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Questions and (some) answers on reactive astrocytes

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Q&A on reactive astrocytes

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51 **Abstract**

52 Astrocytes are key cellular partners for neurons in the central nervous system. Astrocytes react to virtually all
53 types of pathological alterations in brain homeostasis by significant morphological and molecular changes. This
54 response was classically viewed as stereotypical and is called astrogliosis or astrocyte reactivity. It was long
55 considered as a non-specific, secondary reaction to pathological conditions, offering no clues on disease-causing
56 mechanisms and with little therapeutic value.

57 However, many studies over the last thirty years have underlined the crucial and active roles played by astrocytes
58 in physiology, ranging from metabolic support, synapse maturation and pruning to fine regulation of synaptic
59 transmission. This prompted researchers to explore how these new astrocyte functions were changed in disease,
60 and they reported alterations in many of them (sometimes beneficial, mostly deleterious). More recently, cell-
61 specific transcriptomics revealed that astrocytes undergo massive changes in gene expression when they become
62 reactive. This observation further stressed that reactive astrocytes may be very different from normal, non-
63 reactive astrocytes and could influence disease outcomes. To make the picture even more complex, both normal
64 and reactive astrocytes were shown to be molecularly and functionally heterogeneous. Very little is known about
65 the specific roles that each subtype of reactive astrocytes may play in different disease contexts.

66 In this review, we have interrogated researchers in the field to identify and discuss points of consensus and
67 controversies about reactive astrocytes, starting with their very name. We then present the emerging knowledge
68 on these cells and future challenges in this field.

69

70

71 **Keywords**

72 Reactive astrocytes, brain diseases, neuron-glia interactions, astrogliosis, animal models

73

74

75 **Main Points**

- 76 - Astrocytes react to brain homeostasis alteration by morphological and molecular changes
- 77 - This response is complex, heterogeneous and subject to controversies
- 78 - New tools, models and concepts will help better understand this widespread reaction

79 1. Introduction

80 Astrocytes have key functions in the brain ([Verkhatsky & Nedergaard, 2018](#)). New discoveries are made
81 regularly on their active roles in ion homeostasis, vascular coupling, synaptic plasticity, circuit building, synapse
82 turnover, waste clearance or higher functions like sleep-wake cycle, food intake or memory ([Verkhatsky &](#)
83 [Nedergaard, 2018](#)). One peculiar feature of these glial cells, first observed by 19th century anatomopathologists
84 is that they look different in the diseased brain [**Fig. 1**, ([P. Chaslin, 1891](#); [Ramón y Cajal](#))]. The original observations
85 reported morphological and histological changes, with increased fibrillary structures and more visible cellular
86 elements in scarring brain tissue from patients [**Fig. 1**, see also ([Liddelow & Barres, 2017](#))]. Such changes in
87 astrocyte appearance are observed in the brain of patients suffering from a broad range of brain pathologies
88 (e.g. epilepsy, neurodegenerative disease, brain cancer, ischemia, infection, axotomy, invasive injury, toxin
89 exposure), as well as in animal models thereof (**Fig. 2**, and references in legend). *Astrocyte reactivity*, *Astrogliosis*,
90 *Astrocyte activation*, *Reactive gliosis* or *Astrocytosis* are among the terms used to describe such molecular,
91 morphological and functional changes in astrocytes. Even if definitions of astrocyte reactivity were proposed by
92 Prof. M. Sofroniew ([Sofroniew, 2009, 2014a](#); [Sofroniew & Vinters, 2010](#)) and others ([Pekny et al., 2016](#)), a review
93 of the literature shows that the use and meaning of these different terms are quite broad and inconsistent.
94 Indeed, we surveyed ~40 researchers in the field (see complete list in **Supplemental Table 1**), and found that
95 they have quite different visions of what reactive astrocytes are, or are not (**Table 1a**) and they do not agree on
96 the nomenclature (**Table 1b**).

97 Beyond the discrepant terminology, some common features of reactive astrocytes emerge from this survey.
98 A broad definition could be summarized as “astrocytes sense and respond to an abnormal situation in the brain.
99 They change at the morphological, biochemical, transcriptional and functional levels. These changes are
100 maintained while the pathological stimulus is present but some aspects may resolve. Reactive astrocytes are
101 heterogeneous and may have various effects on disease progression”. Indeed, reactive astrocyte heterogeneity
102 is underlined by most researchers and contested by none of them (**Table 1a**). This opens new areas of research
103 to understand its origin and consequences (**Section 5**).

104 Other points that remain controversial will be covered later in this review: Are glial fibrillary acid protein
105 (GFAP) and morphological changes appropriate markers of reactive astrocytes (**Section 4**)? Can we identify better
106 markers (**Section 6**)? Do reactive astrocytes do good or bad things in disease (**Section 8**)? Do they die (**Section**
107 **9**)? Should aging astrocytes be considered as reactive (**Section 12**)? Other points were not necessarily raised by
108 surveyed researchers, but are still actively studied: What are the exact triggers and downstream signaling
109 pathways controlling this response (see **Section 7**)? Where do reactive astrocytes come from and what do they
110 become (see **Section 10**)? How do reactive astrocytes interact with other cell types involved in innate and
111 adaptive immunity (see **Section 11**)? Addressing all these questions will help provide a refined vision of this
112 complex brain response.

113 The aim of this review is not to provide an extensive overview of the now abundant literature on reactive
114 astrocytes, but instead, discuss emerging research questions and unresolved issues on this topic.

115
116

117 2. How to best name them?

118 But first, it is important to name our research subject and define what we are talking about. Our survey of
119 researchers in the field of astrocytes, showed that even three broadly-used terms had different inferred
120 meanings (**Table 1b**). Many surveyed PIs agreed that the very definition of astrocyte reactivity was ambiguous
121 and that a clear nomenclature would benefit the field.

122 The heterogeneity of this response and the variety of “reactive states” (see **Section 5**), call for a broad and
123 inclusive definition that can further be refined in each context. Indeed, all recognized that drastic changes happen
124 to astrocytes in pathological conditions, with some core and some disease-specific alterations (**Table 1a**,
125 **Supplemental Text**). We thus need words to describe this phenomenon. What are the most appropriate ones?
126 There was some agreement that *astrocyte activation* is misleading because it can apply to physiological activation
127 like transient Ca²⁺ signaling in response to normal neuronal activity (see **Section 4-Timescale**). It is thus better to
128 avoid this term. Another point of partial convergence was that *astrogliosis* implied something different (e.g.

129 stronger or irreversible; with scarring, proliferation or immune infiltration), which definitely does not apply to all
130 disease conditions (**Table 1b**). We are therefore left with the term *astrocyte reactivity*. The problem with this
131 expression, as stressed by several PIs, is that it implies an “ability” to become (See **Table 1a**). As discussed by Dr.
132 A. Serrano-Pozo, *reaction* would be more correct to define the final state of astrocytes (see **Supplemental Text**).
133 We thus propose to avoid the use of *astrocyte activation* and *astrogliosis* and instead use *reactive astrocytes* or
134 *astrocyte reaction* and add to *stroke/epilepsy/Alzheimer disease* to further define it. Expressions like *scar-forming*
135 *astrocytes*, *proliferating reactive astrocytes*, *phospho-STAT3⁺ reactive astrocytes* are also very useful to
136 functionally or molecularly define these cells (see details in **Section 5**). We will use this nomenclature in our
137 review, but a more widespread agreement on terminology would be beneficial to the astrocyte community.

138
139

140 **3. Why bother with reactive astrocytes?**

141 There are more than 17,500 articles recovered in PubMed with the query “Reactive astrocyte” OR “Astrocyte
142 reactivity” OR “Astrogliosis”, with more than 400 articles published each year since 2000. Why does such a broad
143 and somehow ill-defined concept trigger this significant interest? Indeed, if astrocytes become reactive in
144 response to something already going wrong, why should we care? It may already be too late, the initial
145 pathological event may have started well before and triggered an irreversible disease cascade.

146 It is striking that astrocyte reaction is such a widespread response, reported in virtually all brain diseases,
147 brain regions, and multiple species including invertebrates, like *Drosophila*, many mammals and Humans
148 [([Kremer, Jung, Batelli, Rubin, & Gaul, 2017](#); [Sofroniew & Vinters, 2010](#)), see **Fig. 2**]. It is thus very important to
149 better understand what it means for an astrocyte to engage in this phenotype switch and how it can influence
150 surrounding cells.

151 Astrocyte reaction is by definition a secondary event; yet, it may still impact disease progression, which lasts
152 for months or years in the case of tumor, neurodegenerative disease or epilepsy. More importantly, astrocytes
153 are reactive at the clinically visible stages of the disease, when patients seek diagnosis and treatment. Turning
154 reactive astrocytes into beneficial partners for vulnerable neurons exposed to a chronic disease or to the long-
155 term consequences of an acute injury, would be a valuable therapeutic strategy.

156 In addition, as astrocytes react to altered homeostasis in the brain, they are endogenous biomarkers for brain
157 diseases. Development of non-invasive imaging techniques, like magnetic resonance imaging (MRI) or positron
158 emission tomography (PET) to visualize when and where astrocytes become reactive would help disease
159 diagnostic. Available imaging methods are not quite specific for reactive astrocytes, they rather detect
160 neuroinflammation as a whole (i.e. reactive glial cells, sometimes infiltration of peripheral immune cells) or
161 associated changes, for example in brain metabolism ([Aiello et al., 2018](#); [Carrillo-de Sauvage et al., 2015](#); [Lavissee
162 et al., 2012](#)). Indeed, astrocytes may significantly contribute to imaging signals, such as those measured with
163 blood oxygenation level-dependent (BOLD) functional MRI or [¹⁸F]-fluorodeoxyglucose uptake by PET, and
164 therefore their reactive state may impact these measurements ([Carter et al., 2019](#); [Mishra, 2017](#)). Refined
165 approaches that are more selective for reactive astrocytes are being developed ([Carter et al., 2019](#); [Ligneul et
166 al., 2019](#); [Rodriguez-Vieitez et al., 2016](#); [Scholl et al., 2015](#)). Such improvements will be facilitated by basic studies
167 that establish the molecular and functional profile of reactive astrocytes (see **Section 6**) but also of their microglia
168 or neuronal neighbors, allowing the identification of new and specific astrocyte targets.

169 Last, some astrocyte proteins like GFAP or their break-down products may also end up in the cerebrospinal
170 fluid of patients subject to traumatic brain injury [TBI, ([Halford et al., 2017](#))], but also in more progressive diseases
171 like Creutzfeldt-Jakob disease or Alzheimer disease (AD) [for review, see ([Carter et al., 2019](#); [Perez-Nievas &
172 Serrano-Pozo, 2018](#))].

173 Therefore, defining how astrocytes change during disease may *in fine* lead to new biomarkers, better
174 diagnosis tools, and even original therapeutic strategies, which are long-sought goals for many diseases.

175
176

177 4. What are the defining features of reactive astrocytes?

178 Several common features are observed in very different cases of brain injuries and diseases. They can be used
179 to define the core hallmarks of reactive astrocytes.

180
181 **Morphological changes.** In pathological conditions, astrocytes display morphological changes, including
182 hypertrophy of soma and main processes, but not only (see **Fig. 2**). This was already noted by earlier pathologists
183 using impregnation techniques to achieve sparse labeling of astrocytes (**Fig. 1**). Diolistic labeling, dye-filling or
184 expression of a cytosolic or membrane-tagged fluorescent protein reveal the complex and highly ramified
185 astrocyte morphology. These methods evidence subtle alterations in astrocyte morphology that could be missed
186 by cytoskeleton labeling with GFAP antibodies (See **Fig. 2B, D, E, H, I, J**). They show process polarization towards
187 a lesion [([Bardehle et al., 2013](#)), **Fig. 2H**] or ramification changes while the overall 3D domain covered by a single
188 astrocyte is not massively disrupted [([Wilhelmsson et al., 2006](#)), **Fig. 2E**]. In more severe diseases like epilepsy,
189 astrocytes may also retract their fine peripheral processes, become asymmetric and overlap more with their
190 neighbors [([Oberheim et al., 2008](#); [Sun & Jakobs, 2012](#)), **Fig. 2J**]. An extreme case is the glial scar caused by
191 mechanical lesions of brain or spinal parenchyma (**Fig. 2F**), or severe focal lesions like tumors (**Fig. 2R**). Astrocytes
192 become elongated and assemble to form a compact and permanent scar. Other cell types, such as fibroblasts,
193 oligodendrocyte progenitor cells (OPC), ependymal cells or pericytes, may also contribute to this scar ([Adams &
194 Gallo, 2018](#); [Sabelstrom, Stenudd, & Frisen, 2014](#)). This question and the overall effect of the glial scar on axonal
195 regrowth are still debated ([Anderson et al., 2016](#); [Silver, 2016](#)). Readers are referred to excellent reviews on the
196 topic ([Adams & Gallo, 2018](#); [Sofroniew, 2018](#)).

197
198 **Molecular changes.** A defining feature of reactive astrocytes is their overexpression of intermediate filament
199 proteins like GFAP or vimentin. The “*increased number and size of fibrils in neuroglia of sclerotic brain tissue in
200 epileptic patients*” was noted by anatomopathologists already at the end of the 19th century [see **Fig. 1**, ([P.
201 Chaslin, 1891](#))]. Electron microscopy also evidences large bundles of filaments in reactive astrocytes (**Fig. 2M'**).
202 In AD brains, GFAP accumulates to the extent that it forms protein aggregates resembling Rosenthal fibers in
203 reactive astrocytes ([Wegiel & Wisniewski, 1994b](#)). The surveyed researchers broadly acknowledged the validity
204 of GFAP as a marker for reactive astrocytes (**Table 1a**), but several of them also underlined its limits (see further
205 discussion in **Section 6**).

206 Owing to refined methods to isolate astrocytes and investigate their transcriptome at the genome-wide level,
207 recent studies revealed that astrocyte reaction involves massive transcriptional changes that go well beyond
208 *Gfap* induction. Hundreds of genes are either up- or down-regulated in astrocytes in AD models and patients
209 ([Ceyzériat et al., 2018](#); [Orre, Kamphuis, Osborn, Jansen, et al., 2014](#); [Sekar et al., 2015](#)), in a mouse model of
210 hyperammonia ([Lichter-Konecki, Mangin, Gordish-Dressman, Hoffman, & Gallo, 2008](#)), or multiple sclerosis (MS)
211 ([Itoh et al., 2018](#)), following spinal cord injury [SCI, ([Anderson et al., 2016](#))], cortical stab wound injury [SWI, ([Sirko
212 et al., 2015](#))], middle cerebral artery occlusion (MCAO) or lipopolysaccharide (LPS) injection ([Zamanian et al.,
213 2012](#)). Several genes induced in reactive astrocytes both in the LPS and MCAO models were identified. Among
214 them, *Serpina3n* and *Lcn2* were further validated as strongly, but transiently induced following LPS injection or
215 MCAO ([Zamanian et al., 2012](#)). They are also induced in other disease models ([Itoh et al., 2018](#); [Suk, 2016](#);
216 [Switonski, Szlachcic, Krzyzosiak, & Figiel, 2015](#)). Change in transcriptome is a conserved feature of astrocyte
217 reaction, similarly observed in *Drosophila* glia ([Lu et al., 2017](#)).

218 Interestingly, genes that are down-regulated in reactive astrocytes may also hold the key to understanding
219 the roles of these cells in disease. Some genes associated with important astrocyte functions like the potassium
220 channel KIR4.1 [*Kcnj10*, ([Nwaobi, Cuddapah, Patterson, Randolph, & Olsen, 2016](#))], the glutamate transporter
221 GLT1 [*Slc1a2*] or glutamine synthase GS [*Glu1*, ([Sheldon & Robinson, 2007](#))], are repeatedly reported as down-
222 regulated in disease. Likewise, reduced expression of several homeostatic astrocyte genes is reported in mouse
223 models of SWI ([Sirko et al., 2015](#)) and TBI ([Shandra et al., 2019](#)) (see also **Section 10**), but there is no established
224 list of genes down-regulated in reactive astrocytes across multiple diseases. Overall, the significant phenotypic
225 alterations observed in reactive astrocytes involve large-scale transcriptome modifications and functional
226 changes (see **Section 8**).

227
228 **Migration & proliferation.** The very first observers of astrocytes noticed increased numbers of nuclei in sclerotic
229 tissue of epileptic brains, and discussed the proliferative capacity of neuroglia [Fig. 1, (P. Chaslin, 1891; Ramón y
230 Cajal)]. But more recent studies based on two-photon imaging of astrocyte reaction, fate mapping and
231 bromodeoxyuridine (BrdU) labeling in animal models, challenged this dogma [(Bardehle et al., 2013; Buffo et al.,
232 2008), Fig. 2H]. Immunostaining with Ki67 or Proliferating Cell Nuclear Antigen in patients confirmed that only a
233 small percentage of reactive astrocytes undergoes proliferation (Perez-Nievas & Serrano-Pozo, 2018). These
234 proliferative astrocytes appear to require a stimulus from outside the central nervous system (CNS): they are in
235 direct contact with the lesion in SCI [(Wanner et al., 2013), Fig. 2F], are exposed to blood-borne substrates
236 following SWI (Sirko et al., 2013), or their cell bodies are in apposition to blood vessels (Bardehle et al., 2013).
237 Notably, proliferative astrocytes perform only one or two rounds of division (Bardehle et al., 2013; Sirko et al.,
238 2013). Two-photon microscopy also showed that reactive astrocytes do not migrate like microglia or
239 macrophages do after a focal mechanical injury (Bardehle et al., 2013; Nimmerjahn, Kirchhoff, & Helmchen,
240 2005). Similarly, in the spinal cord, astrocytes remain in their allocated regional domain and do not migrate to a
241 nearby SWI (Tsai et al., 2012).

242
243 **Timescale.** Increased GFAP and nestin protein expression is detected as soon as 90 min after mouse euthanasia
244 and preparation of acute slices, showing that molecular changes may occur rapidly (and even *ex vivo*) (Takano et
245 al., 2014). In addition, In different striatal injury models caused by acute neurotoxin injection, *Gfap* mRNA levels
246 are induced 6 h later, while GFAP protein levels increase significantly only after 12-72 h, depending on the model
247 (O'Callaghan, Kelly, VanGilder, Sofroniew, & Miller, 2014). Astrocyte reaction can be viewed as a change of state
248 or a conversion (Table 1a). By becoming reactive, astrocytes undergo a set of morphological, transcriptional and
249 functional changes that transform them into different cells, with acquired, lost or altered properties and
250 functions (see Section 8). This is different from a rapid stimulation by neurotransmitters for example, which will
251 produce transient movements of perisynaptic processes (Bernardinelli et al., 2014), Ca²⁺ signals or gliotransmitter
252 release (Araque et al., 2014). This physiological response (which is better qualified as activation, see Table 1b
253 and Section 2), will not necessarily be long-lasting or associated with large scale transcriptional changes that shift
254 astrocyte phenotype. On the contrary, reactive astrocytes may persist over months and even years in chronic
255 brain diseases, although they may evolve overtime.

256
257 **Reversibility.** Astrocyte reaction is reversible and may resolve. Manipulation of specific signaling cascades *in vitro*
258 and *in vivo* can normalize the transcriptome of astrocytes. Whether such “de-activated” astrocytes are truly
259 normal or are in a different state remains to be fully explored. Indeed, it is known that a given stimulus has a
260 different effect on astrocytes, when they were previously exposed to a first injury, a process known as priming
261 (Hennessy, Griffin, & Cunningham, 2015). A very elegant study recently showed that grafting reactive astrocytes
262 in a normal mouse spinal cord is sufficient to revert them to a non-reactive state (Hara et al., 2017). Conversely
263 (but less surprising), grafting normal astrocytes in an injured environment turns naïve astrocytes into reactive
264 astrocytes based on both morphological and molecular criteria, showing that reactive astrocytes are plastic and
265 regulated by environmental cues. Among the reported signals involved in maintaining a non-reactive state or
266 resolving astrocyte reaction are fibroblast growth factor (Kang et al., 2014), β1 integrin (Hara et al., 2017; Robel
267 et al., 2009), transforming growth factor α (Rothhammer et al., 2018), microbiome-derived tryptophan
268 metabolites (Rothhammer et al., 2016), suppressor of cytokine signaling 3 [SOCS3, (Ceyzériat et al., 2018)] or
269 Sonic Hedgehog [SHH, (Garcia, Petrova, Eng, & Joyner, 2010)]. Such signaling molecules offer unique
270 opportunities to tune astrocyte reaction and evaluate the consequences on specific outcomes in different
271 disease models (see Section 8).

272
273

274 5. Do all astrocytes react the same way?

275 As nearly all surveyed researchers noted (Table 1a), the global expression “reactive astrocytes” falls short of
276 describing the different responses that astrocytes may express in different disease conditions or even in response

277 to the same stimulus (**Table 2**). As Prof. A. Messing puts it, citing Leo Tolstoy, “*All happy families are alike; each*
278 *unhappy family is unhappy in its own way*”, suggesting that astrocytes react in a specific manner in each
279 pathological situation. This was nicely illustrated by two-photon monitoring of astrocyte responses following
280 focal SWI. All astrocytes proximal to the lesion became hypertrophic but only half of them polarized their
281 processes towards the lesion, the other half remained static and only 10% of them underwent proliferation
282 [([Bardhele et al., 2013](#)), **Fig. 2H**]. Likewise, a lineage tracing method was used to determine whether astrocytes
283 derived from the same developmental clone display similar morphological changes following SWI or
284 experimental autoimmune encephalomyelitis (EAE). In both cases, reactive astrocytes from the same clone
285 tended to behave similarly, indicating that they are controlled by intrinsic cues established during development.
286 However, some astrocytes reacted differently than other cells in the same clone, showing that environmental
287 signals further diversify astrocyte response [([Bribian, Perez-Cerda, Matute, & Lopez-Mascaraque, 2018](#); [Martin-
288 Lopez, Garcia-Marques, Nunez-Llaves, & Lopez-Mascaraque, 2013](#)), **Fig. 2B**].

289 The heterogeneity of reactive astrocytes is also evidenced by spatial gradients in the intensity of response,
290 which culminates at the core of ischemia injury, SCI, mechanical lesion or epileptic focus (see **Fig. 2A** for example).
291 This is defined as topographical heterogeneity ([Anderson, Ao, & Sofroniew, 2014](#)) and is basically determined by
292 the distance to the injury core. As the concentration of molecular stimuli decreases with distance to the injury
293 core, so does astrocyte reaction, at least based on morphological changes or GFAP induction (see **Table 2**). As
294 Prof. S. Sirko explains it “*as in Newton's third law, the action and the reaction [of astrocytes] are equivalent in
295 magnitude*”. But this apparent continuum in the intensity of astrocyte reaction may in fact hide different, discrete
296 reactive states. For example, proliferative reactive astrocytes are only found proximal to the lesion [([Herrmann
297 et al., 2008](#); [Wanner et al., 2013](#)), **Fig. 2F**]. Nearly ten years ago, Prof. M. Sofroniew described three categories
298 of astrocyte reactivity: mild to moderate; severe diffuse and severe with glial scar. It was a noticeable effort to
299 better define this process and recognize its heterogeneity ([Sofroniew & Vinters, 2010](#)). This classification is based
300 on measurable criteria (proliferation, process extension, maintenance or loss of exclusive 3D domains) but there
301 is no absolute quantitative categories (*e.g.* to what extent astrocytes need to elongate their processes to fall into
302 the mild or severe category?). This classification may thus be difficult to translate to any disease or model, and
303 does not take advantage of objective molecular markers. Indeed, it was recently shown that reactive astrocytes
304 that form the glial scar and lose their 3D domain have a different molecular profile than hypertrophic reactive
305 astrocytes located farther away. “Scar-forming” astrocytes express specific transcripts such as chondroitin sulfate
306 proteoglycans (*e.g.* *Acan*, *Pcan*) and N-Cadherin (*Cdh2*), while hypertrophic reactive astrocytes express several
307 members of the β -catenin pathway (*e.g.* *Ctnnb1*, *Plaur*) ([Hara et al., 2017](#)). Interestingly, both types of reactive
308 astrocytes overexpress *Gfap* and *Vim* compared to normal astrocytes ([Hara et al., 2017](#)). In addition, scar-forming
309 astrocytes proliferate more than more distant hypertrophic reactive astrocytes [see **Section 6, Table 2**, ([Wanner
310 et al., 2013](#))]. Overall, these data suggest that the scar-forming astrocytes are a specific reactive astrocyte
311 subtype and not a mere exacerbation of hypertrophic reactive astrocytes.

312 Other sources of heterogeneity have been described, such as regional differences, even more than 20 years
313 ago (**Table 2**). Astrocytes from different CNS regions exposed to the same toxic stimulus (Amyloid β) respond
314 differently *in vitro* ([Hoke, Canning, Malemud, & Silver, 1994](#)), showing that astrocyte heterogeneity is at least
315 partially intrinsic, as it is maintained in a dish. Likewise, astrocytes from gray and white matter react differently
316 to SWI ([Mattugini et al., 2018](#)). This could be due to pre-existing differences between astrocytes from distinct
317 brain regions ([Boisvert, Erikson, Shokhiev, & Allen, 2018](#); [Chai et al., 2017](#); [Itoh et al., 2018](#); [John Lin et al., 2017](#);
318 [Lanjakornsiripan et al., 2018](#); [Morel et al., 2017](#); [Torigoe, Yamauchi, Zhu, Kobayashi, & Murakami, 2015](#)). Another
319 demonstration of different molecular classes of reactive astrocytes came from the Barres laboratory. They
320 reported that the molecular changes induced in astrocytes by LPS injection or MCAO only partially overlap
321 ([Zamanian et al., 2012](#)). This led to the description of A1 and A2 reactive astrocytes, each characterized by a set
322 of 10-13 genes, in addition to a panel of 10-13 common genes (*i.e.* pan reactive) including *Gfap*, *Vimentin* and
323 *Serpina3n* ([Liddelow et al., 2017](#)). The molecular profile of LPS-induced A1 reactive astrocytes was replicated
324 quite faithfully by treating immunopanned rodent astrocytes with interleukin 1 α (IL1 α), complement 1q (C1q)
325 and tumor necrosis factor (TNF) ([Liddelow et al., 2017](#)). A detailed functional characterization of A1 reactive
326 astrocytes showed that they release factors that are toxic to neurons and oligodendrocytes, are less synaptogenic

327 and have defective phagocytosis. But this dual classification may be quite restrictive to define other potential
328 types of reactive astrocytes existing in the complex world of brain diseases ([Cunningham, Dunne, & Lopez-](#)
329 [Rodriguez, 2018](#)). Indeed, many intermediate molecular profiles were observed after treatment of
330 immunopanned astrocytes with different molecules, not only A1 or A2 ([Liddelow et al., 2017](#)). In a complex *in*
331 *vivo* multicellular environment with multiple stimuli, reactive astrocyte diversity may even be stronger. Both A1
332 and A2 genes are induced concomitantly in different models, such as mouse models of AD ([Ceyzériat et al., 2018](#)),
333 Tauopathy ([Litvinchuk et al., 2018](#)) or ischemia ([Liddelow et al., 2017](#)).

334 Overall, some markers may display graded changes, proportional to the intensity of the initial injury [GFAP,
335 cytokines, ([Sofroniew, 2014a](#))], while others may undergo an all-or-none response, being present only in some
336 forms of reaction [e.g. A1 versus A2 reactive astrocytes ([Liddelow et al., 2017](#)); scar-forming versus hypertrophic
337 reactive astrocytes ([Hara et al., 2017](#)), ephrin type-B receptor 1 (EphB1) versus interleukin (IL)6-induced reactive
338 astrocytes ([G. E. Tyzack et al., 2017](#)), **Table 2**].

339 There are several origins and several manifestations of reactive astrocyte heterogeneity (**Fig. 3, Table 2**).
340 Indeed, as stated by Prof. A. Volterra « *the combination of the intrinsic features of a given astrocytic population,*
341 *of its microenvironment and the type of insult will concur to produce different types of reactivity and different*
342 *functional outcomes*». More precisely, astrocyte reaction is determined by core changes (induction of *Gfap*
343 expression, morphological plasticity), combined with disease-specific changes on a preexisting heterogeneous
344 background (**Fig. 3**), resulting in an extreme variety of possible reactive astrocyte subtypes. This leads us to the
345 next question, very central to the field.

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6. What are the appropriate markers of reactive astrocytes?

349 As discussed earlier, GFAP overexpression and morphological changes are the most commonly used of
350 reactive astrocyte markers ([Liddelow & Barres, 2017](#)). Both are easy to monitor on different types of samples
351 (see **Fig. 2, Table 2**). *Gfap* is one of the most consistently induced gene in transcriptomic datasets of reactive
352 astrocytes, confirming its usefulness as a reactive marker [([Hol & Pekny, 2015](#); [Liddelow et al., 2017](#); [Orre,](#)
353 [Kamphuis, Osborn, Jansen, et al., 2014](#); [Zamanian et al., 2012](#)), see also **Table 2** and **Section 4**]. It is important to
354 note however, that the level of *Gfap* induction can be very different between conditions (see **Table 2** and **Section**
355 **5**) or even between cells ([Pekny, Wilhelmsson, Tatlisumak, & Pekna, 2019](#)), but GFAP expression globally
356 increases at the population level, in a wide range of brain diseases.

357 Are GFAP induction and morphological changes enough to identify reactive astrocytes? Several surveyed PIs
358 think that these indexes can be misleading (**Table 1a**). Indeed, additional markers would be helpful with some
359 specific forms of reactive astrocytes that display unconventional morphological alterations or lower GFAP
360 immunoreactivity (see **Section 9**). In addition, they would be useful to define specific types of reactive astrocytes.
361 Genome-wide transcriptional profiling can identify potential common and class-specific genes ([Hara et al., 2017](#);
362 [Liddelow et al., 2017](#)). How many markers are needed to define a class? For example, of the ~10 genes forming
363 the A1 and A2 panels, should they all be induced in a given condition to qualify a cell as an A1 reactive astrocyte
364 or 2-3 are enough? In fact, the expression of only a few protein markers (Complement 3, Complement factor b
365 and MX dynamin-like GTPase 1) was tested in the brain of patients and these three genes were not in the original
366 A1 panel [([Liddelow et al., 2017](#)), **Fig. 2T, U**]. When the full panel of A1 genes is tested, not every single gene of
367 the A1 cassette is induced in several diseases, like *in vitro* and *in vivo* models of Parkinson disease ([Yun et al.,](#)
368 [2018](#)) or AD mouse models ([Ceyzériat et al., 2018](#)). In addition, individual reactive astrocytes co-expressing A1
369 and A2 genes are observed in the MCAO rodent model and in the aging mouse brain ([Clarke et al., 2018](#)),
370 suggesting that it may be difficult to define classes of reactive astrocytes with only a few genes.

371 To improve the panel of reactive astrocyte molecular markers, it would be useful to extend the transcriptomic
372 analysis of reactive astrocytes performed by Zamanian *et al.* in LPS and MCAO models ([Zamanian et al., 2012](#)), to
373 many different, genetic and sporadic, acute and chronic, degenerative and inflammatory diseases. It would help
374 define with greater power the core sets of genes systematically induced or down-regulated in reactive astrocytes,
375 and identify disease-specific markers. Of course, such analysis would provide even more insight if performed on
376 human samples. However, *post mortem* delays induce noise and artifacts and the physical isolation of astrocytes

377 is quite difficult, although it may be possible to gain some insight into astrocyte-specific transcriptomic changes
378 by co-expression analysis on bulk samples ([Kelley, Nakao-Inoue, Molofsky, & Oldham, 2018](#)). A method of choice
379 to study cell diversity at the molecular level is single-cell RNAseq (scRNAseq) ([Svensson, Vento-Tormo, &
380 Teichmann, 2018](#)) or single-nuclei RNAseq (snRNAseq) ([Habib et al., 2017](#)). These methods have gained
381 significant momentum, and several landmark papers have reported brain cell heterogeneity, including glial cells,
382 throughout development or between regions ([Macosko et al., 2015](#); [Pollen et al., 2014](#); [Zeisel et al., 2018](#)). There
383 are only few articles on brain diseases, and to date, only on other glial cells like microglia ([Hammond et al., 2018](#);
384 [Masuda et al., 2019](#)). Such unsupervised approaches will help define populations of reactive astrocytes with
385 associated gene markers in different conditions (see **Section 13**).

386 Another option to classify reactive astrocytes is to combine molecular with functional indexes. A good
387 example is the variable capacity of reactive astrocytes to proliferate. As mentioned earlier, only a subset of
388 reactive astrocytes undergo cell division. These proliferative astrocytes may thus be considered as a different
389 class, of particular interest because they may repopulate the damaged brain (see **Section 10**). But other specific
390 functions (either gained, lost or altered, see **Section 8**) may also serve as functional markers of reactive
391 astrocytes, like enhanced phagocytic capacities around plaques, as shown for “disease associated microglia”
392 ([Keren-Shaul et al., 2017](#)). For example, only a fraction of reactive astrocytes phagocytose myelin debris in the brain
393 of patients with MS or leukoencephalopathy [([Ponath et al., 2017](#)), **Fig. 2N**]. A classification based on production
394 of γ -amino-butyric acid (GABA) and brain-derived neurotrophic factor (BDNF) by reactive astrocytes was
395 proposed by Prof. C.J. Lee [see **Table 1a**, and **Supplemental text**, ([Chun et al., 2018](#))], since reactive astrocytes
396 produce more GABA in AD ([Jo et al., 2014b](#); [Z. Wu, Guo, Gearing, & Chen, 2014](#)). This is a potentially interesting
397 functional classification of reactive astrocytes, but it needs to be further explored, to evaluate whether this is
398 translatable to multiple diseases, animal models and of course patients. For example, contrary to AD models,
399 astrocyte GABA production is reduced in a mouse model of Huntington disease [HD, ([Jo et al., 2014b](#); [Wojtowicz,
400 Dvorzhak, Semtner, & Grantyn, 2013](#))]. Importantly, a good marker needs to be easy to use and compatible with
401 other exploratory techniques like electrophysiology or functional imaging. Therefore, mRNA and protein markers
402 remain favored options.

403 A problem that may be very difficult to overcome is the dynamic, flexible and context-dependent phenotype
404 of astrocytes. It was nicely discussed for astrocytes in physiology ([Poskanzer & Molofsky, 2018](#)), and it may even
405 be exacerbated in disease, when astrocytes express gene markers of other cell types and cell identities become
406 blurrier (see **Section 10**). It may thus be impossible to establish fixed classes and we rather should try to define
407 states, dependent on previous phenotype, activated signaling and environment (see **Fig. 3**). The ambitious
408 Human Cell Atlas project that aims to define all cells in the human body with a range of single-cell approaches
409 will probably provide the astrocyte field with new tools and concepts to better address the challenge of reactive
410 astrocyte classification.

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413 **7. What are the molecular cascades triggered in reactive astrocytes?**

414 First, astrocytes sense a pathological signal. This signal can be extracellular (*e.g.* cytokines, purines,
415 aggregated proteins, myelin debris), trans-cellular (*e.g.* transmembrane adhesion molecules like ephrins or
416 integrins), membrane bound [*e.g.* phosphatidyl-serine ([Chung et al., 2013](#))], as well as intracellular (*e.g.*
417 aggregated proteins, nucleic acids from infecting pathogens, ions like Ca^{2+}), [see ([Buffo, Rolando, & Ceruti, 2010](#);
418 [Cunningham et al., 2018](#); [Kang & Hebert, 2011](#); [Sofroniew, 2014a](#)) for review]. Interestingly, a recent study
419 reported that astrocytes are also very sensitive to environmental pollutants ([Wheeler et al., 2019](#)). To sense all
420 these molecular triggers, astrocytes are equipped with a wide range of membrane or intracellular receptors,
421 including G Protein-coupled receptors (GPCR, like metabotropic glutamate or P2Y purinergic receptors),
422 ionotropic receptors (*e.g.* P2X purinergic receptors), multimeric cytokine receptors (*e.g.* IL6 family receptors),
423 Toll like receptors [TLR, although their expression by astrocytes is quite disputed ([Cunningham et al., 2018](#))] or,
424 tyrosine kinase receptors (*e.g.* Epidermal growth factor receptor), [see ([Kang & Hebert, 2011](#); [Verkhatsky &
425 Nedergaard, 2018](#)) for review]. It is important to note however that there is rarely a direct and formal
426 demonstration that each of these stimuli can trigger a full reactive program (*i.e.* resulting in morphological as

427 well as complex transcriptional changes), without the involvement of other cell types like microglia. Indeed, this
428 is typically tested by applying high doses of these compounds *in vitro* or through injection or overexpression *in*
429 *vivo*. It is therefore difficult to know whether they activate astrocytes directly or through microglial cells (see
430 **Section 11**). Interestingly, astrocytes are also mechano-sensitive. They can detect changes in their environment
431 mechanical properties, discriminate soft from stiff material and adjust by changing their own stiffness
432 ([Moeendarbary et al., 2017](#); [Moshayedi et al., 2014](#)).

433 After stimulus sensing, a step of signal transduction takes place and converge to the nucleus. This can occur
434 through direct shuffling of activated down-stream transcription factors to the nucleus after phosphorylation,
435 dephosphorylation or release from inhibitors. Signal transducer and activator of transcription 3 (STAT3), nuclear
436 factor κ B (NF- κ B) and nuclear factor of activated T-cells (NFAT), the downstream effectors of the Janus kinase
437 (JAK)-STAT3, NF- κ B and calcineurin-NFAT pathways respectively, are regulated by such a mechanism ([Ceyzeriat,](#)
438 [Abjean, Carrillo-de Sauvage, Ben Haim, & Escartin, 2016](#); [Sompol & Norris, 2018](#); [Q. Zhang, Lenardo, & Baltimore,](#)
439 [2017](#)). Many signaling cascades are associated with astrocyte reaction ([L. Ben Haim, Carrillo-de Sauvage,](#)
440 [Ceyzeriat, & Escartin, 2015](#); [Buffo et al., 2010](#); [Kang & Hebert, 2011](#)), but the STAT3 pathway seems to play a
441 prominent role in different disease conditions, acting as a master regulator of reactive astrocytes [([L. Ben Haim,](#)
442 [Ceyzeriat, et al., 2015](#); [Ceyzeriat et al., 2016](#); [Herrmann et al., 2008](#)), **Fig. 20**]. Ca^{2+} signaling may also be involved
443 in astrocyte reaction. Ca^{2+} can activate or inhibit many downstream signaling intermediates like the phosphatase
444 calcineurin ([Sompol & Norris, 2018](#)) or the transcriptional repressor Pumilio 2 ([Kanemaru et al., 2013](#)), which will
445 activate other downstream pathways like the NFAT or N-cadherin pathways respectively and trigger important
446 transcriptional changes.

447 Activation of specific transcription factors will induce expression of target genes such as *Gfap* or cytokines
448 but also of transcription factors or retro-inhibitors of other pathways (*e.g.* SOCS3 for the JAK-STAT3 pathway or
449 κ B for the NF- κ B pathway), which will further shape the transcriptome of reactive astrocytes. This step may
450 involve successive waves of transcriptional regulation, starting with induction of immediate early genes ([Jenab](#)
451 [& Quinones-Jenab, 2002](#); [Priller, Reddington, Haas, & Kreutzberg, 1998](#); [Y. E. Wu, Pan, Zuo, Li, & Hong, 2017](#)),
452 followed by subsequent waves of gene induction. The transcription of some genes may be repressed. Indeed,
453 the number of down-regulated genes may even be higher than those over-expressed, as observed AD mouse
454 astrocytes ([Orre, Kamphuis, Osborn, Jansen, et al., 2014](#)). Importantly, the precise time course of transcriptional
455 induction is not very well known. It was established for specific transcripts or proteins (mostly GFAP and
456 cytokines) in mice exposed to neurotoxins ([O'Callaghan et al., 2014](#)) or LPS ([Biesmans et al., 2015](#); [Norden,](#)
457 [Trojanowski, Villanueva, Navarro, & Godbout, 2016](#)). Transcriptional profiling of astrocytes was performed in a
458 mouse model of epilepsy, in two brains regions and three time points following pilocarpine injection ([Clasadonte](#)
459 [et al., 2016](#)). This extensive analysis showed subtle differences between disease stages or brain regions (see
460 **Table 2**). Such genome-wide, longitudinal analysis of relevant *in vivo* models of other brain diseases would
461 provide key insight into the temporal regulation of astrocyte reaction.

462 Some changes observed in reactive astrocytes do not require transcriptional induction, such as morphological
463 plasticity. The molecular mechanisms underlying astrocyte morphological changes and process motility are
464 mostly studied *in vitro*, where these cells are grown in 2D and usually have a much simpler morphology
465 (sometimes even no processes) [see ([Schiweck, Eickholt, & Murk, 2018](#)), for review]. But *in vivo*, reactive
466 astrocytes do not migrate [([Bardehle et al., 2013](#)), **Section 2**] and show little motility of main processes compared
467 to microglia ([Nimmerjahn et al., 2005](#)), calling for *in vivo* validation of the signaling described *in vitro*. For
468 example, knockout of the Rho GTPase *cdc42* reduces astrocyte polarization *in vitro* in the scratch wound assay,
469 while it exacerbates it after SWI *in vivo* ([Robel, Bardehle, Lepier, Brakebusch, & Gotz, 2011](#)). As mentioned earlier
470 (**Section 3**), reactive astrocytes not only present hypertrophy, but also subtle morphological changes. For
471 example, reactive astrocytes retract their processes following stimulation of Slit-Robo signaling by neuroblasts
472 migrating from the subventricular zone after stroke. This *cdc42*-dependent remodeling of astrocyte cytoskeleton
473 facilitates neuroblast migration towards lesion sites ([Kaneko et al., 2018](#)).

474 Less is known about mechanisms of epigenetic regulation in reactive astrocytes in disease. Based on what
475 happens during astrocyte development, it is suspected that epigenetic processes (chromatin remodeling through

476 DNA methylation or histone post-translational modifications, as well as expression of regulatory microRNA) could
477 influence astrocyte conversion into reactive cells ([Neal & Richardson, 2018](#)).

478 The profound transcriptional changes occurring in reactive astrocytes translate into functional alterations
479 that may impact virtually all astrocyte functions.

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481

482 **8. Do reactive astrocytes do good things?**

483 Reactive astrocytes are the usual suspects in many diseases, but they are now considered by many, as
484 beneficial partners for neurons, as illustrated in **Table 1a**. An overview of the literature shows that depending on
485 the strategy employed to modulate reactive astrocytes (*e.g.* pharmacological or genetic approaches, targeting of
486 astrocyte proteins or signaling pathways, ablation of astrocytes), the outcomes vary ([L. Ben Haim, Carrillo-de](#)
487 [Sauvage, et al., 2015](#); [Cunningham et al., 2018](#)). Of course, the disease studied and its model itself (*e.g.* transgenic
488 versus knock-in, *in vivo* versus *in vitro*, species) will influence how astrocyte reaction will play out. More
489 importantly, some models do not reproduce astrocyte reaction well. For example, most HD mouse models do
490 not display reactive astrocytes, while GFAP up-regulation is robustly detected in the caudate-putamen of HD
491 patients ([Faideau et al., 2010](#); [Selkoe, Salazar, Abraham, & Kosik, 1982](#); [Vonsattel et al., 1985](#)). This could be due
492 to low GFAP expression in the mouse striatum compared to other brain regions ([Chai et al., 2017](#)), significant
493 species differences ([Oberheim et al., 2009](#); [Y. Zhang et al., 2016](#)) or a simple failure of mouse models to
494 recapitulate all HD features.

495 How do reactive astrocytes functionally impact the diseased brain? Virtually all astrocyte functions are
496 reported to be altered in disease: neurotransmitter uptake ([Escartin et al., 2006](#); [Sheldon & Robinson, 2007](#)),
497 gliotransmitter release ([Jo et al., 2014a](#); [Z. Wu et al., 2014](#)), metabolic activity ([Escartin et al., 2007](#); [Gavillet,](#)
498 [Allaman, & Magistretti, 2008](#); [Valenza et al., 2010](#)), ion buffering ([Tong et al., 2014](#)), release of cytokines,
499 complement factors or trophic factors ([Chou et al., 2008](#); [Lian et al., 2015](#); [Sofroniew, 2014b](#)), phagocytosis
500 ([Gomez-Arboledas et al., 2018](#); [Liddelow et al., 2017](#); [Morizawa et al., 2017](#)), production and detoxification of
501 reactive oxygen species [ROS, ([Allaman et al., 2010](#); [Cassina et al., 2008](#); [Ye et al., 2015](#))]. These functions may
502 be enhanced or reduced by the reactive state. For example, reactive astrocytes may display enhanced or reduced
503 connectivity through gap junctions, depending on the disease ([Escartin & Rouach, 2013](#); [Pannasch & Rouach,](#)
504 [2013](#)). They may display deficits in glutamate uptake ([Sheldon & Robinson, 2007](#)), or show enhanced uptake
505 capacity when reaction is induced by the cytokine ciliary neurotrophic factor (CNTF) ([Escartin et al., 2006](#)).
506 Reactive astrocytes may release more GABA in AD mice ([Jo et al., 2014b](#); [Z. Wu et al., 2014](#)) or do the opposite
507 in HD mice ([Wojtowicz et al., 2013](#)).

508 It is beyond the scope of this review to list all their described functional changes and contributions to specific
509 diseases. Readers are referred to recent reviews on astrocytes in HD ([Khakh et al., 2017](#)), AD ([Chun & Lee, 2018](#);
510 [Osborn, Kamphuis, Wadman, & Hol, 2016](#); [Perez-Nievas & Serrano-Pozo, 2018](#)), MS ([Wheeler & Quintana, 2019](#)),
511 SCI ([Adams & Gallo, 2018](#); [Sofroniew, 2018](#)), TBI ([Burda, Bernstein, & Sofroniew, 2016](#)), stroke ([Pekny et al.,](#)
512 [2019](#)), and epilepsy ([Coulter & Steinhauser, 2015](#); [Robel & Sontheimer, 2016](#)). In general, deficits in normal
513 astrocyte functions are reported and the existence of “killer astrocytes” releasing toxic molecule(s) was even
514 proposed in amyotrophic lateral sclerosis [ALS, ([Haidet-Phillips et al., 2011](#); [Nagai et al., 2007](#))] and other
515 neurodegenerative diseases [([Liddelow et al., 2017](#)), see **Section 5**]. But there are also strong evidence for
516 beneficial reactive astrocytes in acute or chronic diseases. For example, over the years, the Sofroniew laboratory
517 has convincingly demonstrated that scar-forming reactive astrocytes demarcate damaged tissue ([Bush et al.,](#)
518 [1999](#); [Faulkner et al., 2004](#)) and even promote axonal regrowth through the lesion ([Anderson et al., 2016](#)).
519 Likewise, STAT3-dependent reactive astrocytes reduce degeneration of axotomized motoneurons in the facial
520 motor nucleus, and promotes synapse maintenance through thrombospondin 1 release ([G. E. Tyzack et al., 2014](#)).
521 CNTF-induced reactive astrocytes display enhanced glutamate uptake, promote metabolic resilience and protect
522 neurons against excitotoxicity ([Beurrier et al., 2010](#); [Escartin et al., 2006](#); [Escartin et al., 2007](#)). Even A1 neurotoxic
523 reactive astrocytes may have some beneficial roles in specific diseases, for example by killing damaged,
524 dysfunctional or infected neurons ([Liddelow et al., 2017](#)).

525 A way to study common functional features of reactive astrocytes, is to activate (or inhibit) a specific signaling
526 pathway to trigger reactive conversion (see **Section 8**). For example, JAK-STAT3 pathway activation in astrocytes
527 induces many reactive markers and is sufficient to alter synaptic transmission and plasticity in the hippocampus
528 ([Ceyzeriat et al., 2018](#)). Activation of the NF- κ B pathway by expression of a constitutive form of the upstream
529 I κ B kinase (IKK) in adult astrocytes also induces a reactive profile and Purkinje cell loss in the cerebellum ([Lattke](#)
530 [et al., 2017](#); [Oeckl, Lattke, Wirth, Baumann, & Ferger, 2012](#)). Such approaches are useful to isolate functional
531 changes in reactive astrocytes, independently of a specific disease condition. Alternatively, blocking astrocyte
532 reaction may help uncover the net effect of reactive astrocytes in each disease context [see ([L. Ben Haim, Carrillo-](#)
533 [de Sauvage, et al., 2015](#))]. This requires an efficient strategy that i) only impacts the reactive state and not normal
534 astrocyte functions, ii) does not affect other cell types, and iii) inhibits all (or only the targeted) classes of reactive
535 astrocytes. With new and maybe more selective molecular markers, it will be important to extensively validate
536 the efficiency and universality of such methods and determine how these “de-activated” astrocytes are different
537 from non-reactive astrocytes.

538 Overall, the range of functional changes displayed by reactive astrocytes and their effects on disease are
539 extremely large. They are governed by the pre-existing astrocyte molecular and functional profile, in addition to
540 the pathological trigger itself (**Fig. 3, Section 5**). Indeed, even reactive astrocytes activated by the same pathway
541 can have different effects on specific disease outcomes. STAT3 signaling in reactive astrocytes has detrimental
542 effects in mouse models of AD ([Ceyzeriat et al., 2018](#); [Reichenbach et al., 2019](#)), or hypoxia ([Hristova et al., 2016](#)),
543 no significant effect in the context of acute mitochondria toxicity ([O'Callaghan et al., 2014](#)) but has beneficial
544 effects in neonatal white matter injury ([Nobuta et al., 2012](#)), after SCI, by promoting glial scar formation
545 ([Anderson et al., 2016](#); [Herrmann et al., 2008](#); [Okada et al., 2006](#)), and in HD models, by reducing mutant
546 huntingtin aggregation ([L. Ben Haim, Ceyzeriat, et al., 2015](#)). Intriguingly, a recent study by Tyzack *et al.* suggested
547 that the upstream activator (IL6 or EphB1-ephrine-B1 signaling) controls the final molecular profile induced by
548 STAT3 in reactive astrocytes [([G. E. Tyzack et al., 2017](#)), **Table 2**].

549 It is now important to define what reactive astrocytes do in each situation and the underlying signaling
550 cascades, before targeting these cells for therapy. There are new opportunities and yet many challenges to use
551 reactive astrocytes for therapeutic purposes.

552
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554 **9. Do reactive astrocytes eventually die?**

555 There may be extreme forms of responses leading to the loss of key astrocyte proteins and functions or even
556 their death. Astrocytes are considered more resilient than neurons, but they may degenerate as well. As seen
557 with TUNEL or caspase stainings, astrocytes may undergo apoptotic cell death in ischemia ([Giffard & Swanson,](#)
558 [2005](#)), in ALS mice ([Rossi et al., 2008](#)), or in the brain of AD patients ([Perez-Nievas & Serrano-Pozo, 2018](#)).
559 Alternatively, mouse astrocytes may die by necrosis at the infarct core after stroke ([Lukaszevicz et al., 2002](#)).

560 Major alterations of astrocyte morphology, including severe process atrophy or fragmentation, swollen or
561 vacuolated cell bodies are described in brain samples from patients with AD, stroke or infection for example, and
562 it is called clasmotodendrosis [see references in ([Perez-Nievas & Serrano-Pozo, 2018](#); [Tachibana et al., 2019](#))]. It
563 is also reproduced in animal models of these diseases ([Olabarria, Noristani, Verkhatsky, & Rodriguez, 2010](#);
564 [Sullivan, Bjorkman, Miller, Colditz, & Pow, 2010](#)). In addition, astrocytes may be directly or primarily targeted by
565 the disease process, like in Alexander disease caused by *Gfap* mutation ([Messing, 2018](#)) or *neuromyelitis optica*
566 caused by autoantibodies against the astrocyte protein aquaporin 4 [see ([Verkhatsky, Zorec, & Parpura, 2017](#))
567 for a complete review].

568 Interestingly, in a mouse model of tauopathy ([Bussian et al., 2018](#)) and in AD patients ([Bhat et al., 2012](#)),
569 astrocytes express markers of cellular senescence (p16^{INK4a} and β -galactosidase). Genetic ablation of senescent
570 cells prevents tau pathology and cognitive decline ([Bussian et al., 2018](#)), suggesting that they have deleterious
571 effects. It is not possible however, to know whether senescent astrocytes are responsible alone or if senescent
572 microglia also play a role. Interestingly, interleukins IL6 and IL1 β are classic senescence markers ([Salminen et al.,](#)
573 [2011](#)) and senescent astrocytes in AD brains express high levels of GFAP ([Bhat et al., 2012](#)), suggesting that
574 senescence could be yet another specific reactive state.

575 Overall, such atypical astrocyte responses characterized by major loss of key homeostatic astrocyte proteins,
576 senescence and/or altered morphology will need to be further characterized by genome wide and refined
577 temporal analysis to really qualify as a form of astrocyte reaction. Do astrocytes first become reactive and then
578 adopt this dysfunctional, senescent phenotype and die, or these are distinct non-overlapping processes?
579

580

581 **10. Where do reactive astrocytes come from or what do they become?**

582 Reactive astrocytes are in a very distinct state from astrocytes in physiological conditions. Thus, one may
583 wonder whether reactive astrocytes 1) can further transform into other cell types and 2) come only from the
584 conversion of a non-reactive astrocyte. Both questions have important therapeutic implications, especially if
585 reactive astrocytes are able to generate new neurons.

586 As mentioned earlier, only a subset of reactive astrocytes proliferate (*e.g.* juxta-vascular or scar-forming
587 astrocytes), they only undergo one round of division and invariably generate two sister astrocyte cells (see
588 **Section 4**). Strikingly, the *in vitro* situation is quite different. In a culture medium promoting cell proliferation,
589 acutely isolated reactive astrocytes are able to generate different cell types, including neurons ([Gotz, Sirko,
590 Beckers, & Irmeler, 2015](#)). It shows that some permissive signals are lacking in the brain environment [like SHH
591 signaling, ([Sirko et al., 2013](#))] or conversely, that restrictive factors prevent astrocytes from returning to a
592 multipotent state and differentiating into neurons [like Notch signaling, ([Magnusson et al., 2014](#))]. Significant
593 efforts are made to identify and target such factors, to promote the neurogenic potential of reactive astrocytes
594 and their reconstruction of damaged neuronal circuits [for a complete review, see ([Lei, Li, Ge, & Chen, 2019](#))].

595 Regarding the origin of reactive astrocytes, scar-forming reactive astrocytes were proposed to come from
596 other proliferating cell types, like progenitors cells ([Benner et al., 2013](#); [Faiz et al., 2015](#)) or ependymal cells
597 ([Sabelstrom et al., 2013](#)). Fate mapping by Cre-reporters or viral targeting suggests that this phenomenon is
598 marginal, with the majority of reactive astrocytes originating from previously labelled astrocytes ([Buffo et al.,
599 2008](#); [Ren et al., 2017](#)), but it may be insult- and region-dependent ([see Gotz et al., 2015, for a complete
600 discussion](#)).

601 These two questions are intimately linked to cell identity. At present, there is no single univocal marker for
602 brain cell types [as discussed for reactive astrocytes in **Section 6**, see ([Gotz et al., 2015](#)), for a complete
603 discussion]. For example, GFAP is also expressed by progenitor cells. A type of thalamic glial cell expresses both
604 Connexin43 and Olig2, which are typical astrocyte and OPC markers respectively ([Griemsmann et al., 2015](#)). Such
605 blurred cell identities are even exacerbated in disease. Reactive astrocytes express nestin and other makers of
606 neural stem cells ([Gotz et al., 2015](#)). Likewise, transcriptomic studies reveal that reactive astrocytes overexpress
607 many genes characteristic of microglia (*e.g.* *Cst7*, *Trem2*, *Cts*) ([Ceyzériat et al., 2018](#); [Orre, Kamphuis, Osborn,
608 Jansen, et al., 2014](#)). Indeed, cells co-expressing astrocyte and microglia markers are observed in the spinal cord
609 of an ALS rat model ([Trias et al., 2013](#)), the deafferented mouse hippocampus or the brain of AD, Lewy body
610 dementia or stroke patients ([Wilhelmsson et al., 2017](#)). Moreover, reactive astrocytes may lose some of their
611 defining functional features like input resistance, membrane currents and gap-junction coupling, as described in
612 human brains and in a mouse model of sclerotic mesial temporal lobe epilepsy ([Bedner et al., 2015](#)). They may
613 also express lower levels of key astrocyte proteins, as discussed earlier (**Section 4, 9**), and as shown after mild
614 repetitive TBI with loss of GLT1, GS, KIR4.1 and even GFAP ([Shandra et al., 2019](#)). This will complicate their
615 identification as astrocytes.

616 When astrocytes become reactive, they undergo profound transformations, losing their original features and
617 “disguising” as other cells. Refined fate mapping methods with specific drivers and tight time control will be
618 valuable to trace the origin and future of single astrocytes in disease.
619

620

621 **11. How do reactive astrocytes interact with other innate immune cells?**

622 The dialogue between reactive astrocytes and other cellular partners involved in inflammation and immunity
623 (*e.g.* microglia, macrophages, lymphocytes) is quite complex. It is generally admitted that microglial cells react
624 first to many injury signals, in particular danger- and pathogen-associated molecular patterns, and then activate

625 astrocytes through cytokine release (Sofroniew, 2014b). There are several reports of microglial cells driving
626 astrocyte towards a specific reactive state. LPS-activated microglia produce IL1 α , C1q and TNF and induce A1
627 reactive astrocytes (Liddelow et al., 2017). But microglia made reactive by methotrexate chemotherapy induce
628 astrocytes to express A2 genes, not A1 (Gibson et al., 2019). Alternatively, when they release vascular endothelial
629 growth factor B (VEGF-B) during EAE, microglial cells induce a possibly different deleterious type of reactive
630 astrocyte, which needs to be fully characterized (Rothhammer et al., 2018). In TBI, microglia drives a beneficial
631 form of astrocyte reaction through down-regulation of P2Y1 receptors (Shinozaki et al., 2017).

632 Overall, these studies suggest that microglia dictate the profile of reactive astrocytes, but it may go the other
633 way around. Indeed, reactive astrocytes overexpress many cytokines, chemokines and signaling molecules that
634 could activate neighboring microglial cells (Ceyzériat et al., 2018; Orre, Kamphuis, Osborn, Jansen, et al., 2014;
635 Zamanian et al., 2012). Astrocyte-specific NF- κ B activation induces significant astrocyte reaction that secondarily
636 causes microglia activation (Oeckl et al., 2012; Ouali Alami et al., 2018). Accordingly, astrocytes may become
637 strongly reactive while microglial is barely affected after viral infection (Ortinski et al., 2010), or CNTF exposure
638 (Lavisse et al., 2012), showing that astrocytes have the ability to become reactive on their own.

639 Reactive astrocytes may also interact with peripheral immune cells. A recent study showed that regulatory T
640 cells reduce astrocyte reaction (including A1 markers) after stroke, through amphiregulin, IL6 and STAT3 signaling
641 (Ito et al., 2019). Alternatively, phospho-STAT3⁺ reactive astrocytes found around brain metastatic cells reduce
642 CD8⁺ lymphocyte recruitment and increase the number of CD74⁺ macrophage/microglia, which are more
643 permissive to metastatic proliferation [(Priego et al., 2018), Fig. 2R]. Proliferating, juxta-vascular reactive
644 astrocytes were also shown to inhibit monocyte infiltration following SWI (Frik et al., 2018). Using reporters to
645 track expression of two genes typical of different phagocyte states, Locatelli et al., also showed that astrocytes
646 release factors that convert polarized phagocytes expressing inducible nitric oxide synthase into arginase-
647 expressing cells *in vitro* (Locatelli et al., 2018).

648 Overall, reactive astrocytes engage in complex bi-directional communications with other immune cells. It
649 remains to be determined where and when these interactions take place, as peripheral immune cells entry into
650 the brain is tightly regulated. Microglial cells and peripheral immune cells themselves show heterogeneous
651 phenotypes, adding yet another layer of complexity to understand the role of reactive astrocytes in disease (Song
652 & Colonna, 2018).

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654

655 12. Are aging astrocytes a type of reactive astrocytes?

656 The human aging brain displays higher GFAP immunoreactivity and mRNA levels [see references in (Munger
657 et al., 2019)], and it was assumed that aging causes progressive astrocyte reaction. But this idea is not consensual
658 (see Table 1a). It is possible for example that the analyzed subjects were exposed to some pathological stimuli
659 (mild trauma, micro-infarcts, inflammation or infection) that caused GFAP increase, not aging itself. Again,
660 transcriptomics studies in mice provide a fuller view on what happens to astrocytes with aging. Results showed
661 that aging astrocytes express higher levels of genes linked to immunity and inflammation (Boisvert et al., 2018;
662 Orre, Kamphuis, Osborn, Melief, et al., 2014). Another study showed that 2-year-old astrocytes express several
663 pan and A1 genes at higher levels than young astrocytes (Clarke et al., 2018). Aging astrocytes also display
664 reduced expression of some genes linked to cholesterol or ROS detoxification (Boisvert et al., 2018; Clarke et al.,
665 2018). But overall, the molecular changes occurring in aging mouse astrocytes are rather limited. Interestingly,
666 there are regional differences, with larger variations in hippocampal and striatal astrocytes than in their cortical
667 counterparts, even if *Gfap* is induced in all brain regions (Boisvert et al., 2018; Clarke et al., 2018). A genome-
668 wide study in Humans also evidenced significant, region-dependent changes in astrocyte-specific genes with
669 aging (Soreq et al., 2017).

670 When analyzed in a healthy aging brain, astrocytes display mild reactive changes. However, aging astrocytes
671 have a high probability to have encountered previous pathological conditions in their lifetime, and they may thus
672 be in a primed state that will change their subsequent response (Cunningham et al., 2018). Astrocyte reaction

673 and possible priming in the aging brain need to be thoroughly analyzed, as aging is a major risk factor for several
674 brain diseases.

675

676

677 **13. Which new approaches and tools will move the field forward?**

678 There are now many techniques and models to study astrocytes, some mentioned in the previous paragraphs
679 [e.g. new transgenic mice, purification methods, human induced pluripotent stem cells (iPSC)-derived astrocytes
680 ([Almad & Maragakis, 2018](#); [Guttenplan & Liddelw, 2019](#))]. In addition, refined cellular and molecular methods
681 developed in other fields could prove very useful to study reactive astrocytes like spatial transcriptomics
682 ([Rodrigues et al., 2019](#); [Wang et al., 2018](#)), scRNAseq ([Svensson et al., 2018](#)), Cas9 genome editing and screening
683 ([Shalem, Sanjana, & Zhang, 2015](#)) and multiplexed immunostainings ([Goltsev et al., 2018](#)). Miniaturization (in
684 terms of quantity of input sample), extension to large brain regions and multiplexing to hundreds or thousands
685 of target genes or proteins will achieve unprecedented resolution to decipher how astrocytes react in a given
686 disease context and define better molecular markers (see **Section 6**). But in the end, it is the function that
687 matters. How will these molecularly defined reactive astrocytes perform their normal functions? This is easier
688 tested *in vitro* where several functions can be quickly screened, [e.g. phagocytosis, glutamate uptake, catabolism
689 of specific metabolites, production of cytokines/trophic factors/complement factors, toxicity towards other cell
690 types, effect on synapses, ([Diaz-Amarilla et al., 2011](#); [Escartin et al., 2007](#); [Liddelw et al., 2017](#); [G. E. Tyzack et al., 2014](#))]. It may be trickier to explore astrocyte functions *in vivo* or at least in *ex vivo* settings like acute brain
692 slices or acutely dissociated astrocytes. It is important to combine functional assessment with some
693 morphological or molecular markers to ascertain that probed astrocytes are indeed reactive and ideally provide
694 some insight into their molecular features. Therefore, methods with cellular resolution like electrophysiology
695 combined with fluorescent detection of markers, multidimensional cytometry and two-photon imaging with
696 functional sensors are methods of choice to establish how specific types of reactive astrocytes function. Several
697 elegant studies recently succeeded in providing new insight into the complexity of astrocyte functions in the
698 normal brain ([Bindocci et al., 2017](#); [Chung et al., 2013](#); [Martin, Bajo-Graneras, Moratalla, Perea, & Araque, 2015](#);
699 [Nimmerjahn & Bergles, 2015](#)) and in disease ([Bardehle et al., 2013](#); [Delekate et al., 2014](#); [John Lin et al., 2017](#);
700 [Yu et al., 2018](#)). Future studies will need to implement such refined methods in relevant disease models, to study
701 reactive astrocyte responses at the single-cell level.

702 Importantly, it is now clear that human astrocytes are more complex than their rodent counterparts and
703 express specific genes ([Oberheim et al., 2009](#); [Y. Zhang et al., 2016](#)). *In vitro*, human and mouse astrocytes are
704 reactive to different stimuli and overexpress different genes [([Tarassishin, Suh, & Lee, 2014](#)), **Table 2**]. It is thus
705 important to eventually go back to human samples to confirm findings obtained in animal models ([Arranz & De
706 Strooper, 2019](#)). Patient brains are a valuable resource but with associated bias due to *post mortem* delay,
707 comorbidities and other confounding factors. Derivation of human astrocytes from iPSCs taken from patients is
708 opening new research opportunities to probe disease-specific changes ([G. Tyzack, Lakatos, & Patani, 2016](#)).
709 However, the study of reactive astrocytes may be particularly difficult, as iPSC-derived astrocytes (and cultured
710 astrocytes in general) tend to be already reactive, especially when exposed to serum. It is thus required to
711 optimize differentiation and culture protocols to obtain a mature phenotype, reactive to subsequent stimulation
712 ([Perriot et al., 2018](#)). It will also be important to define which subtype of reactive astrocytes is modeled and to
713 confirm that this subtype truly exists *in vivo*.

714 Research on astrocytes is at an exciting stage, with potent approaches, new models and refined concepts to
715 study their role in the normal and diseased brain.

716

717

718 **Concluding remarks**

719 It is now becoming obvious that broad and quite old expressions like *Astrocyte reactivity* or *Astrogliosis*, hide
720 in fact a striking complexity with subtle regulations. Our survey highlights that several aspects of astrocyte
721 reaction are still unclear or even controversial, starting with their very name. But there is a strong interest in
722 better understanding this specific transformation of astrocytes in response to a pathological stimulus. Reactive

723 astrocytes may have significant impact on disease progression, diagnosis or even treatment. Therefore, we
724 should now aim to disentangle this widespread and complex brain response to disease and define which aspects
725 are amenable to therapeutic improvement.

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1373

1374 Figure legends

1375 Figure 1. Original drawings of reactive astrocytes in Humans

1376 I-II. (P. Chaslin, 1891). Chaslin's drawings of sclerotic cortical brain sections from an adult epileptic patient,
 1377 impregnated by the picro-carmin method. I. This drawing represents a non-lesioned region. A blood vessel (d)
 1378 connected by a star-shaped astrocyte (c) is observed, as well as few small nuclei. II. The drawing of a lesioned
 1379 tissue shows an accumulation of large bundles of fibers and many nuclei, characterized by Chaslin as "gliotic
 1380 tissue". III-VII. (Ramón y Cajal). Ramon y Cajal's drawings of cortical (III-VI) and cerebellar (VII) brain sections from
 1381 an adult patient suffering from general progressive paralysis, after silver impregnation. III. A reactive astrocyte
 1382 with thick branches polarizing towards a blood vessel (a). Thin processes emerge from the other side of the cell
 1383 body (b). Microglia cells (e, d) and one neuron (c) are also visible. IV. Large bundles of fibers named "Weigert
 1384 fibers" (A), emanating from glial cells, which are barely visible. Note the similitude with Chaslin's drawing (II). C:
 1385 microglia. V. Reactive astrocytes with twisted processes (a, b, c, d) surrounding an infiltration nodule (A).
 1386 Degenerating neurons with protein aggregates in their cell bodies are visible (G). D: blood vessels; f: astrocyte
 1387 endfeet. VI. Reactive astrocytes with numerous polarized processes have lost their individual, non-overlapping
 1388 domains. Astrocyte cell bodies are sometimes in direct contact, suggesting "proliferative astrocyte centers" (A,
 1389 C, E), as proposed by Ramon y Cajal. D: blood vessels. VII. Hypertrophic cerebellar astrocytes (B, C, D). Two of
 1390 them (C, D) have multinuclear cell bodies, suggesting ongoing cell division. b: blood vessel.

1391

1392 Figure 2. Astrocytes become reactive in a variety of pathological conditions and species.

1393 Different methods are used to evidence astrocyte reaction to different diseases, in different species and brain
 1394 regions, showing the universality of this response but also some context-specific changes. A. Frontal cortex
 1395 mouse brain section following SWI. A gradient of reactive astrocytes (GFAP⁺, green) is visible around the injury
 1396 site. Scale bar: 500 μ m (Frik et al., 2018). B. Reactive astrocytes in the cortex of a mouse EAE model. Reactive
 1397 astrocytes are labeled with StarTrack multicolor lineage tracing system to identify developmental clones by their
 1398 pattern of fluorescent protein expression. Scale bar: 80 μ m (Bribian et al., 2018). C. Immunofluorescence for
 1399 GFAP and S100 β (green), Ki67 (white) and CD31 (blood vessels, red) in the mouse cortex, 5 d after MCAO. Several
 1400 reactive astrocytes are proliferating (Ki67⁺) in the ischemic penumbra (yellow arrowheads) (Frik et al., 2018). D.
 1401 3D rendering of the morphology of a normal (blue) and a hypertrophic CNTF-induced reactive astrocyte (brown)
 1402 in the mouse striatum. Scale bar: 50 μ m (Ligneul et al., 2019). E. A non-reactive (up) and reactive (down) astrocyte
 1403 in the mouse cortex, 4 d after cortical lesion. Dye-filling reveals the astrocyte ramified morphology and process
 1404 enlargement in reactive astrocytes. Scale bar: 25 μ m (Wilhelmsson et al., 2006). F. Immunofluorescence for GFAP
 1405 (cyan) and BrdU (red) in the mouse spinal cord after SCI. The border of the lesion core (upper part) presents a
 1406 high proportion of BrdU⁺/GFAP⁺ proliferative reactive astrocytes forming the glial scar. Scale bar: 25 μ m (Wanner
 1407 et al., 2013). G. Immunoelectron micrograph of a phagocytic reactive astrocyte in the mouse striatum 3 d after
 1408 MCAO. GFAP staining is outlined in blue. Phagocytic inclusions (arrowheads) are visible. Scale bar: 2 μ m
 1409 (Morizawa et al., 2017). H. Two-photon microscopy of GLAST-eGFP mouse cortex, 28 d after SWI. A GFP⁺
 1410 astrocyte undergoes cell division (green arrowheads), while some of its processes (yellow arrows) polarize
 1411 towards the lesion (yellow star). Scale bar: 20 μ m (Bardehle et al., 2013). I. A dextran-filled astrocyte in a rat
 1412 transected optic nerve. This reactive astrocyte displays increased caliber of individual fibers and loss of global
 1413 complexity. Scale bar: 30 μ m (Butt & Colquhoun, 1996). J. Image of 2 adjacent GFP⁺ astrocytes (white) labeled
 1414 with Dil (green) and DiD (red) in the mouse cortex, 1 w after iron injection to induce epilepsy. Their processes
 1415 overlap more (box), showing partial loss of domain organization. Scale bar: 20 μ m (Oberheim et al., 2008). K.
 1416 Reactive astrocytes around an amyloid plaque in the hippocampus of 3xTg-AD mice (GFAP in green and A β in
 1417 red). Scale bar: 20 μ m (Olabarria et al., 2010). L. Reactive astrocytes (GFAP, green), around a vessel overexpress
 1418 the chemokine CCL2 (red) in a mouse model of prion disease (ME7), 2 h after TNF α injection in the hippocampus
 1419 (Hennessy et al., 2015). M-M'. Electron micrographs of a CNTF-induced reactive (M') and a control (M) rat
 1420 astrocyte. The reactive astrocyte displays an enlarged process filled with bundles of filaments (black star). Scale
 1421 bar: 1 μ m (Escartin et al., 2006). N. A human perivascular reactive astrocyte (GFAP, brown) close to a
 1422 leukoencephalopathy lesion contains phagocytosed LFB⁺ myelin debris (blue, arrow). Scale bar: 25 μ m (Ponath
 1423 et al., 2017). O. Triple immunofluorescence for STAT3 (green), GFAP (red), and Huntingtin aggregates (magenta)
 1424 in the putamen of a macaque lentiviral model of HD. Reactive astrocytes display STAT3 nuclear labeling. Scale

1425 bar: 40 μm ([L. Ben Haim, Ceyzeriat, et al., 2015](#)). **P.** Reactive astrocytes around an amyloid plaque in the
 1426 hippocampus of an AD patient, visualized by GFAP (black) and $\text{A}\beta$ (brown) immunohistochemistry. Note similarity
 1427 with image in K. Scale bar: 50 μm ([Pike, Cummings, & Cotman, 1995](#)). **Q.** Electron micrograph showing an
 1428 enlarged perivascular reactive astrocyte endfoot enclosing a cortical vessel (V) in the brain of an AD patient. x
 1429 7,000 ([Wegiel & Wisniewski, 1994a](#)). **R.** Human cortical reactive astrocytes labeled for GFAP (green) and
 1430 phospho-STAT3 (red) around brain metastases from lung cancer (dotted lines). Scale bar: 35 μm ([Priego et al.,](#)
 1431 [2018](#)). **S-S'.** GFAP immunohistochemistry on *substantia nigra pars compacta* sections from a control and a
 1432 parkinsonian macaque treated with MPTP ([C. Barcia et al., 2011](#)). **T.** Reactive astrocytes in acute lesions of a MS
 1433 patient. Triple immunofluorescent staining of reactive astrocytes with GFAP (green), Complement 3 (C3, red) and
 1434 activated microglia/macrophages with CD68 (white). Scale bar: 100 μm ([Liddelow et al., 2017](#)). **U.**
 1435 Immunofluorescence staining for S100 β (green) and *in situ* hybridization for C3 (red) in an ALS patient. Scale bar:
 1436 10 μm ([Liddelow et al., 2017](#)). **V.** 3D rendering of a reactive astrocyte stained with vimentin around human
 1437 glioblastoma. Scale bar: 35 μm ([C. Barcia, Sr. et al., 2013](#)).

1438

1439 **Figure 3. Heterogeneity of reactive astrocytes: causes and manifestations**

1440 Normal astrocytes are already heterogeneous due to different sources of diversity [listed in blue, see ([L. Ben](#)
 1441 [Haim & Rowitch, 2017](#)), for references]. Upon injury or disease, astrocytes display even more heterogeneity
 1442 (listed in brown), depending on the exact molecular trigger (*e.g.* open versus closed injury, extracellular cytokines
 1443 versus intracellular aggregated proteins, aberrant neuronal activity versus cell death), their distance from it
 1444 (topography), the exposure time to this stimulus (disease stage) and the signaling cascades activated. The
 1445 combination of pre-existing and induced heterogeneity gives rise to potentially very diverse populations of
 1446 reactive astrocytes with unique molecular and functional features. However, there are some core changes that
 1447 are common to most forms of reactive astrocytes (*e.g.* GFAP induction, morphological changes, represented in
 1448 red).

1449

1450

1451 **Table legends**

1452

1453 **Table 1: Reactive astrocytes: definitions, consensus and controversies.**

1454 In December 2018 and January 2019, we surveyed 61 researchers actively working in the field of (reactive)
 1455 astrocytes with different approaches (molecular, morphological, and functional), on different diseases and
 1456 models or in physiology. We asked them the following two questions:

1457

1458 *a-* What is your definition of astrocyte reactivity, in a few sentences? (**Responses listed in Table 1a**)

1459 *b-* Do you consider “astrogliosis”, “astrocyte activation” and “astrocyte reactivity” as synonymous terms?
 1460 (**Responses listed in Table 1b**)

1461

1462 We collected 38 replies (see **Supplemental Text** for full replies) from junior and more senior researchers, from
 1463 both genders and 12 countries (see list in **Supplemental Table 1**). It is not a perfect or unbiased sampling of the
 1464 community, but it represents the first attempt to survey different researchers working and publishing on
 1465 astrocytes. It shows that some points are consensual while other are more controversial.

1466 Replies were analyzed and grouped under different features or concepts (1st column), addressing different
 1467 questions listed in gray boxes above. Respondents, identified by their initials, either agreed to these definitions
 1468 (2nd column), agreed and provided further explanations (3rd column) or disagreed (4th column). Pie charts
 1469 represent the percentages of responses (green = agree; red = disagree; gray = not mentioned) for features
 1470 mentioned by more than 18 respondents or for controversial features.

1471

1472 The definitions given in response to question **a** are linked to the nomenclature discussed in response to question
 1473 **b**, since several researchers provide specific definitions for each term. For the sake of simplicity, we considered

1474 that responses to question **a** may apply to any of the three terms (astrogliosis, astrocyte activation, and astrocyte
 1475 reactivity). Responses to question **b** help better pin down further differences linked to terminology.

1476

1477 In Table 1a: Glu, glutamate; ND, neurodegenerative diseases; NSC, neural stem cells.

1478 In Table 1b: * Active astrocytes = contain proBDNF with no GABA, hypertrophy. Reactive astrocytes = elevated
 1479 MAO-B, high GABA, low proBDNF. Astrogliosis = severe reactive astrocyte, with proliferation.

1480

1481 **Table 2. Astrocyte reaction is a heterogeneous response**

1482 This table presents a selection of relevant studies, performed mostly *in vivo*, to illustrate heterogeneity of
 1483 astrocyte reactions. Different levels of observed heterogeneity can be listed as originally proposed by ([Anderson
 1484 et al., 2014](#)). In addition, differences in responses are observed depending on disease stage or age (temporal),
 1485 species, and gender. Interestingly, several levels of heterogeneity may co-exist (see Additional levels of
 1486 heterogeneity). Most of the time, the reactive state of astrocytes was established by GFAP overexpression and
 1487 morphological changes. Morphological changes were estimated qualitatively (visual), unless mentioned in the
 1488 table. Some studies identified additional markers of (subtypes) of reactive astrocytes.

1489 *Abbreviation list (by lexical field): CNS Regions: Cb, Cerebellum; Cx, Cortex; Hip, Hippocampus; SC, Spinal cord;*
 1490 *Str, Striatum; Th, Thalamus; WM, White matter. Diseases: AD, Alzheimer disease; ALS, Amyotrophic lateral*
 1491 *sclerosis; MS, multiple sclerosis; NWMl, neonatal white matter injury; Neuroinfla., neuroinflammation; PD,*
 1492 *Parkinson disease; SCI, Spinal cord injury; TBI, traumatic brain injury. Experimental models: EAE, experimental*
 1493 *autoimmune encephalomyelitis; KA, kainate; LPS, lipopolysaccharide; MCAO, Middle cerebral artery occlusion;*
 1494 *SWI, stab wound injury. Species: H, Human; Mc, Macaque; Mm, Mammalian; Ms, Mouse; R, Rat. Other fields:*
 1495 *Astro: astrocytes; CSPG: chondroitin sulfate proteoglycans; IHC/IF, Immuno-histochemistry or -fluorescence; IR,*
 1496 *Immunoreactivity; WB, Western Blotting; =, unchanged; ↗, increase.*

1497

1498

1499

1500 **Supplemental Material**

1501 **Supplemental Table 1**

1502 List of all surveyed PIs with their affiliation and initials used in **Table 1a** and **1b**.

1503

1504 **Supplemental Text 1**

1505 Full answers of all surveyed PIs (list by alphabetical order), to the two questions:

1506 *a. What is your definition of astrocyte reactivity, in a few sentences?*

1507 *b. Do you consider “astrogliosis”, “astrocyte activation” and “astrocyte reactivity” as synonymous terms?*

1508

1509 **Author contribution**

1510 CE wrote the review, performed the survey and generated Table 1a, Table 1b and Fig 3. OG generated Table 2.

1511 MACS produced Fig 1 and 2. All authors edited and finalized the review.

1512

1513

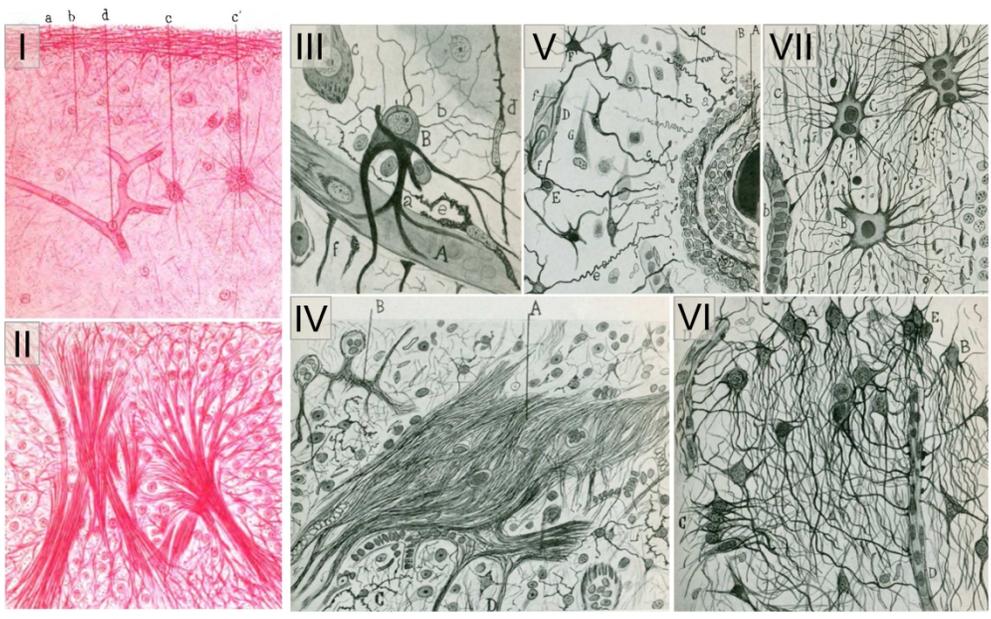


Figure 1

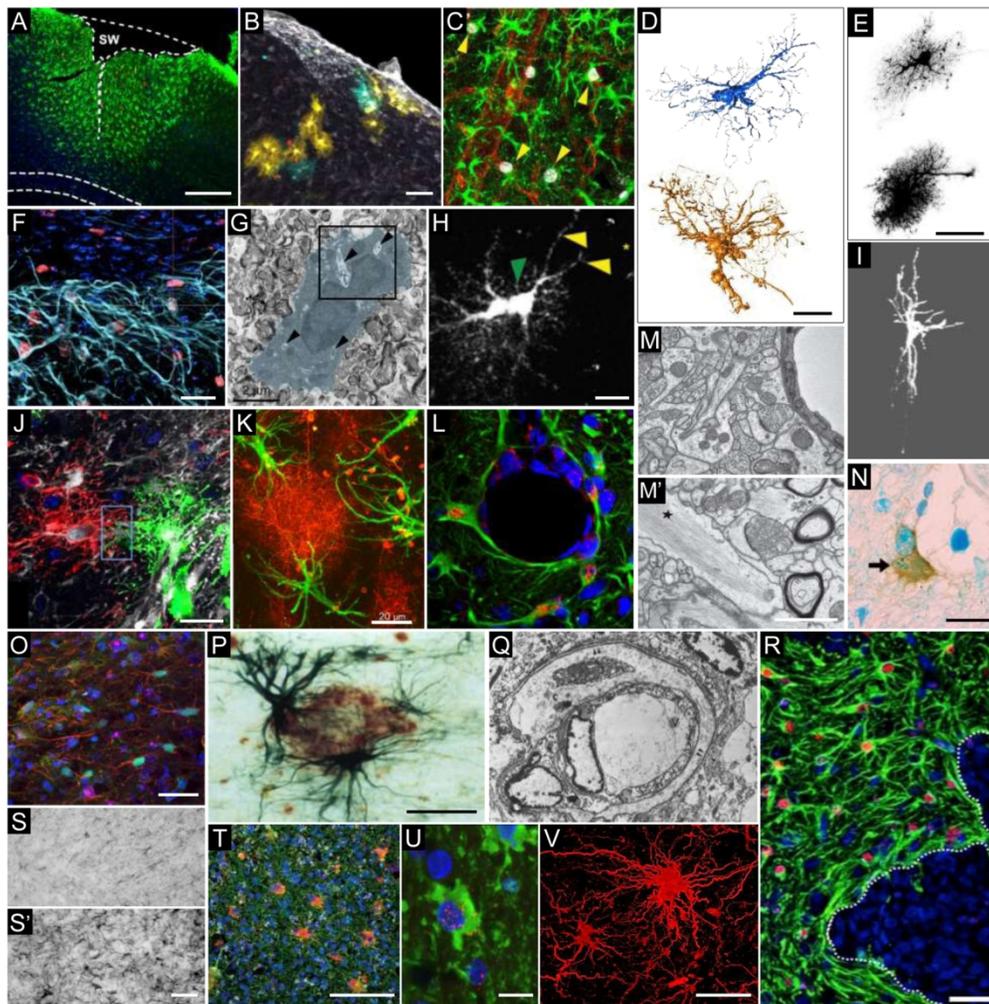


Figure 2

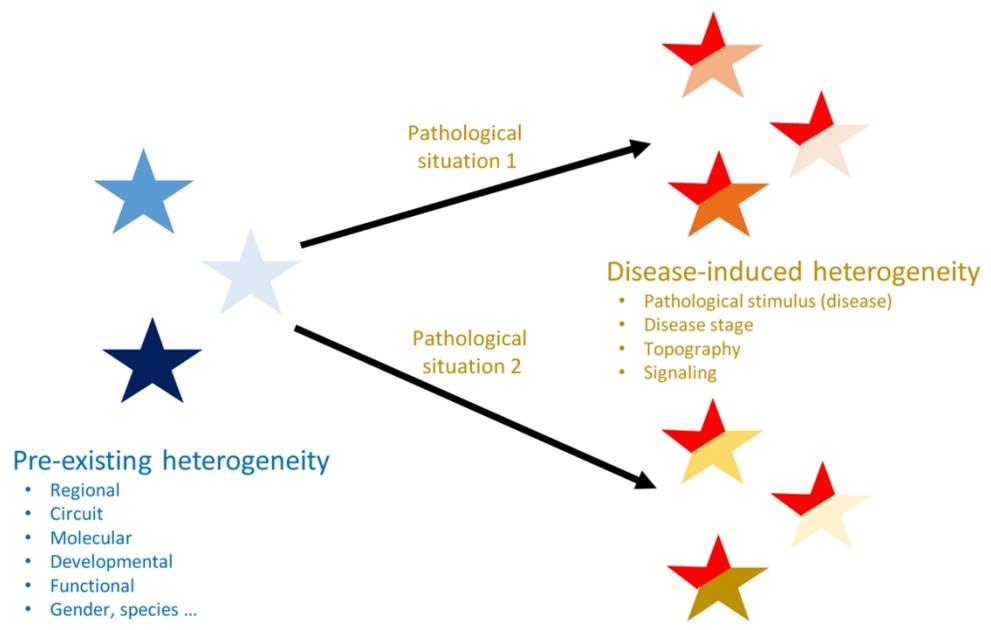


Figure 3

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TABLE 1a: Definitions of astrocyte reactivity			
Feature/concept	Agree	Disagree	
	What is it?		
A phenotypic change, alteration	AA AM ASP AP AVO CC CS EG FP GC HK HS LP MF MS NA PH SHRO SL SR VG	GFAP: short term changes also (Ca ²⁺ , Glu/GABA/K ⁺ buffering, coupling...) MW: dynamic state IW: changes of viable, not wounded/dying astrocytes	
A response	AL AM ASP EG FP GC HS IW JOC MF MG MS NA SL SHRO SO SS VG	ASP: genes & functions down-regulated as well AVO: go back to more immature/plastic state DB: may come from latent progenitors SK: become a different type of cells CC: they are now more reactive to a future stimulation LP: capacity to become	
A reprogramming, transformation, conversion	AKe KM		
An ability, propensity	SS ASP SO		
What does it change in astrocytes?			
Molecular (mRNA & proteins), morphological, functional changes	AA AM AVO ASP CS EG FP GC HK HS JOC LB MS NA SK SR SS VG	AP: reactive astrocytes integrates & regulates information differently CN: initial response (biochemical, then transcriptional) SHRO: biochemical as well GAP IW KM: Activation of specific signalling pathways	
Both gain & loss of functions	ASP CN MS	GC: importance of Ca ²⁺ signalling HS: global loss of proteins involved in ion/neurotransmitter homeostasis & change in extracellular matrix production SHRO: gain/loss of function can occur without reactive phenotype	
Proliferation not prevalent	ASP KM LP	EG: may refer to GFAP ⁺ NSC converting into astrocytes MS: newborn astrocytes form scars	
What induces it?			
Non-physiological conditions (injury, disease, stress, environment alterations)	ASP CN CS EG FP GC JOC HK HS IW MS NA SL SO SR VG	AL GAP MF SHRO: not exclusively pathological stimulus AMT: exclude any physiological changes	
External/environmental stimulus or signal	AL ASP GAP MF SHRO	JOC: in response to glia injury as well = internal signal	
Aging also	ASP SR	CS: aging is not necessarily pathological	
Is it a homogeneous response?			
Heterogeneous:	AL AM ASP AVO AVO CC CIL CS CN DB DR EG GAP GC HK JOC KM LB MF MG MS NA PH RS SL SS	AVe MS SS: tuned to the nature & strength of the insult AVe CS DB: more than AL/A2 CS: worsens with disease progression DB: worsens with age	
- continuum	GAP MF PH		
- dictated by type of insult/disease ...	AM ASP EG GC HK MF MG NA SL		
... and by previous heterogeneity, brain regions, age	AVe AVO CS CN KM SS	DB MS: also by signalling	
GFAP & morphological changes are core hallmarks/defining features	AA DR EG GAP JOC KM MF NA PH RS	ASP: morphological changes not systematic AVO: hypertrophy may be an artifact of increased GFAP staining AVe CIL BS: misleading AVe CS DB: misdiagnosis instead of reactive astrocytosis GC: characterize early astrocytosis	
Can have good or bad effects	DR GC LP MS SK	AVe: change good, evolutionary driven. Even neurotoxic astrocytes may have defensive roles. AVe HS IW SO: objective = restore homeostasis IW: form a scar to limit lesion expansion CS: reactive astrocytes are pathologically altered CIL: always bad in ND through GABA/H ₂ O ₂ release	
Reversible & transient	CN GC MS SO	GFAP SS: astrogliosis is not	

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Levels of observed heterogeneity	Disease modelled	Experimental model	CNS region	Species	Examples of heterogeneity	Additional levels of heterogeneity	Hypertrophy observed? Method used	GFAP observed? Method used	Other markers of reactive astro	Reference
Species	Neuronitis	Primary astro exposed to LPS, IL1, Poly I:C		H, Ms	Only Ms astro dependent on TLR4 or CD14. Ms & H reactive astro produce different cytokines	Signaling	n.m.	n.m.		Terasaki 2014
Gender	Stroke	MPTP (M ₁ , 6-OHDA, IR)	Str	Mc, R	Mc: \downarrow Cx30 IR; \uparrow Cx30 IR		visual	IHC/IF		Charon 2014
Disease	AD, epilepsy	TG2576, EA	Cx	Ms	\uparrow GFAP IR F-AM		visual	IHC/IF		Cordau 2007
	Trauma, stroke, AD	SWI, MCAO, APP/PS1	Cx	Ms	Loss of astro domain organization in epilepsy but not in AD	Morphological	visual	IHC/IF	Vimentin	Acari-Fonseca 2015
	Neuronitis, stroke	LPS, MCAO	Cx	Ms	SWI promotes astro proliferation & stem cell potential in open lesion only (SWI & MCAO)	Signaling	Dilute labeling	visual		Oberheim 2008
	Trauma, AD	SWI, APP23	Cx	Ms	50% regulated genes are disease-specific	Molecular	visual	IHC/IF	Scpna2b, Gfz2	Shih 2013
Temporal	ALS	SOD1 ^{G93A}	SC	Ms	Different GFAP mRNA \uparrow		visual	IHC/IF, qPCR		Zamanian 2012
Regional	MS	EAE	Cx, Hip, Ch, SC	Ms	Presymptomatic stage: astro NF- κ B activation delays disease progression. Symptomatic: accelerates disease progression	Regional, Molecular	visual	IHC/IF		Burbach 2004
	AD	astro cultures exposed to β APP	Cx, Hip, Ch, SC	R	Early stage: \uparrow \uparrow IHC/IF mRNA, \uparrow cholesterol synthesis pathway. Late stage: \uparrow IHC/IF mRNA, \downarrow cholesterol synthesis pathway		n.m.	qPCR		Ouali Akem 2018
Topographical	Epilepsy	Phenacipine	Hip, Cx	Ms	Reaction induced only in Cx & Hip	Disease stage	visual	IHC/IF	CSPG	Hole 1994
	AD	/	Cx	H	Different transcriptional changes between Hip & Cx astro	Molecular	visual	IHC/IF, qPCR		Chauvigny 2016
	Trauma	APP ^{sw/PS1ⁱⁿ}	Cx	Ms	\uparrow Cx43 IR around plaques	Signaling	visual	IHC/IF, EM		Hag 1996
	SCI, trauma	Laminectomy L1/L2, Cx3-injury	SC, Cx	Ms	\uparrow P2Y ₁ mediated Ca ²⁺ signaling in reactive astro near plaques. Proliferation of juxta-vascular astro only	Functional	visual	IHC/IF		Diekate 2014
Morphological	Trauma/Excitotoxicity	SWI/AA	Hip	Ms	Distal: no proliferation & hypertrophy (\uparrow GFAP). NFATc3 astro are found only around lesions	Morphological, Topographical	Morphometry	IHC/IF		Bardelle 2013
	AD	3MxTAD	Hip	Ms	Atrophy away from plaques (\downarrow GFAP surface & volume). At injury site: mesh-like morphology & small cell bodies. At the border: enlarged soma & thick processes	Topographical, Functional	visual	IHC/IF	NFATc3	Wanner 2013
Signaling	Trauma	Needs-induced lesion	WM, Hip, Cx	Ms	Intervened processes in Hip & Cx; Thick, shortened processes in Th.	Regional	visual	IHC/IF		Kim 2012
	TBI	Lateral fluid percussion	Th	R	No vimentin induction in Th	Disease stage	visual	IHC/IF, WB		Serrano-Perez 2010
	Stroke	Purified astro treated with EphA2 or IL6	Cx	Ms	EphA2 (but not IL6) induces protective transcriptional profile in astro via STAT3 signaling	Molecular, Functional	visual	IHC/IF, WB		Glabarra 2010
	Stroke	MCAO	Cx	Ms	Only Notch1-STAT3-ETBR reactive astro proliferate	Functional	visual	IHC/IF, WB		Martin-Lopez 2013
Molecular	Trauma	Phentorbol	Cx	Ms	Only Notch1-STAT3-ETBR reactive astro proliferate	Functional	visual	IHC/IF		Hill 1996
	Trauma	SWI	Cx	Ms	Only Galectin 1 & 3 reactive astro proliferate	Functional	visual	IHC/IF		Trayek 2017
Functional	SCI	Contusion	Cx	Ms	Type1 collagen ⁺ astro induce scar formation via N-cadherin pathway. Not active in hypertrophic reactive astrocytes	Topographical, Molecular, Functional	visual	IHC/IF, WB		LuComte 2015
	Neuronitis	Immunopanned astro LPS treated mice	SC	Ms	"A1" neurotoxic reactive astro induced by microglia. "A2" reactive astro express different genes, function uncharacterized	Functional	visual	IHC/IF, qPCR		Benner 2013
Functional	Brain metastasis	Hypoxic-ischemic encephalopathy	Cx	H	"A1" neurotoxic reactive astro induced by microglia. "A2" reactive astro express different genes, function uncharacterized	Functional	visual	IHC/IF, qPCR		Shih 2015
	MS, multifocal encephalopathy	Tumor resection	WM	H	"A2" reactive astro induce OPC maturation arrest via COX2, p38 β , signaling	Functional	visual	IHC/IF, qPCR		Hara 2017
Functional	MS, multifocal encephalopathy	/	WM	H	Some reactive astro uptake myelin & produce more cytokines	Functional	visual	IHC/IF		Liddelow 2017
	MS, multifocal encephalopathy	/	WM	H	Some reactive astro uptake myelin & produce more cytokines	Functional	visual	IHC/IF		Shaw 2017
Functional	MS, multifocal encephalopathy	/	WM	H	Some reactive astro uptake myelin & produce more cytokines	Functional	visual	IHC/IF		Prineas 2018
	MS, multifocal encephalopathy	/	WM	H	Some reactive astro uptake myelin & produce more cytokines	Functional	visual	IHC/IF		Ponath 2017

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Supplemental text 1

Dr. Nicola Allen

1) *Definition: An alteration in astrocyte properties in response to a detrimental insult, for example an infection, a lesion or a stroke. There are core changes that define a reactive astrocyte that happen in response to all insults e.g. upregulation of GFAP, and others that are specific to the type of insult.*

2) *Astrogliosis and astrocyte reactivity are interchangeable; I find astrocyte activation too vague, as it could also apply in a healthy situation where an astrocyte responds to a stimulus for example with an increase in intracellular calcium.*

Prof. Alfonso Araque

1) *Astrocyte reactivity is a phenotypic alteration manifested as structural changes of astrocyte morphology (e.g., enlargement of cellular processes) and expression regulation of proteins (e.g., GFAP).*

2) *I consider astrogliosis and astrocyte reactivity as synonymous terms. Others would may consider astrocyte activation as synonymous as well. However, as physiologist, I prefer to consider astrocyte activation referred to cellular activity, i.e., astrocyte are activated by signaling molecules such as neurotransmitters, which acting on transmitter receptors activate signaling pathways that regulate cellular activity (e.g., regulating the calcium-based cellular activity that is characteristic of astrocyte physiology).*

Prof. Luis Barbeito

It's true that the terms we use to describe astrocyte functional or morphological states are somewhat confusing, overlapping and conceived with an "old mind" that must be updated.

In my understanding "Reactive astrocytes" preferably refers to a morphological feature of A (hypertrophy, long processes, etc).

It also involves GFAP overexpression although this is phenotyping. The definition is linked to the concept of primary or secondary cellular or tissue "damage" or dysfunction, with the potential to induce "activation".

Then, reactive astrocytes can be subdivided into multiple subsets by applying immunophenotyping, transcriptome analysis or functional profile, which results in multiple and heterogeneous types of cells. That's the complexity we currently face.

While astrocyte reactivity is a morphological feature, astrocyte activation is mostly functional or phenotypic. Could be a link between both but refer to different attributes.

Astrogliosis comes from classical neuropathological observations and implies an increased number of astrocytes and hypertrophic.

Prof. Dwight Bergles

This sounds like a very worthwhile project, one that will help the field adopt more specific terminology and perhaps spur the development of additional tools to assess phenotypic changes in astrocytes.

Although assigning cells to discrete states (e.g. M1 and M2 for microglia and A1 and A2 for astrocytes) is a useful construct and clearly encompasses shared features among cells, I expect that reactivity exists on a continuum, with cells exhibiting different phenotypic changes relative to the timing of the insult (or state of disease) and proximity to other pathology. As we learn more about the diversity among astrocytes, we may find that different regions or different "classes" of astrocytes have different capacities to alter specific pathways associated with a "reactive" status. Likely, such differences will be magnified by age. In addition, some reactive astrocytes that appear in the CNS may also be derived from latent progenitors, rather than through transformation of existing astrocytes.

Regarding the terms, I guess I would group these terms together. But, as they are so vague, they don't really carry much value by themselves without additional quantitative descriptors of what criteria were used to assign cells to this category.

Prof. Giorgio Carmignoto

1. I would say that the reactivity of astrocytes, i.e. the change in morphology and function in response to unphysiological situations, such as brain trauma, stroke or diseases, represents a striking example of the high complexity of the astrocytic role in the brain.

Reactive astrocytes lose their physiological roles and acquire new actions. Certainly, however, we have not a clear understanding of how these changes develop under pathological conditions and, most importantly, whether and to what extent these astrocytes oppose, or favor, the progression of a specific disease (see Bussian et al. Nature 2018).

An important aspect is the calcium signalling that is also affected in reactive astrocytes (in Parkinson, Alzheimer's disease etc...). Given that it regulates the release of gliotransmitters, inflammatory agents etc... its alteration affects the reciprocal communications between astrocytes and other cells, including neurons and microglia. The role of astrocytic calcium signal dysregulations in disease onset and progression remains poorly understood. This is, in my opinion, an important issue that can be adequately addressed in future studies also thanks to genetically encoded calcium indicators.

I would add that the "reactive response" of astrocytes is not linked exclusively to chronically altered conditions and it occurs also following episodic dysregulations of neural circuit activities, such as the transient, local hyperactivity of neurons that characterizes epileptic seizures. This strengthens the idea that the "astrocyte reactivity" is not a standardized response and its distinct features (and role) depends on the specific context of the different brain disorders.

2. "Astrogliosis" refers, in general, to the change in astrocyte morphology and the upregulation of GFAP linked to pathological conditions. In contrast, "astrocyte activation" refers to an event that occurs in a physiological context, linked, for example, to a change in calcium signal dynamics or other signaling pathways.

The term "astrogliosis" reminds me of the hypertrophy of the astrocytic processes, whereas "astrocyte reactivity" refers more to functional changes. They are not, in my opinion, synonymous terms.

Dr. Colm Cunningham

1. I think of astrogliosis as a property of a population while astrocyte reactivity should refer to the activation status of individual cells (since astrocyte phenotype is heterogeneous and may be different even in cells that are relatively close together). "Reactive" as commonly used, suggests that an astrocyte has taken up a different phenotype (i.e. has 'reacted' to some change in its environment) but also implies a propensity to NOW be more reactive than it was previously. This fits with the idea of primed astrocytes as hyperactive to a secondary stimulus (i.e. they are more reactive).

2. I think of astrogliosis as representing increased numbers and altered morphology while astrocyte activation simply reflects that they have been in some way activated by pathology or change in the milieu - but this is therefore an ambiguous term - unless one knows what has activated them or what the resulting phenotype is the term 'activated' has no specific meaning. Astrocyte reactivity is probably my favourite because it encompasses how 'reactive' they are: including increased responsiveness to a secondary stimulus.

Prof. Marc Freeman

1- I think the phrase astrocyte reactivity can be used in many scenarios. Simply put, I think of it as the set of changes that astrocytes undergo in response to an external stimulus. This is usually studied in the context of "bad" things like injury or disease, and the small things we know about have been lumped in together. For instance, axotomy has been used to study how astrocytes respond to brain trauma. Some of those same responses (e.g. hypertrophy and increased GFAP) also occur in

astrocytes in neurodegenerative disease, but I suspect if we performed a much more comprehensive study (like RNA-seq) of how astrocytes respond to axotomy versus neurodegenerative disease that we would see major differences. So I prefer a looser definition, which can include the spectrum of responses that glia exhibit in response to stressful stimuli.

2- I think astrogliosis implies that there is some proliferation going on, in addition to changes in gene expression or morphology. The same is not necessarily true for the other terms. I think astrocyte activation and reactivity are fairly interchangeable, and fit with the definition described above.

Prof. Elena Galea

1- The so-called reactive astrocytes are astrocytes undergoing a stress response to tissue damage. Such response is accompanied with: (i) striking morphological change caused by thickening of intermediate filaments composed of GFAP, and (ii) context-specific changes in their transcriptomic profiles, for 'reactive' astrocytes are molecularly heterogeneous. As to possible functions, in acute injury, I consider astrocyte reactivity as an adaptive response aimed to isolate the damaged tissue from the healthy one *by a scar*; the healthy tissue eventually recovers homeostasis with newborn astrocytes from GFAP⁺ NSC cells. By contrast, in chronic injury astrocyte reactivity might be maladaptive, and render astrocytes chronically dysfunctional with respect to their homeostatic and computational roles.

2. 'Reactive astrocytes' and 'astrogliosis' are equivalent, and they are non-useful terms because they refer to a GFAP-driven morphological change that does not inform about context-specific molecular and functional heterogeneity, and hence it says nothing about the net contribution of such astrocytes to disease pathogenesis. The term 'astrocyte activation' in for physiological contexts, but it might be too vague; if we do not say 'active neurons', we should not say 'active astrocytes' either.

Prof. Vittorio Gallo, PhD

1. Morphological, molecular and functional changes seen in astroglial cells/astrocytes responding to CNS injury and other neurological diseases.

2. No, I don't consider these as synonymous terms. Astrogliosis involves astrocyte proliferation. Activation and reactivity don't necessarily involve proliferation. Astrocyte activation could involve intermediate changes that precede a full reactive phenotype.

Prof. Magdalena Götz

I guess I would be very simplistic and define a reactive astrocyte as an astrocyte reacting to a major alteration in its environment. I would also add that this is not one state but several (and probably many) states. We have shown for example that in APPPS1 mice where astrocytes are very 'activated' (large some, very high GFAP levels) they do not proliferate, while in traumatic and ischemic injuries a subpopulation of them proliferates (see e.g. Sirko et al., 2013, 2015, Frik et al., 2018). So the term reactive astrocytes comprises a) a heterogeneous population and b) different states depending on the alteration in the environment.

In regard to your second question I guess each of these terms is not well defined by themselves, so in that sense it is even more difficult to say whether and how much they are overlapping. In 'colloquial terms', i.e. in many manuscripts and reviews they are used interchangeable, but by definition they are not.

The best suggestion I could come up with is to order them according to the strength/intensity/extend of changes to the homeostatic state – astrocyte activation could be a mild activation, astrocyte reactivity would probably more used for stronger changes and astrogliosis is often used for even stronger stages often accompanied by inflammation. But your review could achieve something very important if you'd suggest more clean definitions.

Prof. Philip G Haydon

Here is a simple overview of my thoughts. Of course, as you realize, this is a complex process and a few sentences leads to oversimplifications. ...

1. *Reactive astrogliosis is defined and characterized by gross hypertrophy of the cell body and processes of astrocytes in injured and/or diseased areas of the brain. Accompanying these anatomic changes is enhanced expression of, but not limited to, glial cytoskeletal proteins such as glial fibrillary acidic protein (GFAP) and vimentin. However, this is not a bistable state - reactive vs non-reactive - but rather there are different shades of grey and significant heterogeneity in astrocyte reactivity.*
- 2- *No. I think it is important to clearly define each term being used and use the different terms to discriminate between different states/processes that are on-going in the astrocyte. Too frequently terms are not defined leading to confusion.*

Prof. Dr. Helmut Kettenmann

1. *My definition would be an altered phenotype manifested by morphological alterations, change in RNA expression pattern and functional parameters due to an alteration in the brain environment related to pathology or injury. This altered phenotype can be quite diverse depending on the type of pathology.*
2. *I think that these three terms have been used to describe the same event.*

Prof. Schuichi Koizumi

- 1- *I think that the definition of astrocyte reactivity can be divided into two. The first is to distinguish by form and molecular biological difference, the second is from the aspect of function (beneficial & hazardous etc). In either case, I think that it is necessary for astrocyte to become a state as if it became a different types of cells from normal astrocytes.*
- 2- *I think that these three words contain the same meaning in part. Astroglial reactivity means reactive astrocytes, but has a strong implication of becoming a proliferative astrocyte. Astrocyte reactivity and astrocyte activation have almost the same meaning, i.e., they become reactive astrocytes.*

Dr. Andras Lakatos

1. *For me this term encompasses astrocyte responses to any external stimuli, while historically this has been used to describe morphological changes with increases in intermediate filaments in response to injury. It transpires that people still strongly associate this term with a detrimental astrocytic function that is non-permissive for CNS repair. I don't see the problem of using this term in the right context, but then it should be decorated with adjectives implying the type of pathological or physiological astrocyte state. In the new era of single cell omics it can be further argued if "astrocyte reactivity" should be used as a collective term at all to describe intracellular changes, given the differences in astrocyte responses based on their subpopulation- or region-specific variations in transcription and signalling.*
2. *I regard astrocyte activation and reactivity as interchangeable terms because both words carry the meaning of "response to any stimuli". However, there is probably more consensus regarding the vast difference between astrocyte activation (reactivity) and the term astroglial reactivity that latter indicates a cascade of events following activation by pathological stimuli, which may involve at least astrocyte proliferation if not other processes as well, such as activation/influx of various cell types into lesion environments.*

Prof. C. Justin Lee

NB: [...] edited for confidential information about unpublished data

I fully agree with you on the fact that reactivity is loosely defined in the past and we need to establish a consensus. ...

The problem of use of the term, reactive astrocyte is that it is based on the morphological criteria. And traditionally, people have called reactive astrocyte as the one that shows hypertrophy GFAP staining. We have been studying this hypertrophy of astrocytes in depth and we have finally found the molecular mechanism of this hypertrophy (or cause of this hypertrophy). We currently submitted our work, [...].

Therefore, my answer to your question #1 is that I would define reactive astrocyte as the one that contain GABA at least in cortical and hippocampal astrocytes. The answer to your question #2 is that the terms “astrogliosis”, “astrocyte activation” and “astrocyte reactivity” cannot be synonymous according to my definition of active and reactive astrocytes. Active astrocytes= contain proBDNF with no GABA. Reactive astrocytes = elevated MAO-B, high GABA, low proBDNF. Astrogliosis= severe reactive astrocyte. [...]

I don't think the role of reactive astrocytes in neurodegenerative diseases is “elusive.” The meaning of reactive astrocyte might be elusive, but the role of these GABA positive reactive astrocytes has been clearly laid out in numerous occasions. For example, in Alzheimer's disease, we and Gong Chen group have clearly demonstrated that the GABA positive reactive astrocytes release GABA to strongly inhibit neighboring neurons to cause learning/memory impairment.

Although not published, we have been trying to publish the similar mechanistic story [...]

In summary, the GABA-containing, GABA-releasing, H₂O₂-producing reactive astrocytes have critical role in neurodegenerative diseases. Unfortunately, most of these works are not published yet and will be available hopefully soon.

Dr. Shane Liddelow

1. The OED states that 'reactivity' is 'The quality of being reactive or the degree to which something is reactive'. It follows then a 'reactive astrocyte' is any astrocyte that has a FUNCTION that is altered from its normal physiological state, that is, an astrocyte with a function that is altered in response or reaction to some non-physiological setting. There could then be a reactive astrocyte for each individual stimulus (and infinite number of states), or a smaller number of states that collectively respond to a combined number of stimuli.

2. Yes. Though I would be less inclined to use 'activation' as it suggests that astrocytes are not normally active in a physiological state - and we know this is untrue. MY personal preference is 'reactivity' but 'gliosis' is similarly useful. Again, I think the most important thing is not so much the nomenclature itself, but what functions are changed (though I do have a pet hate for researchers constantly coming up with their own names for things, rather than sticking with names already in the literature, but adding to the body of knowledge that we have)... but all things must change with time.

Prof. Albee Messing

My first thoughts about a definition of a reactive astrocyte go back to Tolstoy:

"All happy families are alike; each unhappy family is unhappy in its own way."

But, trying to be more helpful, I'd say my definition is a “change in properties in response to injury or disease, reflected by alterations of morphology, gene expression, and function.” This intentionally excludes anything related to what you might call “normal physiology”. And then your second question of course includes several loaded terms that are difficult to pin down. In my mind astrogliosis fits my definition above most closely – an abnormal state. But obviously astrocytes get “activated” in many normal ways, and in English at least “activation” and “reaction” could both easily apply to normal states, so it gets messy very quickly.

I imagine you are contacting me because of Alexander disease. I think the astrocytes here acquire some properties in common with other types of reactive astrocytes, but also have properties that are unique to the disease.

Prof. Keith Murai

1. *IMO, astrocyte reactivity is the conversion or transformation of the basal state of an astrocyte to a dynamic, pathological state that normally involves a constellation of structural and molecular changes including astrocytic process hypertrophy and remodeling, upregulation of particular genes (i.e. classical GFAP increase and neuroinflammatory cytokines), activation of specific signaling pathways (i.e. STATs), and potentially re-instatement of cell division (although this is not always the case). However, astrocyte reactivity can differ between brain regions and is influenced by injury type and likely by astrocyte heterogeneity.*

2. *I consider astrogliosis and astrocyte reactivity as mostly synonymous terms although I tend to think of astrogliosis more in terms of astrocyte reactivity following physical CNS damage (i.e. spinal cord injury) that is accompanied by glial scar formation. Although this may be more related to my past background in spinal cord injury research. I have never used the term 'astrocyte activation'. I reserve the term 'activation' for microglia which has a different time-course and series of cellular changes.*

Prof. Christopher Norris

I'll answer both of these together.

I think astrocyte reactivity, astrocyte activation, and astrogliosis can overlap, but are not the same things.

To me, astrocyte reactivity is an initial (primarily biochemical) response to some form of injury or degeneration. The reaction may vary depending on the area of the brain, the cytoarchitectural context (e.g. gray vs white matter, surrounding neuron subtypes), and perhaps the nature of the insult. For instance, a reactive astrocyte may release trophic factors, or ROs; may adjust its processes around synapses or blood vessels; and/or may adjust the connectivity of its gap junction network. The distinction between reactive and activated astrocytes is harder to articulate (at least for me). I think that once an astrocyte reacts to an injury it can undergo a phenotypic transformation involving induction of unique transcriptional programs, functional changes, and structural changes (e.g. GFAP induction). So, to me, "astrocyte activation" describes the post-phenotypic transformation of reactive astrocytes (which may also vary in nature depending on area of the brain, context, ...etc). Astrocyte activation can be short lived (resolvable) or chronic (unresolved).

I've always thought of astrogliosis as the proliferation of astrocytes, which may persist in an activated state.

Dr. James O'Callaghan

1. *Astrocyte reactivity is the homotypic response of astrocytes to elaborate gene expression and proteins following all types of neural (neuronal and glial) injury, including disease, trauma, and chemically-induced damage. The hallmark remains the enhanced expression of GFAP (both biochemically and morphologically because astrocyte reactivity is characterized by the accumulation of glial filaments at the EM level and GFAP remains the major protein component of these filaments, therefore, by definition, if you accumulate glial filaments as a signature of astrocyte reactivity you will accumulate GFAP at immunohisto and immunoassay level. Yes, you can argue about subtypes of GFAP positive astrocytes based on a variety of gene expression and morphological criteria...but by and large they have to be GFAP positive to be an astrocyte and respond with an increase from all types of damage.*

2. *Yes, as long as these 3 terms refer to responses of astrocytes to CNS injury*

Prof. Seiji Okada

I strongly agree that terminology of astrocyte research has highly ambiguous.

For me, non-native speaker for English, it is difficult to understand or explain subtle nuances, but in my opinion,

1. *Astrocyte reactivity is a cellular response to several kinds of environmental changes for the homeostasis maintenance or tissue repair.*

2. *I consider "astrocyte activation" and "astrocyte reactivity" as almost same, both term are for the cellular state or ability. Activated or reactive astrocytes can revert to the un-activated or normal state. However, astrogliosis is the "process" of glial scar formation. Glial scar is a basically paramagnet, stable tenacious tissue to seclude the injury site from healthy tissue. This process is crucial for the tissue repair after the CNS insult (Please refer Okada et al., Nat Med, 2006).*

Dr. Stéphane H.R. Oliet

It is a complex question. I am not a specialist on astrocyte reactivity but I think that it does not necessarily imply astrogliosis.

Tome, astroglial reactivity, which has become "astroglial activation" for some researchers because they do not like the "reactive" term, corresponds to a rather radical change in the morphology and biochemistry of astrocytes, which may or may not be accompanied by gliosis.

This change occurs in response to a stress / stimulation, often of pathological type.

But the main mistake would be to think that this reactivity is the only mode of "activation" of astrocytes. A gain or loss of function of these cells can be achieved without reactivity and most of their physiological functions occur in a non-reactive state.

Dr. Aude Panatier

1- *Astrocyte reactivity is a modification of the "physiological state" of the astrocyte that will "allow" (or induce) it to integrate and in turn regulate differently the information.*

It is going from a modification of gene transcription to a modification of astrocyte morphology, and its functional interaction with, blood vessels, synapses and neighboring cells.

2- *For me "astrogliosis" implicates an increase of the astrocytic domain, which is probably not really the case. It can be the ultimate state of "astrocyte reactivity".*

So astrogliosis is not always synonymous of astrocyte reactivity.

Regarding "astrocyte activation", for me yes, it can be synonymous of "astrocyte reactivity".

Prof. Luc Pellerin

1. *Astrocyte reactivity is closely linked to the notion of phenotypic change. Astrocytes undergo modifications to move from a "resting" state to a "reactive" state. The classical markers of such a phenotypic change are 1) Altered morphology with a thickening of processes 2) enhanced expression of characteristic proteins, GFAP being the gold standard. The appearance of this new phenotype has been observed in several pathological situations and often associated with the notion of inflammation. The presence of cytokines, either produced by reactive astrocytes or acting on astrocytes to induce phenotypic change is characteristic of such an inflammatory state. The notion of proliferation often associated with reactive astrocytes in the past is controversial and contested. Not much is known about the functional consequences of such a phenotypic change although it is likely that it will modify several aspects of their numerous features (e.g. metabolic, trophic, signalling, etc).*

2. *I do not consider "astrogliosis", "astrocyte activation" and "astrocyte reactivity" completely equivalent. This is particularly true for "astrogliosis".*

Astrogliosis contains the notion of proliferation, in addition to reactivity

*Astrocyte activation is the passage from resting astrocyte to reactive astrocyte
Astrocyte reactivity is the capacity to become as well as the state of reactive astrocytes*

Dr. Gertrudis Perea

1. It would be the physiological changes happening into astrocytes triggered by stimuli of different nature. The main changes are typically related with GFAP expression (extension and thickness of the processes); however, other changes take place in shorter time periods, such as Ca²⁺ signaling, glutamate/GABA uptake, K⁺ buffering, gap-junction coupling, which contribute to transiently alter the function of astrocytes over the neuronal circuits.

2- No, I consider that "astrocyte activation" and "astrocyte reactivity" may represent the physiological response to astrocytes to normal (activation) and abnormal (reactivity) neuronal activity, represented by neurotransmitter release, K buffering, pH measurements, glucose/metabolic state, etc.

On the other hand, astrogliosis could be considered as a new physiological and permanent state after neuronal/brain insult.

Prof. Dr. Gabor Petzold

1- Astrocyte reactivity is an umbrella term for the signaling mechanisms employed by astrocytes in response to acute or sustained pathological stimuli. The main component of this response can be molecular, functional or morphological, or a combination of those. Moreover, this astroglial phenotype is not only a reaction to brain pathology, but also an important contributor to neuronal regeneration and survival. Whether reactive astrocytes amplify or ameliorate neurodegeneration likely depends on the nature and duration of the stimulus, as well as the presence of co-morbidities and the contribution of other cell types.

2- Surprisingly, although changes of astrocytes to brain injury have been known for over a century, the terms describing these alterations have remained highly subjective and ill-defined. To me, these terms describe points on a continuous spectrum. "Astrocyte activation" describes any change in astrocyte function, e.g. molecular or functional, without necessarily implying a pathological event or morphological changes. "Astrocyte reactivity" implies that the stimulus is strong enough to perturb brain homeostasis, evoking a functional and morphological reaction of astrocytes. "Astrogliosis" is the strongest reaction of astrocytes, and implies morphological changes in astrocytes that result in varying degrees of gliotic scar formation.

Dr. Frank W. Pfrieger

1. Reactivity is the ensemble of changes in astrocytes that are evoked by a pathologic condition (genetic, injury etc.)

2. No. Astrogliosis or gliosis is a bit ill-defined, but it may mean the same. Astrocyte activation does not necessarily require a pathology.

Dr. Stefanie Robel

1. My definition for astrocyte reactivity is pretty broad: Any changes to astrocyte morphology, transcriptome, proteome or function. This can be induced by acute injury, neurological disease or aging.

2. I consider astrocyte activation to be different from astrocyte reactivity. Activity to me means that an astrocyte domain or subdomain is functionally active, for example in response to neuronal activity.

I use astrogliosis and astrocyte reactivity synonymous.

Prof. David Rowitch

1- I consider reactive astrocytes to be defined by marker expression (eg, GFAP) in gray and white matter as well as morphology. They can have both damaging and beneficial functions in the context of injury. There in fact might be heterogeneity in RA across regions of the brain, but this has not been sufficiently defined.

2- No, I consider astrogliosis to be a clinical term signifying brain injury. Activation and reactivity could mean more subtle changes seen in response to cytokines or intrinsic cell death of neighboring cells. But, all these terms are rather non-specific and confusing!

Dr. Alberto Serrano-Pozo

"Astrocyte reactivity" = the potential or capacity of astrocytes to mount an astrocyte reaction.

Astrocyte reaction (or response) is a change in astrocyte phenotype that is triggered by external noxious stimuli in pathological brain conditions and/or by normal aging, involves the turning on and/or off of specific gene expression programs depending on the trigger, leading to functional changes, and may or not be accompanied by morphological changes and proliferation.

"Astrogliosis", "astrocyte activation" and "astrocyte reactivity" are, in my view, not synonyms and therefore not interchangeable. I believe the term "astrogliosis" should be abandoned because the suffix "-osis" in medicine generally implies a pathological state (i.e. neurosis) and, specifically in pathology, implies proliferation/increased number (i.e. leukocytosis, neurofibromatosis) or invasion/infiltration/spreading (i.e. carcinomatosis, amyloidosis), whereas astrocyte reaction is not necessarily associated with a pathological state (i.e. normal aging) or associated with astrocyte proliferation or migration and invasion. The term "astrocyte activation" suggests that astrocytes can react or "set themselves off" autonomously or for no reason, and fails to recognize that there is usually a trigger of astrocyte reaction (including aging), and that astrocyte reaction may involve inhibition (rather than activation) of some normal functions (i.e. neurotrophic, synaptic). The term "reactivity" literally means potential or capacity to react, which is different from the "reaction" itself. Therefore, I prefer the terms "astrocyte reaction" or "astrocyte response" to refer to the results or effects of "astrocyte reactivity". The concept of "astrocyte reactivity", devoid of its consequence – the astrocyte reaction -, may fit better with the scenario of normal aging, similar to the concept of "microglia priming".

Prof. Dr. Svetlana Sirko

"astrogliosis", "astrocyte activation" and "astrocyte reactivity" are related but not synonymous terms.

Personally, I prefer to speak about "astrocyte reactivity" as the ability of astroglia to develop an adequate response to a local or systemic pathophysiological stimuli. However, the degree of reactivity (regardless at which level, e.g. transcriptional, morphological, behavioural) is strongly dependent on the type, localization and severity of pathology but also on state of health as well as age of organism. "astrogliosis" as a state of astroglial population associated with chronic, mostly irreversible changes of astrocyte phenotype in context with neuropathologies.

"astrocyte activation" as a very quick functional adaptation on different physiological (and not necessarily pathological) needs, which can up to a point compensate for natural (or pathological) changes (e.g. activated state of astrocytes in aged brain).

In principle, it is like temporal changes in astrocyte state, starting with astrocyte activation (as result of physiological adaptation or exposure to path stimuli) -> astrocyte reactivity (multiple changes in phenotype at different levels)-> astrogliosis (chronic, mostly irreversible changes of astrocyte phenotype). This is, if you want, like determined in the Newton's third law: the action and the reaction are equivalent in magnitude and simultaneous part of an interaction, neither exists without the other.

Prof. Michael Sofroniew

I would imagine that a definition should be broad and able to encompass different roles and functions. People made have contrasting views about specific things, but the general concept should be inclusive and flexible.

1- 'Astrocyte reactivity' is a spectrum of changes in astrocytes that occur in response to all forms and severities of CNS injury and disease. These changes vary with the nature and severity of the insult along a graded continuum of progressive alterations in molecular expression, progressive cellular hypertrophy and, in severe cases, proliferation and scar formation. The changes associated with astrocyte reactivity are regulated in a context-specific manner by a diverse set of molecular signaling events. The changes undergone by reactive astrocytes have the potential to alter astrocyte activities both through gain and loss of functions that can impact both beneficially and detrimentally on surrounding neural and non-neural cells. Astrocyte reactivity is not an all-or-none response, nor is it a single uniform process, nor is it ubiquitously synonymous with scar formation. Instead, astrocyte is a finely graded continuum of progressive changes in gene expression and cellular changes that are subtly regulated by complex inter- and intra-cellular signaling mechanisms.

We first proposed and published these definitions 10 years ago because there were no formal modern definitions in the literature at that time (see full quotes from 2 papers below).

Sofroniew (2009) Trends Neurosci 32:638-647

Sofroniew and Vinters (2010) Acta Neuropathol 119:7-35.

In my opinion, the definitions are still valid and I do not know of any new findings that would compel me to change or update them.

You mention that there is a lot of variety and contrasting views in the definitions that people have sent you. I think that is interesting and perhaps rather sad that after so many years there is still confusion among 'experts'... - - It reminds me about the poem of the blind men who argued about their descriptions of the elephant ...

2- I consider "astrogliosis" and "astrocyte reactivity" as synonymous and I use them interchangeably. However, I strongly disagree with the use of the term "astrocyte activation" to refer to 'astrocyte reactivity'. This practice is out of date and is left over from the time when astrocytes in healthy tissue were referred to as "resting". There is no such thing as a "resting" astrocyte. Astrocytes in healthy tissue continually exhibit physiological activation in the form of transient, ligand-evoked elevations in intracellular calcium ([Ca²⁺]_i) that represent a type of astrocyte excitability, involved in mediating many critical dynamic astrocyte functions, including interactions with synapses and regulation of blood flow as discussed in other articles in this volume. Thus, astrocyte activation can range from physiological contexts in healthy CNS to pathophysiological contexts that involve responding to CNS injury or disease. In keeping with these definitions, there seems to be no place for the notion of an "activated astrocyte" as a single uniform entity that occurs only in response to injury or disease. (I have published this idea in the article Sofroniew MV (2015) Astrogliosis. Cold Spring Harb Perspect Biol 7:a020420. – the direct quote is below)

Here are some direct quotes from papers:

I hope this all helps with your article.

Direct quote on definition of astrocyte reactivity taken from the article Sofroniew MV (2009) Molecular dissection of reactive astrogliosis and glial scar formation. Trends Neurosci 32:638-647.

"In spite of the increasing recognition that astrocytes play central roles in normal CNS function and that reactive astrocytes are primary responders to injury and disease, the concept of reactive astrogliosis seems generally elusive, with no commonly agreed upon definition or model. This article proposes a definition and model of 'reactive astrogliosis' that integrates four interdependent

key features: (i) reactive astrogliosis is a spectrum of changes in astrocytes that occur in response to all forms and severities of CNS injury and disease including subtle perturbations; (ii) the changes undergone by reactive astrocytes vary with the nature and severity of the insult along a graded continuum of progressive alterations in molecular expression, progressive cellular hypertrophy and, in severe cases, proliferation and scar formation (Figs. 1,2), (iii) the changes of astrogliosis are regulated in a context-specific manner by specific signaling events that have the potential to modify both the nature and degree of those changes; (iv) the changes undergone during reactive astrogliosis have the potential to alter astrocyte activities both through gain and loss of functions that can impact both beneficially and detrimentally on surrounding neural and non-neural cells.

According to this definition and model, reactive astrogliosis is not an all-or-none response, nor is it a single uniform process, nor is it ubiquitously synonymous with scar formation. Instead, reactive astrogliosis is a finely graded continuum of progressive changes in gene expression and cellular changes (Figs. 1,2) that are subtly regulated by complex inter- and intra-cellular signaling as discussed in detail below. In its mild and moderate forms, reactive astrogliosis exhibits the potential for resolution if the triggering mechanism has resolved, in which the cells return to an appearance similar to that in healthy tissue (Fig. 2A). The extent to which various molecular changes resolve or persist is not well known. In this context, it is interesting to note that, in healthy tissue, the extensive network of finely branched processes of individual astrocytes occupy contiguous non-overlapping domains¹⁰. In mild-to-moderate reactive astrogliosis, there appears to be preservation of the individual non-overlapping domains of reactive astrocytes in spite of the hypertrophy of the cell body and processes¹¹ (Fig. 1B, 2A). At its extreme level of activation in response to overt tissue damage and inflammation, reactive astrogliosis involves scar formation that incorporates newly proliferated cells and in which astrocyte processes overlap in manners not seen in healthy tissue¹²⁻¹⁴ (Fig. 1C,2B). It deserves mention that astrocytes interact with other cell types, in particular fibromeningeal and other glial cells (such as NG2-positive glia) to form complex glial scars in the CNS^{14,15} (Fig. 2B). The structural changes associated with scar formation are long lasting and persist long after the triggering insult may have resolved (Fig. 1C,2B). The striking potential differences along the continuum of reactive astrocyte responses to insults of different kinds are likely to be of importance when considering the functions and impact of reactive astrogliosis on CNS functions, as discussed below. In other words, reactive astrogliosis of different kinds will have different consequences.”

Direct quote on definition of astrocyte reactivity taken from the article Sofroniew MV, Vinters HV (2010) Astrocytes: biology and pathology. *Acta Neuropathol* 119:7-35.

Based on a large body of observations in experimental animals, a definition of reactive astrogliosis has recently been proposed [226] that encompasses four key features: (i) reactive astrogliosis is a spectrum of potential molecular, cellular and functional changes in astrocytes that occur in response to all forms and severities of CNS injury and disease including subtle perturbations; (ii) the changes undergone by reactive astrocytes vary with severity of the insult along a graded continuum of progressive alterations in molecular expression, progressive cellular hypertrophy, and in severe cases, proliferation and scar formation, (iii) the changes of reactive astrogliosis are regulated in a context-specific manner by inter- and intra-cellular signaling molecules; (iv) the changes undergone during reactive astrogliosis have the potential to alter astrocyte activities both through gain and loss of functions that can impact both beneficially and detrimentally on surrounding neural and non-neural cells [226]. Here, we propose to apply and extend this definition to identifying different gradations of reactive astrogliosis and glial scar formation that may be encountered in histopathological examinations of human disorders (Figs. 3,4). According to this definition, reactive astrogliosis is not an all-or-none response, nor is it a single uniform process, nor is it ubiquitously synonymous with scar formation. Instead, reactive astrogliosis is a finely graded continuum of progressive changes in gene expression and cellular changes. Although the increasing severities of reactive astrogliosis transition seamlessly along a continuum, it is convenient for purposes of description and classification to recognize three broad categories:

Mild to moderate reactive astrogliosis. In mild or moderate reactive astrogliosis there is variable up regulation of expression of GFAP and other genes [226], as well as hypertrophy of cell body and processes that can vary in degree but that occurs within the domains of individual astrocytes [257] without substantive intermingling or overlap of processes of neighboring astrocytes or loss of individual domains (Figs. 3b,4b) [226]. There is little or no astrocyte proliferation in mild or moderate reactive astrogliosis, however, the up regulation of GFAP expression in astrocytes that do not express detectable levels of GFAP in healthy tissue (Figs. 3a,4a) can lead to the staining of more cells (Figs. 3b,4b), sometimes giving the false impression of proliferation. Mild or moderate reactive astrogliosis is generally associated with mild non-penetrating and non-contusive trauma, diffuse innate immune activation (viral infections, system bacterial infections) and in areas that are some distance to focal CNS lesions. Because there is little or no reorganization of tissue architecture, if the triggering mechanism is able to resolve, then mild or moderate reactive astrogliosis exhibits the potential for resolution in which the astrocytes return to an appearance similar to that in healthy tissue [226]. The physiological consequences of mild or moderate reactive astrogliosis are not well understood.

Severe diffuse reactive astrogliosis. In severe diffuse reactive astrogliosis there is pronounced up regulation of expression of GFAP and other genes, together with pronounced hypertrophy of cell body and processes, as well as astrocyte proliferation, resulting in considerable extension of processes beyond the previous domains of individual astrocytes. As a result, there is substantive intermingling and overlapping of neighboring astrocyte processes with blurring and disruption of individual astrocyte domains (Figs. 3c,4c). These changes can result in long lasting reorganization of tissue architecture that can extend diffusely over substantive areas without the formation of dense, compact barriers as found in glial scars along borders to necrotic tissue (see below). Severe diffuse reactive astrogliosis is generally found in areas surrounding severe focal lesions, infections or areas responding to chronic neurodegenerative triggers.

Severe reactive astrogliosis with compact glial scar formation. Severe reactive astrogliosis with compact glial scar formation includes changes associated with milder forms, such as pronounced up regulation of GFAP and other genes, and pronounced hypertrophy of cell bodies and processes. In addition, glial scar formation progresses beyond these changes with groups of reactive astrocytes that exhibit pronounced overlapping of reactive astrocyte processes, obliteration of individual astrocyte domains, evidence of substantive astrocyte proliferation and the clear formation of dense, narrow and compact glial scars (Fig. 4d). Recent experimental evidence indicates that these astrocyte scars act as neuroprotective barriers to inflammatory cells and infectious agents, and that they form in particular along borders to severe tissue damage, necrosis, infection or autoimmune-triggered inflammatory infiltration (Fig. 4d) [33, 59, 68, 95, 226, 251]. An important feature of these glial scars is the interaction of reactive astrocytes with other cell types, in particular fibromeningeal and other glial cells (Fig. 4d) [31, 95], and the deposition of a dense collagenous extracellular matrix that contains many molecular cues that inhibit axonal and cellular migration [219]. Triggering insults include penetrating trauma, severe contusive trauma, invasive infections or abscess formation, neoplasm, chronic neurodegeneration, systemically triggered inflammatory challenges. It is noteworthy that the glial scar formation is associated with substantive tissue reorganization and structural changes that are long lasting and persist long after the triggering insult may have resolved.

The findings summarized here show that there are pronounced differences along the continuum of potential responses of reactive astrocyte to insults of different kinds and severities. These differences are likely to be of consequence when considering the functions and impact of reactive astrogliosis on CNS disorders and pathologies.

Direct quote regarding differences between “astrocyte activation” and “astrocyte reactivity” taken from the article Sofroniew MV (2015) Astrogliosis. Cold Spring Harb Perspect Biol 7:a020420.

We will not use “activation” or “activated astrocytes” as terms that refer exclusively to astrocyte responses to injury or disease. Astrocytes in healthy tissue continually exhibit physiological activation in the form of transient, ligand-evoked elevations in intracellular calcium ($[Ca^{2+}]_i$) that represent a

type of astrocyte excitability, involved in mediating many critical dynamic astrocyte functions, including interactions with synapses and regulation of blood flow as discussed in other articles in this volume. Thus, astrocyte activation can range from physiological contexts in healthy CNS to pathophysiologic contexts that involve responding to CNS injury or disease. In keeping with these definitions, there seems to be no place for the notion of an "activated astrocyte" as a single uniform entity.

Prof. Harald Sontheimer

For me reactive astrocytes are:

Astrocytes that have undergone both morphological and functional changes as a result of insult or injury typically with the purpose to seal off the location of an injury or disease. Functional changes typically include a global loss of proteins involved in ion and neurotransmitter homeostasis and a change in extracellular matrix produced.

Reactive astrocytes and astrogliosis are certainly analogous. The activated astrocytes could refer to astrocytes that show Ca²⁺ signaling

Prof. Dr. Christian Steinhauser

I'm in the astrocyte field since many years, but my impression is that the term 'reactive' astrocyte still lacks a clear definition; everyone understands something different by it.

1. would define an 'reactive' astrocyte as an astrocyte with pathologically altered molecular, functional and/or morphological properties. Given that i) the physiological properties of astrocytes significantly vary during development as well as within and across brain areas (e.g. between hippocampus, cortex, thalamus, Griemsmann et al., 2015, Cereb Cortex), ii) the 'reactive state' usually progresses/worsens with ongoing disease (e.g. in epilepsy, see Bedner et al., 2015, Brain) and iii) in different diseases astrocytes are differently affected, it is clear that there must be a high heterogeneity among 'reactive' astrocytes (certainly not just A1 and A2 astrocytes). Curiously, some colleagues also speak of 'reactive' astrocytes in the physiologically aged brain; I find this usage inappropriate (because an aged brain is not necessarily a diseased brain).

2- 'Astrogliosis' and 'astrocyte reactivity' in my view are synonymous terms. 'Astrocyte activation' of course also occurs in physiology (e.g. when Ca²⁺ transients are evoked through GPCR activation), therefore the latter term should not be used to describe pathologically altered astrocytes.

Prof. Raymond Swanson

1) I do not think the term reactive astrocyte has any uniform meaning, and I try to avoid the term. My understanding is that it was introduced in the 1800s by pathologists (French, I think) who noted enlarged astrocytes near sites of injury or tumors; hence the term "reactive". It was later found that astrocytes with this morphology have increased GFAP, and that later became a defining feature. But, an assumption was made that all cells with these hallmarks are similar to one another and share similar other features. That part is almost certainly wrong; e.g. there are no data that I know of that all cells with reactive morphology have the same changes in gene expression, and lots of reasons to think they do not. This is exactly parallel to the microglia, where the term "activated" pertains to any cell with retracted processes despite the proven fact that the actual gene expression patterns of these cells is very diverse.

2) Yes, I consider them all synonyms, and all equally uninformative.

Prof. Alexej Verkhratsky

...indeed in my view we do not have an agreed and proper definition of "reactive astrogliosis";

My definition (taken from Verkhratsky A, Zorec R, Parpura V (2017) Stratification of astrocytes in healthy and diseased brain. Brain Pathol 27:629-644 doi:10.1111/bpa.12537) but this was reiterated in many of my papers in last 3-5 years) is:

Reactive astrogliosis is an evolutionary conserved defensive reprogramming of astroglia aimed at: (i) increased neuroprotection and trophic support of nervous tissue; (ii) isolation of the lesioned area; (iii) reconstruction of the damaged blood-brain barrier; and (iv) providing for post-lesion regeneration of brain circuits (10, 177, 178, 232). Activation of astrocytes is a complex process which arguably produces multiple "reactive" phenotypes, which demonstrate disease specificity. Gene expression profiling of reactive astrocytes demonstrated significant context-dependent (ischaemia vs. endotoxin activation) differences (290). All in all, initiation of astroglial programme proceeds through a controlled continuum of changes in cellular biochemistry and function that are tuned to the nature and strength of the insult.

It is cumbersome and still I believe we may need to expand it even more.

The common definition of astrogliosis as hypertrophy and increase in GFAP/Vim expression is of course trivial and misleading; e.g. GFAP may go up and down in physiological conditions for example in SON in circadian fashion.

The recent addition of A1/A2 is welcome as it shows two broad groups of phenotypic outcomes and yet I feel that the reality is much more complex and there are many more phenotypes which are context, age, disease, comorbidity &c., &c. specific.

Finally I do not know what to think about "neurotoxic" phenotypes - obviously evolution never selects for anything detrimental unless it increases survivability at large; so neurotoxic forms might also have positive defensive meaning; (in a way similarly to scar formation which is definitely protective but could be detrimental in spinal cord injury but evolution does not care about species with broken spine...).

(...)

yes "astrocyte activation", "astrocyte reactivity" and "astrogliosis" refer to the same process; you also forgot another word frequently used: "astrocytosis"

Prof. Andrea Volterra

1. I don't think we have a defined understanding of what a reactive astrocyte is. Previous work indicated that a major feature of reactive astrocytes was their change in morphology, notably the presence of thicker processes, but this was then understood to be an artefact of GFAP (cytoskeletal) staining. Today reactivity is thought to drive a more global "program" change, such as the return to a more immature and plastic state of the astrocyte, accompanied by a large change in its gene expression profile. Since it is increasingly evident that astrocytes are anatomically and biochemically heterogeneous depending on brain areas and circuits, I suspect gene expression changes related to reactivity will depend also on the specific molecular fingerprint of different astrocytic subpopulations. Likewise, they will depend on the specificities of the local microenvironment surrounding an astrocytic population. Moreover, the events triggering reactivity maybe quite different, from microorganism colonization of brain parenchyma, to vascular accidents, to acute traumatic insults to slow processes of protein aggregation and deposition, etc. I suspect astrocytes will turn out to react differently to any of such different conditions. In synthesis, the combination of the intrinsic features of a given astrocytic population, of its microenvironment and the type of insult will concur to produce different types of reactivity and different functional outcomes.

2. I do not personally consider "astrogliosis", "astrocyte activation" and "astrocyte reactivity" as synonymous terms. However, we should have a precise definition for each of these phenomena and I don't think we have. So, this leads many authors to interchange them.

Dr. Ina Wanner

Astrocyte reactivity is the active response of viable astrocytes to mechanical injury, non-neural cell contact or a chemical insult in order to protect CNS tissues adjacent to injuries and launch a systemic immune response. Viable astrocytes undergo reactivity, not wounded or dying astrocytes that release diagnostic biomarkers due to integrity compromise [1, 2]. Reactive astrocytes activate signaling pathways like the JAK-STAT cascade that induce gene expression changes. Results are proliferation, functional and structural astrocyte changes that contribute to the formation of a scar and wound healing [3]. Astrocyte shape changes after traumatic CNS injuries or after mechanical trauma or non-neural cell confrontation *in vitro* are defined by hypertrophy – displaying thick and elongated processes [4-7]. Injury models show a stereotypical astrocyte choreography of aligned elongated processes that wind around microglia or meningeal fibroblasts in co-cultures and that form borders around tears from mechanical injury inflicted by pressure-pulse stretching [4, 5, 7]. Perilesional reactive astrocytes in the injured spinal cord are elongated and associate with each other to bundles that corral non-neural cells and prevent their infiltration. This astrocyte-astrocyte interaction forms a scaffold that establishes the scar border around the lesion limiting its expansion [3, 7].

Astrocyte activation during scar formation is captured by astrocyte-specific protein synthesis after mouse spinal cord injury [8]. Major changes were in protein groups of the biological processes, the JAK-STAT cascade, inflammation, NO biosynthesis, calcium ion transport, gliogenesis and angiogenesis; and of the cellular components, cell adhesion, vesicle and extracellular matrix. These essential protein groups mediate scar assembly and are aimed at re-establishing the neuro-vascular unit and ion homeostasis. Interestingly, quantitative proteomic analysis of *in vitro* matured human trauma-reactive neocortical astrocytes resulted in changes of the same essential protein groups [manuscript in preparation, [5]. These findings are supported by literature analysis grouping most frequently reported astrocyte protein changes after spinal cord injury in a survey of over 200 publications in the last 30 years.

Astrogliosis, astrocyte reactivity and activation are essentially describing similar astroglial processes. In the literature the term “astrogliosis” associates more frequently with histopathology, while the term “astrocyte activation” associates more frequently with expression changes. The term “astrocyte reactivity” is applied *in vivo* and *in vitro* models of astrocyte injury responses. Thus, their heritage and common use differ, yet since structural changes are based on molecular and protein changes, these terms can be seen as part of the same astrocyte response program.

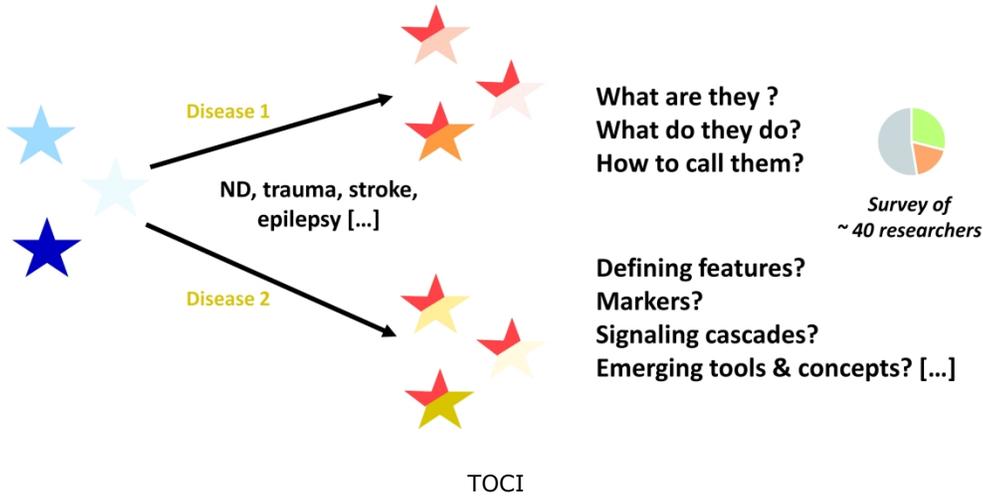
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