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Commentary on: “Does COVID19 Infect the Brain? If So, Smokers Might Be at a Higher Risk”

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While it is of critical importance to rapidly publish the latest findings on COVID-19, recent high profile retractions of COVID-19 reports (Mehra, Desai, Kuy, Henry, & Patel, 2020; Mehra, Desai, Ruschitzka, & Patel, 2020), reminds us that it is important to be vigilant for the accuracy of this literature.

A recent paper published in Molecular Pharmacology suggests that there is an interaction of nicotinic cholinergic receptors and angiotensin-converting enzyme 2 (ACE2) in the brain that predisposes smokers to increased susceptibility to infection of the brain by SARS-CoV-2 (Kabbani & Olds, 2020), above and beyond the general damage of smoking to the airways . However, the purported mechanism for this toxicity is unsubstantiated and does not accurately reflect current knowledge of predisposing factors for COVID-19 toxicity. This commentary addresses some of these issues.

ACE2 is a protein that is considered to be part of the renin-angiotensin system as well as the primary receptor by which SARS-CoV-2 enters cells (Figure) (Hoffmann, et al., 2020). And, while there is little doubt that smoking nicotine-containing tobacco products predisposes smokers to increased disease susceptibility, this predisposition arises from adverse effects of nicotine on the cardiovascular system https://www.cdc.gov/tobacco/campaign/tips/diseases/heart-disease-stroke.html (accessed 4/25/20) as well as the inhalation of particulate and volatile substances that directly injure lung cells https://www.cdc.gov/tobacco/campaign/tips/diseases/index.html?s_cid=OSH_tips_D9389

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(accessed 4/25/20) (Oakes, Fuchs, Gardner, Lazartigues, & Yue, 2018). Specifically, it has been shown that both acute and subacute nicotine administration to female rats increased blood-brain-barrier permeability by altering tight junction proteins of the cerebral microvessel endothelial cells (Hawkins, et al., 2004), an effect independent of ACE2.

Linking increased brain susceptibility to SARS-CoV-2 infection with smoking "…based upon known functional interactions between the nicotinic receptor and ACE2." (Kabbani & Olds, 2020) is unsubstantiated, as none of the papers cited by these authors for demonstrating co-localization of NAChRs on the same brain cells as ACE2 (Changeux, 2010; Nordman, Muldoon, Clark, Damaj, & Kabbani, 2014; Tolu, et al., 2013) mention the word angiotensin or the acronym ACE2 as being associated with nicotinic receptor-containing cells. Of note, colocalization of NAChRs and components of the RAS in bronchial and alveolar epithelial cells in the lungs has been reported (Oakes, et al., 2018).

A subsequent claim for an association of NAChRs and ACE2 comes from a concurrent publication by these authors (Olds & Kabbani, 2020) "nicotine stimulation of the nAChR can increase ACE2 expression within them (Olds and Kabbani, 2020)." They cite a medRxiv paper by Cai et al., 2020 https://www.preprints.org/manuscript/202002.0051/v1 demonstrating that tobacco smoking is associated with increased ACE2 gene expression. However, a peer-reviewed manuscript from this same author noted that it has not been determined whether the 25% increase in ACE2 gene expression is due to nicotine, or the other components of inhaled tobacco smoke (Cai, Bosse, Xiao, Kheradmand, & Amos, 2020). Moreover, nicotine has been shown to decrease ACE2 expression (Oakes, et al., 2018), which contradicts the hypothesis that nicotine increases ACE2 expression (Kabbani & Olds, 2020). This implies that it is the other components of tobacco smoke, not nicotine, that increase ACE2 expression.

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Later in the manuscript the authors write “Interactions between nAChRs and ACE2 have been studied in several of these [brain] regions including the ventrolateral medulla (Deng et al., 2019)” (Kabbani & Olds, 2020). However, Deng et al., 2019 described changes in acetylcholine in this brain region in relation to ACE2 expression, and that paper does not mention NAChRs at all.

It is regrettable that the companion paper (Olds & Kabbani, 2020) cited by Kabbani and Olds (Kabbani & Olds, 2020) also contains questionable statements, e.g., “ACE2 appears to play both protective and pathogenic roles within RAS pathways, and its direct mechanisms of function in cells remain less understood [7,8].” (Olds & Kabbani, 2020). ACE2 is an extremely well characterized protein (Feng, Xia, Santos, Speth, & Lazartigues, 2010; Raizada & Ferreira, 2007; Soler, Wysocki, & Batlle, 2008; Turner, Hiscox, & Hooper, 2004; Turner & Hooper, 2002) and has been overwhelmingly recognized as only playing a beneficial role within the renin-angiotensin system (RAS) (R. A. Santos, Ferreira, Verano-Braga, & Bader, 2013).

There is a considerable body of literature regarding the interaction of SARS-CoV-2 with the RAS, in particular ACE2 , which serves as its receptor for entry into cells (Hoffmann, et al., 2020) . Most published papers and cardiovascular medicine societies cf (Gurwitz, 2020; Reynolds, et al., 2020; Speth, 2020a, 2020b, 2020c; Sriram & Insel, 2020; Vaduganathan, et al., 2020) support the continued use of angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) based upon the predominant beneficial effects of reducing the ability of angiotensin II to promote inflammation acting via the AT_1 receptor (Ranjbar, et al., 2019). ACE2 by metabolizing Ang II and forming angiotensin 1-7, which has anti-inflammatory actions via its receptor Mas (R. A. S. Santos, et al., 2018) may help to

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minimize the cytokine storm (Annweiler, et al., 2020; Mahmudpour, Roozbeh, Keshavarz, Farrokhi, & Nabipour, 2020) that exacerbates lung damage associated with COVID-19.

The adverse effects of smoking on outcomes of COVID-19 infection are indisputable. However, it is necessary to accurately determine what aspect of smoking and which target tissues mediate this increase in morbidity and mortality.

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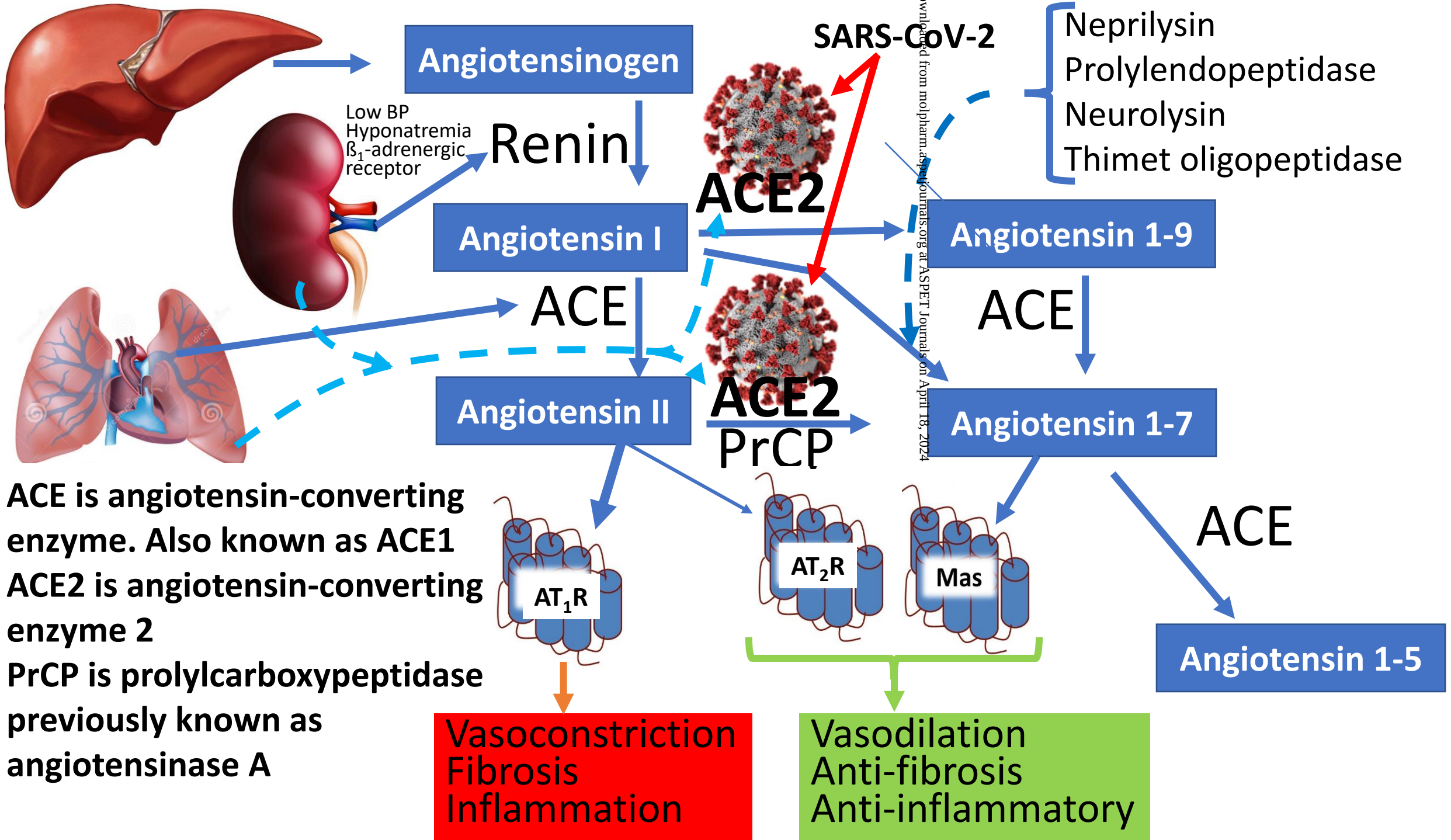
Legend for Figure: Simplified diagram of renin-angiotensin system. SARS-CoV-2 spike protein S1 domain binds to the extracellular domain of ACE2 leading to internalization of the SARS-CoV-2-ACE2 complex which decreases ACE2 expression on cell membranes. ACE2, and AT_1 and Mas receptors are present in lung and kidney, two of the tissues most adversely affected by SARS-CoV-2 infection. Angiotensin 1-5 has no established function. BP is blood pressure. Liver image from https://www.pcosnutrition.com/fattyliver/ Kidney image is from https://www.alportsyndrome.org/stages-of-kidney-disease/ Lung image is from https://www.dreamstime.com/stock-images-pulmonary-hypertension-image27276044 SARS-CoV-2 image from https://www.cdc.gov/media/subtopic/images.htm



ACE is angiotensin-converting enzyme. Also known as ACE1
ACE2 is angiotensin-converting enzyme 2
PrCP is prolylcarboxypeptidase previously known as angiotensinase A