Clinical and biochemical study of D-serine metabolism among schizophrenia patients

Hamdy N El-Tallawy¹
Tahia H Saleem²
Abdallah MAA El-Ebidi³
Mohammed H Hassan⁴
Romany H Gabra¹
Wafaa MA Farghaly¹
Nagwa Abo El-Maali⁵
Hoda S Sherkawy³

¹Department of Neuropsychiatry, ²Department of Medical Biochemistry and Molecular Biology, Faculty of Medicine, Assiut University, Assiut, ³Department of Medical Biochemistry and Molecular Biology, Faculty of Medicine, Aswan University, Aswan, ⁴Department of Medical Biochemistry and Molecular Biology, Qena Faculty of Medicine, South Valley University, Qena, ⁵Department of Chemistry, Faculty of Science, Assiut University, Assiut, Egypt

Introduction

Schizophrenia is a complex and multifaceted neuropsychiatric disorder characterized by delusions, hallucinations, passivity phenomena, disordered thought process, disorganized behavior and progressive cognitive deficits.¹ According to the World Health Organization, the global prevalence of schizophrenia is ~3.8%–8.4%.² Schizophrenia remains a leading cause of disability worldwide.³ Schizophrenia symptoms can be categorized as positive and negative; positive symptoms include delusions and hallucinations, whereas negative symptoms include anhedonia, asociality, alogia, avolition...
and blunted emotional response. In addition, schizophrenia patients suffer from varying degrees of cognitive deficit with impairments in attention, memory and executive functions.\(^4\)

Schizophrenia is a chronic condition that generally appears in late adolescence or early adulthood. Several data suggest that hypofunction of glutamatergic neurotransmission, via the \(N\)-methyl-\(D\)-aspartate receptor (NMDA-R), plays a crucial role in the pathophysiology of schizophrenia.\(^5\)\(^6\) \(d\)-serine (\(d\)-Ser), an important co-agonist at the NMDA-R, is integral to neurotransmission via NMDA signaling throughout development.\(^7\) Several clinical studies have demonstrated a disturbed NMDA-R neurotransmission, due to decreased \(d\)-Ser levels, as a main cause of the pathophysiology of schizophrenia.\(^8\)

First, many reports have shown lower levels of \(d\)-Ser in the blood, cerebrospinal fluid (CSF) and postmortem brain tissue from patients with schizophrenia, relative to normal controls.\(^9\) Second, treatment with \(d\)-Ser proved to be beneficial for alleviating several symptoms associated with schizophrenia.\(^10\) Although two meta-analysis studies supported the findings that \(d\)-Ser is effective in treating schizophrenia,\(^11\) \(d\)-Ser is not approved as a therapeutic drug for schizophrenia. Third, several studies showed an increase in mRNA expression and the activity of \(d\)-amino acid oxidase (DAAO), which metabolizes \(d\)-Ser, in postmortem brains of schizophrenic patients.\(^12\)

Despite the growing amount of data supporting the role of \(d\)-Ser in the pathophysiology of schizophrenia, some reports show no evidence of decreased \(d\)-Ser in the schizophrenia brain.\(^13\)

\(d\)-Ser is synthesized from \(L\)-serine (\(L\)-Ser) via one enzymatic step catalyzed by the enzyme serine racemase (SR).\(^14\) \(L\)-Ser is biosynthesized from 3-phosphoglycerate, a glucose metabolite, via three enzymatic steps catalyzed by 3-phosphoglycerate dehydrogenase (PHGDH), phosphoserine aminotransferase 1 (PSAT1) and phosphoserine phosphatase (PSP).\(^15\)

\(d\)-Ser can be degraded by DAAO.\(^16\)\(^17\) \(d\)-Ser is an endogenous NMDAR co-agonist,\(^18\) and it is reported that the associated metabolic pathways can participate in schizophrenia pathophysiology.\(^19\)

Based on the assumption that SR and DAAO are key molecules in the pathophysiology of schizophrenia,\(^20\) the present study was carried out to further clarify the pattern of metabolism of \(d\)-Ser in schizophrenia and if its serum level is affected by the clinical type of the schizophrenia or the duration of antipsychotic therapy. This might open the field to new therapeutic strategies for such patients.

### Patients and methods

#### Study design

This cross-sectional case–control study was carried out on 100 patients (38 females and 62 males). Their mean age was 31.0±8.7 years, with the mean duration of schizophrenia of 5.99±4.90 years. Apparently, 50 healthy age- and sex-matched subjects (20 females and 30 males) were selected as a control group (they were selected from paramedical volunteers’ personnel). The total duration of the study was 12 months, from April 1, 2015, to March 31, 2016. Prior to the initiation of the study, every patient was informed about the aim of the study and gave a written consent. Patients were recruited from the outpatients’ Psychiatric Unit of the Neuropsychiatric Department of Assiut University Hospital, Upper Egypt, after approval of the university ethics committee.

#### Data collection

Detailed history for all included patients was taken, including personal history (age, sex, duration of illness); family history of psychiatric disorders, including schizophrenia, mood disorder and anxiety disorder; and therapeutic history (duration of antipsychotic intake and if there was associated electroconvulsive therapy [ECT]). Thorough neurological examination was carried out. The type of schizophrenia according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), and the severity of schizophrenia according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), were determined.

#### Methodology

Patients’ blood samples (5 cc) were taken from antecubital veins. Serum separator tubes were used, and samples were allowed to be clotted for 30 minutes before centrifugation for 15 minutes at 1,000 rpm. Serum of each sample was transferred and divided into three aliquots using 1 mL cryotubes and stored at −20°C till the time of analysis. All samples were measured in a single assay to avoid repeated freeze–thaw cycles.

Serum \(d\)-Ser levels were estimated using an Agilent High-Performance Liquid Chromatography (HPLC) 1200 Series system (Agilent Technologies, Santa Clara, CA, USA) consisting of degasser, quaternary pump, autosampler, thermostated column department and photodiode array detector, which were all controlled by Agilent ChemStation. A Zorbax Extend-C18 column (150×4.6 mm ID ×5 μm particle size) was used for determination. The analysis was done according to the following chromatographic conditions: 0.2 mL from
Statistical analysis
The data were tested for normality using the Anderson–Darling test and for homogeneity variances prior to further statistical analysis. Categorical variables were described by number and percent (n, %), whereas continuous variables were described by mean and standard deviation (mean, SD). Chi-square test and Fisher’s exact test were used to compare categorical variables, while Student’s t-test and analysis of variance (ANOVA) were used to compare continuous quantitative variables of parametric data. Pearson correlation coefficients were used to assess the correlation between continuous variables. A two-tailed test was considered significant when P was < 0.05 and highly significant when P was < 0.01. All analyses were performed using the IBM SPSS version 20.0 software (IBM Corporation, Armonk, NY, USA).

Results
The baseline characteristics of the studied patients are presented in Table 1.

Table 1 Baseline characteristics of the studied patients

<table>
<thead>
<tr>
<th>Variables</th>
<th>Patients group (n=100)</th>
<th>Control group (n=50)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>17–64</td>
<td>17–65</td>
<td>0.706</td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>31.0±8.7</td>
<td>31.6±10.0</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male, n (%)</td>
<td>36 (62)</td>
<td>36 (72)</td>
<td>0.225</td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>38 (38)</td>
<td>14 (28)</td>
<td></td>
</tr>
<tr>
<td>Duration of illness (years)</td>
<td>Total (n=100)</td>
<td>Sex (Males n=62, Females n=38)</td>
<td></td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>5.99±4.90</td>
<td>5.66±4.41</td>
<td>6.33±5.63</td>
</tr>
<tr>
<td>0.17–&lt;5 years, n (%)</td>
<td>54 (54.0)</td>
<td>35 (64.8)</td>
<td>19 (35.2)</td>
</tr>
<tr>
<td>5–&lt;10 years, n (%)</td>
<td>21 (21.0)</td>
<td>12 (57.1)</td>
<td>9 (42.9)</td>
</tr>
<tr>
<td>≥10 years, n (%)</td>
<td>25 (25.0)</td>
<td>15 (60.0)</td>
<td>10 (40.0)</td>
</tr>
<tr>
<td>Therapeutic history, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>100 (100)</td>
<td>66 (66)</td>
<td>34 (34)</td>
</tr>
<tr>
<td>Antipsychotics + ECT</td>
<td>50 (50)</td>
<td>33 (66)</td>
<td>17 (34)</td>
</tr>
<tr>
<td>Family history of schizophrenia or mental illness, n (%)</td>
<td>26 (26)</td>
<td>16 (61.5)</td>
<td>10 (38.5)</td>
</tr>
</tbody>
</table>

Abbreviations: SD, standard deviation; ECT, electroconvulsive therapy.

Table 2 Clinical data of the studied patients

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total (n=100)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive symptoms, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delusion</td>
<td>79 (79)</td>
<td>49 (62)</td>
<td>30 (38)</td>
</tr>
<tr>
<td>Hallucination</td>
<td>85 (85)</td>
<td>54 (63.5)</td>
<td>31 (36.5)</td>
</tr>
<tr>
<td>Negative symptoms, n (%)</td>
<td>7 (7)</td>
<td>5 (71)</td>
<td>2 (29)</td>
</tr>
<tr>
<td>Associated mood symptoms, n (%)</td>
<td>63 (63)</td>
<td>41 (65)</td>
<td>22 (35)</td>
</tr>
<tr>
<td>Manic symptoms</td>
<td>40 (40)</td>
<td>28 (70)</td>
<td>15 (30)</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>23 (23)</td>
<td>16 (69.5)</td>
<td>7 (30.5)</td>
</tr>
<tr>
<td>Degree of severity of schizophrenia according to DSM-5, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>15 (15.0)</td>
<td>9 (60)</td>
<td>6 (40)</td>
</tr>
<tr>
<td>Severe</td>
<td>85 (85.0)</td>
<td>53 (62)</td>
<td>32 (38)</td>
</tr>
<tr>
<td>Clinical types of schizophrenia patients according to DSM-IV, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid</td>
<td>46 (46)</td>
<td>25 (54)</td>
<td>21 (46)</td>
</tr>
<tr>
<td>Disorganized</td>
<td>14 (14)</td>
<td>8 (57)</td>
<td>6 (43)</td>
</tr>
<tr>
<td>Catatonic</td>
<td>8 (8)</td>
<td>2 (25)</td>
<td>6 (75)</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>24 (24)</td>
<td>20 (83)</td>
<td>4 (17)</td>
</tr>
<tr>
<td>Residual</td>
<td>8 (8)</td>
<td>6 (75)</td>
<td>2 (25)</td>
</tr>
</tbody>
</table>

Abbreviations: DSM-5, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.
DAAO and between SR and DAAO was found, as shown in Figures 2–4.

There was a non-significant difference in the serum levels of the studied biochemical parameters between moderate and severe schizophrenia. Significant highest serum levels of d-Ser and SR in the residual type and significant highest serum levels of DAAO in the disorganized type followed by the paranoid type were found (Table 4). Combined receiver-operating characteristic (ROC) curve for serum d-Ser, SR and DAAO is presented in Table 5. The serum level cutoff points were ≤61.4 mg/L for d-Ser and ≤15.5 pg/mL for SR at a sensitivity of 100% and a specificity of 100% for both. The serum level cutoff point for DAAO was >35.6 pg/mL at a sensitivity of 67% and a specificity of 88%.

### Discussion

Schizophrenia is a common and devastating mental illness. It is a clinically and etiologically heterogeneous mental disorder that is characterized by delusions, hallucinations and bizarre behaviors.

In the present study, the male:female ratio of schizophrenic patients was 2:1. This finding is in agreement with previous studies that reported a higher prevalence of schizophrenia among males than among females.

All the included patients (100%) were on antipsychotic drugs, and 50% of them were on “ECT” in addition to the antipsychotic medications. In accordance, a study done by Pawelczyk et al reported that approximately half of the included patients with schizophrenia in their study were on ECT together with antipsychotics.

The majority of our schizophrenic patient sample was of severe type (85%), according to DSM-5, as mild and moderate cases usually do not prefer admission to a mental hospital and prefer treatment in outpatients clinic.
This decreased D-Ser level in the periphery may reflect decreased availability of D-Ser to activate NMDA-Rs in the brain.\textsuperscript{26,27} Schizophrenia is a typical NMDAR hypofunction disorder.\textsuperscript{28} The present study revealed significantly lower serum levels of D-Ser among schizophrenia patients compared with the control group. In agreement with this finding, a study done by Hashimoto et al\textsuperscript{39} and Yamada et al\textsuperscript{30} reported lower serum levels of D-Ser in individuals with schizophrenia compared with the healthy controls. Similarly, Mothet et al\textsuperscript{31} found that reduced levels of D-Ser reflect hypofunction of NMDA-Rs in patients with schizophrenia. On the contrary, other studies (Ohnuma and Araki,\textsuperscript{32} Brouwer et al\textsuperscript{33} and Ozeki et al\textsuperscript{34}) found insignificant difference in the serum levels of D-Ser between the control and the schizophrenic patients.

Enhanced DAAO activity is a potential cause of reduced D-Ser and hence impaired NMDAR functioning in schizophrenia.\textsuperscript{34} The present study revealed significantly higher serum levels of DAAO among schizophrenia patients compared to the control group. Consistent with this finding, previous studies done by Chumakov et al,\textsuperscript{35} Boks et al,\textsuperscript{36} Madeira et al\textsuperscript{37} and Burnet et al\textsuperscript{38} found an increased DAAO activity and expression among patients with schizophrenia. D-Ser racemase is a pyridoxal-5′-phosphate (PLP)-dependent enzyme that catalyzes racemization of L-Ser to D-Ser.\textsuperscript{39} The present study revealed significantly lower serum levels of D-Ser among schizophrenia patients compared with the control group. These results are in agreement with a study done by Yamada et al\textsuperscript{40} who reported that D-Ser in the blood may originate from the brain and that reduced serum levels of D-Ser in schizophrenia may reflect a decrease in the enzymatic activity of SR in the brains of schizophrenic patients.

Regarding the correlation between the studied biochemical parameters among the schizophrenia patients, the present study revealed a significant negative correlation between DAAO on one hand and both D-Ser and SR on the other hand. Moreover, there was a significant positive correlation between SR and D-Ser concentrations. These findings are in agreement with those reported by Calcia et al\textsuperscript{41} and Bendikov et al,\textsuperscript{42} who found reduced SR levels and/or elevated DAAO levels with decreased SR/DAAO ratio in patients with schizophrenia.

Regarding the severity of schizophrenia according to DSM-5, there was an insignificant difference in the serum levels of the studied biochemical parameters between patients with moderate and severe schizophrenia. However,
estimation of the serum levels of the studied biochemical parameters in different clinical types of schizophrenia according to DSM-IV revealed that the disorganized type of schizophrenia had the lowest level of D-ser and SR levels, together with the highest level of DAAO. On the contrary, the residual type had the highest level of D-ser and SR. In this context, Morita et al\textsuperscript{41} found less expression of the serine racemase receptors (SRR) gene, which may result in less conversion of L-Ser to D-Ser and less activation of NMDA-Rs in patients with schizophrenia, especially in the paranoid subtype. Similarly, Goltsov et al\textsuperscript{42} showed that the paranoid subtype of schizophrenia was associated with dysregulation of SRR, which contributes to the pathophysiology of schizophrenia.

To the best of our knowledge, no previous studies could be traced in the literature regarding the sensitivity and specificity of D-Ser, SR and DAAO in the diagnosis of schizophrenia. In the present study, combined ROC curve for serum D-Ser and SR indicates that both have equal high positive and negative accuracy (positive predictive value [PPV] =100 and negative predictive value [NPV] =100 for both), which means that these biochemical markers are perfect as regards schizophrenia diagnosis. The best serum level cutoff points at which schizophrenia manifestations start to appear were ≤61.4 mg/L for D-Ser and ≤15.5 pg/mL for SR at a sensitivity of 100% and a specificity of 100% for both. Regarding the ROC curve for serum levels of DAAO, it is considered better positive than negative (PPV =91.8 and NPV =57.1) in schizophrenia diagnosis beside the clinical correlation. The best serum level cutoff point at which schizophrenia manifestations start to appear was >35.6 pg/mL at a sensitivity of 67% and a specificity of 88%.

**Conclusion**

The data of the present study collectively demonstrate that reduced serum levels of D-Ser and disturbance of its metabolizing enzymes (SR and DAAO) may play an important role in the pathogenesis of schizophrenia. This may shed new light on nontraditional strategies for the future medical treatments of schizophrenia, through normalization of D-Ser metabolism, especially on the genetic levels.

**Study limitations**

The role of other factors such as the type of antipsychotics used, the dosage of antipsychotics (in chlorpromazine equivalent) on the day of biochemical assessment of D-Ser and its metabolizing enzymes (SR and DAAO), body mass index, cigarette smoking and dietary protein intake could not be taken into consideration in the statistical analysis as possible confounders.

**Disclosure**

The authors report no conflicts of interest in this work.

**References**


42. Boks MP, Rietkerk T, Van De Beek MH, Sommer IE, De Koning TJ, Kahn RS. Reviewing the role of the genes G72 and DAOA in glutamate neurotransmission in schizophrenia. *Eur Neuropsychopharmacol.* 2007;17(9):567–572.


