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Free radicals and neonatal encephalopathy: mechanisms of injury, biomarkers, and antioxidant treatment perspectives

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1 **Free radicals and neonatal encephalopathy: mechanisms of injury, biomarkers and**
2 **antioxidant treatment perspectives.**

3
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1 **Abstract**

2 Neonatal encephalopathy (NE), most commonly a result of the disruption of cerebral oxygen
3 delivery, is the leading cause of neurologic disability in term neonates.

4 Given the key role of free radicals in brain injury development following hypoxia-ischemia-
5 reperfusion, several oxidative biomarkers have been explored in pre-clinical and clinical models of
6 NE. Among these, antioxidant enzyme activity, uric acid excretion, nitric oxide, malondialdehyde
7 and non-protein-bound iron have shown promising results as possible predictors of NE severity and
8 outcome. Due to high costs and technical complexity, however, their routine use in clinical practice
9 is still limited.

10 Several strategies aimed at reducing free radical production or up-regulating physiological
11 scavengers have been proposed for NE. Room-air resuscitation has proved to reduce oxidative
12 stress following perinatal asphyxia and is now universally adopted. A number of medications
13 endowed with antioxidant properties, such as melatonin, erythropoietin, allopurinol or N-
14 acetylcysteine, have also shown potential neuroprotective effects in perinatal asphyxia;
15 nevertheless, further evidence is needed before these antioxidant approaches could be implemented
16 as standard care.

17

1 **Role of free radicals in the pathogenesis of hypoxic-ischemic encephalopathy**

2 Neonatal encephalopathy (NE) most commonly results from an acute or subacute disruption of
3 cerebral blood flow and oxygen delivery to the brain during the perinatal period. The incidence of
4 NE ranges from 1 to 8 per 1000 live births in high-income countries to as high as 26 per 1000 live
5 births in low-income countries (1). Despite the advent of therapeutic hypothermia, this condition is
6 still a major cause of death and neurodevelopmental disability in term neonates worldwide (2).

7 Specific antepartum risk factors (e.g., maternal pyrexia, prolonged rupture of membranes, persistent
8 occipito-posterior position), or a well-recognized intrapartum event responsible for an acute
9 decrease of placental perfusion (e.g., placental abruption, prolapse of the umbilical cord, uterine
10 rupture, shoulder dystocia) can be often identified (3,4). The development of hypoxic-ischemic
11 brain damage is more likely in the presence of umbilical cord arterial pH <6.8, base excess <-20
12 mEq/l, Apgar score of ≤ 3 at 10 min and other negative prognostic factors, such as absent fetal heart
13 rate variability prior to birth, seizures in the first day of life, and multi-organ injury (5). The
14 characteristics of the asphyxiating insult (i.e., intermittent, persistent, chronic), together with the
15 infant's gestational age, prior metabolic and cardiovascular status and individual sensitivity to
16 oxidative stress further contribute to the severity of NE (5). The Sarnat staging system, based on the
17 combination of specific clinical signs (e.g., abnormalities of consciousness, tone, reflexes and/or
18 electrical brain activity), classifies NE into three stages of increasing severity: the higher the stage,
19 the lower the probability of survival without major neurological sequelae (6).

20 The main phases of NE, with the related mechanisms of injury and the therapeutic strategies
21 currently proposed in research settings, are summarized in Figure 1. The event sequence leading to
22 NE includes oxygen deprivation, energy depletion, and re-oxygenation. As illustrated in Figure 2,
23 these events contribute to the generation of reactive oxygen (ROS) and nitrogen species (RNS),
24 which harmfully interact with nearby proteins, nucleic acids or membrane lipids, altering their
25 function and converting them into free radicals (7). ROS are finely regulated by specific antioxidant
26 enzymes, such as superoxide dismutase (SOD), catalase (CAT), reduced glutathione (GSH) and

1 glutathione peroxidase (GP); the imbalance between ROS production and clearance leads to
2 oxidative stress (OS) in the newborn (8,9).

3 The metabolic consequence of acute cerebral hypoperfusion is the inhibition of oxidative
4 phosphorylation in the electron transport chain (ETC) of the mitochondria, resulting in anaerobic
5 metabolism. Glucose utilization in anaerobic glycolysis is highly inefficient and contributes to a
6 rapid depletion of cerebral glucose, the primary energy source for neural cells (10). The resulting
7 decrease in adenosine triphosphate (ATP) leads to the inactivation of ATP-dependent ion pumps,
8 with intracellular accumulation of sodium and water, progressive cell swelling and cellular necrosis.
9 This event cascade culminates into glutamate excitotoxicity, which not only activates apoptotic
10 pathways via N-methyl-D-aspartate (NMDA) and glutamate receptors, but also up-regulates nitric
11 oxide synthase (NOS) to induce a compensatory increase in cerebral blood flow (11). The ensuing
12 NO surge, however, triggers the production of potent RNS that actively contribute to brain damage
13 (12).

14 Following acute hypoxia-ischemia in term neonates, the deep grey nuclei appear most vulnerable.
15 The enhanced susceptibility of this area is due to the presence of NOS-expressing (NOS+) striatal
16 neurons that are paradoxically resistant to hypoxic-ischemic injury but, by producing high amounts
17 of RNS, exert a harmful bystander effect on nearby neural and glial cells (13-16).

18 Following the acute insult, there is a restoration of cerebral perfusion, which, while essential for
19 survival, paradoxically contributes to the so-called reperfusion injury, mediated by excessive free
20 radical production (17). This results not only in an oxidative burst but also in a progressive
21 disruption of the mitochondrial ETC, leading to secondary ATP depletion and subsequent apoptotic
22 brain damage (18).

23 The progressive accumulation of hypoxanthine that follows ATP depletion, and the reoxygenation-
24 driven conversion of xanthine dehydrogenase (XD) to xanthine oxidase (XO), a superoxide-
25 producing enzyme which, using O₂ as a cofactor, produces •O₂⁻ and uric acid from xanthine or
26 hypoxanthine, are primary sources of ROS after reperfusion (19). Non-protein-bound iron (NPBI),

1 released from hemoglobin, enhances hydroxyl radical formation via the Fenton reaction, thus
2 raising ROS levels exponentially (20). ROS and RNS further worsen the mitochondrial damage
3 begun by primary ATP depletion and glutamate excitotoxicity, contributing to the progressive
4 disruption of oxidative phosphorylation that ensues in secondary energy failure and neuronal
5 apoptosis (19). These latter events, however, are preceded by a phase of latency, which may last up
6 to 6 hours following reperfusion and represents a crucial therapeutic window (4).

7 Understanding the role of free radicals in NE has led to the discovery of several biomarkers of
8 oxidation or nitrosylation, with possible diagnostic and prognostic implications. Also, there is a
9 potential of developing novel neuroprotective approaches based on antioxidant therapies. This
10 review aims to provide an overview of the role of free radical biomarkers and antioxidant therapies
11 in NE. Literature search methods are provided in Supplemental Table S1 (online).

12

13 **Free radical biomarkers in NE**

14 The diagnosis of NE mainly relies on clinical, neurophysiological and neuroimaging abnormalities.
15 However, both the neurological status and cerebral electrical activity can be significantly altered by
16 sedatives, anticonvulsants, and therapeutic hypothermia (TH) (21). Moreover, diagnostic changes
17 on magnetic resonance (MR) imaging may take several days to become apparent. The validation of
18 molecular biomarkers of hypoxia-ischemia and ensuing free radical burden may help identifying
19 neonates at higher risk of moderate-to-severe NE, who could qualify for early neuroprotective
20 treatments. The following section focuses on current biomarkers for oxidative and nitrosative stress,
21 which are summarized in Table 1 (22).

22 Gas chromatography coupled to mass spectrometry has long been the gold-standard technique for a
23 qualitative and quantitative estimation of oxidative compounds on different specimens (16).
24 Recently, the development of high or ultra-performance liquid chromatography (LC-MS/MS),
25 which allows a simultaneous measurement of different compounds on smaller sample volumes, has
26 contributed to ease the assessment of oxidative status in the neonatal population (23). Nevertheless,

1 high costs and need for trained personnel are major limitations to the routine clinical application of
2 these methods, which are therefore often confined to research facilities (24).

3

4 ***1. Antioxidant enzymes***

5 SOD, GP and CAT are the first-line antioxidant defense against OS. Following a hypoxic-ischemic
6 hit, their activity acutely rises to counteract the ensuing ROS production and its harmful effects.
7 Significantly higher SOD, CAT and GP levels have been reported in cord blood samples of
8 asphyxiated newborns compared to controls (25); at 24 hours, however, only CAT and SOD, but
9 not GP, maintained higher plasma concentrations in infants with NE compared to controls (26–28).
10 A positive correlation between CAT and SOD cord levels and Sarnat stages was also observed (25),
11 suggesting that the up regulation of these enzymes may mirror NE severity. Given their acute
12 increase, these data suggest that the evaluation of antioxidant enzymes in cord blood may add
13 useful information on both timing and severity of perinatal asphyxia within the decision-making
14 window for TH. Nevertheless, it should be noted that they are based on small cohorts, thus needing
15 further confirmation in larger clinical trials.

16 Very little is known about antioxidant enzymatic activities in other biological fluids. One study has
17 reported a significantly enhanced SOD activity in cerebrospinal fluid (CSF) between 0 and 72 hours
18 in 30 term neonates with NE, whereas GP and CAT activity increased only in the severe NE
19 subgroup (29). However, there was a wide time interval during which lumbar puncture was
20 performed (anytime within 72 hours of life) making it difficult to interpret.

21 Most of these cited studies were performed before the routine introduction of TH, whose potential
22 modulatory effect on antioxidant enzymatic activities requires further evaluation.

23

24 ***2. Uric acid***

25 The reoxygenation-driven conversion of XD to XO, which produces $\bullet\text{O}_2^-$ and uric acid, plays a key
26 role in oxidative brain damage. Urinary excretion of uric acid has thus been proposed as an

1 economical and non-invasive marker for XO-related ROS production in asphyxiated newborns.
2 Several studies have consistently reported an increased urinary uric-acid-to-urinary-creatinine ratio
3 within 48-72 hours of life in term and preterm asphyxiated newborns (30–35), and a positive
4 correlation between this ratio and Sarnat stage has also been reported (31). A cut-off of 2.3 mg/mg
5 over the first 72 hours has been proposed as diagnostic of perinatal asphyxia in a single study on 40
6 asphyxiated infants in a low/middle resource setting (35). In this study, however, the diagnosis of
7 perinatal asphyxia was mainly based on Apgar score and cord pH at birth; moreover, no post-natal
8 clinical data of the infants enrolled are available, other than none of them were undergoing TH at
9 the time of urine collection. Values ≥ 2.6 mg/mg may predict impending death in asphyxiated term
10 infants with good sensitivity and specificity (31), but again, this data was based on a small study of
11 only 20 infants and performed before the introduction of TH. Larger studies are therefore needed on
12 patients undergoing TH.

13

14 **3. Nitric oxide (NO)**

15 Ischemia-induced up-regulation of NOS enhances NO and RNS production. A raised concentration
16 of NO in blood and CSF NO, as well as a higher plasma nitrates/nitrites ratio (which serves as a
17 proxy for NO levels), have been detected in neonates with NE within the first 24 hours (27,36–38),
18 with higher NO concentration related to higher Sarnat stage (26,37,38). Furthermore, plasma NO
19 was increased in asphyxiated infants with early evidence of brain damage compared to those with
20 normal neuroimaging (37). However, these studies ~~trials~~ were carried out before the introduction of
21 TH. Future studies, though, could also help to evaluate the role of this biomarker in selecting those
22 infants who might benefit of specific antioxidant treatments such as xanthine oxidase inhibitors,
23 which hinder the formation of peroxynitrite from xanthine-oxidase-derived superoxide and NO and
24 the subsequent activation of downstream pathways that lead to cerebral endothelial and tissue injury
25 (38).

26

1 **4. Non-protein-bound iron (NPBI)**

2 Following hypoxia-reoxygenation, hemoglobin-released NPBI interacts with $\bullet\text{O}_2^-$ and H_2O_2 and
3 forms highly reactive $\bullet\text{OH}$. Studies conducted in the pre-cooling era reported increased
4 concentrations of plasma NPBI with increasing NE severity (39), although low or undetectable
5 NPBI levels were also seen in moderately and severely asphyxiated infants. However, low or
6 undetectable concentrations values were significantly associated with normal neurological outcome
7 at 1 year, irrespective of NE stage; these latter data, however, were obtained from a small number
8 of infants and need to be confirmed on larger samples (39). Higher NPBI levels in plasma and CSF
9 have been described within the first 72 hours in neonates with moderate-to-severe NE who died or
10 developed neurological sequelae (40,41). More recently, increased plasma NPBI levels at 4-6 hours,
11 but not at 24-72 hours and 5 days of life, were detected in 80 infants with severe NE who
12 underwent TH, compared to those with mild-moderate NE (42), suggesting not only a possible
13 prognostic value of NPBI in the earliest phases after the perinatal insult, but also a possible
14 influence of TH on this biomarker or, more generally, on OS levels. Nevertheless, diagnostic NPBI
15 levels for NE still have to be defined.

16

17 **5. Lipid peroxidation markers**

18 The extent of lipid peroxidation following hypoxia-ischemia can overwhelm the adaptive up-
19 regulation of antioxidant systems, leading to harmful effects on membrane phospholipids,
20 functional loss and programmed cell death. Once this process is initiated, it generates a wide variety
21 of lipid peroxidation products that, given the rich lipid composition of the infant brain, might reflect
22 the extent of cerebral oxidative damage.

23

24 *Malondialdehyde (MDA) and 4-hydroxynonenal (4-HNE)*

25 MDA, a biomarker for n-3 and n-6 fatty acid peroxidation, has been widely investigated, as it can
26 be easily determined by thiobarbituric acid assay, a widely available spectrophotometric technique

1 (43). The current literature is consistent in reporting increased MDA levels in cord blood of
2 severely asphyxiated neonates (31,34,44) and in the serum of infants with NE (26-28,36,41,45)
3 compared to controls. As for prognostic implications, serum MDA at 24 hours positively correlates
4 with NE severity (27,28), with highest values in infants who died (41,45) or developed persistent
5 neurological abnormalities (40,41,45).

6 Being water-soluble, MDA is detected in urine, and its excretion rate has also been tested in the
7 context of NE. The ratio between urinary MDA and urinary creatinine (uMDA/uCr) was
8 significantly increased over the first 48 hours of life in asphyxiated neonates compared to controls,
9 and positively correlated with Sarnat stage (31,34). A higher uMDA/uCr ratio was also observed in
10 asphyxiated neonates who died compared to survivors, and values $>3.49 \mu\text{g}/\text{mg}$ on day 1 have been
11 proposed to predict mortality following perinatal asphyxia in a small number of asphyxiated infants
12 (31). Since most of these studies did not include infants who underwent TH, it is unclear whether
13 this treatment can influence MDA levels.

14 A possible limitation of serum and urinary MDA is the lack of specificity for the cerebral tissue, as
15 it may also reflect the extent of lipid peroxidation following extensive multiorgan damage. MDA
16 concentration in CSF should provide a better estimate of oxidative brain damage in asphyxiated
17 infants. Significantly higher CSF levels of MDA have been reported at 24-48 hours in asphyxiated
18 term infants compared to controls, with a positive correlation with Sarnat stages (25), and also in
19 infants with NE who expired or developed neurological deficits compared to those with normal
20 neurological status at hospital discharge (41). However, further data are needed to validate CSF
21 MDA as a reliable marker for oxidative brain damage in NE.

22 As for 4-HNE, a metabolite of n-6 fatty acid peroxidation, Schmidt et al reported significantly risen
23 cord blood levels following a perinatal hypoxic insult (46). To date, however, no additional data are
24 available to add knowledge on this biomarker in the context of NE. This could be due the unstable
25 nature of 4-HNE that contributes to the technical complexity of its determination, which benefits
26 from the use of advanced liquid chromatography methods (47).

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Prostaglandin-like peroxidation products (PPPs)

Isoprostanes, neuroprostanes and neurofurans are prostaglandin-like compounds derived from free radical-catalyzed peroxidation of arachidonic (AA) and docosahexaenoic (DHA) acid.

F2-isoprostanes seem to best reflect OS extent after hypoxia-reperfusion (48) and, thanks to ultra-performance LC-MS/MS, can be determined even in the neonatal population. Higher cord blood levels of 8-iso-15(R)-PGF2 α and total isoprostanes were detected in acidotic and depressed infants compared to healthy neonates; 8-iso-15(R)-PGF2 α positively correlated with the severity of asphyxia (49). However, serial evaluation of serum F2-isoprostanes over the first 5 days showed no difference between neonates who developed severe compared to mild-to-moderate NE nor any correlation with brain damage at neuroimaging (42). Given this scarce and inconclusive evidence, further studies are necessary to define whether PPPs may reflect PUFA oxidation after perinatal asphyxia.

6. Protein oxidation markers

Protein carbonyls (PC) and advanced oxidation protein products (AOPP) result from protein carbonylation, nitration, cross-linking or loss of thiol groups by free radicals. Increased serum PC have been observed at birth and 48 hours in asphyxiated term neonates, with higher levels in those who developed seizures; however, no difference was observed in relation to Sarnat stage or developmental outcome at 9 months (45). Buonocore et al. previously reported increased cord levels of AOPP in hypoxic compared to normoxic preterm infants, and a positive correlation between this marker and plasma hydroperoxides (50).

Recently, higher plasma AOPP at 4-6 hours of life have been described in term infants with severe NE, who required TH, compared to mild/moderate NE (42). Later measurements (i.e., 24-72 hours and 5 days) showed no difference between cooled asphyxiated infants and controls. This is consistent with previous findings by Mutlu et al, who compared AOPP levels between 30 cooled

1 NE infants and 30 healthy term controls at 6-24 hours and 5 days (28). Given this lack of difference
2 in AOPP levels during and after TH, it suggests a possible role of cooling in modulating protein
3 oxidation, which warrants further investigation. A significant independent association between MRI
4 scores suggestive of brain injury and blood levels of AOPP over the first 5 days of life in neonates
5 with NE has also been reported, with a stronger correlation in male infants, suggesting a possible
6 role for AOPP as a biomarker of brain oxidative damage (42).

7

8 ***7. DNA peroxidation markers***

9 Oxidative stress can lead to harmful peroxidative changes to nucleic acids. The oxidized DNA
10 nucleoside 8-hydroxydeoxyguanosine (8-OHdG), resulting from DNA peroxidation, has been
11 proposed as a biomarker for oxidative DNA damage in the neonatal population (51,52), and has
12 also been used to evaluate the efficacy of TH in reducing OS-related DNA damage (53).
13 Nevertheless, to the best of our knowledge, current clinical evidence on its diagnostic role in NE is
14 limited to a small, pilot study aimed at evaluating 8-OHdG concentration in urine and CSF samples
15 of children with brain damage, including a small subgroup with NE (54). Despite significantly
16 higher CSF and urinary 8-OHdG levels were observed in this population compared to control
17 subjects, the study sample is undersized to draw any conclusion, and data on the timing of specimen
18 collection are not available. Moreover, this biomarker is also increased in other causes of brain
19 injury (e.g., status epilepticus, central nervous system infections), thus suggesting a lack of
20 specificity for NE.

21

22 **Antioxidant strategies for neuroprotection in NE**

23 The role of free radicals in the development of brain injury following hypoxia-ischemia-reperfusion
24 has provided the rationale to explore antioxidant therapeutic approaches for NE, aimed either at up-
25 regulating the physiological scavenging systems or hindering ROS and RNS production at different
26 levels. While the use of room air for the resuscitation of depressed term infants has become part of

1 standard neonatal care, the use of other antioxidant molecules is mainly limited to research settings,
2 with only variable pre-clinical and/or clinical supportive evidence (see Table 2).

3 The main neuroprotective strategies currently adopted or proposed to dampen oxidative brain
4 damage after perinatal asphyxia ~~will be~~ are analyzed and discussed below.

5

6 ***a. Use of room air and novel inhaled antioxidant strategies for neonatal resuscitation***

7 The beneficial effects of the use of 21% oxygen for the resuscitation of asphyxiated neonates on
8 clinical outcomes and mortality was first reported two decades ago (55) and largely confirmed over
9 the following years, thus becoming the standard of care for term infants' delivery room
10 management since 2010 (56). In parallel, the relation between OS and the oxygen amount provided
11 during resuscitation after perinatal asphyxia has been investigated in animal and human studies,
12 producing a growing body of evidence towards a reduction of the oxidative burden following room-
13 air resuscitation (57–60).

14 Based on this evidence, novel inhaled antioxidant strategies have been recently proposed for
15 perinatal resuscitation. The use of inhaled hydrogen with room air has shown an encouraging
16 attenuation of cerebral oxidative biomarkers in swine models of NE (61,62); clinical evidence,
17 however, is lacking. Due to its ability to cross the blood–brain barrier (BBB), inhaled xenon has
18 also attracted broad interest as a potential neuroprotective agent for NE, although its mechanism of
19 action is mainly ascribable to NMDA receptor antagonism rather than to antioxidant properties.
20 Current evidence from randomized-controlled trials, however, are limited to Azzopardi et al., who
21 did not demonstrate any added effect to TH in infants with NE (63,64), despite of the acknowledged
22 possible limitations (e.g., timing of the treatment start and duration of dose).

23 Recently, due to its cheaper costs compared to xenon, inhaled argon has also been proposed for
24 neuroprotection following perinatal asphyxia. Encouraging preliminary evidence of reduced white
25 matter lactate and N-acetyl aspartate at 24 and 48 hours, as well as of reduced apoptotic burden and
26 faster recovery of amplitude-integrated electroencephalography has been observed in asphyxiated

1 piglets undergone TH and 45-50% argon inhalation 2 hours after the insult, compared to a TH-only
2 group (65). Nevertheless, the safety of argon needs to be further assessed before translational
3 clinical trials can commence.

4

5 ***b. Therapeutic hypothermia***

6 The efficacy of TH in decreasing brain injury (66) and reducing major neurocognitive sequelae (67)
7 in neonates with moderate-to-severe NE has been largely established, and is currently the standard
8 of care for term and late-preterm infants with NE (4). The beneficial effects of TH mainly result
9 from the down-regulation of cerebral energy metabolism, which dampens the apoptotic burden of
10 secondary cerebral energy failure (68). However, other suggested mechanisms through which TH
11 exerts neuroprotection include inhibiting neuronal cell death, limiting excitotoxicity, modulating glial
12 cell activation (69) and activating cold-inducible RNAs (70). Moreover, a direct reduction of
13 oxygen-based free radicals following an ischemic insult and subsequent reperfusion has been
14 reported in both *in vitro* (71) and *in vivo* animal studies (72).

15 In animal models, TH has proved to effectively decrease striatal and cortical NO-mediated
16 production of cyclic GMP (73) and lipid peroxidation products in white matter (74), suggesting a
17 protective effect against not only oxidative but also nitrosative stress. In clinical studies, decreased
18 serum levels of MDA and PC and increased SOD, GP and glutathione S-transferase activities have
19 been documented in adults undergoing hypothermia after cardiac arrest (75), whereas no significant
20 difference in serum hydroperoxides was observed in hypothermic compared with normothermic
21 asphyxiated term infants over the first 3 days of life (76). The small amount of preliminary data
22 would suggest that TH has a beneficial effect on free radical production (28,42). Moreover, a
23 combined role of TH and other neuroprotective strategies with known antioxidant properties (e.g.,
24 erythropoietin, melatonin, allopurinol, N-acetylcysteine, DHA) in reducing hypoxic-ischemic brain
25 damage has also been reported, suggesting a synergistic mechanism of action.

26

1 ***c. Erythropoietin (Epo)***

2 By binding to its receptors (Epo-R), which are largely expressed in the central nervous system, Epo
3 inhibits apoptotic pathways, reduces proinflammatory cytokines and dampens glutamate
4 excitotoxicity (77), with promising therapeutic implications in NE (78). Under hypoxic conditions,
5 Epo-R expression and Epo secretion are significantly up-regulated but, while the former increases
6 promptly, the latter rises more slowly (79); hence, the potential therapeutic role of exogenous Epo is
7 greatest during this period.

8 Pre-clinical research has provided robust evidence in support of the neuroprotective effects of Epo
9 following perinatal hypoxia, reporting reduced neuronal apoptosis and inflammation, less damage
10 to white and grey matter, lower mortality rates and long-term improvements in motor and cognitive
11 functions (80-84). An *in vitro* suppression of ROS production in microglia and reduced lipid
12 peroxidation products have also been reported in fetal murine brain following Epo administration
13 (85,86), suggesting possible antioxidant properties.

14 Consistent evidence has been obtained from controlled clinical trials on asphyxiated infants treated
15 with Epo, either alongside TH (87) or alone (88-92). Epo administration has been associated with
16 decreased serum SOD and GP levels (91) fewer seizures (88,90), less abnormalities at
17 neuroimaging (87,90), better psychomotor outcomes up to 24 months of age (89–91), and, when
18 compared to supportive care, reduced mortality (91,92). Current clinical evidence, however, is
19 derived from small studies and, as such, it is burdened by pronounced differences in terms of
20 settings (e.g., high or medium-low income), Epo dose ranges or timing of administration, outcome
21 evaluation etc. Hence, further data on a larger scale are needed to confirm these positive
22 preliminary results. To this regard, two multicenter randomized double-blind controlled trials are
23 currently recruiting (NCT02811263 and NCT03079167).

24

25 ***d. Melatonin***

1 Melatonin has broad antioxidant, anti-inflammatory and anti-apoptotic properties. As an
2 antioxidant, it acts as a ROS scavenger and also enhances ETC efficiency and the enzymatic
3 activity of SOD, GP and glutathione reductase (93); moreover, by reducing NOS expression, it
4 contributes to decrease peroxynitrite formation (94). Due to its lipophilic nature, this molecule can
5 easily cross the placental interface and the BBB, with useful therapeutic implications.

6 Antioxidant benefits in NE are largely supported by pre-clinical evidence reporting lower brain
7 levels of ROS, lipid and protein peroxidation products, free iron and NO, increased GSH in
8 periventricular white matter, reduced neuronal apoptosis and improved long-term developmental
9 outcomes (95–99). Alongside TH, melatonin significantly enhanced hypothermic neuroprotection in
10 asphyxiated newborn piglets by reducing the area under the p-MRS curve for lactate/N-acetyl
11 aspartate (NAA) and lactate/total creatine ratios in deep grey matter, improving cerebral energy
12 metabolism and decreasing the apoptotic burden in basal ganglia and internal capsule (100). In
13 order to enhance its solubility in aqueous vehicles, however, melatonin administered in the above
14 studies was diluted in ethanol, which, at low doses, has been associated with *in vitro* protective
15 effects against ischemia/reperfusion-mediated brain injury, and could have thus acted as a possible
16 confounder (101). This issue has been recently addressed by Robertson et al., who tested the
17 neuroprotective effects of an ethanol-free melatonin formulation, administered at 5 and 15 mg/kg,
18 compared to TH in a piglet model of NE (102). Reduced cell death in the sensorimotor cortex was
19 observed with 15 mg/kg melatonin, but not with lower concentrations; moreover, no between-group
20 difference in lactate/NAA was found at p-MRS evaluation.

21 In one small clinical study, lower serum levels of MDA, nitrosative biomarkers and reduced
22 mortality rates have been reported in a small cohort of asphyxiated neonates given melatonin (103).

23 In another trial, the combination of melatonin and TH resulted in decreased serum NO, fewer
24 seizures, reduced white matter injury at neuroimaging and improved survival without
25 neurodevelopmental abnormalities at 6 months (104); however, the different rates of severe NE in
26 the two study groups (TH only vs. TH plus melatonin), together with the limited study sample, may

1 have biased these observed results. A targeted trial aimed at assessing the appropriate melatonin
2 dosage to achieve neuroprotective effects in infants with NE undergoing TH (NCT02621944) is
3 currently recruiting. Based on current literature, neonatal melatonin administration holds promising
4 potential for translation to standard practice in NE, although further studies are warranted for its
5 validation.

6 The ability of melatonin to cross the placenta has led to the evaluation of maternal intrapartum
7 administration to minimize the harm of intrauterine fetal asphyxia. A reduction of lipid peroxidation
8 products has been reported in the cerebral tissue of late-gestation lambs (105), but equivalent
9 clinical studies are not available yet. Perinatal asphyxia, however, often results from a sudden and
10 unpredictable event, thus possibly limiting the viability for research validation and subsequent
11 clinical implementation of this approach.

12

13 *e. Allopurinol*

14 The neuroprotective potential of allopurinol results from its antioxidant properties, such as XO
15 inhibition and free radicals scavenging, combined with its ability to cross the BBB and the placenta.
16 Significantly reduced acute cerebral edema and extent of brain injury have been reported in the
17 treated arm of a murine model of NE (106,107), with possible gender-related effects (108).

18 When first translated into clinical research, allopurinol administration had been associated with
19 significantly lower serum levels of NPBI and uric acid, no rise in serum MDA, and more stable
20 cerebral blood flow and electrical activity in treated compared to untreated asphyxiated infants
21 (109). Nonetheless, no effect on mortality and morbidity in severe neonatal asphyxia was
22 documented (110). Decreased NO levels in serum, but not in CSF, were also reported at 72-96
23 hours of life following allopurinol treatment, commenced within 2 hours from the perinatal
24 asphyxiating insult (38). Importantly, no adverse effects on blood cell count, skin, and liver
25 enzymes have been reported (38,109,110).

1 Longer term effects of post-asphyxia allopurinol treatment on neurodevelopment have also been
2 investigated. While Gunes et al. (38) observed improved outcomes at ≥ 12 months of age, the 5-year
3 follow-up of Van Bel and Benders' trials demonstrated protective effects only for the moderate NE
4 subgroup (111); these studies, however, were performed before the routine introduction of TH.
5 The efficacy of antepartum allopurinol administration in the presence of fetal hypoxia has been
6 examined in animal (111,112) and human (113-115) studies. While reduced cord blood levels of
7 NPBI and neuronal damage biomarkers were preliminary reported in neonates born from treated
8 mothers (113), results from a multicenter randomized placebo-controlled trial (ALLO-trial) failed to
9 demonstrate any decrease in cord blood biomarkers of neuronal damage and lipid peroxidation
10 (114) or improved developmental and behavioral outcomes at 5 years in infants from the treated
11 arm (115). However, it should be noted that, as reported by the authors, none of the infants included
12 in the ALLO-trial had developed NE, and no significant differences in Apgar scores, cord pH and
13 base excess were noted between the treated and control arms (114). While these results would
14 suggest that further clinical studies are warranted, there remains an issue regarding the feasibility of
15 maternal intrapartum treatment in relation to the unpredictability of perinatal asphyxia, if the aim is
16 to prevent NE.

17 Available clinical evidence on the neuroprotective effects of antenatal or postnatal allopurinol in
18 NE is still inconclusive (116). Data from an ongoing study (ALBINO, NCT03162653;
19 <http://www.albino-study.eu>) evaluating the efficacy and safety of allopurinol administration
20 immediately after birth to near-term infants with NE in addition to TH may help to clarify the
21 validity of postnatal therapy in the upcoming years.

22

23 *f. NOS inhibitors*

24 NO production is mediated by different NOS isoforms: neuronal (nNOS), endothelial (eNOS) and
25 inducible (iNOS). These isoforms, expressed in neurons, astrocytes and endothelial cells, are

1 significantly up-regulated under hypoxic conditions; as such, NOS inhibition has been proposed as
2 a possible neuroprotective strategy for NE (117).

3 In murine models of NE, pre-hypoxic administration of iNOS, nNOS and constitutive NOS
4 inhibitors, such as aminoguanidine, 7-nitroindazole and N^G-nitro-L-arginine effectively reduced NO
5 levels during hypoxia and re-oxygenation (118–126). Similar results, however, were not obtained
6 after post-insult administration (120-122); given the unpredictability of perinatal asphyxia, this
7 represents a significant limitation.

8 The selective nNOS and iNOS inhibitor 2-iminobiotin (2-IB), administered in a repeated dosing
9 regimen before and after the hypoxic insult, has shown neuroprotective effects in asphyxiated
10 female mice (14,123). Based on this pre-clinical evidence, 2-IB efficacy in human NE is currently
11 being tested in two clinical trials (EudraCT2015-003063-12, NTR5221), whereas another one
12 (NCT01626924) was prematurely terminated because TH, which was an exclusion criterion for the
13 trial enrolment, had soon become the standard of care. The mechanisms of action of 2-IB,
14 nevertheless, seem to ensue from the blockage of cytochrome C/caspase-3 apoptotic cascade rather
15 than from NOS inhibition (123–125).

16 Eventually, a novel class of computer-designed nNOS inhibitors has been tested in animal models
17 of NE, proving better than 7-nitroindazole in nNOS down-regulation (126). These molecules have
18 also shown protective effects against nitrosative stress on striatal neurons and improved motor and
19 neurobehavioral outcomes (127–129), paving the way for its potential clinical translation.

20

21 *g. N-Acetylcysteine (NAC)*

22 NAC is a cysteine precursor endowed with antioxidant effects, such as ROS scavenging and GSH
23 replenishment in deficient cells (130). These properties, together with its lipophilic nature and low-
24 toxicity profile (131), have made NAC an interesting candidate for neuroprotection in NE.

25 Post-resuscitation NAC administration in asphyxiated piglets has been associated with decreased
26 inflammatory markers in the prefrontal cortex and cerebellum (132,133), significantly attenuated

1 H₂O₂ surge in the cortex and decreased cortical levels of lipid hydroperoxide and oxidized
2 glutathione (134,135). Similar findings, together with reduced brain nitrotyrosine, were reported
3 also in a rodent model of lipopolysaccharide-sensitized hypoxia-ischemia (136). Moreover, when
4 combined with TH, NAC effectively reduced brain volume loss, increased myelin expression and
5 improved functional outcomes after hypoxic-ischemic brain injury in neonatal rats (137).

6 Preliminary clinical evidence from a small cohort of asphyxiated newborns who had previously
7 undergone TH has shown a significant GSH surge in basal ganglia on MR spectroscopy within 30
8 minutes from intravenous NAC administration (138). Nevertheless, further studies are needed to
9 evaluate NAC efficacy and safety in NE.

10 Encouraging neuroprotective effects after maternal intrapartum NAC administration have been
11 observed in newborns exposed to chorioamnionitis (139). Trials on asphyxiated neonates, however,
12 are not available yet.

13

14 ***h. Docosahexaenoic acid (DHA)***

15 Based on its free radical scavenging ability, and following evidence of decreased glutamate
16 excitotoxicity, reduced NO and increased antioxidant enzymatic activities in DHA-enriched
17 neuronal cultures (140), a possible neuroprotective role for DHA has been hypothesized. In a swine
18 model of NE, post-insult DHA significantly reduced cortical and hippocampal lipid peroxidation
19 markers (141), increased hippocampal GSH levels and showed an added effect to TH in decreasing
20 urine F4-neuroprostanes (142) and cortical lactate/N-acetylaspartate ratio at MR spectroscopy
21 (143). In rodent studies, pre-insult DHA reduced brain volume loss and improved functional
22 outcome after hypoxia-ischemia (144), whereas post-insult administration achieved similar results
23 only in combination with TH (145). Clinical trials on DHA administration in NE, however, are
24 lacking; hence, targeted studies are warranted to evaluate whether the above pre-clinical evidence
25 can be translated to clinical settings.

26

1 *i. Edaravone*

2 Edaravone (3-methyl-1-phenyl-pyrazolin-5-one) is a free radical scavenger whose multiple
3 antioxidant effects have been tested in different experimental settings, including animal models of
4 NE (146). In a murine study, pre- and post-insult edaravone administration effectively decreased the
5 burden of apoptosis and necrosis and dampened down mitochondrial injury (147), whereas its
6 administration before, during and after hypoxia led to a dose-dependent inhibition of lipid
7 peroxidation in the neonatal rat brain (148). Eventually, post-insult edaravone reduced both the
8 number of apoptotic neurons and the expression of 8-OHdG, a marker of DNA peroxidation, within
9 48 h after the hypoxic-ischemic insult (149). To date, however, clinical evidence on the
10 neuroprotective effects of edaravone is limited to a small cohort of pediatric patients with cerebral
11 infarction, who showed improved neurological outcome without significant adverse effects (150),
12 whilst data on its efficacy and safety in the neonatal population are still lacking.

13

14 **Conclusion**

15 Free radicals play a major role in the development of brain injury following hypoxia-ischemia-
16 reperfusion in asphyxiated neonates. Over the past decades, a number of oxidative and nitrosative
17 biomarkers from different biological fluids have been proposed to assess the burden of free radical
18 damage following perinatal asphyxia. Among them, antioxidant enzymes, uric acid excretion rate,
19 NO, MDA and NPBI have been investigated more extensively in experimental and clinical
20 research, showing also a possible predictive value for NE severity and outcome, whereas other
21 biomarkers (e.g., F2-isoprostanes, AOPP) have come into the spotlight more recently, and require
22 larger evaluation. Nevertheless, small and highly heterogeneous study samples together with the
23 lack of commercially available reference standards often hinder the clinical validation of these
24 biomarkers and call for larger, multicenter trials, aimed also at establishing normal values and
25 evaluating the influence of TH. Moreover, it is an open matter of debate whether plasma or urine
26 metabolites truly report brain oxidation extent or rather reflect the multiorgan oxidative damage that

1 often accompanies severe NE. While CSF specimens are more specific, they are harder to collect,
2 particularly in sick or unstable infants, and only few biomarkers have been currently assessed in this
3 biological fluid. Eventually, by enhancing OS, several conditions different from perinatal asphyxia,
4 either antenatal (e.g., maternal pre-eclampsia (151), exposure to maternal tobacco (152) etc.) or
5 postnatal (e.g., sepsis (153), respiratory distress (154) etc.) may alter the oxidant status of newborn
6 infants, and therefore should be taken into account when clinical trials evaluating oxidative or
7 nitrosative biomarkers are designed.

8 Different antioxidant strategies have been explored as neuroprotective candidates for NE. While
9 room-air resuscitation of asphyxiated term neonates is universally recommended and TH has
10 become the standard of care for NE, a number of molecules endowed with antioxidant properties
11 are currently under investigation. Melatonin and Epo have shown mild beneficial effects in clinical
12 studies but require further large-scale validation before being introduced in routine neonatal care,
13 whereas evidence on allopurinol efficacy is still inconclusive. Encouraging neuroprotective effects
14 of NOS inhibitors, NAC and DHA have been shown in pre-clinical trials, thus calling for clinical
15 translation. In addition to the limitations already discussed for free radical biomarkers, such as
16 undersized and heterogeneous samples, often from the pre-cooling era, current literature evaluating
17 antioxidant treatments in clinical settings is further weakened by important differences in the
18 dosages adopted and in the outcomes examined. Large, prospective multicenter randomized
19 controlled clinical trials, assessing both the efficacy and safety of the above antioxidant treatments,
20 are required before they enter routine clinical use.

21

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1 **Figure legends**

2

3 Figure 1. Summary of the phases of neonatal encephalopathy with related mechanisms of injury and
4 proposed antioxidant strategies.

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6 Figure 2. Mechanisms of free radical production following hypoxia-ischemia and reperfusion.

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