of ‘free’ activin A in the circulation. Nevertheless, the lack of relationship between FSH and activin A would also support the speculation that all activin A in the male circulation is bound to follistatin.

Consistent with other reported studies, of the four groups of infertile males, those with primary testicular failure exhibited the lowest levels of inhibin B, whereas those with obstructive azoospermia, oligospermia (with normal motility) and miscellaneous sperm dysfunction (impaired motility, but normal sperm count or decreased sperm count) had higher levels, although the values for all groups were significantly lower than those seen in normal controls.

As demonstrated previously, there is a correlation between FSH and inhibin B in the males with spermatogenic disorders. This correlation was not observed for activin A. Significant negative correlation between follistatin and inhibin B ($r = -0.74$, $P < 0.01$) in the primary testicular failure group and a positive correlation ($r = 0.75$, $P = 0.02$) between follistatin and inhibin B in the obstructive azoospermic group are not explainable at present. Men with primary testicular failure had the highest levels of FSH and those with other types of spermatogenic dysfunction also had levels that were elevated above those seen in controls.

The role of inhibin measurement in the clinical management of male infertility has been explored since the development of the ‘Monash’ RIA for inhibin. However, results with this method proved disappointing, with no obvious differences between fertile and infertile men, excluding those with idiopathic hypogonadotrophic hypogonadism (23, 24).

This study, for the first time, has explored the potential of activin A and follistatin as discriminatory biochemical markers of spermatogenic disorders. Data suggest that ‘total’ activin A may be useful in predicting obstructive spermatogenic disorder. However, larger studies have to be carried out to confirm this observation and to have the statistical power to analyse the predictive statistics. It will also be interesting to compare a group of castrate men to confirm the testicular contribution of activin A to the male systemic circulation. There seems little value in serum measurement of follistatin in predicting spermatogenic disorders.

In contrast to the largely reproductive tract origin of the inhibins, activins are ubiquitous, being synthesised by a large number of tissues (25) and are viewed as paracrine rather than endocrine factors (26). The function of follistatin in serum appears to be to bind and neutralise circulating activin, thereby preserving activin’s ability to act as a locally acting factor without interference from a high background level in the
circulation. However, the activin/follistatin system may play a significant autocrine/paracrine role in the testis.

In summary, this study has explored the relationship between serum activin A, follistatin, FSH and inhibin B in men with spermatogenic disorders. Activin A may prove to be useful in predicting obstructive azoospermia. The follistatin:activin A molar ratio confirms that all activin A in the circulation is bound to follistatin, suggesting that activin A cannot have an endocrine role at the pituitary. This is supported by the lack of a significant relationship between FSH and activin A in the circulation.

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Activin A and follistatin in males 429

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