High-Density Lipoproteins and Their Constituent, Sphingosine-1-Phosphate, Directly Protect the Heart Against Ischemia/Reperfusion Injury In Vivo via the S1P3 Lysophospholipid Receptor

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Background—All treatments of acute myocardial infarction are aimed at rapid revascularization of the occluded vessel; however, no clinical strategies are currently available to protect the heart from ischemia/reperfusion injury after restitution of blood flow. We hypothesized that some of the cholesterol transport–independent biological properties of high-density lipoprotein (HDL) implied in atheroprotection may also be beneficial in settings of acute myocardial reperfusion injury.

Methods and Results—In an in vivo mouse model of myocardial ischemia/reperfusion, we observed that HDL and its sphingolipid component, sphingosine-1-phosphate (S1P), dramatically attenuated infarction size by 20% and 40%, respectively. The underlying mechanism was an inhibition of inflammatory neutrophil recruitment and cardiomyocyte apoptosis in the infarcted area. In vitro, HDL and S1P potently suppressed leukocyte adhesion to activated endothelium under flow and protected rat neonatal cardiomyocytes against apoptosis. In vivo, HDL- and S1P-mediated cardioprotection was dependent on nitric oxide (NO) and the S1P3 lysophospholipid receptor, because it was abolished by pharmacological NO synthase inhibition and was completely absent in S1P3-deficient mice.

Conclusions—Our data demonstrate that HDL and its constituent, S1P, acutely protect the heart against ischemia/reperfusion injury in vivo via an S1P3-mediated and NO-dependent pathway. A rapid therapeutic elevation of S1P-containing HDL plasma levels may be beneficial in patients at high risk of acute myocardial ischemia. (Circulation. 2006;114:1403-1409.)

Key Words: lipoproteins ■ inflammation ■ apoptosis ■ endothelium ■ sphingolipids ■ microcirculation ■ reperfusion

The main therapeutic goals in patients with acute myocardial infarction are to minimize myocardial damage, improve cardiac repair, and reduce myocardial remodeling. State-of-the-art therapy is rapid reperfusion of the infarcted myocardium through revascularization of the occluded vessel. However, the benefit of reperfusion is compromised by the endothelial injury and inflammation that follow reinstitution of blood flow, leading to additional myocardial damage, a process termed “ischemia/reperfusion injury.” Despite all efforts to prevent the sequelae of reperfusion injury in patients,1 there are currently no clinical strategies available to effectively protect cardiac tissue from the inflammatory damage inherent to reperfusion.2 High-density lipoproteins (HDLs) are the most powerful independent negative predictor of cardiovascular events evident in all large prospective epidemiological studies.3,4 Clinical trials designed to elevate HDL levels have shown that with each increment of 1 mg/dL in HDL cholesterol (HDL-
C), the risk for complications of coronary heart disease decreased by 2% to 3%. The long-term beneficial effect of HDL has been largely attributed to their key role in reverse cholesterol transport that leads to lipid unloading of the plaque. However, short-term HDL elevation has also been shown to be beneficial: In patients with acute coronary syndromes, each 1-mg/dL increment of HDL-C during the course of a 16-week treatment with atorvastatin resulted in a 1.4% risk reduction for recurrent adverse events. Because of such short-term beneficial effects, the potent antioxidative, antiinflammatory, and vasodilatory properties of HDL have been implicated in the stabilization of vulnerable coronary lesions. We hypothesized that in addition to atheroprotection, such properties may be also beneficial for the coronary microcirculation in settings of myocardial reperfusion injury. Direct effects of HDL on posts ischemic myocardium in vivo have not yet been reported.

The constituents of the HDL particle that mediate its diverse biological effects are still under investigation. Recently, we and others have identified several sphingolipids, such as sphingosine-1-phosphate (SIP), as constituents of human HDL and have found them responsible for part of the nitric oxide (NO)–mediated vasodilatory effect of HDL. Acute administration of recombinant HDL has been shown to normalize the endothelial dysfunction of hypercholesterolemic patients and individuals heterozygous for ABC1 in an NO-dependent manner. Because NO is also a crucial player in myocardial ischemia/reperfusion injury, we hypothesized that HDL in general and its SIP content in particular may have a beneficial effect on myocardial damage after ischemia/reperfusion.

Methods

Materials

HDL (d=1.125 to 1.210 g/mL) and low-density lipoprotein (LDL; d=1.019 to 1.069 g/mL) were isolated from human plasma as described previously and administered intravenously to mice bred in the central animal facility of the University Hospital Münster in 100 μL of 0.9% saline per 10 g of body weight. SIP (Sigma, Taufkirchen, Germany) from methanol stocks was air-dried and dissolved in phosphate-buffered saline/1% bovine serum albumin (PBS; Life Technologies, Gardena, Calif) from methanol stocks was air-dried and dissolved in phosphate-buffered saline/1% bovine serum albumin (PBS; Life Technologies, Gardena, Calif) and administered intravenously in 100 μL/10 g. N^3-nitro-l-arginine methyl ester (L-NAME) administration (1.5 mg/mL drinking water) was initiated 21 days before ischemia and continued until the end of the reperfusion. Mortality due to the ischemia/reperfusion procedure was not different among treatments.

Myocardial Ischemia/Reperfusion in Mice

HDL and SIP treatments were assessed in an outbred Swiss strain of mice. All studies were repeated in the C57Bl6 background of the SIP,+/− mice to ensure strain independence of the effects. A total of 74 Swiss, 23 C57Bl6/N, and 19 SIP,+/− mice grouped in age- and sex-matched clusters of the different treatment modalities were used for infarct-size measurements. For histology, 17 additional Swiss mice were used. Transient myocardial ischemia (30 minutes) followed by 24-hour reperfusion was inflicted with the approval of the Institutional Review Board. Briefly, in barbiturate-anesthetized mice, thoracotomy and ligation of the left anterior descending coronary artery at the level of the left atrium was performed with silk 7-0 sutures tied transiently over PE10 tubing for 30 minutes. The chest was closed, and the animals were weaned from the ventilator. For leukocyte depletion, 2 mg of hydroxy carbamide per gram was administered intraperitoneally 2 days before ligation, with another 1 mg/g given on the following day (Bristol-Myers Squibb, Brussels, Belgium). For infarct-size measurements, animals were reanesthetized and perfused with 0.9% saline through the abdominal aorta.

The coronary ligation was retied, and 2% Coomassie Blue was injected to delineate the area at risk. The heart was sectioned into 5 equal slices and immersed in 2.3,5-triphenyltetrazolium chloride (Sigma, Taufkirchen, Germany) at 37°C for 10 minutes. Left ventricular area, area at risk (AAI), and area of infarction were determined morphometrically as previously published with NIH Image software. In untreated mice, left ventricular cross-sectional area was 13.9±0.7 mm². Ligation resulted in an ischemic area of 7.6±0.5 mm² (n=7), which constituted the AAR, and the infarcted area was 3.4±0.4 mm² (n=7). Treatment with SIP reduced infarct size to 2.9±0.4 mm² (n=8). Neither left ventricular area nor AAR was statistically different between treatment groups. Immunohistochemistry for polymorphonuclear leukocytes was performed with a monoclonal antibody (MCA771G, Serotec, Oxford, England) and terminal dUTP nick end-labeling assays with the ApopTag kit (Chemicon, Temecula, Calif). The number of stained cells was determined semiautomatically on 3 sections per heart with morphometry software (AnalySis, Münster, Germany).

Flow-Chamber Studies and Cardiomyocyte Apoptosis

Endothelial adhesiveness for mouse peritoneal macrophages was determined with a parallel-plate flow-chamber model as described previously. Thioglycolate-elicited peritoneal macrophages were labeled with Cell Tracker Green (Molecular Probes, Leiden, Netherlands) and perfused at 100 s⁻¹ across tumor necrosis factor (TNF)-α–activated immortalized murine endothelial cells (END.5). The number of rolling cells was determined from 3-minute video streams captured on a confocal microscope (UltraView, Perkin Elmer, Jügesheim, Germany). Firm adhesion was quantified on pictures taken from 15 high-power fields after 3 minutes of cell perfusion followed by 3 minutes of buffer wash. Apoptosis of rat neonatal cardiomyocytes was induced by growth factor and glucose deprivation for 4 hours and evaluated by Western blotting for active caspase-3 (Cell Signaling, Frankfurt, Germany) and cleavage of poly–adenosine diphosphate (ADP)–ribose polymerase (Becton Dickinson, Heidelberg, Germany).

Statistical Analysis

Data are presented as mean±SEM. Because of the likely non-Gaussian distribution of the data, a nonparametric Kruskal-Wallis test was performed, followed, if P<0.05, by a Mann-Whitney U test to identify significant differences between groups at P<0.05 (InStat, GraphPad Inc, San Diego, Calif).

The authors had full access to the data and take full responsibility for their integrity. All authors have read and agree to the manuscript as written.

Results

Administration of HDL and SIP Reduces Infarct Size After Myocardial Ischemia/Reperfusion in Mice

To test whether an acute rise in HDL levels may have a beneficial effect on acute myocardial infarction, we intravenously injected HDL in a mouse model of myocardial reperfusion injury (30-minute ischemia/24-hour reperfusion). Intravenous administration of human HDL 100 μg/g body weight 30 minutes before transient coronary artery ligation reduced infarct size by 20±3.2% compared with vehicle-treated controls, whereas HDL 10 μg/g or LDL 100 μg/g had no effect (Figure 1A and 1B). Because sphingolipids contained in HDL account for several of their biological effects, we tested whether SIP had an impact on reperfusion injury. Compared with vehicle control, SIP 19 and 38 ng/g body weight (which corresponds to a final calculated plasma concentration of 1.1 and 2.2 μmol/L, respectively) dose-dependently reduced infarct size by 32±6.5% and 40±2.5%, respectively, whereas 3.8 ng/g was ineffective (Figure 1C).
HDL and S1P Reduce Leukocyte Recruitment in the Infarcted Area and Leukocyte Adhesion to Activated Endothelium Under Flow

HDLs are known to possess potent anti-inflammatory properties. A large part of the myocardial damage we have observed in our reperfusion injury model is due to reperfusion-associated inflammation caused by the recruitment of polymorphonuclear leukocytes (PMNs). Accordingly, induction of panleukopenia by hydroxyurea abolished the typical increase of infarct size between 3 and 24 hours of reperfusion (Figure 2A). To test whether HDL and S1P may protect by inhibiting inflammation, we assessed their impact on PMN recruitment into the infarcted area 24 hours after ischemia/reperfusion. Morphometric quantification revealed that HDL 100 μg/g body weight decreased PMN recruitment to 75% of vehicle-treated controls, and S1P 38 ng/g body weight decreased PMN recruitment to 50% of controls (Figure 2B). To test whether HDL and S1P have an effect on leukocyte adhesion under flow in vitro, we used a parallel-plate flow-chamber model in which murine macrophages were perfused over a confluent monolayer of TNF-α-activated murine endothelial cells. Stimulation with TNF-α (100 ng/mL) increased macrophage firm adhesion by 480% compared with unstimulated endothelial cells (3423 ± 408/mm² versus 713 ± 103/mm², P < 0.001). Cotreatment of endothelial cells with TNF-α and HDL 100 μg/mL or S1P 1 μmol/L for 4 hours reduced macrophage adhesion by 31% and 51%, respectively, compared with TNF-α alone (Figure 2C). Macrophage rolling was not affected, and pretreatment of macrophages with S1P had no effect on adhesion (data not shown).

HDL and S1P Protect Cardiomyocytes Against Apoptosis In Vitro and In Vivo

The damage inflicted by leukocytes during myocardial reperfusion is mediated by the oxidative burst and release of cytotoxic mediators, which leads to both necrosis and apoptosis in cardiomyocytes. Because S1P receptors are present and functional in cardiomyocytes, and both HDL and S1P are potent antiapoptotic signaling mediators in a number of experimental systems, we tested whether they may protect cardiomyocytes against apoptosis. In vivo, HDL-treated mice and S1P-treated mice had 35% and 45% less apoptotic cell death, respectively, in the myocardial infarction area than vehicle-treated controls, as measured by terminal dUTP nick end-labeling staining (Figure 3A). In vitro, HDL 1 mg/mL and S1P 10 μmol/L potently protected rat neonatal cardiomyocytes from apoptosis induced by glucose and growth factor withdrawal, as seen by the inhibition of caspase-3 processing and poly-ADP-ribose polymerase cleavage (Figure 3B). In contrast, the major protein component of HDL, apolipoprotein A1, had no effect (Figure 3B).

HDL- and S1P-Mediated Protection From Reperfusion Injury Depends on NO

NO plays an important role in the protection of the myocardium against ischemia/reperfusion injury. Because both HDL and S1P have been shown to generate NO in endothelial cells, we tested whether the beneficial effects of HDL and S1P on reperfusion injury were due to their ability to generate NO. Treatment of endothelial cells with 10 μmol/L L-NAME completely abolished the antiadhesive effect of HDL and S1P on leukocytes under flow in vitro (Figure 4A). In vivo, L-NAME administration in mice for 21 days before myocardial ischemia/reperfusion completely eliminated the protec-
tion afforded by HDL and S1P, which resulted in infarcts as large as those in untreated mice (Figure 4B).

Protection From Reperfusion Injury by HDL and S1P Is Mediated by the S1P3 Lysophospholipid Receptor

We have previously reported on the requirement of the S1P3 receptor for NO-dependent vasodilation by HDL and S1P.10 Therefore, we tested its role in mediating the protective effect of HDL and S1P on infarct size using S1P3−/− mice. In S1P3−/− mice, neither HDL nor S1P conferred any protection against reperfusion injury compared with the respective wild-type controls (Figure 5).

Discussion

Increasing evidence suggests that HDLs may be atheroprotective through several inherent properties that are separable from and independent of their role in reverse cholesterol transport.8,21 The present study has identified another unique biological property of HDL: the ability to directly protect ischemic myocardium from reperfusion injury in vivo. A recent study has shown improved functional postischemic recovery of isolated rat hearts by HDL and has attributed it to scavenging of myocardially released TNF-α.21 In contrast, we have observed that the protective effect of HDL depended on the S1P3 receptor and was mimicked by exogenous S1P, which suggests that the S1P content of HDL was responsible for cardioprotection. In previous studies, we have shown that this content is sufficient for engaging the S1P3 receptor (287±17 pmol S1P/mg HDL).10

In the present study, blockade of NO generation abolished the beneficial effect of HDL and S1P on reperfusion injury.
NO exerts a plethora of beneficial biological effects in the myocardial microcirculation, and its decreased bioavailability has been implied in all aspects of microcirculatory reperfusion injury: (1) decreased endothelium-dependent vasodilator capacity, (2) no/low-reflow, and (3) increased microvascular permeability. Conversely, NO donors or interventions aimed at increasing NO bioavailability have been shown to attenuate myocardial reperfusion injury in mice, rabbits, and humans by a mechanism related to pharmacological preconditioning. Release of NO and S1P receptor signaling are closely linked: Several groups, including ours, have shown that engagement of S1P receptors including S1P₁ by HDL and S1P leads to NO generation and vasodilation. In addition, S1P regulates the endothelial cell barrier by potently inhibiting transcellular and microvascular permeability and leakage, effects that are also ascribed to NO. In fact, NO may be mediating these S1P effects, as suggested by a recent study in which S1P inhibited TNF-α-mediated monocyte adhesion to aortic endothelium in mice. We provide mechanistic evidence that NO is indeed causally involved in mediating the antiadhesive effect of S1P in vitro and in reducing inflammatory cell infiltration during reperfusion injury in vivo. Thus, the dramatic decrease of reperfusion injury caused by HDL and S1P may be due to both attenuation of endothelial dysfunction and inhibition of leukocyte extravasation through NO generation. In addition, HDL and S1P may have direct beneficial effects on the myocardium itself, on the basis of the following: (1) both agents protected cardiomyocytes against apoptosis in vitro and in vivo in the present study; (2) sphingosine kinase-1, the key enzyme in S1P synthesis, has been shown to mediate ischemic preconditioning in Langendorff hearts and its genetic deficiency sensitized the myocardium to ischemia/reperfusion injury; and (3) several S1P receptors are present and functional in cardiomyocytes, which suggests the possibility of direct receptor-mediated antiapoptotic effects. Thus, S1P may protect the heart by acting on both the endothelial cells and cardiomyocytes, and S1P₁ may be involved in both processes.

Indisputably, HDL is the most potent endogenous antiatherogenic factor inversely correlated to long-term cardiovascular risk. However, by identifying HDL as a direct guardian of the myocardium against reperfusion injury, we put forward the hypothesis that a patient’s current HDL level may influence the extent of myocardial damage he or she would suffer during acute ischemia. Indeed, short-term pharmacological elevation of HDL has been shown to reduce the high risk for recurrent adverse events in patients with acute coronary syndromes. By broadening the scope of beneficial HDL effects beyond “mere” atheroprotection, the present study suggests that the direct cardioprotective effect of HDLs...
may independently contribute to their inverse correlation with cardiovascular risk. The implications of our observations may open a new field of clinical research to address important questions on the timing, extent, and means for elevating HDL in a way that best exploits its direct cardioprotective effect. Yet unknown are the patient collectives that would most benefit from HDL-raising interventions: Is it “only” the high-risk patient with an acute coronary syndrome, certain patients in preoperative settings (cardiac or noncardiac), or maybe even anyone scheduled for a routine percutaneous coronary intervention? In any case, rapid-HDL-elevation strategies or pharmacological HDL surrogates would be required. Nicotinamide, statins, and statins are known to increase HDL-C levels, but other drugs that preferentially affect HDL, such as the cholesteryl ester transfer protein inhibitors, are under investigation.6,34 Exogenous HDL mimetics, such as reconstituted HDL particles, recombinant apolipoprotein A1, or apolipoprotein A1 Milano, have the advantage of rapid bioavailability and immediate effects13 and have been shown to reduce ischemia/reperfusion injury in rabbits (ETC-216).35 In this respect and on the basis of the present study, S1P analogues may also be considered as functional HDL mimetics, especially because structural S1P homologs such as FTY720, currently in phase III clinical trials for immunosuppression in kidney transplant patients,36 potently generate NO via the same mechanism as S1P contained in the HDL particle.37 Furthermore, the S1P content of HDL may not only be a target for intervention but also constitute a novel predictor of cardiovascular risk, because 54% of the total plasma S1P is contained in HDL.38,39

Clearly, strategies designed to rapidly elevate HDL levels in general and their S1P content in particular may improve the prognosis of the myocardium at risk for ischemia and reperfusion. The concept of exploiting the direct beneficial effects of HDL for immediate cardioprotection may become very attractive for both patients and physicians, because it potentially applies to any clinical setting with imminent myocardial ischemia, from interventional cardiology and cardiac surgery to perioperative care for the cardiovascular high-risk patient.

Acknowledgments

We gratefully acknowledge the technical assistance of M. Lox, S. Brodner, G. Gaede, M. Greiwe, S. Lütke Enking, D. Bürger, K. Abouhamed, S. Mersmann, and V. Brinkmann.

Sources of Funding

This study was supported in part by the Deutsche Forschungsgemeinschaft (Th667/3-1, LE 940/3-1, and SFB656, projects A1, C3, and Z2, Germany), Federal Ministry of Education and Research (Fo.01KS9604/O), Interdisciplinary Center for Clinical Research Münster (project C21, The1/68/04, and ZPG 4a), Innovative Meineckische Forschung (Th110319 to Dr Theilmeier), the National Institute of Mental Health, the National Institute of Neurological Disorders and Stroke, and the National Institute of Drug Abuse (MH51699, MH07123, NS048476, and DA019674 to Dr Chun), and the H-H. Deuchmann Foundation for Atherosclerosis Research (to Dr Levkau).

Disclosures

None.

References


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*Circulation*. 2006;114:1403-1409; originally published online September 18, 2006; doi: 10.1161/CIRCULATIONAHA.105.607135

*Circulation* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231

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Print ISSN: 0009-7322. Online ISSN: 1524-4539

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