

Frequently asked questions in hypoxia research

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Abstract: "What is the O₂ concentration in a normoxic cell culture incubator?" This and other frequently asked questions in hypoxia research will be answered in this review. Our intention is to give a simple introduction to the physics of gases that would be helpful for newcomers to the field of hypoxia research. We will provide background knowledge about questions often asked, but without straightforward answers. What is O₂ concentration, and what is O₂ partial pressure? What is normoxia, and what is hypoxia? How much O₂ is experienced by a cell residing in a culture dish in vitro vs in a tissue in vivo? By the way, the O₂ concentration in a normoxic incubator is 18.6%, rather than 20.9% or 20%, as commonly stated in research publications. And this is strictly only valid for incubators at sea level.

Keywords: gas laws, hypoxia-inducible factor, Krogh tissue cylinder, oxygen diffusion, partial pressure, tissue oxygen levels

Introduction

A criticism often heard in hypoxia research is that the setting "1% O₂" in a cell culture incubator does not match any physiological situation in vivo. So, what is a physiological O₂ concentration in the body? What is normoxia, and what is hypoxia? With the exponential rise in our knowledge on hypoxia-inducible signaling pathways, it has become increasingly clear to every scientist cultivating cells in vitro that not only temperature, humidity, and CO₂ but also O₂ needs to be controlled. Corresponding incubators are on the way to becoming standard equipment for cell culture, just like it has been standard for decades to control CO₂. It appears obvious that the precise O₂ concentration cells are exposed to in these incubators must be disclosed in scientific publications. But, quite remarkably, in contrast to the measured hypoxic O₂ concentrations, the actual normoxic O₂ concentrations are almost never correctly indicated but rather given as "21%", "20.9%", or "20%" O₂, which corresponds to the O₂ concentration of dry room air rather than incubator air. This review is addressed to newcomers to the hypoxia research field and explains the simple but not always intuitive properties of gases required for the daily work in cell culture. Herein, we will also discuss the actual O₂ concentration, or better O₂ partial pressure, inside tissues and cultured cells, a point that has all too often been subjected to over-simplifications. Using the example of the normoxic O₂ concentration in a cell culture incubator, a simple introduction to the physics of gases will be given.

What is the O₂ concentration in the gas phase?

Whether at sea level or Mount Everest, whether on a pole or the equator, the O₂ concentration is always the same! The value of sufficient precision for biological

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considerations is 20.9% (volume/volume or v/v). However, this value is for dry air only, ignoring the fact that there is usually also water in its gaseous form in the atmosphere. The other gases in the air, mostly nitrogen, are not really relevant for cellular processes under physiological conditions.

What is the O₂ partial pressure?

What changes at high altitude is not the concentration of any given gas but the total pressure of the air. Air pressure at a given altitude is built up by the height of the air column above. This air column has a certain mass that exerts force onto the gas below it under the influence of gravity. Because in contrast to liquids gases are compressible, the density of the air increases exponentially rather than linearly with the height/weight of the overlaying air column. Vice versa, air pressure falls exponentially with increasing altitude. The corresponding physical law allows the calculation of the decrease in atmospheric pressure with increasing altitude (a) expressed in kilometers (km), assuming that earth's gravity is equal on the entire surface of the planet (which is a simplification, of course): $P_a = P_0 \times e^{-(0.127 \times a)}$. P_0 is the atmospheric pressure at sea level. For this calculation, it does not matter which pressure unit is chosen. The official unit is Newton (the unit of force) per square meter (N/m²), also called Pascal (Pa). At sea level, the atmospheric pressure is 101.3 kPa. However, biologists still prefer the old unit millimeter mercury (mmHg), also called Torr (torr). At sea level, a manometer filled with mercury shows a column height of 760 mm (ie, 101.3 kPa = 760 mmHg). This is an average value that is only theoretically constant, since both minor changes in gravity as well as, more importantly, the actual weather condition can slightly affect this value. The 20.9% of this total atmospheric pressure will result in the O₂ partial pressure (pO₂), that is, 159 mmHg. According to the formula mentioned earlier, at 0.5 km altitude, for instance, the atmospheric pressure is 713.2 mmHg, and the pO₂ is 149.1 mmHg.

Why must humidity be considered?

Cultured cells must be kept in 100% (relative to saturation) humidified incubators. Otherwise, the medium evaporates, and cell metabolism is compromised by changes in osmolarity, eventually resulting in cell death. Evaporated water molecules in the gas phase also generate a partial gas pressure, p_{H₂O}. This pressure is even built up if the gas is in equilibrium with its frozen aggregation state (ie, ice) by a process called sublimation. The p_{H₂O} increases with increasing temperature of the liquid source of the evaporated water, assuming that liquid and gas phases have the

same temperature. Because tissue culture incubators usually mimic the human core body temperature, their temperature is set to 37°C, resulting in a p_{H₂O} of 47 mmHg. Remarkably, this partial pressure is independent of the atmospheric pressure. As long as there is a balance between the liquid and gas phases, that is, the gas phase is water saturated, there is always a p_{H₂O} of 47 mmHg at 37°C, whether we are at sea level, on Mount Everest, or in a vacuum chamber. That is also one of the reasons why cosmonauts cannot leave their spaceships without pressure suits: their body fluids of 37°C temperature would start to boil if exposed to environmental atmospheric pressure <47 mmHg (eg, the water of the lung alveolar surface), which according to the formula mentioned earlier happens at >22 km altitude.

What is the O₂ concentration in a normoxic incubator?

In order to understand how all relevant gases in a cell culture incubator, that is, N₂, O₂, H₂O, and CO₂, sum up to the total atmospheric pressure, which is the same inside and outside normobaric incubators, we need a simple physical law, also called Dalton's law. It says that gas partial pressures are additive. This means that the partial pressures of all relevant gases together must be equal to the atmospheric pressure. The p_{H₂O} is 47 mmHg if we culture the cells at 37°C. The CO₂ concentration is usually set (and measured) at 5% (v/v), resulting in a pCO₂ of 5% of 760 mmHg, that is, 38 mmHg. Therefore, the remaining dry room air in the incubator has only 760–47–38 = 675 mmHg at its disposal. The 20.9% thereof is required for O₂, resulting in a pO₂ of 141 mmHg. This partial pressure corresponds to an O₂ concentration of 18.6%, the "true" normoxic oxygen condition in every day's cell culture (Figure 1). However, this is correct only at sea level. At 0.5 km altitude, for example, the pO₂ would be 20.9% of 713.2–47–35.7 = 630.5 mmHg, that is, 131.8 mmHg, corresponding to an O₂ concentration of 131.8/713.2×100% = 18.5%. Thus, the relative effect of the constant p_{H₂O} on the final O₂ concentration increases with increasing altitude.

What is the O₂ concentration in the liquid phase?

As nice as it is to know the O₂ concentration in the gas phase, it will never be what the (adherent) cells in a tissue culture dish actually experience, since they are attached to the bottom of the dish. To understand how oxygen actually reaches the cells, another simple physical law is required, also called Henry's law. It says that the partial pressure of

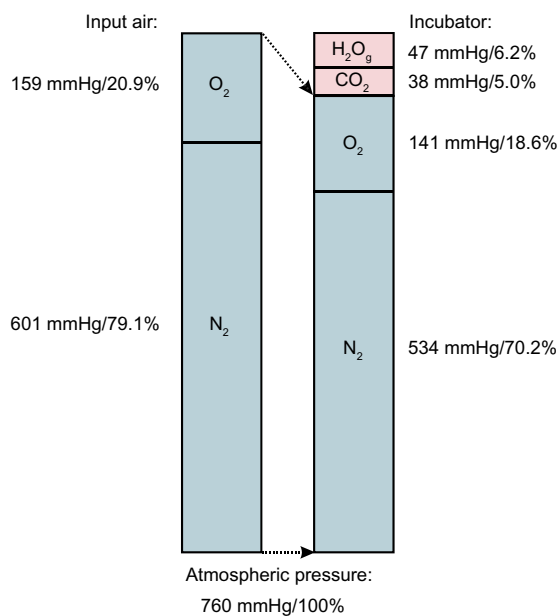


Figure 1 Composition of the gas phase in a tissue culture incubator.
Notes: Input room air (left) is mixed with gaseous water and CO₂ to form the incubator's gas mixture (right).

a gas in the liquid phase is equal to its partial pressure in the gas phase. Whereas this law is neither dependent on the nature of the gas nor of the liquid, the actual gas solubility is highly variable between different gases and liquids. At least, the dissolved gas concentration can easily be calculated as it is directly proportional to the partial pressure. The solubility constant, also called Bunsen's constant, is a specific number for each gas, depending on the nature and composition of the liquid as well as on the temperature. At 37°C, 1.32 μM O₂ dissolves in pure water per 1 mmHg O₂ partial pressure. However, the presence of dissolved salts lowers O₂ solubility. If we take as a likely approximation that typical cell culture media have properties similar to blood plasma, the plasma O₂ solubility of 1.26 μM O₂ per 1 mmHg at 37°C¹ would result in 1.26 μM/mmHg × 141 mmHg = 177.66 μM O₂ concentration under normoxic incubator conditions. This value increases in a nonlinear manner with decreasing temperature and vice versa. Importantly, O₂ solubility in the aqueous phase is rather low, and other biologically relevant gases have clearly distinct solubility constants. CO₂, for instance, dissolves in blood plasma at 30 μM per 1 mmHg CO₂ partial pressure,¹ that is, in a 5% CO₂ incubator, this would result in 30 μM/mmHg × 38 mmHg = 1,140 μM CO₂ concentration.

How is O₂ distributed in the liquid phase?

Strictly speaking, Henry's law is only valid for stirred liquids or for the liquid phase just below the surface in resting liquids.

At least for adherent cell culture, the medium is usually not stirred. Unfortunately, under these typical cell culture conditions, O₂ will not reach the cells at the same partial pressures (or concentrations) as calculated earlier. The mechanism by which gases reach the bottom of the tissue culture dish or flask is by diffusion, which is almost always “the” limiting factor for cellular oxygenation. This is also called diffusion limitation. As described by Fick's law, diffusion is directly proportional to the partial pressure difference (ie, the driving force of diffusion), directly proportional to solubility, and inversely proportional to the diffusion distance. As a rule of thumb, O₂ diffusion in tissues becomes limited at ~100–200 μm.^{2–4} This is not a problem for our lungs, where the diffusion distance from the alveolar surface to the hemoglobin inside the erythrocytes is only ~2 μm.¹ However, in a “10 cm” petri dish, ~10 mL medium is required, resulting in a medium height of 1.72 mm (assuming an inner diameter of 8.6 cm and a culture area of 58 cm²). This exceeds the O₂ diffusion limit by an order of magnitude and will inevitably result in an (unknown) low pericellular pO₂ and poor cellular oxygenation, eventually resulting in hypoxic cells even under normoxic incubator conditions. In contrast, because the solubility of CO₂ is ~24-fold higher than that of O₂ (as explained in the section “What is the O₂ concentration in the liquid phase?”), CO₂ diffusion is usually not limited in cell culture. As the usual bicarbonate buffer system used in cell culture determines the actual pH in equilibrium with the CO₂ concentration, equal CO₂ distribution also ensures equal pH values.

Taken together, O₂ diffusion is dependent on the driving force (the delta pO₂ or ΔpO₂) and several matter constants that cannot be altered in cell culture such as the poor O₂ solubility. The ΔpO₂ is the difference between the incubator's pO₂ and the pericellular pO₂, that is, the difference between O₂ supply and O₂ sink. In principle, the ΔpO₂ can be decreased by lowering the pO₂ in the incubator (eg, by experimental hypoxic conditions) and/or by elevating the pericellular pO₂ (eg, by lowered cell density and/or lowered O₂ consumption). To make the situation even more complex, an important physiological mechanism of cellular adaptation to hypoxia is lowered mitochondrial O₂ consumption. Thus, the pericellular pO₂ is also a function of time since these adaptive processes can take hours to days.

Figure 2 shows exemplary results of pO₂ measurements as a function of the distance from the surface of the medium toward the bottom of a cell culture dish. After moving the dish out of an normoxic incubator and exposing it to room air conditions, the environmental O₂ supply acutely increases

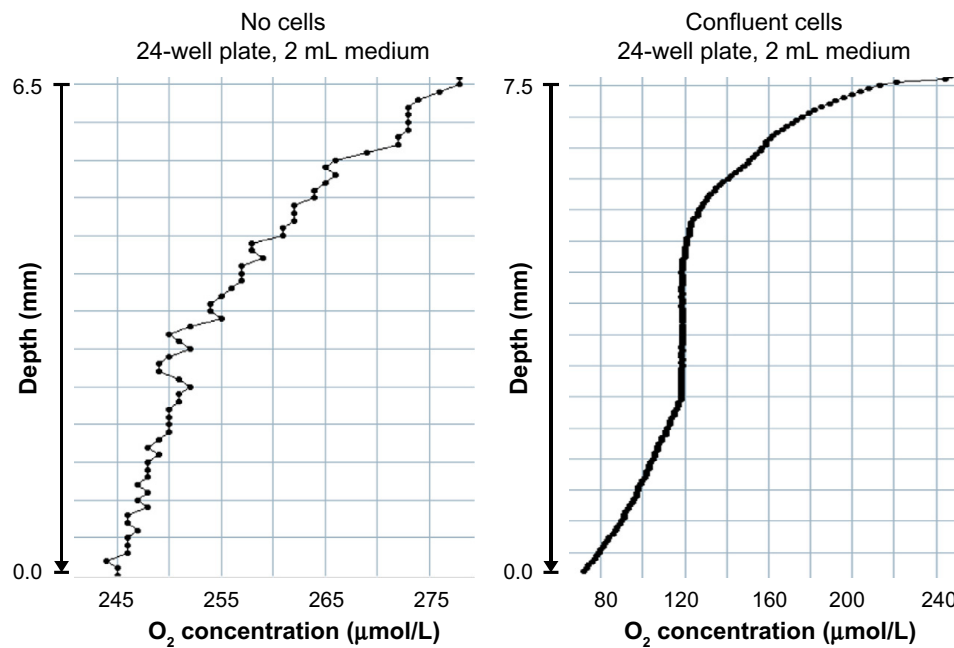


Figure 2 O₂ concentration gradients in cell culture medium.

Notes: Normal 24-well tissue culture plates without (left) or with (right) confluent HeLa cell layers were removed from a normoxic 37°C incubator, and O₂ concentration profiles were determined under room air conditions at 25°C using a needle-type O₂ sensor (PreSens, Regensburg, Germany). Note that the change from incubator air to room air results in a higher pO₂ (no gaseous water, no pCO₂) and a better O₂ solubility (temperature change from 37°C to 25°C).

and a shallow pO₂ gradient forms due to the poor O₂ diffusion in unstirred medium, even in the absence of cells (left panel). When cells are present at high density attached to the bottom of the dish (right panel), they consume considerable amounts of O₂ and form an O₂ sink. The resulting steep pO₂ gradient leads, on the one hand, to a strong ΔpO₂ as driving force for the O₂ flux from the gas phase toward the cells. On the other hand, this O₂ sink creates its own pericellular hypoxic microenvironment, even if the incubator's gas phase was set to "normoxic" conditions.⁵ Note that the O₂ concentration profile is non-steady. This is the result of increased O₂ solubility due to decreased culture medium temperature profiles combined with uncontrolled convection at different medium heights when the culture dish is taken out of the incubator. Altogether, these hardly controllable variables result in nonpredictable O₂ concentration profiles.

What is the influence of the geometry of tissue culture flasks and dishes?

One should be aware that the culture medium pO₂ gradient also leads to differing pO₂ levels at the bottom of uneven medium heights, such as in the tilted neck region of tissue culture flasks or below the meniscus region of tissue culture dishes. The relative proportion of these areas becomes higher when the flasks and dishes are smaller. Especially in

96-well dishes, a large proportion of cells are located along the outer rim, that is, below higher fluid levels, due to the adhesive forces that "lift" the water along the plastic walls of the dish. Thus, the actual average pO₂ level can be different depending on the geometry of the used plasticware, even in the same hypoxia chamber. This might also explain variabilities between research groups, underlying the need for clear statements about this issue in the "Methods" section of a publication. Obviously, it is important to keep all tissue culture dishes absolutely horizontal, especially regarding the minimal medium volume that must be used in hypoxic experiments. A water level may be required to adjust the horizontal orientation of the dishes and to prevent uneven medium heights.

What is the pericellular pO₂ in cultured cells?

As discussed earlier, only pericellular "on-line" pO₂ measurements would allow for accurate monitoring of the actual O₂ availability of cultured cells. Figure 3 shows an exemplary result of pericellular pO₂ measurements as function of medium height and cell density. As expected, based on theoretical considerations,⁶ the pericellular pO₂ drops with increasing medium height and cell density. Somewhat frustratingly, these results clearly demonstrate that the knowledge of the precise O₂ concentration in the incubator air is

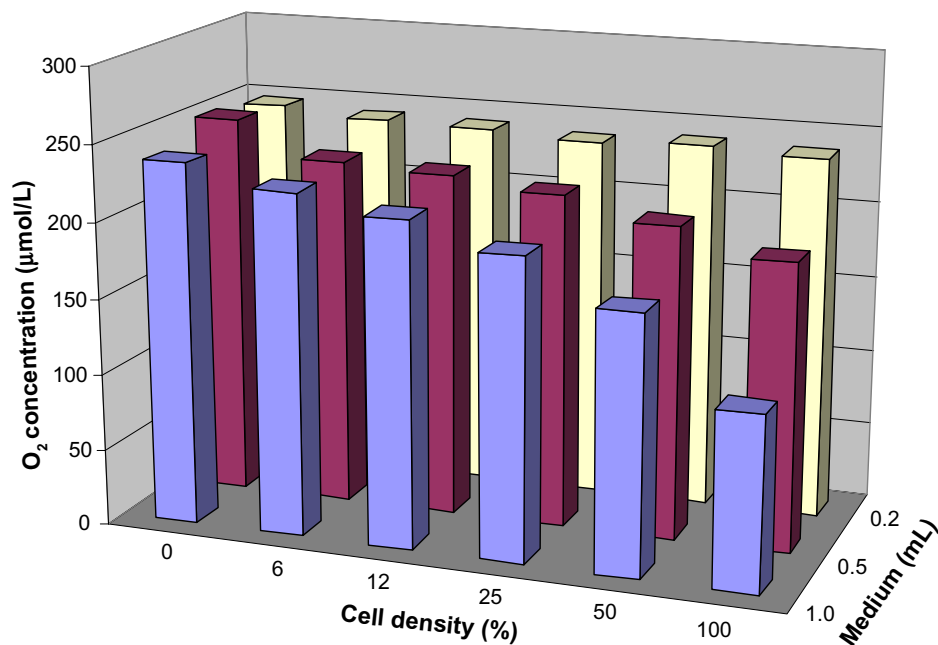


Figure 3 Pericellular O₂ concentration as a function of medium height and cell density.

Notes: 24-Well SensorDish tissue culture plates were filled with different medium volumes and seeded with HeLa cells at various densities, resulting in 0%–100% confluency as indicated. The SensorDishes were removed from the 37°C incubator and the pericellular O₂ concentration determined under room air conditions at 25°C (resulting in a higher pO₂ and better O₂ solubility than within the incubator) using a SensorDish Reader (PreSens, Regensburg, Germany).

quite useless for the prediction of the pericellular pO₂. So, how can this problem be solved? The usual approach is to ignore it and to simply compare “normoxic” with “hypoxic” exposure under otherwise identical conditions, knowing that these expressions refer to the incubator’s air composition only and have nothing to do with the physiological tissue situation. More precisely, but rarely done, the pericellular pO₂ could be measured just below the cells, using oxygen-sensitive phosphorescent dyes (as used in Figure 3). Another approach would be the use of O₂ permeable cell culture dishes, where O₂ reaches the cells by diffusion through the bottom plastics and where the pO₂ can hence be assumed to be identical to the gas phase.⁷ Unfortunately, many cell lines poorly adhere to such dishes, which are hence rarely used.

How long does it take to reach hypoxic conditions?

The onset of hypoxic exposure is usually defined as the moment when the doors of the hypoxic incubator are closed. However, it will take several minutes to several hours until the medium O₂ concentration asymptotically approximates the desired value, even if the incubator would change the gas phase composition rapidly.^{8,9} A theoretical calculation with 1.72 mm medium height (refer to section “How is O₂ distributed in the liquid phase?”) in the absence of cells reveals a duration of 38 minutes, 45 minutes, and 60 minutes to fall

below a pO₂ value of 1.2-fold of the input value if a cell culture dish is acutely switched from 20% O₂ to 2%, 1%, or 0.2% O₂ concentration, respectively.

One possibility to circumvent this problem is to pre-equilibrate the medium in the hypoxic incubator by removing the cap of the medium bottle. However, without stirring, this will result in little change in the overall O₂ content since only the surface region actually releases O₂. A better solution to this problem would be to bubble nitrogen through the medium, to shake it vigorously, or to use large petri dishes with small medium heights for pre-equilibration. Somehow counterintuitively, bulk medium pre-equilibration works more efficiently if the medium is cooled while removing O₂ and then warmed up again under the desired hypoxic conditions before use. A more or less immediate O₂ equilibration of the cells can be expected if O₂ permeable cell culture dishes are used. Finally, for suspension cells, so-called tonometers have been applied, allowing a tight control of the culture medium oxygenation by using spinning cups that generate very thin liquid layers along the cups’ walls while simultaneously exposing these liquid layers to high gas flow rates.^{10,11}

How long does it take to lose hypoxic conditions?

Unfortunately, even the briefest opening of an incubator’s door will ruin a hypoxic experiment. Gas exchange with room air

occurs almost instantaneously, and it will take up to 1 hour until hypoxic conditions in the incubator's gas phase are reestablished (the theoretical considerations outlined earlier are valid in both directions). There is little tolerance toward reoxygenation because this immediately generates reactive oxygen species, which are well known to have signaling, as well as toxic, properties. To prevent such reoxygenation artifacts, the incubator is allowed to be opened only at the time of cell collection, and all harvesting must be performed as quickly as possible, replacing the medium immediately with precooled washing or lysis solutions. It is always better to culture, harvest, and lyse the cells within hypoxic workstations. However, one should be aware that certain biological reactions, such as O₂ sensing by hypoxia-inducible factor α (HIF α) prolyl-4-hydroxylation, will continue even in (non-denatured) cell lysates whenever O₂ is available.^{12,13}

What is the O₂ concentration in biological fluids?

For biological purposes, it is often more important to know the pO₂ than the O₂ concentration, that is, the total O₂ present in a certain volume of the fluid phase. In fact, the O₂ concentration is the sum of dissolved O₂ plus O₂ bound to proteins. The dissolved O₂ is proportional to the pO₂ (as discussed earlier). Bound O₂ depends, in addition to pO₂, on the O₂ affinity, concentration, and composition of O₂-binding proteins. For example, in arterial blood, only a small part of O₂ is dissolved and >98% of O₂ is bound to hemoglobin, resulting in an O₂ concentration of 20% (v/v) (ie, 200 mL O₂ per 1 L of blood with a hemoglobin concentration of 150 g/L), assuming normal inspiratory O₂ and lung function. Coincidentally, 20% is the same O₂ concentration as in the atmosphere. However, within cells, neither the ratio between dissolved and bound O₂ nor the relative concentrations and affinity curves of O₂-binding proteins are known. Anyway, this is not a problem because it is the pO₂ and not the O₂ concentration that drives the diffusion of O₂ molecules to their targets, such as O₂-sensing dioxygenases or O₂-reducing cytochrome *c* oxidase in mitochondria. O₂-binding proteins only experience the pO₂ and not the O₂ concentration. Therefore, life scientists should use pO₂ rather than O₂ concentration as the preferred unit for biological tissue O₂ availability.

What is the pO₂ in biological tissues?

Unfortunately, most of the publications provide single values for the tissue pO₂ in different organs, not seldom – and even worse regarding what has been said so far – %O₂

concentrations are given. However, life would not be possible if O₂ was equally spread throughout the tissue, that is, if neither supply nor sinks existed. Obviously, O₂ is unevenly distributed in tissues, forming pO₂ gradients. One gradient is found longitudinally along the small blood capillaries (ie, the O₂ exchange segments of the blood vessel system) from the arterial to the venous ends. This gradient ranges from ~90 mmHg in arterial blood to 40 mmHg in mixed venous blood (corresponding to 75% O₂ saturation of hemoglobin), but it can also be much lower at the venous end of a capillary if the corresponding tissue has a high O₂ extraction capacity such as the heart. Another gradient is formed radially from the O₂-delivering hemoglobin to the actual O₂ sinks in the mitochondria of O₂-consuming cells. Therefore, normal pO₂ values distal to the venous end of a capillary can readily be <10 mmHg. The resulting pO₂ profiles can be estimated within a cylinder of ~30 μ m radius (ie, half of the average distance between two capillaries) around each blood vessel, the so-called Krogh tissue cylinder (Figure 4).

How can the tissue pO₂ be visualized?

No imaging/measurement technique is currently available to directly assess pO₂ profiles within tissues. Infrared (pulse oximetry) and magnetic resonance (blood oxygenation level-dependent [BOLD]) techniques rely on hemoglobin O₂ saturation rather than tissue pO₂ levels. Polarographic and optical detection methods involve tiny electrodes and glass fibers, respectively, which are pierced into the tissues. Their diameters are minimally ~20 μ m but usually ~100 μ m; obviously still far too large to reliably detect biologically relevant pO₂ profiles, not to mention the tissue damage they cause, leading to tissue compression, bleeding, edema, and O₂ diffusion/convection along the penetration canal. It is

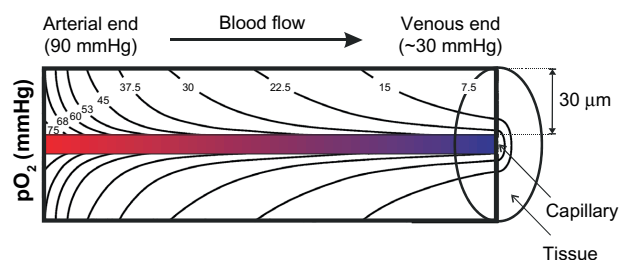


Figure 4 Krogh's tissue cylinder.

Notes: Overlapping longitudinal (convective) and radial (diffusive) pO₂ gradients form the physiological tissue O₂ distribution (calculated isobaric pO₂ profiles assuming constant tissue O₂ consumption). All cells located within this pO₂ profile are considered to be physiologically "normoxic", despite the highly variable absolute pO₂ levels.

mandatory that histogram distributions over several hundred measurement sites are provided rather than single mean or median tissue pO_2 values.^{14,15}

A very popular method to visualize tissue hypoxia, especially in cancer research, is the IV injection of nitroimidazole compounds briefly before the (tumor) tissue is resected.¹⁶ A large variety of such compounds exists, including derivatives bearing antibody epitopes (eg, pimonidazole or EF5), positron emission tomography tracers (eg, ¹⁸F-fluoromisonidazole), and hypoxia-activated pro-drugs (eg, TH-302).¹⁷ A four-electron reduction of these compounds by cellular nitroreductases is required to convert them into reactive species that covalently bind to macromolecules such as proteins and DNA. At pO_2 levels above ~10 mmHg, the first of these four-electron reduction steps – forming a nitro radical anion (RNO_2^-) – is reversed.¹⁷ Therefore, nitroimidazole compounds cannot deliver a detailed map of different pO_2 levels but only a “yes-or-no” picture of tissue regions with a $pO_2 < 10$ mmHg, which is then often called “hypoxic” even if this represents an oversimplification. Moreover, one should be aware that two-electron nitroreductases, such as DT-diaphorase, can circumvent the O_2 -sensitive step, leading to false-positive results.

Another emerging technique relies on heme-based probes whose phosphorescent lifetime is quenched by physiological ranges of pO_2 , that is, the signal is not dependent on probe concentration. While in theory such probes should provide graded maps of pO_2 variability, their limited tissue concentrations (they are not enriched in hypoxia areas), considerable costs, and the requirement for specialized microscopy equipment have prevented so far a more widespread application of these probes.^{18,19}

Because of the lack of more appropriate methods, biology-based techniques, such as antibody-mediated detection of the O_2 -sensitive HIF α subunits and their downstream target genes, are still commonly used to detect “hypoxic” tissue areas. For carbonic anhydrase IX, at least in cancer tissues, probably the most strongly induced HIF target gene, a non-antibody-mediated fluorescent in vivo probe (called HypoxiSense 680) has been developed.^{20,21} However, at best, these techniques provide only indirect evidence for tissue hypoxia due to self-adaptation,²² “normoxic” regulation, and cell type-specific expression.²³ At least the latter point has been circumvented by the generation of transgenic mice ubiquitously and constitutively expressing a luciferase reporter gene fused to the O_2 -dependent degradation domain of HIF-1 α .²⁴ Following the injection of luciferin, hypoxia-dependent

bioluminescence can be imaged, which at least partially overlaps with pimonidazole and HIF α immunodetection.²⁵

What is the pO_2 in organs?

In addition to the general features of tissue pO_2 distribution discussed earlier, several organotypic and cell type-specific characteristics must be considered (Figure 5).^{26,27} Liver and kidney, for instance, display pronounced physiological pO_2 gradients,^{28,29} which can even be visualized by using EF5 or VEGF expression as HIF-1-dependent surrogate marker.³⁰ Lung alveolar epithelium contains the highest pO_2 levels as it is oxygenated directly by the inspiratory air. Heavily working skeletal muscle has a large O_2 extraction capacity and hence a huge variety of pO_2 levels. Cardiomyocytes experience cyclic hypoxia with each heartbeat. Some tissues, such as the avascular cornea of the eye and nucleus pulposus of the intervertebral discs, have a very low pO_2 but still must remain blood vessel free. Also central luminal cells of the testicular seminiferous tubuli reside within a very low pO_2 .³¹ Finally, some cell types, such as neurons, are strikingly hypoxia-intolerant,³² whereas others, such as certain stem cells, need a hypoxic niche to remain in an undifferentiated stage.³³

What is normoxia, and what is hypoxia?

It may seem peculiar, but nobody has a precise answer to this apparently simple question. Physiological O_2 availability is a continuum from lung alveolar pO_2 of ~100 mmHg to functional anoxia at pO_2 levels that are below the O_2 affinity of mitochondrial cytochrome *c* oxidase. Mitochondrial P_{50} values from 0.06 mmHg to 0.45 mmHg pO_2 have been reported, that is, 10–100-fold below the typical intracellular pO_2 .³⁴ However, the O_2 -sensing PHD-HIF system ensures that mitochondrial respiration is adapted to decreased oxygenation long before limiting pO_2 levels are reached.³⁵ Many cell types do not even need mitochondria for their energy (ATP) production and solely rely on anaerobic glycolysis. Cancer cells usually maintain glycolytic energy metabolism even under high pO_2 levels, the so-called aerobic glycolysis or Warburg effect. Therefore, no threshold pO_2 level exists, which would define “hypoxia” based on limited mitochondrial respiration.

As outlined in Figure 4, tissue O_2 is distributed along the pO_2 profiles according to Krogh’s tissue cylinder. All cells residing within this pO_2 profile are physiologically “normoxic”. Thus, it does not make sense to define a single pO_2 value below which cells are called “hypoxic”.

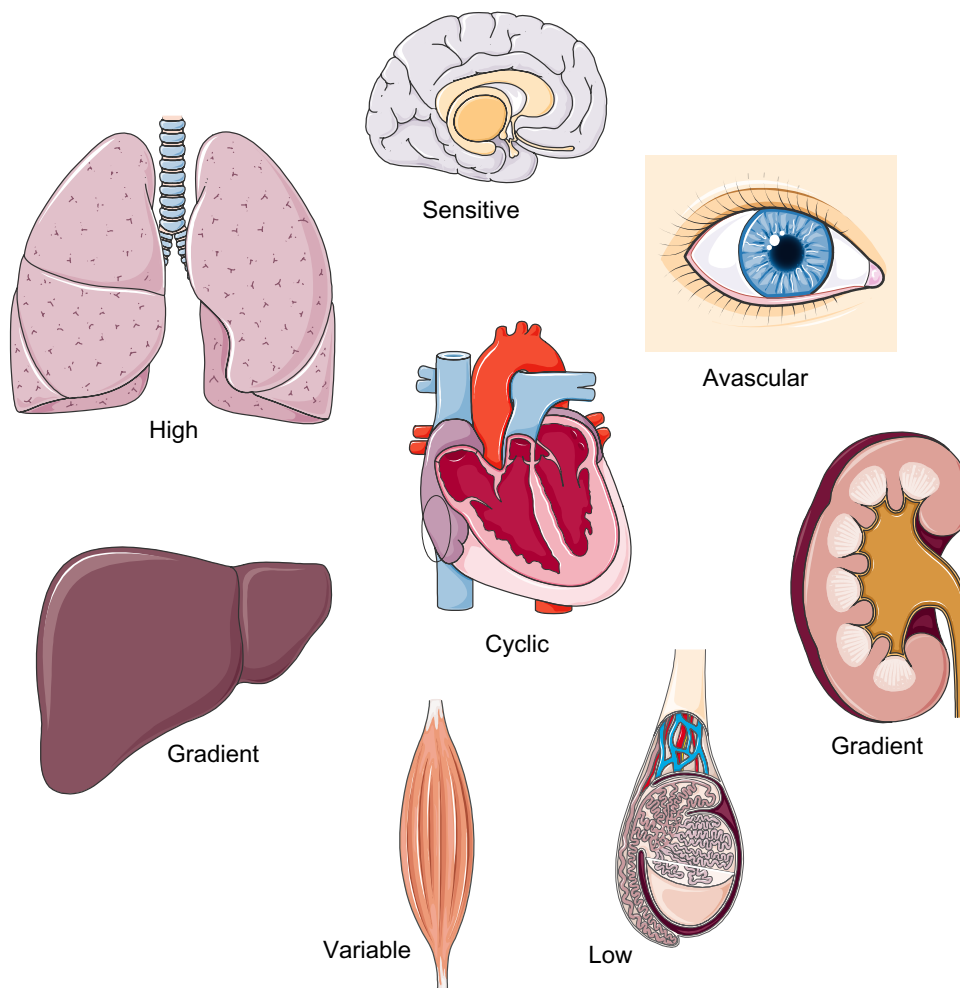


Figure 5 Organotypic characteristics in tissue oxygenation and O_2 metabolism.

Notes: Combined spatial and temporal processes result in a broad spectrum of physiologically “normoxic” tissue pO_2 values. For details see section: What is the pO_2 in organs?

Although 20.9% incubator O_2 conditions are usually referred to as “normoxic”, in physiological terms, they are rather “hyperoxic” because not even lung alveolar cells are ever exposed to 20.9% O_2 . Since the cellular O_2 -sensing system is self-adaptive,²² cells do not “know” the absolute pO_2 levels in their microenvironment. In fact, “hypoxia” is a temporal rather than a spatial term. Every decrease in pO_2 that causes a biological effect, for example, a (transient) increase in HIF α protein stability, can be called “hypoxia”.

Conclusion

Considering the discussed principles of biological O_2 distribution in vitro and in vivo, it becomes evident that it is quite useless to ask for the “correct” O_2 concentration in an incubator to mimic a certain cellular pO_2 corresponding to a specific tissue location. For routine experimental work, it is usually acceptable to compare at least two O_2 concentrations that are sufficiently different to cause specific biological effects while

not affecting general cell viability. In cases where absolute pO_2 levels need to be compared, for example, between different laboratories, only the actually measured pericellular pO_2 levels but not the adjusted gas phase O_2 concentrations in the incubator are relevant.

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Disclosure

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