Heart Failure

Cardiac S100A1 Protein Levels Determine Contractile Performance and Propensity Toward Heart Failure After Myocardial Infarction

Patrick Most, MD; Hanna Seifert, MD; Erhe Gao, MD, PhD; Hajime Funakoshi, MD, PhD; Mirko Völkers, MD; Jörg Heierhorst, MD; Andrew Remppis, MD; Sven T. Pleger, MD; Brent R. DeGeorge, Jr, BS; Andrea D. Eckhart, PhD; Arthur M. Feldman, MD, PhD; Walter J. Koch, PhD

Background—Diminished cardiac S100A1 protein levels are characteristic of ischemic and dilated human cardiomyopathy. Because S100A1 has recently been identified as a Ca²⁺-dependent inotropic factor in the heart, this study sought to explore the pathophysiological relevance of S100A1 levels in development and progression of postischemic heart failure (HF).

Methods and Results—S100A1-transgenic (STG) and S100A1-knockout (SKO) mice were subjected to myocardial infarction (MI) by surgical left anterior descending coronary artery ligation, and survival, cardiac function, and remodeling were compared with nontransgenic littermate control (NLC) and wild-type (WT) animals up to 4 weeks. Although MI size was similar in all groups, infarcted S100A1-deficient hearts (SKO-MI) responded with acute contractile decompensation and accelerated transition to HF, rapid onset of cardiac remodeling with augmented apoptosis, and excessive mortality. NLC/WT-MI mice, displaying a progressive decrease in cardiac S100A1 expression, showed a later onset of cardiac remodeling and progression to HF. Infarcted S100A1-overexpressing hearts (STG-MI), however, showed preserved global contractile performance, abrogated apoptosis, and prevention from cardiac hypertrophy and HF with superior survival compared with NLC/WT-MI and SKO-MI. Both Gq-protein–dependent signaling and protein kinase C activation resulted in decreased cardiac S100A1 mRNA and protein levels, whereas Gs-protein–related signaling exerted opposite effects on cardiac S100A1 abundance. Mechanistically, sarcoplasmic reticulum Ca²⁺ cycling and β-adrenergic signaling were severely impaired in SKO-MI myocardium but preserved in STG-MI.

Conclusions—Our novel proof-of-concept study provides evidence that downregulation of S100A1 protein critically contributes to contractile dysfunction of the diseased heart, which is potentially responsible for driving the progressive downhill clinical course of patients with HF. (Circulation. 2006;114:1258-1268.)

Key Words: calcium ■ contractility ■ heart failure ■ myocardial infarction

S100A1, a dimeric Ca²⁺-binding protein of the EF-hand type, belongs to the S100 protein family in which members are predominantly expressed in a tissue-specific manner. S100A1, highly prevalent in cardiac and less abundant in skeletal muscle, shows a subcellular location at the sarcoplasmic reticulum (SR), myofilaments, and mitochondria. Like other S100 proteins, S100A1 seems to require a Ca²⁺-dependent conformational change to recognize downstream effectors, thereby eliciting a specific biological response as a Ca²⁺-sensor protein in the heart. We previously identified S100A1 as a crucial regulator of cardiac and skeletal muscle contractile performance exerting a marked positive inotropic effect in vitro and in vivo. In particular, S100A1 increases contractile performance of cardiac and skeletal muscle by enhancing intracellular Ca²⁺ transients through increased excitation-contraction coupling gain.

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This phenotypic change in cardiac muscle is mediated exclusively through improved SR Ca²⁺ cycling because S100A1 affects neither L-type Ca²⁺ channel nor sodium-calcium exchanger activity. Mechanistically, S100A1 interacts both with the SR Ca²⁺-release channel (RyR2) and the SR Ca²⁺ pump (SERCA2) in a Ca²⁺-dependent manner, resulting in enhanced Ca²⁺-induced SR Ca²⁺ release and SR Ca²⁺ reuptake, respectively. In addition, S100A1 can decrease the diastolic SR Ca²⁺ leak through attenuated Ca²⁺ spark frequency, suggesting a biphasic Ca²⁺-dependent mod-

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From the Center for Translational Medicine, George Zallie and Family Laboratory for Cardiovascular Gene Therapy, Department of Medicine, Thomas Jefferson University, Philadelphia, Pa (P.M., E.G., H.F., S.T.P., B.D., A.D.E., A.M.F., W.J.K.); Department of Internal Medicine III, Laboratory for Cardiac Stem Cell and Gene Therapy, Division of Cardiology, University of Heidelberg, Heidelberg, Germany (P.M., H.S., M.V., A.R., S.T.P.); and St Vincent’s Institute of Medical Research, Department of Medicine, University of Melbourne, Fitzroy, Victoria, Australia (J.H.).

The online-only Data Supplement is available with this article at http://circ.ahajournals.org/cgi/content/full/CIRCULATIONAHA.106.622415/DC1. Correspondence to Patrick Most, MD, and Walter J. Koch, PhD, Center for Translational Medicine, Department of Medicine, Thomas Jefferson University, Philadelphia, PA 19107. E-mail patrick.most@jefferson.edu and walter.koch@jefferson.edu

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ulation of the RyR2 through interaction with S100A1. In addition to regulating SR function, S100A1 has been shown to modulate Ca$^{2+}$ responsiveness and passive tension development of cardiac myofilaments via a Ca$^{2+}$-dependent interaction with cardiac titin.

In terms of clinical application, the therapeutic potential of S100A1 has become apparent because failing human myocardium displays a marked loss of S100A1 expression at both the transcriptional and translational levels. However, signaling pathways involved in S100A1 downregulation have not yet been elucidated. Recently, we provided the first evidence for the therapeutic effectiveness of viral-based S100A1 gene transfer in an experimental heart failure (HF) model. Intracoronary adenoviral S100A1 gene delivery restored diminished S100A1 protein levels and dysfunctional SR Ca$^{2+}$ cycling that, in turn, rescued contractile function and reversed remodeling of failing myocardium. However, the favorable therapeutic effect of cardiac S100A1 gene delivery is not confined to the chronically failing heart but is also effective in a setting of acute myocardial infarction (MI), in which intracoronary adenoviral S100A1 gene delivery prevented acute post-MI contractile dysfunction and remodeling in experimental MI as a result of the preservation of intracellular Ca$^{2+}$ homeostasis. These studies demonstrate S100A1 gene delivery as a potential clinically powerful and novel therapeutic strategy to treat both the acute and chronically failing heart.

Despite the loss of S100A1 expression in end-stage failing human hearts, the pathophysiological contribution of decreased cardiac S100A1 expression for the development and progression of HF per se has not yet been examined. In the present study, we addressed this issue in a clinically relevant setting. S100A1-transgenic (STG) and S100A1-knockout (SKO) mice displaying a cardiac-specific S100A1 protein overexpression and deficiency, respectively, were subjected to MI, and the course of post-MI remodeling, cardiac failure, and molecular alterations was comprehensively studied in vitro and in vivo. We found a significant disparity in the post-MI phenotype in SKO versus STG mice. Our results clearly show that levels of cardiac S100A1 play a critical role in post-MI HF and provide novel evidence that downregulation of this Ca$^{2+}$ sensor aggravates contractile dysfunction of the compromised heart and potentially contributes to the steady downhill clinical course in HF patients. However, prevention of this S100A1 loss confers protection from post-MI remodeling and HF.

**Methods**

The generation of the SKO and STG mouse lines was previously described. The experimental procedures for left coronary artery ligation, assessment of infarct size and survival, and echocardiographic and hemodynamic analysis of cardiac function are described in the expanded Methods section in the online-only Data Supplement. Detailed procedures for assessment of myocardial histopathology and apoptosis, $\beta$-adrenergic receptor density and adenyl cyclase activity, calcium measurements, quantitative real-time polymerase chain reaction, Western blot analysis, and isolation and culture of rat neonatal ventricular cardiomyocytes (NVCMS) are available in the expanded online-only Data Supplement. Data are generally expressed as mean±SEM. An unpaired 2-tailed Student $t$ test and 2-way repeated ANOVA were performed for between-group comparisons. Survival analysis was performed by the Kaplan-Meier method, and between-group differences in survival were tested by the log-rank test. For all tests, a probability value $<0.05$ was considered significant. The authors had full access to the data and take full responsibility for its integrity. All authors have read and agree to the manuscript as written.

**Results**

**S100A1 Prevents Development of Postischemic Heart Failure**

Serial echocardiography and LV catheterization were performed to assess the contribution of different cardiac S100A1 protein levels on contractile performance after MI. Figure 2A and 2B provide representative original tracings of M-mode echocardiography and invasive hemodynamics 7 days after MI in all groups compared with sham NLC/WT. Ischemic injury provoked an acute and progressive decrease of systolic contractile function in NLC/WT-MI hearts, as evidenced by impaired fractional shortening (Figure 2C) and $dP/dt_{\text{min}}$ (Figure 2D). Corresponding alterations were found for $dP/dt_{\text{max}}$ (data not shown) and LV end-diastolic pressure (LVEDP) (Figure 2E). Concomitantly, expression levels of S100A1 protein in remote NLC/WT-MI myocardium continuously declined to 35% of levels found in sham hearts (Figure 2F and 2G) (0.07±0.01 versus 0.21±0.02 ng S100A1 protein/µg myocardial protein; $P<0.05$; n=6; Figure II in the online-only Data Supplement). In contrast, STG-MI hearts displaying persistently elevated S100A1 protein levels (0.72±0.03 ng S100A1 protein/µg myocardial protein) (Figure 2F and 2G and Figure II in the online-only Data Supplement) exerted only an acute reduction in contractile performance in response to MI, with further preservation of systolic and diastolic cardiac function at the level of sham-NLC/WT hearts (Figure 2C to 2E). However, SKO-MI hearts, lacking S100A1 protein (Figure 2F), responded with acute cardiac decompensation and accelerated transition to HF (Figure 2C to 2E) during the study period.

**Gq-Protein–Coupled Receptor Agonists Involving Protein Kinase C Downregulate Cardiac S100A1 mRNA and Protein Expression**

To delineate pathways causing loss of myocardial S100A1 expression in the course of post-MI HF, NVCMS were subjected to prohypertrophic Gq-protein–coupled receptor
agonists such as endothelin-1 (ET-1) and phenylephrine. As previously described, both Gq-protein–coupled receptor agonists exerted a significant time- and dose-dependent upregulation and downregulation of ANP and SERCA2a mRNA levels, respectively (data not shown). Stimulation of NVCMS with ET-1 and phenylephrine resulted in a dose- and time-dependent decrease of S100A1 mRNA levels to 30% to 40% compared with levels seen in control cells (Figure 3A, 3B, 3D, and 3E). These transcriptional alterations were translated into a significant \( \approx \)2-fold reduction of S100A1 protein levels compared with untreated NVCMs (Figure 3C and 3F).

Because protein kinase C (PKC) is known to play a crucial role in Gq-protein–coupled receptor–dependent hypertrophic signaling, NVCMs were subjected to phorbol 12-myristate 13-acetate (PMA) to assess the impact of activated PKC on S100A1 transcription and translation. PMA caused a significantly stronger dose- and time-dependent decline in S100A1 mRNA expression than Gq-protein–coupled receptor agonists (Figure 3G and 3H) that was translated into a significant \( \approx \)2-fold reduction of S100A1 protein levels (Figure 3I).
NLC/WT-MI hearts (Figure 5D and Figure IV in the online-only Data Supplement). Finally, we investigated the activation of mitogen-activated protein kinase (MAPK; p44/42) and stress-activated protein kinase (SAPK; p38, p54/46) signaling modules in STG-MI hearts. Compared with NLC/WT-MI, phosphorylation status of p44/42, p38 as well as p54/46 was blunted in STG-MI remote myocardium (Figure 5E and 5F). In contrast, significantly augmented phosphorylation of both MAPK and SAPK was evident in SKO-MI myocardium compared with both NLC/WT-MI and STG-MI (Figure 5E and 5F).

S100A1 Inhibits Postischemic β-Adrenergic Signaling Defects

SKO-MI hearts displayed an accelerated decrease in β-adrenergic receptor density (Figure 6A) and elevated GRK2 protein levels 7 days after MI (Figure 6B) compared with NLC/WT-MI hearts that showed similar alterations 28 days after MI (Figure 6A and 6B). Impaired cAMP formation in response to isoproterenol confirmed severe uncoupling of β-adrenergic receptor signaling in remodeled SKO-MI hearts (Figure 6C). In contrast, remote STG-MI myocardium neither exerted a significant suppression of β-adrenergic receptor density (Figure 6A) nor increased GRK2 levels (Figure 6B) during the study period, and this was associated with normal cAMP production (Figure 6C). In accord with accelerated in vitro alterations of β-adrenergic receptor signaling, SKO-MI hearts showed impaired in vivo contractile β-adrenergic receptor responsiveness (Figure 6D). Moreover, the phosphorylation state of phospholamban at ser-16 7 days after MI was impaired in SKO-MI hearts (Figure 7A). Similar but less pronounced alterations were evident in NLC/WT-MI hearts (Figures 6D and 7A).
In contrast, STG-MI hearts exerted a robust in vivo responsiveness to the \(\alpha\)-adrenergic receptor agonist isoproterenol (Figure 6D), accompanied by a normal-like increase in phospholamban ser-16 phosphorylation (Figure 7A).

**S100A1 Preserves SR Ca\(^{2+}\) Cycling After MI**

SERCA2 protein levels were found to be significantly decreased 4 weeks after MI in failing NLC/WT-MI hearts (Figure 7B). Importantly, accelerated transition to HF was associated with an earlier decline of SERCA2 expression in SKO-MI hearts (Figure 7B). STG-MI remote myocardium, however, showed preserved SERCA2 expression up to 4 weeks after MI (Figure 7B). Like decreased abundance, enhanced nitration of SERCA2a has recently been reported to play a role in SR function and hence contractile performance in failing human myocardium.\(^{17}\) We found a significantly higher level of SERCA2 nitration in SKO-MI than NLC/WT-MI compared with sham NLC/WT and SKO myocardium 28 days after MI (Figure 7C). In contrast, STG-MI myocardium showed only a small increase in SERCA2 nitration (Figure 7C).

To investigate the functional consequences of altered SERCA2 abundance and nitration, we assessed Ca\(^{2+}\) uptake in SR microsomes derived from remote myocardium of infarcted and sham hearts. STG hearts displayed a significantly higher Ca\(^{2+}\) uptake than NLC/WT and SKO myocardium (Figure 8A and 8B). In contrast, SR vesicles from failing NLC/WT-MI exerted a significant reduction in Ca\(^{2+}\) uptake that was more pronounced in failing SKO-MI (Figure 8A and 8B).
8A and 8B). Subsequent analysis of SR Ca$^{2+}$/H$_{11001}$ leak revealed a significant increase in Ca$^{2+}$/H$_{11001}$ leakage in SR microsomes derived from failing NLC/WT-MI, and this defect was significantly more pronounced in SKO-MI myocardium (Figure 8C and 8D). Likewise, in Ca$^{2+}$/H$_{11001}$ uptake, the gain in caffeine-induced SR Ca$^{2+}$ release was nearly preserved in SR vesicles from STG-MI (Figure 8E and 8F). However, the decrease of SR Ca$^{2+}$/H$_{11001}$ release was more pronounced in failing SKO-MI than in NLC/WT-MI myocardium (Figure 8E and 8F).

**Discussion**

The phenotype of S100A1-transgenic and S100A1-null mice reported here demonstrates that S100A1, although dispensable for cardiac muscle development and function under basal conditions, is a critical factor required for the compromised heart to functionally adapt to increased mechanical workload under pathophysiological conditions. Notably, the absence of S100A1 significantly accelerates the development of contractile dysfunction after MI with a rapid onset of cardiac remodeling and transition to HF combined with excessive mortality. Conversely, increased cardiac S100A1 expression effectively preserves global contractile performance even in the face of a significant LV infarct and protects the heart from maladaptive hypertrophy and HF with superior survival. Thus, our study clearly provides proof of principle for the essential pathophysiological relevance of altered cardiac S100A1 expression in the course of HF per se.

Because we have previously shown that S100A1 evokes a Ca$^{2+}$/H$_{9252}$-dependent positive inotropic pathway, our data suggest that the hypercontractile remote myocardium in STG-MI hearts can functionally compensate for the loss of viable myocardium, thereby enabling even the damaged heart to successfully cope with chronically elevated hemodynamic stress. Subsequently, a preserved normal-like systolic and diastolic contractile function of STG-MI hearts seems to mechanistically prevent injurious signaling from both biomechanical overload and maladaptive hyperadrenergic activation. That, in turn, apparently eliminates the most important triggers causing cardiac remodeling. This conclusion is further corroborated by the finding that STG-MI remote myocardium exhibited neither relevant molecular β-adrenergic receptor signaling defects nor impaired β-adrenergic receptor responsiveness in vivo and showed nearly preserved diastolic functional parameters, indicating unaltered cardiac preload. In accord with this salient feature, we have previously provided evidence for ameliorated

![Figure 4](https://example.com/figure4.png)

**Figure 4.** Impact of cardiac S100A1 protein levels on postischemic reactivation of fetal and extracellular matrix gene expression. A through F, Quantitative analysis of atrial natriuretic peptide (ANP), brain natriuretic peptide (BNP), α-myosin heavy chain (α-MHC), β-myosin heavy chain (β-MHC), transforming growth factor-β1 (TGF-β1), and collagen-1 mRNA expression in remote myocardium from sham and infarcted hearts 7 and 28 days after MI. Unchanged 18s rRNA and CSQ mRNA were used for normalization. *P<0.05 vs sham NLC/WT; †P<0.05 vs NLC/WT-MI; n=5 in each group.
β-adrenergic receptor desensitization in failing and acutely infarcted myocardium through viral-based cardiac S100A1 gene therapy in vivo. Although it is unknown whether S100A1 directly interferes with components of the hypertrophic signaling machinery, our study provides novel evidence for S100A1-mediated abrogation of GRK2 upregulation that might inhibit β-arrestin–dependent MAPK and SAPK prohypertrophic signaling in remote post-MI myocardium. Moreover, the finding that GRK2 upregulation is enhanced in the more rapidly deteriorating SKO-MI hearts is consistent with our previous findings that GRK2 is associated with early HF progression in other mouse models. This is in addition to a reversal of the fetal gene program, which has previously been observed with S100A1 overexpression in myocytes and is in agreement with previous reports showing reverse remodeling of failing and infarcted myocardium in vivo after adenoviral S100A1 gene transfer.

Similarly, apoptosis, thought to contribute to the progressive deterioration of contractile function through “dropout” of cardiomyocytes, was minimized in STG-MI remote myocardium. Several previously reported mechanisms might contribute at least in part to this effect. First, extracellular S100A1 protein has recently been shown to exert direct antiapoptotic actions at cardiomyocytes in vitro. Second, STG-MI remote myocardium exerts no induction of S100B protein expression (data not shown), which extracellular release from myocardium has recently been shown to exhibit potent proapoptotic actions on cardiomyocytes. Finally, S100A1-mediated prevention of increased wall stress, commonly known as a potent trigger for apoptosis, might indirectly contribute to the prosurvival effects on myocardium. In contrast to the favorable effects seen in STG-MI myocardium, lack of cardiac S100A1 expression immediately disabled the infarcted heart to functionally adapt to increased biomechanical stress, resulting in an accelerated onset of cardiac hypertrophy and reactivation of a fetal gene program. Importantly, these striking results are in agreement with a previous report showing immediate contractile failure but unaltered cardiac hypertrophy in SKO mice subjected to transaortic constriction.
were observed in infarcted control mice that displayed a progressive downregulation of S100A1 protein even in the stage of LV hypertrophy. SKO-MI hearts, however, immediately evolved to overt contractile failure, indicating that even lower S100A1 levels seen in post-MI NLC hearts can be beneficial compared with a lack of expression.

Because SKO mice have normal cardiac function at rest but impaired cardiac reserve in response to both β-adrenergic receptor stimulation and incremental extracellular Ca²⁺ concentration, this finding strongly supports the notion of a fundamental downstream defect in SKO hearts. Accordingly, isolated ventricular cardiomyocytes derived from control SKO hearts displayed nearly normal Ca²⁺ cycling under basal conditions but blunted cytosolic Ca²⁺ transients in response to enhanced transsarcolemmal Ca²⁺ influx and β-adrenergic receptor stimulation in vitro (data not shown). Thus, the defective in vivo “flight-or-fight” response characteristic for SKO myocardium might apparently rely on inadequate mobilization of intracellular Ca²⁺ cycling disabling SKO-MI from the first to adequately compensate for the loss of myocardium even in response to concentrated β-adrenergic receptor stimulation. In turn, absence of S100A1 promoted an earlier onset of β-adrenergic receptor dysfunction than in infarcted control mice that had residual S100A1 expression. Hence, the immediate failure of functional compensation in STG-MI hearts resulted in accelerated hyperadrenergic activation and excessive mechanical overload, promoting the seamless transition from hypertrophy to cardiac dilation and failure.

In accord with clinical results, the accelerated kinetics of this sequence in SKO-MI mice resulted in excessive mortality, confirming cardiac hypertrophy as a major predictor for HF and sudden death. In contrast, favorable hemodynamic effects in STG-MI were translated into superior survival. This is important to note because other strategies targeting SR Ca²⁺ cycling, eg, by means of SERCA2 gene addition, can result in impaired survival in response to ischemic cardiac injury. Thus, under clinical conditions, application of a therapeutic target like S100A1 that seems to modulate cardiac excitation-contraction coupling through gene transfer might be a superior approach even in response to repetitive ischemic periods.

Because altered intracellular Ca²⁺ cycling plays a key role in the development of HF, we analyzed both abundance and function of major SR Ca²⁺ cycling proteins as a surrogate for altered cardiac intracellular Ca²⁺ handling. STG-MI remote myocardium displayed preserved supranormal SR function that might account in part for the prolonged resistance to increased hemodynamic workload. These results are supported by our previous data showing rescued intracellular Ca²⁺ turnover and SR Ca²⁺ handling in failing myocardium through intracoronary S100A1 adenoviral gene transfer.

Figure 6. Effect of different cardiac S100A1 protein levels on postischemic β-adrenergic receptor (βAR) signaling. A, Cardiac β-adrenergic receptor density 7 days after MI in sham and infarcted NLC/WT, STG, and SKO hearts. B, Representative serial GRK2 Western blot and densitometric quantitative analysis of the GRK2/CSQ ratio in sham and infarcted NLC/WT, STG, and SKO mice. Densitometric values are given as arbitrary units (n = 5 in each group). C, Adenylyl cyclase activity 7 days after MI in membrane fractions obtained from sham and infarcted hearts under basal conditions and in response to isoproterenol (Iso) (n = 5 in each group). D, Inotropic reserve of NLC/WT-MI, STG-MI, and SKO-MI in response to β-adrenergic receptor stimulation 7 days after MI by the change in dP/dtmax to increasing dosages of isoproterenol (n = 8 in each group). *P < 0.05 vs sham NLC/WT; †P < 0.05 vs NLC/WT-MI.
Moreover, protection from enhanced SR Ca\(^{2+}\)/H11001 leak in STG-MI myocardium might be explained by a recent finding showing that S100A1 protein can decrease Ca\(^{2+}\)/H11001 spark activity in ventricular cardiomyocytes under diastolic conditions.\(^1\) In contrast, failing SKO hearts exhibited severely disturbed SR Ca\(^{2+}\)/H11001 fluxes. On a molecular level, we also observed an earlier downregulation of SERCA2 expression accompanied by increased nitration of the SR Ca\(^{2+}\)/H11001 pump in failing SKO-MI myocardium. Several mechanisms might contribute at least in part to these deleterious defects. First, hemodynamic overload and pronounced hyperadrenergic activation most likely contribute to the accelerated decline of SERCA2 protein in failing SKO-MI hearts. Second, increased susceptibility of SERCA2 to nitrosative stress could also depend, at least in part, on the lack of cardiac S100A1 expression because S100A1, capable of interacting with the SR Ca\(^{2+}\)/H11001 pump in a Ca\(^{2+}\)/H11001-dependent manner, has recently been shown to efficiently act as a Ca\(^{2+}\)/H11001-dependent NO acceptor and scavenger, respectively.\(^2\) Finally, because S100A1 has been reported to stimulate SERCA2-mediated SR Ca\(^{2+}\)/H11001 uptake,\(^3\) the simple absence of the activator might contribute to decreased SR Ca\(^{2+}\)/H11001 uptake. Similar but less pronounced alterations were observed in infarcted control myocardium showing a persistent but progressive downregulation of S100A1 protein. In contrast, enhanced cardiac S100A1 protein levels might prevent these mechanistic alterations, and this is important to note because even small alterations of SERCA2 can alter SR Ca\(^{2+}\)/H11001 loading, which in turn impairs myocardial function.\(^4\) Furthermore, the preserved contractile function in STG-MI hearts was mirrored by unaltered phospholamban–serine 16 phosphorylation, indicating that preserved in vivo \(\beta\)-adrenergic receptor–mediated inotropy partially relies on adequate diastolic SR Ca\(^{2+}\)/H11001 refilling and systolic Ca\(^{2+}\)/H11001 mobilization. SKO-MI hearts, however, exhibited an accelerated decrease in phospholamban phosphorylation and enhanced expression of GRK2 indicative of pronounced desensitized \(\beta\)-adrenergic receptor downstream signaling compared with infarcted control hearts.\(^5\) Thus, our results strongly support the notion that preserved supranormal SR Ca\(^{2+}\)/H11001 fluxes in STG-MI myocardium likely reflect an intact intracellular cardiac Ca\(^{2+}\)/H11001 homeostasis of remote myocardium causative for preserved global contractile function.

Finally, we identified for the first time clinically relevant prohypertrophic neurohumoral signaling components conveying downregulation of cardiac S100A1 expression levels in vitro. Both Gq-protein–coupled receptor agonists as well as PKC activation seem to be sufficient to cause diminished S100A1 abundance, as seen in failing human myocardium. This is important to note because inhibition of Gq-dependent signaling clinically (eg, through ACE inhibitors) not only may reverse cardiac hypertrophy but also may prevent downregulation of cardiac S100A1 expression. Of note, we have previously shown that selective inhibition of Gq activation in the cardiac myocyte not only prevents pressure-overload ventricular hypertrophy\(^6\) but also prevents maladaptive hy-
pertrophy and cardiac dysfunction chronically. On the basis of our present findings, a contributing mechanism for the positive effects on the stressed heart after Gq inhibition in addition to blunted MAPK and deleterious signaling may be the preservation of S100A1 expression, which would preserve Ca\(^{2+}\) handling and contractile function in the postischemic heart. Eventually, intact cAMP-dependent downstream signaling might contribute to this effect because Gs-protein-coupled receptor and adenylyl cyclase agonists resulted in augmented cardiac S100A1 mRNA and protein levels. Further studies are warranted to delineate the molecular mechanism and physiological significance of in vitro reciprocal Gs- and Gq-dependent regulation of cardiac S100A1 expression.

In summary, by taking advantage of 2 different genetically manipulated mouse models with reciprocal cardiac S100A1 protein levels, our study provides unequivocal evidence for S100A1 as an indispensable regulator of the diseased heart to functionally adapt to pathophysiological stress in the course of post-MI HF. Given the fact that the search for crucial molecular mechanisms involved in the pathogenesis of HF is a current challenge of cardiovascular biology, our results further support the notion that alternative positive inotropic strategies such as S100A1, as it transitions from bench to bedside, might add a promising novel target to the therapeutic armamentarium to prevent development and progression of HF or to restore contractile performance of failing myocardium.

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**Disclosures**

None.

**References**


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**Figure 8.** Impact of different cardiac S100A1 protein levels on postischemic SR Ca\(^{2+}\) fluxes. A through F, Representative original tracings and quantitative analysis of microsomal SR Ca\(^{2+}\) uptake (A and B), Ca\(^{2+}\) leak (C and D), and caffeine-induced Ca\(^{2+}\) release (E and F) in sham and infarcted (MI) NLC/WT, STG, and SKO hearts (n=5 in each group). Changes (n-fold) were normalized to sham-NLC/WT. Arrowheads indicate the addition of ATP (0.5 mmol/L) (A), thapsigargin (TG) (1 \(\mu\)mol/L) (C), and caffeine (Caff.) (5 mmol/L) (E). *P<0.05 vs sham NLC/WT; †P<0.05 vs NLC/WT-MI.


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