Bosentan for the Prevention of Overcirculation-Induced Experimental Pulmonary Arterial Hypertension

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Background—The dual endothelin-receptor antagonist bosentan has been reported to improve pulmonary arterial hypertension, but the role of endothelins in the pathogenesis of the condition remains uncertain. We investigated the roles of endothelin-1 (ET-1), nitric oxide (NO), vascular endothelial growth factor (VEGF), and tenascin in overcirculation-induced pulmonary hypertension in piglets, as a model of early pulmonary arterial hypertension, with or without bosentan therapy.

Methods and Results—Thirty 3-week-old piglets were randomized to placebo or to bosentan 15 mg/kg BID after the anastomosis of the left subclavian artery to the pulmonary arterial trunk or after a sham operation. Three months later, the animals underwent a hemodynamic evaluation followed by cardiac and pulmonary tissue sampling for morphometry, immunohistochemistry, and real-time quantitative PCR. Chronic systemic-to-pulmonary shunting increased circulating plasma ET-1, pulmonary mRNA for ET-1, ETB receptor, inducible NO synthase, VEGF, and pulmonary ET-1 and VEGF proteins. There were increases in myocardial mRNA for ETa receptor and VEGF and in myocardial VEGF protein. Pulmonary and myocardial tissue mRNA for tenascin did not change. Normalized-flow pulmonary artery pressure increased from 20 (2) to 33 (1) mm Hg [mean (SEM)], arteriolar medial thickness increased on average by 83%, and these changes were completely prevented by bosentan therapy. Right ventricular end-systolic elastance increased in proportion to pulmonary arterial elastance with or without bosentan.

Conclusions—Experimental overcirculation-induced pulmonary arterial hypertension appears to be causally related to activation of the pulmonary ET-1 system and as such is completely prevented by the dual endothelin receptor antagonist bosentan. (Circulation, 2003;107:1329-1335.)
Methods
Thirty piglets (Van Gucht, Liedekerke, Belgium) 20±1 days old and weighing 5.9±0.2 kg were included in the present study, which was approved by the institutional Committee on Animal Welfare. The animals were randomized to a sham operation (n=10) or to an anastomosis between the left subclavian artery and the pulmonary arterial trunk followed by random institution of treatment with bosentan 15 mg/kg (n=10) or placebo (n=10) administered orally with food twice a day for 3 months.

Surgical Procedure
After prophylactic cephazoline, premedication with ketamine, midazolam, and atropine, anesthesia with remifentanyl and midazolam, paralysis with pancuronium, intubation, and ventilation as previously described except for the replacement of fentanyl by remifentanyl 75 μg · kg⁻¹ · h⁻¹, a thoracotomy was performed through the left third intercostal space. The left innominate artery was dissected and anastomosed to the main pulmonary trunk according to the classic Blalock-Taussig procedure (Wauthy et al, unpublished observations). Patency of the shunt was checked by the palpation of a thrill. The anastomosis was ligated in the 10 animals that served as sham-operated controls. After careful hemostasis, the chest was tightly closed and pleural air evacuated; anesthesia and paralysis were interrupted, and the animals were weaned from mechanical ventilation. Postoperative analgesia was provided with morphine and paracetamol as required for 72 hours. The day after the procedure, the shunted animals were randomized to bosentan or placebo. In all the shunted animals, daily clinical examination showed a precordial murmur until the end of the 90-day observation period.

Hemodynamic Evaluation
After a 90±1-day observation period, the animals were anesthetized, ventilated, and equipped with catheters and an ultrasonic flow probe on the pulmonary arterial trunk as previously described with in addition a 5F high-fidelity manometer-tipped catheter (SPC 350, Millar) in the right ventricle. Heart rate, mean pulmonary arterial pressure (Ppa), occluded Ppa, systemic arterial pressure, thermodilution cardiac output (Q), ultrasonic instantaneous pulmonary arterial pressure, and blood gases were measured as previously reported. An overdose of anesthesia. After the measurements, the animals were euthanized with an overdose of anesthesia.

Real-Time Quantification PCR
Total RNA was prepared from snap-frozen tissue samples (400 mg) using TRizol (Gibco Life Technologies). RNA was quantified by absorbance at λ=260 nm, and its concentration was adjusted to 0.25 μg/μL. Reverse transcription was performed with the GeneAmp PCR system 2400 (Perkin Elmer) with 1 μg of total RNA in a reaction volume of 20 μL containing 7.5 μmol/L random hexamers, reverse transcription buffer 1X, 9 mmol/L dithiothreitol, 220 μmol/L of each dNTP, 20 U of ribonuclease inhibitor (Applied Biosystems), and 50 U of reverse transcriptase (Superscript, Gibco BRL). Final reverse transcription product was adjusted to 40 μL with RNase-free water. Primers for ET-1 and the report gene, HPRT, were already used in our laboratory. Except for endothelin converting enzyme (EC)-1 and inducible NO synthase (iNOS), the previously reported end-point PCR primers were unaltered to the Sybr Green RTQ-PCR system. To develop specific porcine primers adapted to Sybr Green RTQ-PCR conditions, we engaged classic primers for ET<sub>α</sub>, ET<sub>β</sub>, neuronal NO synthase (nNOS), endothelial NO synthase (eNOS), and VEGF in end-point PCR (GeneAmp PCR system 2400) to amplify cDNA from pig tissue. PCR product was purified and sequenced using the Big Dye protocol (4303149, Applied Biosystems). These sequences and the already reported sequences for VEGFR receptor flk-1 (GenBank AJ245446) and tenascin (GenBank X61599) were used to design, on Primer Express software (Applied Biosystems), porcine specific primers adapted to RTQ-PCR conditions. The primers (Table 1) were produced on an automated synthesizer (Applied Biosystems) according to the manufacturer’s protocol. Sybr Green RTQ-PCR analysis were performed with GeneAmp 5700 (Applied Biosystems). RTQ-PCR was performed using the following cycle parameters: 10 minutes at 95°C, followed by 40 cycles of 15 sec at 95°C and 1 minute at 60°C. For each gene, RTQ-PCR was conducted in duplicate with 25 μL reaction volume of 5 ng of cDNA, 2.5 μL Sybr Green buffer, 250 μmol/L dNTP, 3 mmol/L MgCl<sub>2</sub>, 400 mmol/L of each primer, and 0.625 U amplification Taq Gold polymerase (Applied Biosystems). To ensure the quality of the measurements, both negative and positive controls were systematically included in duplicate in each plate. The statistical analysis of the RTQ-PCR results was done using the ΔΔCt value (Ct<sub>target</sub> - C<sub>Tau</sub> - C<sub>reporter</sub>). Relative gene expression was obtained by ΔΔCt methods (ΔCt<sub>sample</sub> - ΔCt<sub>calibrator</sub>) using the sham group as a calibrator for comparison of every unknown-sample gene expression level. The conversion between ΔΔCt and relative gene expression levels is Fold induction=2<sup>-ΔΔCt</sup>. 

Immunohistochemistry
The immunohistochemistry analysis was performed on lung and right ventricular myocardial tissue as reported by Aguirre et al. with rabbit monoclonal antibody to ET-1 (1/100 dilution) prepared in our laboratory and commercial rabbit polyclonal antibodies against VEGF (A-20-SC-152, 1/100 dilution; Santa Cruz Biotechnology), nNOS (BD610310, 1/50 dilution; Transduction Laboratories), and iNOS (160862, 1/100 dilution; Cayman Chemical Co) and mouse monoclonal antibody against eNOS (NCL-NOS3, 1/80 dilution; Novocastra). Quantitative immunohistochemical assessments were performed as previously reported. A mean optical density, which relates to immunohistochemical staining intensity, was calculated for 20 areas of 4248 μm<sup>2</sup> for right ventricular tissue and in the endothelium of 20 pulmonary arteries of <500 μm. This mean optical density value was obtained by dividing the integrated optical density value for the immunohistochemical staining by the area of tissue covered by this staining.

Statistical Analysis
Values are reported as mean±SEM. Multipoint pressure-flow relations were submitted to linear regression analysis, and standardized pressure values were calculated from individual regressions at Q of 2 and 5 L · min<sup>−1</sup> · m<sup>−2</sup>. Effects of shunt and drugs were analyzed
Results

One of the sham-operated piglets died of a mediastinitis, and one of the shunted piglets randomized to bosentan therapy died of acute postoperative heart failure. Weight gain averaged 40 kg and was not different in the 3 study groups. Arterial blood gases and hematocrits were normal and not different in the 3 study groups. The ratio of pulmonary to systemic flow before closure of the shunt was 1.6±0.1 in the placebo group and 1.7±0.1 in the bosentan group. Chronic systemic-to-pulmonary shunting increased Ppa, occluded Ppa, Ees, and Ea, with no change in heart rate, Q, partition of PVR, or the ratio of Ees to Ea (Table 2). There was an increase in pulmonary arterial medial thickness, and this effect was most pronounced in the smallest arterioles (Figure 1). Ppa/Q relationships were shifted to higher pressures (Figure 2). Plasma ET-1 increased from 2.0±0.1 pg/mL in the sham-operated controls to 2.4±0.1 pg/mL, P<0.05.

Bosentan therapy prevented the increases in Ppa, occluded Ppa, and Ea but not the increases in Ees (Table 2), completely prevented the increase in pulmonary arterial medial thickness (Figure 1) and the shift of Ppa/Q plots (Figure 2), and was associated with a further increase in plasma ET-1 to 4.6±0.5 pg/mL, P<0.05 versus placebo group.

As illustrated in Figure 3, shunting increased whole-lung homogenate gene expression for ET-1, ETB, iNOS, and VEGF without changes in gene expression for ETA, ECE-1, nNOS, eNOS, flk-1, and tenascin and increased pulmonary endothelial immunostaining for both ET-1 and VEGF without changes in nNOS, iNOS, and eNOS. Bosentan therapy was associated with additional increases in ECE-1 and eNOS gene expression.
As illustrated in Figure 4, shunting increased right ventricular myocardial gene expression for ET<sub>A</sub> and VEGF without changes in gene expression for ET<sub>B</sub>, ECE-1, nNOS, eNOS, flk-1, and tenascin and increased right ventricular myocardial immunostaining for VEGF without changes in ET<sub>B</sub>, nNOS, iNOS, or eNOS. Bosentan therapy was associated with an additional increase in eNOS expression and immunostaining for iNOS.

**Discussion**

The present study is the first to show a dominant role of the endothelin system in early overcirculation-induced PAH.

Typical PAH is a classically described complication of congenital heart disease with left-to-right shunts.<sup>9</sup> Previous attempts to reproduce PAH associated with systemic left-to-right shunting often led to disappointingly moderate increases in pulmonary artery pressures related to insufficient duration, pressure, or volume flow of surgically implanted shunting.<sup>7,8,20</sup> In the present study, we performed a Blalock-Taussig operation allowing for shunt flow to increase progressively with growth of the animals. This approach resulted in pronounced medial hypertrophy and Ppas between 30 and 40 mm Hg, compatible with changes seen in early PAH.<sup>21</sup> The partitioning of PVR was unaltered, in keeping with the morphometry showing that the site of overcirculation-induced remodeling is at the normal site of resistance, at the periphery of the pulmonary arterial tree.<sup>22</sup>

Overcirculation-induced PAH was associated with increased circulating ET<sub>1</sub>, increased pulmonary tissue gene expression for ET<sub>A</sub> and VEGF without changes in gene expression for ET<sub>B</sub>, ECE-1, nNOS, iNOS, eNOS, flk-1, and tenascin and increased right ventricular myocardial immunostaining for VEGF without changes in ET<sub>B</sub>, nNOS, INOS, or eNOS. Bosentan therapy was associated with an additional increase in eNOS expression and immunostaining for iNOS.

**Table 1. Primers Used for RTQ-PCR in Porcine Lung and Ventricular Tissue**

<table>
<thead>
<tr>
<th>Gene</th>
<th>Primer Sequences</th>
</tr>
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<tr>
<td>HPRT</td>
<td>Sense 5'-TCAGCCAGTATAATCCAAAGATGGT-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-AGTCTGGTATCTATATACCTACCTCG-3'</td>
</tr>
<tr>
<td>ET-1</td>
<td>Sense 5'-TCTCTGCTTCTCTTCTGATGGA-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-GTGCTCAGAGGTGGTGACC-3'</td>
</tr>
<tr>
<td>ET&lt;sub&gt;A&lt;/sub&gt;</td>
<td>Sense 5'-TTATATCTCCTGCCATCCTGTA-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-GCTCTTGCGCTGTATTCCA-3'</td>
</tr>
<tr>
<td>ECE-1</td>
<td>Sense 5'-CCCTCTCATCTACAGAGATT-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-GACCACACGAGCATAACGATG-3'</td>
</tr>
<tr>
<td>nNOS</td>
<td>Sense 5'-CTCAATCTCTTTTTCACCTCCTC-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-GAGTATTACGTGCTAATTAAAGATTCG-3'</td>
</tr>
<tr>
<td>iNOS</td>
<td>Sense 5'-CTGATGATGATACTACACGCCTGACG-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-AGCTTCTGATCAATGTCATGAGCAA-3'</td>
</tr>
<tr>
<td>eNOS</td>
<td>Sense 5'-CTCTCTCTGTGGCCCTGAAACA-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-CCGTTACTCAGACCCCAAGG-3'</td>
</tr>
<tr>
<td>VEGF</td>
<td>Sense 5'-TACCTCCCAATCGCAGTG-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-GTAGCGGCTCAGATGCTGAC-3'</td>
</tr>
<tr>
<td>flk-1</td>
<td>Sense 5'-ACTGTTCTGGGCAACAAATC-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-CAGAAGAAACGGCTCACTGCA-3'</td>
</tr>
<tr>
<td>Tenascin</td>
<td>Sense 5'-CGCAAAGCGCCATATAATTC-3'</td>
</tr>
<tr>
<td></td>
<td>Antisense 5'-GATGGTGAGCTGGTGATG-3'</td>
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**Table 2. Hemodynamic Effects of Chronic Systemic-to-Pulmonary Shunting in Piglets**

<table>
<thead>
<tr>
<th></th>
<th>Sham (n=9)</th>
<th>Placebo (n=10)</th>
<th>Bosentan (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR, bpm</td>
<td>118 ± 5</td>
<td>121 ± 7</td>
<td>127 ± 7</td>
</tr>
<tr>
<td>Q, L·min&lt;sup&gt;-1&lt;/sup&gt;·m&lt;sup&gt;-2&lt;/sup&gt;</td>
<td>3.4 ± 0.1</td>
<td>3.0 ± 0.1</td>
<td>3.4 ± 0.2</td>
</tr>
<tr>
<td>Psa, mm Hg</td>
<td>131 ± 4</td>
<td>132 ± 8</td>
<td>133 ± 4</td>
</tr>
<tr>
<td>Ppa, mm Hg</td>
<td>21 ± 1</td>
<td>33 ± 1*</td>
<td>21 ± 1†</td>
</tr>
<tr>
<td>Ppao, mm Hg</td>
<td>8 ± 1</td>
<td>11 ± 1*</td>
<td>8 ± 1†</td>
</tr>
<tr>
<td>PVRa, %</td>
<td>65 ± 2</td>
<td>63 ± 2</td>
<td>62 ± 3</td>
</tr>
<tr>
<td>Ees, mm Hg/mL</td>
<td>1.45 ± 0.08</td>
<td>2.11 ± 0.12*</td>
<td>1.94 ± 0.13</td>
</tr>
<tr>
<td>Ea, mm Hg/mL</td>
<td>0.91 ± 0.07</td>
<td>1.43 ± 0.12*</td>
<td>1.07 ± 0.14</td>
</tr>
<tr>
<td>Ees/Ea</td>
<td>1.62 ± 0.09</td>
<td>1.52 ± 0.13</td>
<td>1.97 ± 0.23</td>
</tr>
</tbody>
</table>

HR indicates heart rate; Psa, mean systemic arterial pressure; Ppao, occluded Ppa; and PVRa, arterial component of PVR. Values are expressed as mean ± SEM.

*P < 0.05 sham vs placebo.
†P < 0.05 placebo vs bosentan.
expression for ET-1 and ET_{B}, and increased pulmonary endothelial ET-1 protein, indicating activation of the pulmonary endothelial endothelin system. Activation of the endothelin system with increased circulating ET-1 has been reported in various experimental models of pulmonary hypertension and in clinical pulmonary hypertension. Endothelin receptor blockade has been shown to prevent experimental hypoxic or monocrotaline-induced pulmonary hypertension. In the present study, the dual endothelin receptor antagonist bosentan completely prevented both medial hypertrophy and increase in PVR, suggesting a causal relationship.

The shunted piglets presented with an overexpressed ET_{B} receptor. This has also been observed in rats with hypoxic pulmonary hypertension and in patients with thromboembolic pulmonary hypertension. The ET_{B} receptor has been shown to be involved in the clearance of circulating ET-1, the modulation of ET-1 synthesis through a negative feedback, and the release of endothelium-derived vasodilators but may also contribute to ET-1-induced remodeling. Whether selective ET_{A} blockade would be more or less effective in preventing overcirculation-induced PAH is unknown at present.

Pulmonary eNOS expression has been reported to be decreased in PAH patients but either increased or unchanged in experimental overcirculation-induced PAH. In the present study, eNOS and nNOS mRNAs were unchanged, iNOS mRNA was increased, but there was no change in the protein levels of either NOS. It may be that in the piglet, and only in the early stages of PAH, increased iNOS could contribute to limit the severity of pulmonary hypertension.

Pulmonary vascular disease has been shown to be associated with induction of tenasin-C, a mitogenic cofactor produced through the action of matrix metalloproteases activated by a smooth muscle cell–derived serine elastase. The present results do not favor a role for this pathway in early overcirculation-induced PAH.

The shunted piglets presented with an increase in pulmonary tissue VEGF mRNA and VEGF protein. An increased VEGF expression has been reported previously in hypoxic rats and in pulmonary hypertensive infants.
sion of VEGF could be considered as counterregulatory to the activation of the endothelin system. The myocardial tissue of the shunted piglets showed increased mRNA for ET_\text{A} receptor and VEGF, together with increased VEGF protein. An increased ET_\text{A} receptor could contribute increased right ventricular contractility. Both pathways could have contributed to maintained right ventriculoarterial coupling, as was assessed by the Ees/Ea ratio.

Bosentan therapy was associated with additional expression of pulmonary tissue ECE-1 and eNOS and myocardial tissue eNOS. Increased circulating ET-1 and increased expression of pulmonary tissue ECE-1 have been previously reported with bosentan therapy. Increased eNOS mRNA could conceivably be secondary to decreased ET_\text{B}-dependent eNOS activity.

In summary, overcirculation-induced PAH seems to be causally related to an activation of the pulmonary endothelin system, with counterregulatory NO and VEGF pathways and no role for tenasin. The efficacy of preventive dual endothelin receptor blockade offers a rationale for early therapy with this agent.

**Acknowledgments**

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**References**


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