Adrenomedullin Infusion Attenuates Myocardial Ischemia/Reperfusion Injury Through the Phosphatidylinositol 3-Kinase/Akt-Dependent Pathway

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Background—Infusion of adrenomedullin (AM) has beneficial hemodynamic effects in patients with heart failure. However, the effect of AM on myocardial ischemia/reperfusion remains unknown.

Methods and Results—Male Sprague-Dawley rats were exposed to a 30-minute period of ischemia induced by ligation of the left coronary artery. They were randomized to receive AM, AM plus wortmannin (a phosphatidylinositol 3-kinase [PI3K] inhibitor), or saline for 60 minutes after coronary ligation. Hemodynamics and infarct size were examined 24 hours after reperfusion. Myocardial apoptosis was also examined 6 hours after reperfusion. The effect of AM on Akt phosphorylation in cardiac tissues was examined by Western blotting. Intravenous administration of AM significantly reduced myocardial infarct size (28±4% to 16±1%, P<0.01), left ventricular end-diastolic pressure (19±2 to 8±2 mm Hg, P<0.05), and myocardial apoptotic death (19±2% to 9±4%, P<0.05). Western blot analysis showed that AM infusion accelerated Akt phosphorylation in cardiac tissues and that pretreatment with wortmannin significantly attenuated AM-induced Akt phosphorylation. Moreover, pretreatment with wortmannin abolished the beneficial effects of AM: a reduction of infarct size, a decrease in left ventricular end-diastolic pressure, and inhibition of myocardial apoptosis after ischemia/reperfusion.

Conclusions—Short-term infusion of AM significantly attenuated myocardial ischemia/reperfusion injury. These cardioprotective effects are attributed mainly to antiapoptotic effects of AM via a PI3K/Akt-dependent pathway. (Circulation. 2004;109:242-248.)

Key Words: peptides ▪ reperfusion ▪ apoptosis ▪ myocardial infarction ▪ hemodynamics

Coronary revascularization has been established as the most effective treatment for coronary artery disease. However, reperfusion can elicit a number of adverse reactions that may limit its beneficial actions. Although it has been attempted to reduce ischemia/reperfusion injury in many basic or clinical studies, few agents are clinically available for ischemia/reperfusion injury.

Adrenomedullin (AM) is a potent vasodilatory peptide that was originally isolated from human pheochromocytoma.1 We have shown that AM peptide and mRNA are distributed in the heart2,3 and that plasma and cardiac AM markedly increase after acute myocardial infarction.4,5 AM has been shown to be a possible endogenous suppressor of myocyte hypertrophy6 and fibroblast proliferation.7 In addition, intravenous infusion of AM has beneficial hemodynamic effects in patients with heart failure.8 These findings suggest that AM induces cardioprotective effects not only as a circulating factor but also as a paracrine and/or autocrine factor.

Recently, AM has been shown to activate the Akt pathway in vascular endothelial cells.9 Interestingly, the Akt activation has been reported to lead to the prevention of myocardial injury after transient ischemia in vivo through antiapoptotic effects.10 However, whether AM, a potent Akt activator, attenuates myocardial ischemia/reperfusion injury remains unknown.

Thus, the purposes of this study were (1) to investigate whether short-term infusion of AM reduces myocardial infarct size, inhibits myocyte apoptosis, and thereby improves cardiac function after ischemia/reperfusion and (2) to determine whether the underlying mechanisms are associated with...
the phosphatidylinositol 3-kinase (PI3K)/Akt-dependent pathway.

Methods

Reperfusion Model
We used male Sprague-Dawley rats (Japan SLC Inc, Hamamatsu, Japan) weighing 180 to 220 g. Ligation of the left coronary artery was performed as described previously.11 In brief, under anesthesia with pentobarbital sodium (30 mg/kg) and artificial ventilation, the heart was exposed via left thoracotomy, and the left coronary artery was ligated 2 to 3 mm from its origin between the pulmonary artery conus and the left atrium with a 6-0 Prolene suture. The heart was subjected to regional ischemia for 30 minutes, followed by coronary reperfusion through release of the tie. After ligation of the left coronary artery, AM (0.05 μg · kg⁻¹ · min⁻¹), AM plus wortmannin (16 μg/kg intravenous injection 15 minutes before AM infusion; a PI3K inhibitor),12 or placebo (0.9% saline) was administered for 60 minutes through a catheter inserted into the left jugular vein. Sham-operated rats only underwent left thoracotomy. The chest wall was then closed, and the animal was allowed to recover. This protocol resulted in the creation of 4 groups: sham-operated rats (sham group, n=12), placebo-treated rats with ischemia/reperfusion (I/R-placebo group, n=19). AM-treated rats with ischemia/reperfusion (I/R-AM group, n=19) and AM plus wortmannin–treated rats with ischemia/reperfusion (I/R-Wo+AM group, n=15).

All animal experiments were conducted in accordance with the principles and procedures outlined in the National Cardiovascular Center Guide for the Care and Use of Laboratory Animals, which adheres strictly to the National Institutes of Health animal experimental guidelines, with the approval of the National Cardiovascular Center Animal Experimental Committee.

Hemodynamic Studies
We performed hemodynamic measurements 24 hours after ischemia/reperfusion. A 1.5F micromanometer-tipped catheter was advanced into the left ventricle through the right carotid artery, and a polyethylene catheter (PE-50) was advanced into the right ventricle through the right jugular vein to measure right ventricular pressure. Heart rate was also monitored with an ECG.

Measurement of Plasma AM Level
Blood samples were obtained from the right carotid artery during 0.05 μg · kg⁻¹ · min⁻¹ AM infusion. Plasma AM level was measured by immunoradiometric assay, as described previously.8,11

Assessment of Infarct Size
After hemodynamic measurements, the heart was removed and perfused with a Langendorff apparatus for 10 minutes to wash out the blood and then fixed with 10% neutral buffered formalin. The heart was sliced transversely from the apex to the aortoventricular groove in 2.5-mm thicknesses and weighed separately. Within 24 hours after fixation, each section was embedded in paraffin. Serial 5-μm myocardial sections were cut with microtome and mounted on siliconized slides. After Masson trichrome staining, infarct size of each slice was analyzed by microscopy. Myocardial coagulation necrosis could be distinguished from viable myocardium as a definite alteration of staining, and then the infarct area was outlined and measured by planimetry. Infarct weight was determined with the following equation: % infarct area = × weight of each slice, as described previously.13 Finally, we determined percent infarct size as total infarct weight divided by total left ventricular (LV) weight.

TUNEL Staining
Hearts were isolated from each group (n=5) 6 hours after reperfusion for the terminal dUTP nick-end labeling (TUNEL) assay. After the blood and the fixation were washed out, the heart was also sliced transversely in 2.5-mm thicknesses. Paraffin-embedded, 5-μm-thick myocardial sections were used as described previously.14 In brief, after deparaffinization and enzyme-mediated antigen retrieval, TUNEL staining was performed with a commercially available kit (Apop Tag Plus, Intergen). Samples were incubated with monoclonal anti-desmin antibody (Sigma) followed by tetramethylrhodamine isothiocyanate-conjugated rabbit anti-mouse antibody (DAKO). Counterstaining was performed with propidium iodide. Finally, these slides were mounted with Vector Shield (Vector Laboratories) containing an antifade reagent. We measured the number of TUNEL-positive nuclei in myocytes as means of confocal microscopy (Olympus, Fluoview 500). Quantitative analysis was performed on 60 high-power fields (magnification ×600) with at least 10 randomly selected fields used per section. We counted the number of cardiomyocytes at least >10⁶ cells per heart.

DNA Ladder Assay
We used 10 additional rats for the DNA ladder assay (sham group, n=2; I/R-placebo group, n=4; I/R-AM group, n=4). Rats were killed, and the heart was excised 24 hours after ischemia/reperfusion. Immediately before heart isolation, 1% Evans blue was infused slowly into the left ventricle to delineate the risk area after coronary reperfusion. Then, 40 mg of myocardium in the posterolateral border zone between the nonrisk area and the risk area was resected. Each specimen was frozen in liquid nitrogen and stored at −80°C until DNA extraction. DNA extraction and electrophoresis were performed with a commercially available kit (ApopTosis Ladder Detection Kit, WAKO).

Immunohistochemical Analysis
To assess localization of calcitonin receptor-like receptor (CRLR), a receptor for AM, in cardiac tissues, we performed immunohistochemical analysis using rabbit anti-rat CRLR antibody (Zymed). Localization of Akt phosphorylation was examined with rabbit anti-rat phospho-Akt antibody (Cell Signaling).

Western Blot Analysis
To identify Akt phosphorylation in myocardial tissues after AM infusion, Western blotting was performed with a commercially available kit (PhosphoPlus Akt [Ser 473] antibody kit, Cell Signaling). Myocardial tissues were obtained from rats treated with intravenous AM (0.01, 0.05, and 0.25 μg · kg⁻¹ · min⁻¹), AM (0.05 μg · kg⁻¹ · min⁻¹) plus wortmannin (16 μg/kg intravenous injection 15 minutes before AM infusion), or saline for 60 minutes during ischemia/reperfusion. These samples were homogenized on ice in a 0.1% Tween 20 homogenization buffer with a protease inhibitor (Complete, Roche). After centrifugation for 20 minutes at 4°C, the clear supernatant was used for Western blot analysis. Protein concentration was measured by Bradford’s method (Bio-Rad). Fifty micrograms of each protein extract were transferred in sample buffer, loaded on 7.5% SDS-polyacrylamide gel, and blotted onto nitrocellulose membrane (Bio-Rad) with a wet blotting system. After being blocked for 60 minutes, the membranes were incubated with primary antibodies in blocking buffer (1:500). After washing, the membranes were incubated with secondary antibodies, which were conjugated with horseradish peroxidase (Cell Signaling). Antibodies were used at the manufacturer’s recommended dilution (Cell Signaling). The membranes were incubated with secondary antibodies, which were conjugated with horseradish peroxidase (Cell Signaling), at a final dilution of 1:2000. Signals were detected with LumiGLO chemiluminescence reagents (Cell Signaling).

Statistical Analysis
All data are expressed as mean±SEM unless otherwise indicated. Comparisons of parameters among the 3 or 4 groups were made by 1-way ANOVA for repeated measures, followed by Scheffé test. A probability value <0.05 was considered to indicate statistical significance.

Results

Reduction of Myocardial Infarct Size After AM Infusion
Moderate to large infarcts were observed in Masson trichrome–stained myocardial sections 24 hours after ische-
mia/reperfusion (Figures 1A and 1B). Quantitative analysis revealed that 60-minute infusion of AM (0.05 μg · kg⁻¹ · min⁻¹) significantly reduced myocardial infarct size compared with placebo infusion (16±1 versus 28±4%, P<0.01; Figure 1C). Infusion of AM markedly increased plasma AM level (from 10±2 fmol/mL at baseline to 96±13 fmol/mL at 60 minutes), which suggests that the plasma AM level was pharmacologically high. Pretreatment with wortmannin reversed the reducing effects of AM on myocardial infarct size (from 16±1% to 27±2%, P<0.05 versus I/R-AM group; Figure 1D). Although typical reperfusion injury, including contraction bands, hemorrhage, myocardial cell coagulation, and inflammatory cell infiltration, was observed after ischemia/reperfusion (Figure 1D), there were no histological differences among the 3 groups.

Hemodynamic Effects of AM
Twenty-four hours after ischemia/reperfusion, LV end-diastolic pressure (LVEDP) showed a marked elevation in the I/R-placebo group (19±2 mm Hg); the elevation was significantly attenuated in the I/R-AM group (8±2 mm Hg, P<0.05; Figure 2A). Pretreatment with wortmannin attenuated the reducing effects of AM on LVEDP (from 8±2 to 17±2 mm Hg, P<0.05 versus I/R-AM group; Figure 2A) 24 hours after ischemia/reperfusion. LV dP/dt max tended to be higher in the I/R-AM group than in the I/R-placebo group (5285±285 versus 4524±247 mm Hg/s), and LV dP/dt min tended to be lower in the I/R-AM group than in the I/R-placebo group (−4700±303 versus −3695±165 mm Hg/s; Figure 2B). Furthermore, pretreatment with wortmannin reversed the effects of AM on LV dP/dt max and LV dP/dt min after ischemia/reperfusion (5285±285 to 4570±239 mm Hg/s, −4700±303 to −3843±227 mm Hg/s, respectively; Figure 2B). These results suggest that AM infusion improved LV systolic and diastolic function after ischemia/reperfusion through the PI3K pathway. Interestingly, heart rate was significantly higher in the I/R-placebo and I/R-AM groups than in the sham group (Table). Although mean aortic pressure was significantly lower in the I/R-placebo group than in the sham group, a significant decrease in mean aortic pressure was not observed in the I/R-AM group. Right ventricular systolic pressure was significantly lower in the I/R-AM group than in the I/R-placebo group.

Antiapoptotic Effect of AM in Cardiomyocytes
Representative photomicrographs showed that TUNEL-positive myocytes were more frequently observed in the I/R-placebo group than in the sham group. However, TUNEL-positive myocytes were less frequently observed in the I/R-AM group than in the I/R-placebo group (Figure 3). Although a typical DNA ladder indicating fragmented DNA in cardiomyocytes was also observed in the I/R-placebo group, it was attenuated in the I/R-AM group (Figure 4). Quantitative analyses demonstrated that the number of TUNEL-positive cardiomyocytes was significantly smaller in the I/R-AM group than in the I/R-placebo group (9±4%...
versus 19±2%, P<0.05; Figure 5). Furthermore, pretreatment with wortmannin abolished the AM-induced antiapoptotic effect in cardiomyocytes (from 9±4% to 20±1%, P<0.05; Figure 5). These results suggest that AM exerted antiapoptotic effects through the PI3K-dependent signal.

Akt Phosphorylation Induced by AM Infusion in Cardiac Tissue

Immunohistochemical analysis revealed that CRLR, a receptor for AM, was localized in cardiomyocytes and vascular endothelial cells (Figure 6). After 60-minute infusion of AM, Akt phosphorylation was detected in the nuclei of cardiomyocytes and vascular endothelial cells (Figures 7A and 7B). Western blot analyses also revealed that AM at 0.05 μg · kg⁻¹ · min⁻¹ significantly phosphorylated Akt in cardiac tissue that was exposed to ischemia/reperfusion (Figure 7C). The effect of AM on Akt was inhibited by pretreatment with wortmannin. These results suggest that AM acts directly on myocardium and induces cardioprotective effects through the activation of PI3K/Akt-pathway.
In the present study, we demonstrated that short-term infusion of AM during the early phase of ischemia/reperfusion significantly reduced myocardial infarct size and inhibited myocyte apoptosis, and AM significantly decreased LVEDP and tended to improve LV dP/dt max and dP/dt min. We also demonstrated that AM enhanced Akt phosphorylation in cardiac tissue and that pretreatment with a PI3K inhibitor attenuated AM-induced cardioprotective effects against ischemia/reperfusion and inhibited AM-induced Akt phosphorylation.

Intravenous infusion of AM has beneficial hemodynamic and renal effects in patients with heart failure. However, whether AM has direct cardioprotective effects in vivo remains unclear. In the present study, we demonstrated that short-term infusion of AM during the early phase of ischemia/reperfusion markedly reduced myocardial infarct size.

Cardiomyocyte apoptosis is one of the major contributors to the development of myocardial infarcts, which is related to the pathogenesis of heart failure. We examined whether AM has antiapoptotic effects in cardiomyocytes. Interestingly, short-term infusion of AM significantly reduced myocyte apoptosis after ischemia/reperfusion. This is the first study to demonstrate antiapoptotic effects of AM against myocardial ischemia/reperfusion injury, although AM has been shown to have antiapoptotic effects in vascular endothelial cells. Given that cardiomyocyte apoptosis rather than necrosis contributes to myocyte death after ischemia/reperfusion, the antiapoptotic effects of AM may result in the reduced infarct size after ischemia/reperfusion.

In the present study, 60-minute infusion of AM improved cardiac function after ischemia/reperfusion, as indicated by a significant decrease in LVEDP and a tendency for an increase in LV dP/dt max and a decrease in LV dP/dt min. Previous studies have shown that the susceptibility to cardiac dysfunction...
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Figure 7. A and B, Immunohistochemistry for Akt phosphorylation in rat cardiac tissue. Infusion of AM (0.05 μg · kg⁻¹ · min⁻¹) phosphorylated Akt predominantly in nuclei of cardiomyocytes (A, B) and vascular endothelial cells (B). Arrow indicates nuclei of cardiomyocytes with positive staining for P-Akt antibody. Arrowhead indicates nuclei of endothelium with positive staining for P-Akt antibody. Original magnification ×400. Bar=20 μm. C, Western blot analysis of AM-induced Akt phosphorylation in cardiac tissues. Infusion of AM (0.05 μg · kg⁻¹ · min⁻¹) activated Akt in myocardial tissues exposed to ischemia/reperfusion. Pretreatment with wortmannin significantly inhibited AM-induced Akt phosphorylation. P-Akt indicates phosphorylated Akt; Wo, wortmannin. Data are mean±SEM. *P<0.05 vs placebo.

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References


Conclusions

Short-term infusion of AM significantly attenuated myocardial ischemia/reperfusion injury. These cardioprotective effects were attributed mainly to the antiapoptotic effects of AM via a PI3K/Akt-dependent pathway.

Preclinical studies have demonstrated that a variety of antioxidative or antiapoptotic agents reduce myocardial infarct size after ischemia/reperfusion. However, few agents are clinically available for patients with coronary artery disease. In contrast, the safety and hemodynamic benefits of short-term treatment with intravenous AM (0.05 μg · kg⁻¹ · min⁻¹) have been demonstrated in patients with heart failure and patients with myocardial infarction. Given the results of the present study, a prospective, randomized, placebo-controlled clinical trial should be planned.

Depends on the degree of myocard apoptosis within 24 hours after ischemia/reperfusion. Thus, the early prevention of myocard apoptosis and the resultant reduced infarct size by AM may contribute to the hemodynamic improvement after ischemia/reperfusion. AM infusion reduced right ventricular systolic pressure, which may be attributable not only to the potent vasodilatory effects of AM but also to improvement in cardiac function.

Recently, Akt activation has been shown to reduce myocard apoptosis and thereby prevent myocardial injury after transient ischemia. Akt is the downstream effector molecule for signal transduction initiated by cardioprotective hormones such as insulin-like growth factor I. Thus, Akt is considered to be a powerful survival signal in myocytes. More recently, AM has been shown to activate the PI3K/Akt-pathway in vascular endothelial cells. However, localization of AM-specific receptors in cardiac tissue had been unknown. The present study demonstrated that CRLR was present in rat cardiomyocytes and vascular endothelial cells and that AM infusion accelerated Akt phosphorylation in nuclei of cardiomyocytes and vascular endothelial cells. Furthermore, Western blot analyses demonstrated that AM 0.05 μg · kg⁻¹ · min⁻¹ significantly increased phosphorylated Akt in cardiac tissue compared with placebo treatment and that pretreatment with wortmannin significantly inhibited Akt phosphorylation. Interestingly, pretreatment with wortmannin attenuated the AM-induced beneficial effects, such as reduction of infarct size, hemodynamic improvements, and inhibition of apoptosis. These findings suggest that AM infusion directly induces cardioprotective effects through the PI3K/Akt-dependent pathway.

In the present study, plasma AM level during infusion was much higher than baseline plasma level in rats, plasma level in normal human subjects (~10 fmol/mL), and plasma level in patients with acute myocardial infarction (~14 fmol/mL). These findings suggest that exogenously administered AM functions at pharmacological levels.


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