

Regulation of inflammatory pathways in schizophrenia: A comparative study with bipolar disorder and healthy controls

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1. Introduction

Schizophrenia (SCH) is a severe, complex, multifactorial disorder that affects approximately 0.7% of the world population (1, 2). In recent years, there have been changes in the approach to SCH, with a focus on the search for biological markers (3-7). In this sense, there is renewed interest in immune-inflammatory changes and their associated oxidative-nitrosative consequences as key pathophysiological mechanisms of the neuroprogressive pathways of this disorder (8).

Several hypotheses involving inflammatory processes caused both by external and endogenous factors have been implicated in SCH (8-11). Inflammation is a complex biological protective mechanism, but when excessive in intensity or time, it becomes harmful. Intracellular events, such as cytoplasmic/-nuclear transcription factors, mainly *kappaB* (NFκB), control the expression of several oxidative and nitrosative mediators through activation of inducible enzymes, as key factors in this regulation. Furthermore, intercellular elements such as cytokines and chemokines are crucial elements of proper inflammatory response. Such a complex defense mechanism is finely regulated by compensatory anti-inflammatory pathways (12). One of these mechanisms involves cyclopentenone prostaglandins (PGs) such as 15-deoxy- $\Delta^{12,14}$ -PGJ₂ (15d-PGJ₂) (13), one of the proposed endogenous ligands for the gamma isoform of peroxisome proliferator-activated nuclear receptors, PPAR γ . The PPAR γ is a transcription factor that mitigates inflammation by repressing the expression of pro-inflammatory cytokines and the inducible isoforms of COX and NOS: COX-2 and iNOS (14, 15).

Early studies in SCH described elevations in plasma levels of pro-inflammatory cytokines (16, 17) and decreases in anti-inflammatory cytokines (18). However, recent studies focus on intra- and intercellular biochemical pathways controlling inflammatory response and found a systemic imbalance in some pro-/anti-inflammatory mediators in these patients (11). Most of the imbalance studies have been carried out in early stages of the disease: subtle alterations in immune-inflammatory mediators and oxidative-nitrosative stress have already been found at disease onset (19, 20). In particular, there was an increase in levels of pro-inflammatory NFκB, iNOS and COX-2 in patients with a first episode of psychosis (FEP) compared with healthy controls (HC) (21) and of PGE₂ in patients with established SCH (22). Furthermore, the inhibitory subunit of NFκB, 15d-PGJ₂, and PPAR γ expression and transcriptional activity were lower in FEP patients (21) along with anti-inflammatory PGs in peripheral monocytes in patients with established SCH (23). In addition, the systemic pro-/anti-inflammatory deregulation found in FEP became more severe after a 1-year follow-up (24).

C-reactive protein (CRP) is a widely used biomarker of systemic inflammation, and higher CRP levels have been reported in SCH compared with HC patients (25-29), even in patients without

antipsychotic treatment (30). For homocysteine (Hcy), an intermediate amino acid containing a sulfhydryl radical that can act as an oxidant, the results are controversial. While some studies found higher levels of this oxidative stress biomarker in several subgroups of SCH (31-33) compared with HC patients (31, 34), others did not (35, 36).

A review of the literature suggests that there could be an overlap in peripheral immune-inflammatory mechanisms across severe mental disorders (SMD), what justify our research (37). For example, Goldsmith et al. (2016) describe similarities in the pattern of cytokine alterations in SCH, bipolar disorder (BD), and major depressive disorder (MDD) during the acute (significant increases of IL-6, TNF- α , sIL-2R, and IL-1RA) and chronic (significant increases of IL-6, sIL-2R, and IL-1 β) phases of illness that may suggest the existence of common underlying pathways for immune dysfunction (38). Thus, it is necessary to evaluate markers of inflammation and immune activation across the whole psychosis continuum. In this sense, it was recently found that there is a strong increase in the levels of inflammatory activity in SCH and a relatively lesser increase in schizoaffective and affective disorders respectively (39). In line with the proposed psychosis continuum model, the aim of our study was to identify the potential differential intra- and intercellular biochemical pathways controlling inflammatory response and their oxidative-nitrosative consequences in SCH, compared with BD and healthy controls (HC). An additional aim was to identify whether there are differential pathways of the psychopathological (positive, negative, and depressive), cognitive, and functional dimensions of SCH.

2. Methods

2.1. Study design

Cross-sectional, naturalistic study of a cohort of SCH patients in outpatient treatment at two mental health centers in Oviedo (Corredoria and Ería) in northern Spain, and their controls (BD patients and HC). The Clinical Research Ethics Committee of Hospital Universitario Central de Asturias in Oviedo approved the study protocol. All participants gave written informed consent prior to their enrollment.

2.2. Participants

Of the 325 participants recruited, a total of 305 individuals were included in the analysis after removing outliers. Of these, 123 were SCH patients (mean age 40.75, 67.5% males), 102 BD patients (mean age 48.37, 37.3% males), and 80 HC (mean age 35.81, 38.8% males). If an alpha error of 5% with a power of 90% is considered for the ANCOVA tests performed in this work, an effect size value of $f=0.2634$ is obtained. This value, according to Cohen (1988) can be considered as a medium effect size and suitable for our research purposes (40).

Outpatients attending their regular appointments with their clinicians were offered to participate in the study and healthy controls were recruited by snowball sampling. There were statistically significant differences among the groups in age and gender ($F = 27.668, p < 0.0001$; chi-square = 25.707, $p < 0.0001$).

Inclusion criteria for SCH and BD were: (1) DSM-IV-TR diagnosis of SCH or BD; (2) age >17 years; and (3) written informed consent. Inclusion criteria for HC: (1) no past or current mental disorder (DSM-IV-TR diagnosis) and (2) written informed consent. Exclusion criteria for patients and controls were: (1) no written informed consent; (2) physical comorbidity that could interfere with immune-inflammatory biomarkers (acute infection, fever, acute allergies, cancer, or autoimmune diseases) was determined by directly asking patients about them; (3) treatment with immunosuppressive drugs or vaccines within the 6 months prior to enrollment in the study, or treatment with anti-inflammatory drugs within the two days prior to blood collection.

2.3. Assessments

2.3.1. Psychometric instruments

Psychopathology in SCH patients was evaluated using the Spanish versions of the Clinical Global Impression (CGI) (41), which assesses the severity in global psychopathology, and the Positive and Negative Syndrome Scale (PANSS) (42), which measures the severity of positive, negative, and general psychopathology symptoms. In addition, the Negative Symptom Assessment-16 (NSA-16) (43) and the Hamilton Depression Rating Scale (HDRS) (44) were employed to assess the severity of negative and depressive symptoms, respectively. The Screen for Cognitive Impairment in Psychiatry (SCIP) (45) was used to assess cognition. Finally, to assess patient functioning, we used the Personal and Social Performance (PSP) (46).

2.3.2. Specimen collection and preparation

Venous blood samples (10 mL) were collected at 8:00 am after fasting overnight.

2.3.3. Biochemical analyses of PBMC samples

To perform all biochemical analyses, PBMC samples were first fractionated into cytosolic and nuclear extracts:

- **Preparation of cytosolic and nuclear extracts:** To obtain a high purity nuclear fraction, practically without cytosolic contamination (24) in order to ensure isolation of active components of transcription factors a widely utilized method was employed.

- **Western blot analysis:** The protein levels of inducible nitric oxide synthase (iNOS), cyclooxygenases 1 and 2 (COX-1, COX-2), NLRP3 inflammasome, and the inhibitory subunit of NFκB, IκBα, in the cytosolic extracts and the protein levels of NFκB, the gamma isoform of peroxisome proliferator-activated nuclear receptors, PPARγ, and the Nuclear factor (erythroid-derived 2)-like 2 (Nrf2) in the nuclear extracts from PBMC samples were quantified by western blot (WB) analysis.

2.3.4. Biochemical analyses in plasma and serum

- **Prostaglandin levels:** Plasma levels of COX byproducts PGE₂ and 15d-PGJ₂ were measured by enzyme immunoassay (EIA) using reagents in kit form (Prostaglandin E₂ EIA Kit-Monoclonal, Cayman Chemical Europe, Tallinn, Estonia; and 15-deoxy-Δ^{12,14}- Prostaglandin J₂ ELISA Kit, DRG Diagnostics, Marburg, Germany, respectively) following manufacturer's instructions.

- **Lipid peroxidation:** This was assayed by thiobarbituric acid reactive substances (TBARS) assay (Cayman Chemical Europe), based on the reaction of malondialdehyde (MDA) and thiobarbituric acid (TBA) at high temperature (95°C) and acidic conditions. The MDA-TBA adduct formed was measured colorimetrically at 530-540 nm (Synergy 2).

- **Hcy and CRP:** Both were determined at the Hospital Universitario Central de Asturias (HUCA) laboratory. Plasma levels of homocysteine (Hcy) were obtained by immunochemiluminescence (Inmulite 2000 system, SIEMENS) and serum levels of CRP by immunoturbidimetric analysis (CRPLX, Roche/Hitachi Cobas c501).

2.4. Statistical Analyses

Demographic variables are described as means (SD) and percentages. The outliers of the immune-inflammatory markers were identified by SPSS in the box plots by deleting the individual data points and removed before any statistical analysis. The number of outliers was different for each inflammatory and oxidative-nitrosative marker. The most frequently marker removed was 15d-PGJ₂ for SCH and HC while for BD disorder was PGE₂. Differences between SCH patients and both control groups (BD patients and HC) were assessed using an analysis of covariance (ANCOVA) when the assumptions were met; otherwise, a Quade test (47) -- a non-parametric alternative -- was used. As there were statistically significant differences among the three groups in age and gender, we

controlled for these variables when comparing them. In addition, when comparing SCH and BD patients, we controlled for other potential confounders (length of illness in years, number of cigarettes per day, and body mass index [BMI]). A post hoc analysis (Bonferroni) was done to determine which groups had significant differences.

Finally, to determine the potential differential biomarkers for the psychopathological, cognitive, and functional dimensions of SCH, partial correlations with Bonferroni correction were used in which we controlled for potential confounders (age, length of illness in years, number of cigarettes per day, BMI, and number of antipsychotics). In addition, to control for gender, these same partial correlations were done for men and women separately.

3. Results

3.1. Demographic and clinical characteristics of the sample of SCH patients

The majority were male, never married, living with their family of origin, had a primary or secondary level of education level and a work status of “not working” (Table 1). The mean length of illness was 13.85 (10.9) years, and 56.1% of the patients had a more than 10 year history.

3.2. Pharmacological treatment of SCH and BD patients

The pharmacological treatment of SCH patients is described in table 1. Regarding BD patients, 100% were under mood stabilizers (42.6% lithium, 38.2% quetiapine, 27.7% valproic acid, 5% lamotrigine and 1% oxcarbamacepine), 35.3% were under antipsychotics (11.8% olanzapine, 6.9% aripiprazole, 5.9% paliperidone, 2% paliperidone one-month long-acting injectable, 5.9% risperidone and 3% others), 49% antidepressants (28.6% SSRI, 8.8% SNRI, 3.9% tricyclics and 8.8% others) and 61.8% benzodiazepines.

3.3. Biomarkers of inflammation in SCH patients compared with BD patients and HC

Table 2 and Figures 1 and 2 show the comparisons among the three groups after controlling age and gender. Regarding the pro-inflammatory parameters, expression of NFκB, a crucial inflammatory transcription factor, was higher in SCH than in BC and in HC ($p < 0.001$, $p = 0.003$,

respectively), although no difference was found between BD and HC. COX-1 expression was statistically higher in both patient groups than in HC ($p < 0.0001$), although no differences were found between SCH and BD. Similarly, one of its soluble products, PGE2, was higher in SCH when compared with BC and with HC ($p < 0.001$). Plasma levels of CPR described a gradient among the three groups, that was statistically higher in SCH and BD patients than in HC ($p < 0.0001$, $p = 0.048$), and levels were higher in SCH than in BD patients ($p = 0.031$).

Regarding anti-inflammatory parameters (nuclear expression of PPAR γ , a transcription factor that mitigates inflammation, and plasma levels of 15d-PGJ₂, an anti-inflammatory PG and one of the endogenous PPAR γ ligands), no differences were found between SCH patients and HC. However, BD patients showed changes in these anti-inflammatory pathways: lower PPAR γ and higher 15d-PGJ₂ levels than SCH patients ($p = 0.005$; $p = 0.008$) and HC ($p = 0.001$; $p = 0.001$).

No between-group differences were found in other oxidative/antioxidative parameters.

3.4. Biomarkers of inflammation in SCH compared with BD

The results of the comparison between SCH and BD after controlling for age, gender, length of illness, number of cigarettes per day, and BMI are shown in Table 3. As can be observed, the changes in inflammatory markers in SCH (NF κ B, $p = 0.001$, PGE2, $p < 0.0001$) and anti-inflammatory markers in BD (PPAR γ , $p = 0.041$, 15d-PGJ₂, $p = 0.028$) remain statistically significant. Interestingly, after controlling for these new confounders, the inducible isoforms of the specific inflammatory enzymes iNOS and COX-2 show statistically higher levels in SCH than BD ($p = 0.019$; $p = 0.040$). However, the differences in expression of constitutive COX-1 and plasma CRP levels between SCH and BD disappear.

3.5. Potential differential inflammatory biomarkers of the psychopathological, cognitive, and functional dimensions of SCH

In males, there was a slight positive correlation of the positive dimension with PPAR γ ($r = 0.27$, $p < 0.05$) and the four measures of the negative dimension with Hcy (PANSS negative $r = 0.34$, $p < 0.01$; PANSS Marder Negative Factor $r = 0.38$, $p < 0.01$; NSA global $r = 0.27$, $p < 0.05$; NSA total $r = 0.38$, $p < 0.01$). Furthermore, the cognitive dimension negatively correlated with PPAR γ ($r = -0.30$, $p < 0.05$) (Table 4). After Bonferroni correction only the correlations between Hcy and PANSS Negative, PANSS Marder Negative Factor and NSA total remained significant. None of the immune-inflammatory biomarkers correlated with the depressive dimension or functioning.

In females, the positive dimension positively correlated with Hcy ($r = 0.44, p < 0.05$) and, as in males, the cognitive dimension negatively correlated with PPAR γ ($r = -0.44, p < 0.05$) (Table 5). However, after Bonferroni correction none of the correlations were significant.

4. Discussion

Our study adds support to the hypotheses of an inflammatory process underlying the pathophysiology of SCH, as we found a significant increase in the levels of crucial intra- and intercellular inflammatory response components: NF κ B, iNOS, COX-2, and PGE2 in SCH patients compared with BD and HC. Furthermore, unlike the previous literature on the subject, our results allow us to suggest that these alterations may be considered a specific pro-inflammatory biomarker pattern for SCH, since we included patients with another SMD (BD) as a control group.

Regarding pro-inflammatory parameters, after controlling for age and gender, we found significantly higher levels of COX-1 in SCH and BD patients compared with HC. Therefore, COX-1 may be considered a biomarker of SMD. However, the little literature there is on this constitutive form of cyclooxygenase did not find significant differences in its levels in the post-mortem frontal cortex of SCH patients vs. HC (48). We also identified a significant increase in other pro-inflammatory mediators, NF κ B and PGE2, in SCH patients compared with BD patients and HC, suggesting that these mediators may be specific markers of SCH. The activity of these two markers has also been found to be significantly increased in FEP (21, 24). In patients with established SCH, PGE2 levels were significantly higher than in HC (22, 23), while another study did not detect statistically significant differences between SCH and BD patients (49).

Previous studies on the widely used and nonspecific marker of CRP levels have also found higher levels in SCH than HC (25-30) independent of antipsychotic treatment (30) and disease progression (30). The novelty of the present study is that this marker shows a differential gradient among the three groups, with significantly higher levels in patients with SCH than BD and HC, and also significantly higher levels in patients with BD than HC.

The comparison between patients with SCH and BD allowed us to control for some additional relevant confounding variables. In this case, the previous markers of SCH, NF κ B and PGE2, remained statistically significantly increased, and two new inducible pro-inflammatory and pro-oxidant enzymes, iNOS and COX-2, reached statistical significance. On the contrary, the difference in CRP levels between SCH and BD disappeared, suggesting that it may be related to other associated inflammatory conditions, such as smoking, obesity, or chronicity. In general, our results indicate that the inflammatory component is more pronounced in SCH than in BD, as patients with SCH showed

significantly higher NF κ B, PGE₂, iNOS, and COX-2 activity. It could be argued that our BD patients using lithium may have decreased levels of these biomarkers through the inhibition of GSK-3 (50). However, when we compared them between BD patients with and without lithium we did not find any statistical significance (data not shown). Interestingly, after controlling for relevant confounding variables, specific intra- and intercellular inflammatory parameters remain significant in SCH, whereas other more nonspecific parameters disappear, supporting their possible role as trait biomarkers.

Regarding anti-inflammatory mediators, although previous studies in acutely decompensated chronic SCH (23) and FEP (21, 24) found significantly lower levels of 15d-PGJ₂ and PPAR γ , we found no significant differences between SCH patients and HC. A possible explanation could be a difference in functioning of the pro-/anti-inflammatory system over the stages/phases of SCH, i.e., while in the early and acute phases of the disorder, the anti-inflammatory system is able to fight against activation of the pro-inflammatory system, in the late stages when negative symptoms predominate this ability is lost. Another explanation could be BMI. While in the studies of Martínez-Gras et al. (2011) and García-Bueno et al. (2013; 2014) mean BMI was normal (24.9 kg/m²), the cohort studied here had a mean BMI of 29.4, at the upper limit of overweight. Although more studies are needed, the results presented here point toward a possible role of negative symptoms and increased BMI in the lack of anti-inflammatory system response in chronic SCH. Interestingly, such a response is still present in BD patients, with lower levels of PPAR γ and higher levels of 15d-PGJ₂ than the other two groups, which may represent compensatory mechanism.

With respect to Hcy, although it has been suggested that high levels are a risk factor for SCH (33, 51-53), some studies, including our own research, find no differences between SCH patients and HC (35, 36).

Regarding our aim of determining the potential differential pathways of the psychopathological (positive, negative, and depressive), cognitive, and functional dimensions of SCH, we found PPAR γ was associated with the positive and cognitive dimensions. Higher levels of this anti-inflammatory parameter were related to lower cognitive impairment in both genders. Given the lack of pharmacological approaches to treating this dimension, this finding is of special importance and to our knowledge, this is the first report to show this relationship in chronic SCH patients. These results are in line with studies that have found a relationship between inflammation and poor cognitive performance (54). Levels of inflammatory cytokines and higher levels of CRP have been related to cognitive impairment in SCH (55-60). In SCH patients, PPAR γ -dependent endogenous counterbalancing mechanisms seem to be active, compensating the inflammation and probably exerting the pro-energetic, neuroprotective, and antiexcitotoxic profile previously described in *in vivo* experimental models (61). In FEP patients, after controlling for the possible effects of

confounding factors, better performance on sustained attention tasks is associated with higher levels of anti-inflammatory signaling, which may suggest that this is also a protective factor for cognition (62). In addition, a negative association has been reported between cognitive impairment and oxidative stress (20).

With regard to Hcy, high levels have been related to the severity of psychopathology (63, 64), PANSS total score (65), and the acute phase of the disorder (66). In our case, Hcy levels were related to the positive dimension in females and the negative dimension in males, so these data are difficult to interpret, and more studies will be necessary. In the case of women, these data seem to be in line with studies finding a relationship between higher levels of immune-inflammatory parameters and positive symptoms (25, 67, 68) or acute stages of the disorder (69). Contrary, some studies have found a positive correlation between Hcy levels and the severity of negative symptoms (34, 63, 66).

Some limitations of this study should be noted. First, there are some issues concerning the information obtained from the sample. In this sense, the lack of clinical information (cigarettes/day and BMI) of the HC group could overestimate the biomarkers differences found between this group and the others. Furthermore, physical comorbidities were asked directly to patients, so this information could be not as accurate as expected. Secondly, it is a cross-sectional study, so we cannot make a causal argument for the observed associations. Thirdly, as SCH and BD differ with respect to age (younger age of onset and thus younger age for a similar length of illness in SCH versus BD) and gender (a greater proportion of females with BD than SCH), it was not possible to match the three groups for these variables. Thus, we had to control for these confounding variables as covariates. Moreover, the sample included stable SCH patients on outpatient maintenance treatment, so it is possible that these results are specific to this subgroup of patients, jeopardizing the generalizability of our results to other subgroups with SCH, such as unstable patients. Another potential weakness of the study is antipsychotics as a confounding variable because they have an anti-inflammatory effect and they can induce changes in the weight and metabolism. To that end, we controlled the number of antipsychotics that each patient to mitigate this effect, because the study design did not allow us to control either for type of antipsychotic or equivalent dose of haloperidol, given the different effects of the antipsychotics on endocrine-metabolic and immune-inflammatory biomarkers. Finally, assessment of the SCH dimensions was not as precise as we would have liked, especially with regard to the cognitive and depressive dimensions. Cognition was assessed with a screening test, the SCIP, instead of a more powerful cognitive battery, and the depressive dimension with the HDRS, which is a scale that also includes anxiety symptoms, making it possible to overestimate depressive symptoms.

Key strengths deserve mention. First, we used two control groups, healthy subjects and another SMD with the aim of controlling and thereby increasing the specificity of our results.

Secondly, we included a broad spectrum of inflammatory markers in both PBMC and plasma samples, allowing in-depth insights into relationships between multiple components of the pro- and anti-inflammatory signaling pathways. Thirdly, for assessing the negative dimension of the SCH, in addition to the PANSS negative subscale, we used its Marder Negative Factor and one more specific scale, the NSA. Finally, we excluded people with physical comorbidities or treatment with immunosuppressive or anti-inflammatory drugs, which could interfere with the status of the study's immune-inflammatory biomarkers.

With regard to implications for clinical practice, although more scientific evidence is needed, this study provides further evidence of the inflammatory hypothesis of SMD. It proposes a specific cluster of inflammatory biomarkers for established SCH (NF κ B, iNOS, COX-2, and PGE2) that differentiates it from BD. Moreover, some biomarkers may be related to the positive, negative, and cognitive dimensions of SCH. In future, their pharmacological modulation may constitute a promising therapeutic target.

Authors' contributions

LG-A, MPG-P, PSM and JB designed the study. LG-A, MPG-P, LF-T, LG-B, and PASM acquired the data. JCL and JRC perform biochemical analyses. LG-A and MPG-P conducted statistical analyses. LG-A and MPG-P wrote the 1st draft of the manuscript. The rest reviewed it and gave the final approval.

Disclosure of interest

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References

1. van Os J, Kapur S. Schizophrenia. *Lancet*. 2009;374(9690):635-45.
2. Wittchen HU, Jacobi F, Rehm J, Gustavsson A, Svensson M, Jonsson B, et al. The size and burden of mental disorders and other disorders of the brain in Europe 2010. *Eur Neuropsychopharmacol*. 2011;21(9):655-79.
3. Ding YH, Guo JH, Hu QY, Jiang W, Wang KZ. Protein Biomarkers in Serum of Patients with Schizophrenia. *Cell Biochem Biophys*. 2015;72:799-805.
4. Guest PC, Chan MK, Gottschalk MG, Bahn S. The use of proteomic biomarkers for improved diagnosis and stratification of schizophrenia patients. *Biomark Med*. 2014;8(1):15-27.
5. Harris LW, Pietsch S, Cheng TM, Schwarz E, Guest PC, Bahn S. Comparison of peripheral and central schizophrenia biomarker profiles. *PLoS One*. 2012;7(10):e46368.

6. Kambeitz J, Kambeitz-Illankovic L, Leucht S, Wood S, Davatzikos C, Malchow B, et al. Detecting neuroimaging biomarkers for schizophrenia: a meta-analysis of multivariate pattern recognition studies. *Neuropsychopharmacol.* 2015;40(7):1742-51.
7. Pickard B. Schizophrenia biomarkers: Translating the descriptive into the diagnostic. *J Psychopharmacol.* 2015;29(2):138-43.
8. Kirkpatrick B, Miller BJ. Inflammation and schizophrenia. *Schizophr Bull.* 2013;39(6):1174-9.
9. Lucas SM, Rothwell NJ, Gibson RM. The role of inflammation in CNS injury and disease. *British Journal of Pharmacology.* 2006;147(Suppl 1):S232-S40.
10. Feigenson KA, Kusnecov AW, Silverstein SM. Inflammation and the two-hit hypothesis of schizophrenia. *Neurosci Biobehav Rev.* 2014;38:72-93.
11. Leza JC, Garcia-Bueno B, Bioque M, Arango C, Parellada M, Do K, et al. Inflammation in schizophrenia: A question of balance. *Neurosci Biobehav Rev.* 2015;55:612-26.
12. García-Bueno B, Caso JR, Leza JC. Stress as a neuroinflammatory condition in brain: damaging and protective mechanisms. *Neuroscience & Biobehavioral Reviews.* 2008;32:1136-51.
13. Prasad R, Giri S, Singh AK, Singh I. 15-deoxy-delta12,14-prostaglandin J2 attenuates endothelial-monocyte interaction: implication for inflammatory diseases. *Journal of inflammation.* 2008;5:14.
14. Bernardo A, Levi G, Minghetti L. Role of the peroxisome proliferator-activated receptor-gamma (PPAR-gamma) and its natural ligand 15-deoxy-Delta12, 14-prostaglandin J2 in the regulation of microglial functions. *Eur J Neurosci.* 2000;12(7):2215-23.
15. Subbaramaiah K, Lin DT, Hart JC, Dannenberg AJ. Peroxisome proliferator-activated receptor gamma ligands suppress the transcriptional activation of cyclooxygenase-2. Evidence for involvement of activator protein-1 and CREB-binding protein/p300. *J Biol Chem.* 2001;276(15):12440-8.
16. Garcia-Alvarez L, Garcia-Portilla MP, Gonzalez-Blanco L, Saiz Martinez PA, de la Fuente-Tomas L, Menendez-Miranda I, et al. Differential blood-based biomarkers of psychopathological dimensions of schizophrenia. *Rev Psiquiatr Salud Ment.* 2016;9(4):219-27.
17. Müller N, Schwarz MJ. A psychoneuroimmunological perspective to Emil Kraepelin's dichotomy: schizophrenia and major depression as inflammatory CNS disorders. *Eur Arch Psychiatry Clin Neurosci.* 2008;258(Suppl 2):97-106.
18. Maes M, Bosmans E, Ranjan R, Vandoolaeghe E, Meltzer HY, De Ley M, et al. Lower plasma CC16, a natural anti-inflammatory protein, and increased plasma interleukin-1 receptor antagonist in schizophrenia: effects of antipsychotic drugs. *Schizophr Res.* 1996;21:39-50.
19. Borovcanin M, Jovanovic I, Radosavljevic G, Djukic Dejanovic S, Bankovic D, Arsenijevic N, et al. Elevated serum level of type-2 cytokine and low IL-17 in first episode psychosis and schizophrenia in relapse. *J Psychiatr Res.* 2012;46(11):1421-6.
20. Martinez-Cengotitabengoa M, Mac-Dowell KS, Leza JC, Mico JA, Fernandez M, Echevarria E, et al. Cognitive impairment is related to oxidative stress and chemokine levels in first psychotic episodes. *Schizophr Res.* 2012;137:66-72.
21. García-Bueno B, Bioque M, Mac-Dowell KS, Barcones MF, Martinez-Cengotitabengoa M, Pina-Camacho L, et al. Pro-/anti-inflammatory dysregulation in patients with first episode of psychosis: toward an integrative inflammatory hypothesis of schizophrenia. *Schizophr Bull.* 2013;40(2):376-87.
22. Kaiya H, Uematsu M, Ofuji M, Nishida A, Takeuchi K, Nozaki M, et al. Elevated plasma prostaglandin E2 levels in schizophrenia. *J Neural Transm.* 1989;77:39-46.
23. Martínez-Gras I, Pérez-Nievas BG, García-Bueno B, Madrigal JLM, Andrés-Esteban E, Rodríguez-Jiménez R, et al. The anti-inflammatory prostaglandin 15d-PGJ2 and its nuclear receptor PPARgamma are decreased in schizophrenia. *Schizophr Res.* 2011;128:15-22.
24. García-Bueno B, Bioque M, MacDowell KS, Santabarbara J, Martinez-Cengotitabengoa M, Moreno C, et al. Pro-/antiinflammatory dysregulation in early psychosis: results from a 1-year follow-up study. *Int J Neuropsychopharmacol.* 2014;18(2):pyu037.

25. Fernandes BS, Steiner J, Bernstein HG, Dodd S, Pasco JA, Dean OM, et al. C-reactive protein is increased in schizophrenia but is not altered by antipsychotics: meta-analysis and implications. *Mol Psychiatry*. 2016;21(4):554-64.
26. Joseph J, Depp C, Martin AS, Daly RE, Glorioso DK, Palmer BW, et al. Associations of high sensitivity C-reactive protein levels in schizophrenia and comparison groups. *Schizophr Res*. 2015;168(1-2):456-60.
27. Lin CC, Chang CM, Liu CY, Huang TL. Increased high-sensitivity C-reactive protein levels in Taiwanese schizophrenic patients. *Asia Pac Psychiatry*. 2013;5(2):E58-63.
28. Miller BJ, Culpepper N, Rapaport MH. C-reactive protein levels in schizophrenia: a review and meta-analysis. *Clin Schizophr Relat Psychoses*. 2014;7(4):223-30.
29. Singh B, Chaudhuri TK. Role of C-reactive protein in schizophrenia: an overview. *Psychiatry Res*. 2014;216(2):277-85.
30. Fawzi MH, Fawzi MM, Said NS. C-reactive protein serum level in drug-free male Egyptian patients with schizophrenia. *Psychiatry Res*. 2011;190(1):91-7.
31. Dietrich-Muszalska, Olas B, Glowacki R, Bald E. Oxidative/nitrative modifications of plasma proteins and thiols from patients with schizophrenia. *Neuropsychobiology*. 2009;59(1):1-7.
32. Muntjewerff JW, Kahn RS, Blom HJ, den Heijer M. Homocysteine, methylenetetrahydrofolate reductase and risk of schizophrenia: a meta-analysis. *Mol Psychiatry*. 2006;11(2):143-9.
33. Nishi A, Numata S, Tajima A, Kinoshita M, Kikuchi K, Shimodera S, et al. Meta-analyses of blood homocysteine levels for gender and genetic association studies of the MTHFR C677T polymorphism in schizophrenia. *Schizophr Bull*. 2014;40(5):1154-63.
34. Bouaziz N, Ayedi I, Sidhom O, Kallel A, Rafrafi R, Jomaa R, et al. Plasma homocysteine in schizophrenia: determinants and clinical correlations in Tunisian patients free from antipsychotics. *Psychiatry Res*. 2010;179(1):24-9.
35. Di Lorenzo R, Amoretti A, Baldini S, Soli M, Landi G, Pollutri G, et al. Homocysteine levels in schizophrenia patients newly admitted to an acute psychiatric ward. *Acta neuropsychiatrica*. 2015;27(6):336-44.
36. Wysokinski A, Kloszewska I. Homocysteine levels in patients with schizophrenia on clozapine monotherapy. *Neurochemical research*. 2013;38(10):2056-62.
37. Catala-Lopez F, Moher D, Tabares-Seisdedos R. Improving transparency of scientific reporting to increase value and reduce waste in mental health research. *Rev Psiquiatr Salud Ment*. 2016;9(1):1-3.
38. Goldsmith DR, Rapaport MH, Miller BJ. A meta-analysis of blood cytokine network alterations in psychiatric patients: comparisons between schizophrenia, bipolar disorder and depression. *Molecular Psychiatry*. 2016;21:1696–709.
39. Morch RH, Dieset I, Faerden A, Hope S, Aas M, Nerhus M, et al. Inflammatory evidence for the psychosis continuum model. *Psychoneuroendocrinology*. 2016;67:189-97.
40. Cohen J. *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Earlbaum Associates; 1988.
41. Guy W. *Early Clinical Drug Evaluation (ECDEU) Assessment Manual*. Rockville: National Institute of Mental Health; 1976.
42. Peralta V, Cuesta MJ. Validación de la Escala de los Síndromes Positivo y Negativo (PANSS) en una muestra de esquizofrénicos españoles. *Actas Luso-Esp Neurol Psiquiatr*. 1994;22(4):171-7.
43. Garcia-Alvarez L, Garcia-Portilla MP, Saiz PA, Al-Halabi S, Bobes-Bascaran MT, Bascaran MT, et al. Spanish adaptation and validation of the negative symptom assessment-16 (NSA-16) in patients with schizophrenia. *Rev Psiquiatr Salud Ment*. Submitted.
44. Bobes J, Bulbena A, Luque A, Dal-Re R, Ballesteros J, Ibarra N. A comparative psychometric study of the Spanish versions with 6, 17, and 21 items of the Hamilton Depression Rating Scale. *Med Clin (Barc)*. 2003;120(18):693-700.
45. Pino O, Guilera G, Rojo JE, Gomez-Benito J, Bernardo M, Crespo-Facorro B, et al. Spanish version of the Screen for Cognitive Impairment in Psychiatry (SCIP-S): psychometric properties of a brief scale for cognitive evaluation in schizophrenia. *Schizophr Res*. 2008;99(1-3):139-48.

46. Garcia-Portilla MP, Saiz PA, Bousoño M, Bascaran MT, Guzman-Quilo C, Bobes J. Validation of the Spanish Personal and Social Performance scale (PSP) in outpatients with stable and unstable schizophrenia. *Rev Psiquiatr Salud Ment.* 2011;4(1):9-18.
47. Quade D. Rank analysis of covariance. *J Amer Statist Assoc.* 1967;62(320):1187-200.
48. Yagami T, Koma H, Yamamoto Y. Pathophysiological Roles of Cyclooxygenases and Prostaglandins in the Central Nervous System. *Molecular neurobiology.* 2016;53(7):4754-71.
49. Vuksan-Cusa B, Sagud M, Jakovljević M. C-reactive protein and metabolic syndrome in patients with bipolar disorder compared to patients with schizophrenia. *Psychiatr Danub.* 2010;22(2):275-7.
50. Noma T, Takahashi-Yanaga F, Arioka M, Mori Y, Sasaguri T. Inhibition of GSK-3 reduces prostaglandin E2 production by decreasing the expression levels of COX-2 and mPGES-1 in monocyte/macrophage lineage cells. *Biochemical pharmacology.* 2016;116:120-9.
51. Geller V, Friger M, Sela BA, Levine J. Elevated homocysteine level in siblings of patients with schizophrenia. *Psychiatry Res.* 2013;210(3):769-72.
52. Vuksan-Cusa B, Jakovljevic M, Sagud M, Mihaljevic Peles A, Marcinko D, Topic R, et al. Metabolic syndrome and serum homocysteine in patients with bipolar disorder and schizophrenia treated with second generation antipsychotics. *Psychiatry Res.* 2011;189(1):21-5.
53. Numata S, Kinoshita M, Tajima A, Nishi A, Imoto I, Ohmori T. Evaluation of an association between plasma total homocysteine and schizophrenia by a Mendelian randomization analysis. *BMC medical genetics.* 2015;16:54.
54. Ribeiro-Santos A, Lucio Teixeira A, Salgado JV. Evidence for an immune role on cognition in schizophrenia: a systematic review. *Curr Neuropharmacol.* 2014;12(3):273-80.
55. Dickerson F, Stallings C, Origoni A, Boronow J, Yolken R. C-reactive protein is associated with the severity of cognitive impairment but not of psychiatric symptoms in individuals with schizophrenia. *Schizophr Res.* 2007;93(1-3):261-5.
56. Fan X, Pristach C, Liu EY, Freudenreich O, Henderson DC, Goff DC. Elevated serum levels of C-reactive protein are associated with more severe psychopathology in a subgroup of patients with schizophrenia. *Psychiatry Res.* 2007;149(1-3):267-71.
57. Meyer U, Schwarz MJ, Müller N. Inflammatory processes in schizophrenia: a promising neuroimmunological target for the treatment of negative/cognitive symptoms and beyond. *Pharmacol Ther.* 2011;132:96–110.
58. Misiak B, Stanczykiewicz B, Kotowicz K, Rybakowski JK, Samochowiec J, Frydecka D. Cytokines and C-reactive protein alterations with respect to cognitive impairment in schizophrenia and bipolar disorder: A systematic review. *Schizophr Res.* 2017.
59. Schwarz E, Guest PC, Rahmoune H, Harris LW, Wang L, Leweke FM, et al. Identification of a biological signature for schizophrenia in serum. *Mol Psychiatry.* 2012;17(5):494-502.
60. Schwarz E, Izmailov R, Spain M, Barnes A, Mapes JP, Guest PC, et al. Validation of a blood-based laboratory test to aid in the confirmation of a diagnosis of schizophrenia. *Biomark Insights.* 2010;5:39-47.
61. Garcia-Bueno B, Caso JR, Perez-Nievas BG, Lorenzo P, Leza JC. Effects of peroxisome proliferator-activated receptor gamma agonists on brain glucose and glutamate transporters after stress in rats. *Neuropsychopharmacology.* 2007;32(6):1251-60.
62. Cabrera B, Bioque M, Penadés R, González-Pinto A, Parellada M, Bobes J, et al. Cognition and psychopathology in first-episode of psychosis: are they related to inflammation? *Psychol Med.* 2016;46(10):2133-44.
63. Misiak B, Frydecka D, Slezak R, Piotrowski P, Kiejna A. Elevated homocysteine level in first-episode schizophrenia patients--the relevance of family history of schizophrenia and lifetime diagnosis of cannabis abuse. *Metabolic brain disease.* 2014;29(3):661-70.
64. Narayan SK, Verman A, Kattimani S, Ananthanarayanan PH, Adithan C. Plasma homocysteine levels in depression and schizophrenia in South Indian Tamilian population. *Indian journal of psychiatry.* 2014;56(1):46-53.

65. Song X, Fan X, Li X, Kennedy D, Pang L, Quan M, et al. Serum levels of BDNF, folate and homocysteine: in relation to hippocampal volume and psychopathology in drug naive, first episode schizophrenia. *Schizophr Res.* 2014;159(1):51-5.
66. Petronijevic ND, Radonjic NV, Ivkovic MD, Marinkovic D, Piperski VD, Duricic BM, et al. Plasma homocysteine levels in young male patients in the exacerbation and remission phase of schizophrenia. *Prog Neuropsychopharmacol Biol Psychiatry.* 2008;32(8):1921-6.
67. Dimitrov DH, Lee S, Yantis J, Valdez C, Paredes RM, Braida N, et al. Differential correlations between inflammatory cytokines and psychopathology in veterans with schizophrenia: potential role for IL-17 pathway. *Schizophr Res.* 2013;151(1-3):29-35.
68. Kurian SM, Le-Niculescu H, Patel SD, Bertram D, Davis J, Dike C, et al. Identification of blood biomarkers for psychosis using convergent functional genomics. *Mol Psychiatry.* 2011;16(1):37-58.
69. Miller BJ, Buckley P, Seabolt W, Mellor A, Kirkpatrick B. Meta-analysis of cytokine alterations in schizophrenia: clinical status and antipsychotic effects. *Biol psychiatr.* 2011;70(7):663-71.

Table 1. Demographic and clinical characteristics of the sample of patients with schizophrenia.

Mean age (sd)	40.75 (10.37)	Suicide attempts	
Gender, males [n (%)]	83 (67.5)	Yes [n (%)]	35 (28.5)
Civil status [n (%)]		Mean number (sd)	3.17 (2.90)
Never married	82 (66.7)	CGI-S [mean (sd)]	4.20 (1.03)
Married or cohabiting	29 (23.6)	PANSS [mean (sd)]	
Widowed or separated/divorced	12 (9.8)	Positive	13.50 (5.42)
Living arrangement [n (%)]		Negative	18.93 (5.07)
Alone	19 (15.4)	Marder Negative Factor	17.78 (5.85)
Family of origin	69 (56.1)	General	
Own family	31 (25.2)	psychopathology	32.96 (8.56)
Institutionalized	2 (1.6)	Total	65.56 (15.66)
Other	2 (1.6)	NSA-16 [mean (sd)]	42.96 (12.16)
Educational level [n (%)]		HDRS [mean (sd)]	9.30 (7.15)
Primary school	45 (36.6)	Cognition	
Secondary school	54 (43.9)	SCIP [mean (sd)]	2.87 (1.78)
Higher education	24 (19.5)	Functioning	
Years of education [mean (sd)]	13.02 (4.81)	PSP [mean (sd)]	49.13 (16.23)
Work status [n (%)]		*BMI [mean (sd)]	29.39 (6.03)
Working (full / part-time)	9 (7.3)	Psychotropic medication	
Not working	104 (84.6)	Mean number (sd)	2.77 (1.46)
Homemaker or student	10 (8.1)	Antipsychotic medication	
Alcohol		Mean number (sd)	1.65 (0.84)
Consumption, yes [n (%)]	31 (25.2)	Yes [n (%)]	121 (98.4)
SAUs / week [mean (sd)]	7.61 (10.48)	Paliperidone	58 (47.2)
*Tobacco		Risperidone	39 (31.7)
Consumption, yes [n (%)]	65 (52.8)	Olanzapine	31 (25.2)
Cigarettes / day [mean (sd)]	22.68 (12.67)	Aripiprazole	19 (15.5)
Marihuana		Typical	17 (13.8)
Consumption, yes [n (%)]	5 (4.1)	Quetiapine	15 (12.2)
Days / last month [mean (sd)]	19 (15.10)	Clozapine	11 (8.9)
Months / last year [mean (sd)]	10.60 (3.13)	Ziprasidone	6 (4.9)
*Length of illness, years [mean (sd)]	13.85 (10.88)	Amisulpride	6 (4.9)
Hospitalizations		Antidepressant medication	29 (23.6)
Yes [n (%)]	90 (73.8)	Yes [n (%)]	
Mean number (sd)	3.87 (4.98)	Benzodiazepine medication	60 (48.8)
		Yes [n (%)]	

BMI: Body Mass Index; CGI-S: Clinical Global Impression-Severity; HDRS: Hamilton Depression Rating Scale; NSA-16: Negative Symptom Assessment-16; PANSS: Positive and Negative Syndrome Scale; PSP: Personal and Social Performance; SCIP: Screen for Cognitive Impairment in Psychiatry; sd: standard deviation; SAUs: standard alcohol units.

* Patients with BD: 45.1% smokers [mean of cigarettes per day among smokers: 17.17 (10.49)], mean length of illness 20.58 (11.85) years and BMI 28.98 (4.95).

Table 2. Comparisons of inflammatory and oxidative-nitrosative markers among groups after controlling for age and gender.

	SCH Mean, SE	BD Mean, SE	HC Mean, SE	Statistical test, <i>p</i>	η^2	SCH-BD Statistical test, <i>p</i>	SCH-HC Statistical test, <i>p</i>	BD-HC Statistical test, <i>p</i>
Pro-inflammatory								
NFκB	130.44, 5.72	93.37, 5.92	98.33, 6.25	7.850 (2) ² , 0.001		0.001	0.003	0.444
iNOS	113.54, 4.94	92.37, 5.28	93.96, 5.76	2.164 (2) ² , 0.117				
COX-1	129.56, 3.36	116.35, 3.99	97.54, 4.18	14.941 (2) ² , <0.0001		0.130	<0.0001	<0.0001
COX-2	113.02, 4.66	94.90, 4.99	91.98, 5.69	2.502 (2) ² , 0.084				
PGE2	620.23, 33.12	278.20, 40.66	249.71, 42.72	21.514 (2) ² , <0.0001		<0.0001	<0.0001	0.467
NLRP3	121.55, 5.41	127.50, 6.13	98.37, 6.74	3.370 (2) ² , 0.036		0.229	0.135	0.005
CRP	0.47, 0.05	0.30, 0.05	0.20, 0.06	8.855 (2) ² , <0.0001		4.705 (1), 0.031	18.396 (1), <0.0001	3.984 (1), 0.048
Anti-inflammatory								
PPARγ	109.68, 4.97	79.29, 5.56	100.15, 5.75	6.156 (2) ² , 0.002		0.005	0.916	0.001
15d-PGJ ₂	48.58, 14.67	171.85, 16.27	6.07, 19.43	6.781 (2) ² , 0.001		0.008	0.289	0.001
IκBα	95.33, 4.67	96.82, 5.25	95.24, 5.45	0.140 (2) ² , 0.869				
Oxidants								
MDA	93.65, 6.82	91.62, 8.19	87.51, 8.44	0.158 ¹ , 0.854	0.001			
Hcy	13.47, 0.44	13.08, 0.49	12.65, 0.55	0.693 ¹ , 0.501	0.005			
Ant-ioxidants								
NRF2	135.62, 6.64	106.29, 7.18	97.99, 7.49	2.641 (2) ² , 0.074				

BD: Bipolar Disorder; COX-1 and COX-2: Isoforms 1 and 2 of the enzyme cyclooxygenase; CRP: C-reactive protein; HC: Healthy Controls; Hcy: Homocysteine; IκBα: Inhibitory subunit of NFκB; iNOS: Inducible Nitric Oxide Synthase; MDA: Malondialdehyde; NFκB: Nuclear Factor KappaB; NLRP3: NLRP3 inflammasome; NRF2: Transcription Factor NRF2; PGE2: Prostaglandin E2; 15d-PGJ₂: Prostaglandin J2; PPARγ: Peroxisome Proliferator-Activated Receptor Gamma; SCH: Schizophrenia; SE: standard error. ANCOVA¹; Quade test². Covariables: age, gender. See Figures 1 & 2 for units of each parameter.

Table 3. Comparisons of inflammatory and oxidative-nitrosative markers between SCH and BD after controlling for age, gender, length of illness, cigarettes/day, and BMI.

	SCH Mean, SE	BD Mean, SE	Statistical test, <i>p</i>	η^2
Pro-inflammatory				
NFκB	129.65, 6.54	94.24, 6.92	12.660 ¹ , 0.001	0.089
iNOS	114.71, 5.48	87.49, 6.20	5.579 (1) ² , 0.019	
COX-1	131.25, 3.96	112.87, 4.91	3.432 (1) ² , 0.065	
COX-2	115.06, 5.05	89.74, 5.76	4.306 (1) ² , 0.040	
PGE2	615.51, 39.33	267.14, 50.83	18.754 (1) ² , <0.0001	
NLRP3	122.39, 6.35	125.43, 7.47	0.088 ¹ , 0.767	0.000
PCR	0.46, 0.05	0.32, 0.06	2.611 ¹ , 0.108	0.013
Anti-inflammatory				
PPARγ	108.42, 5.85	83.58, 6.85	4.262 (1) ² , 0.041	
15d-PGJ ₂	43.07, 17.06	154.16, 19.35	4.894 (1) ² , 0.028	
IκBα	94.81, 5.17	93.52, 6.06	0.024 ¹ , 0.877	0.000
Oxidants				
MDA	93.14, 7.35	90.19, 9.10	0.057 ¹ , 0.811	0.000
Hcy	13.61, 0.46	13.30, 0.54	0.171 ¹ , 0.679	0.001
Anti-oxidants				
NRF2	136.18, 7.88	107.77, 8.59	2.182 (1) ² , 0.142	

BD: Bipolar Disorder; COX-1 and COX-2: Isoforms 1 and 2 of the enzyme cyclooxygenase; CRP: C-reactive protein; Hcy: Homocysteine; IκBα: inhibitory subunit of NFκB; iNOS: Inducible Nitric Oxide Synthase; MDA: Malondialdehyde; NFκB: Nuclear Factor KappaB; NLRP3: NLRP3 inflammasome; NRF2: Transcription Factor NRF2; PGE2: Prostaglandin E2; 15d-PGJ₂: Prostaglandin J2; PPARγ: Peroxisome Proliferator-Activated Receptor Gamma; SCH: Schizophrenia; SE: standard error. ANCOVA¹; Quade test². Covariables: age, gender, length of illness, cigarettes/day, and BMI.

Table 4. Partial correlation coefficients between psychopathological, cognitive, and functional dimensions of SCH and inflammatory and oxidative-nitrosative biomarkers after controlling for age, length of illness, cigarettes/day, and BMI (males).

	PANSS positive	PANSS negative	PANSS Marder Negative Factor	NSA global	NSA total	HDRS total	SCIP total	PSP total
Pro-inflammatory								
NFκB	0.07	-0.07	-0.12	-0.05	-0.15	0.05	-0.06	-0.10
iNOS	-0.10	0.19	0.12	0.26	0.25	0.03	0.07	-0.27
COX-1	-0.09	0.04	0.04	0.05	0.01	-0.08	0.07	0.09
COX-2	-0.16	0.04	0.03	0.09	0.00	0.05	0.14	0.03
PGE2	0.01	0.08	0.13	0.07	0.06	0.02	0.18	-0.07
NLRP3	-0.07	0.17	0.11	0.10	0.05	0.18	0.19	-0.17
CRP	0.01	-0.13	-0.17	0.04	0.00	-0.03	0.04	-0.02
Anti-inflammatory								
PPARγ	0.27*	-0.23	-0.20	-0.24	-0.17	-0.09	-0.30*	0.08
15d-PGJ ₂	-0.15	-0.06	-0.07	-0.22	-0.14	0.00	-0.18	0.10
IκBα	0.11	0.06	-0.00	0.01	0.02	0.16	0.04	-0.13
Oxidants								
MDA	0.01	0.02	-0.00	0.05	0.05	0.11	0.10	-0.07
Hcy	-0.09	0.34**	0.38**	0.27*	0.38**	-0.07	0.09	-0.19
Anti-oxidants								
Nrf2	0.13	-0.14	-0.17	-0.07	-0.09	-0.13	-0.26	-0.02

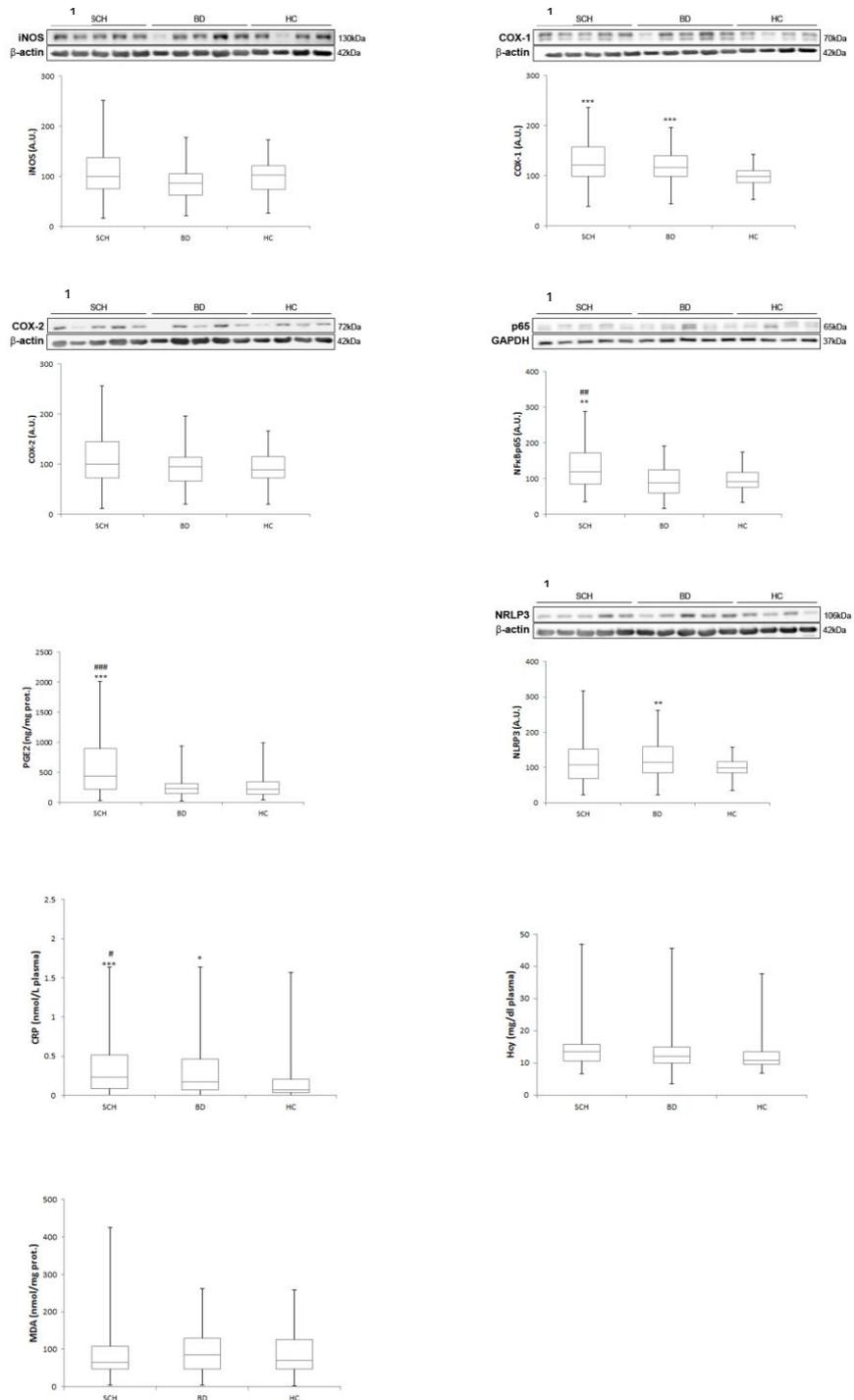
COX-1 and COX-2: Isoforms 1 and 2 of the enzyme cyclooxygenase; CRP: C-reactive protein; HDRS: Hamilton Depression Rating Scale; Hcy: Homocysteine; IκBα: inhibitory subunit of NFκB; iNOS: Inducible Nitric Oxide Synthase; MDA: Malondialdehyde; NFκB: Nuclear Factor KappaB; NLRP3: NLRP3 inflammasome; Nrf2: Transcription Factor Nrf2; NSA-16: Negative Symptom Assessment-16; PANSS: Positive and Negative Syndrome Scale; SCIP: Screen for Cognitive Impairment in Psychiatry; PGE2: Prostaglandin E2; 15d-PGJ₂: Prostaglandin J2; PPARγ: Peroxisome Proliferator-Activated Receptor Gamma; PSP: Personal and Social Performance. *<0.05; **<0.01.

Table 5. Partial correlation coefficients between psychopathological, cognitive, and functional dimensions of SCH and inflammatory and oxidative-nitrosative biomarkers after controlling for age, length of illness, cigarettes/day, and BMI (females).

	PANSS positive	PANSS negative	PANSS Marder Negative Factor	NSA global	NSA total	HDRS total	SCIP total	PSP Total
Pro-inflammatory								
NFκB	0.41	0.07	0.17	0.03	0.01	0.20	-0.42	-0.14
iNOS	-0.00	0.03	0.13	-0.12	-0.08	0.21	0.17	-0.06
COX-1	0.07	-0.25	-0.20	-0.29	-0.34	-0.06	0.13	-0.04
COX-2	0.39	-0.25	-0.18	-0.08	-0.14	-0.10	0.07	-0.20
PGE2	-0.08	0.22	0.17	0.31	0.31	-0.02	0.33	-0.30
NLRP3	0.16	0.07	0.01	0.12	0.08	0.27	0.12	-0.29
CRP	0.15	-0.05	-0.00	0.13	0.10	0.06	0.04	-0.05
Anti-inflammatory								
PPARγ	0.06	-0.12	-0.13	-0.08	-0.14	-0.34	-0.44*	0.23
15d-PGJ ₂	-0.05	-0.09	-0.10	-0.14	-0.17	0.05	0.21	0.08
IκBα	0.16	-0.03	-0.12	-0.18	-0.18	-0.07	0.05	-0.02
Oxidants								
MDA	0.27	-0.08	0.03	0.10	0.06	-0.01	-0.01	-0.06
Hcy	0.44*	-0.03	0.03	-0.07	-0.02	0.14	0.12	-0.12
Anti-oxidants								
NRF2	0.46	-0.09	0.02	-0.02	-0.04	0.12	-0.03	-0.04

COX-1 and COX-2: Isoforms 1 and 2 of the enzyme cyclooxygenase; CRP: C-reactive protein; HDRS: Hamilton Depression Rating Scale; Hcy: Homocysteine; IκBα: Inhibitory subunit of NFκB; iNOS: Inducible Nitric Oxide Synthase; MDA: Malondialdehyde; NFκB: Nuclear Factor KappaB; NLRP3: NLRP3 inflammasome; NRF2: Transcription Factor NRF2; NSA-16: Negative Symptom Assessment-16; PANSS: Positive and Negative Syndrome Scale; SCIP: Screen for Cognitive Impairment in Psychiatry; PGE2: Prostaglandin E2; 15d-PGJ₂: Prostaglandin J2; PPARγ: Peroxisome Proliferator-Activated Receptor Gamma; PSP: Personal and Social Performance. *<0.05; **<0.01.

Figure 1. Mean differences (SD) on inflammatory / oxidative components in plasma and PBMC in patients with schizophrenia compared with bipolar disorder and healthy controls.



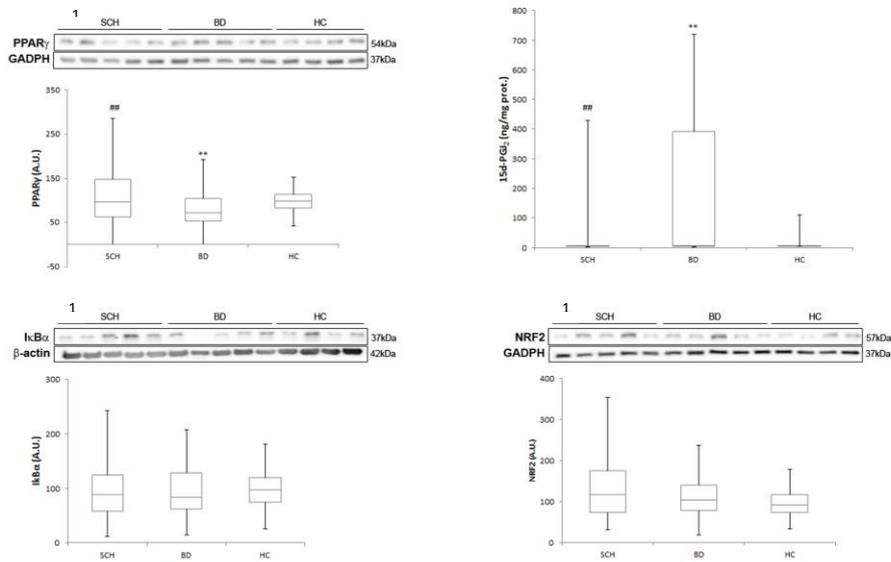
Western blot analysis of iNOS, COX-1, COX-2, Nf- κ B p65 and NLRP3. Plasma levels of CRP, Hcy and MDA. AU, arbitrary units. ANCOVA and Quade test were used. ¹Densitometric analysis of

the proteins studied and with the corresponding housekeeping proteins used as loading control (in cytosolic and nuclear extracts).

*: compared with HC; * $p \leq 0.05$; ** $p \leq 0.005$; *** $p \leq 0.0005$

#: compared with BD; # $p \leq 0.05$; ## $p \leq 0.005$; ### $p \leq 0.0005$

Figure 2. Mean differences (SD) on antiinflammatory / antioxidant components in plasma and PBMC in patients with schizophrenia compared with bipolar disorder and healthy controls.



Western blot analysis of PPAR γ , IkB α and NRF2. Plasma levels of 15d-PGJ2. AU, arbitrary units. ANCOVA and Quade test were used. ¹ Densitometric analysis of the proteins studied and with

the corresponding housekeeping proteins used as loading control (in cytosolic and nuclear extracts).

*: compared with HC; * $p \leq 0.05$; ** $p \leq 0.005$; *** $p \leq 0.0005$

#: compared with BD; # $p \leq 0.05$; ## $p \leq 0.005$; ### $p \leq 0.0005$