Therapeutic Efficacy of AAV1.SERCA2a in Monocrotaline-Induced Pulmonary Arterial Hypertension

Running title: Hadri et al.; SERCA2a gene transfer in pulmonary arterial hypertension

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Abstract:

**Background**—Pulmonary artery hypertension (PAH) is characterized by dysregulated proliferation of pulmonary artery smooth muscle cells (PASMC) leading to (mal)adaptive vascular remodeling. In the systemic circulation, vascular injury is associated with downregulation of sarcoplasmic reticulum Ca\(^{2+}\)-ATPase 2a (SERCA2a) and alterations in Ca\(^{2+}\) homeostasis in vascular smooth muscle cells that stimulates proliferation. We, therefore, hypothesized that downregulation of SERCA2a is permissive for pulmonary vascular remodeling and the development of PAH.

**Methods and Results**—SERCA2a expression was decreased significantly in remodeled pulmonary arteries from patients with PAH and the rat monocrotaline (MCT) model of PAH compared to controls. In human PASMC *in vitro*, SERCA2a overexpression by gene transfer decreased proliferation and migration significantly by inhibiting NFAT/STAT3. Overexpression of SERCA2a in human pulmonary artery endothelial cells (PAEC) *in vitro* increased endothelial nitric oxide synthase expression and activation. In MCT rats with established PAH, gene transfer of SERCA2a via intratracheal delivery of aerosolized adeno-associated virus serotype 1 (AAV1) carrying the human SERCA2a gene (AAV1.SERCA2a) decreased pulmonary artery pressure, vascular remodeling, right ventricular hypertrophy and fibrosis compared to MCT-PAH rats treated with a control AAV1 carrying β-Galactosidase (AAV1.βGal) or saline. In a prevention protocol, aerosolized AAV1.SERCA2a delivered at the time of MCT administration limited adverse hemodynamic profiles and indices of pulmonary and cardiac remodeling compared with rats administered AAV1.βGal or saline.

**Conclusions**—Downregulation of SERCA2a plays a critical role in modulating the vascular and right ventricular pathophenotype associated with PAH. Selective pulmonary SERCA2a gene transfer may offer benefit as a therapeutic intervention in PAH.

**Key words:** animal model of human disease remodeling, pulmonary hypertension, pulmonary artery, calcium signaling, cardiovascular research, right ventricular systolic pressure, SERCA2a, Adeno-associated virus, nitric oxide synthase, proliferation
Introduction

Pulmonary arterial hypertension (PAH) is characterized by dysregulated pulmonary vascular remodeling that leads to an increase in pulmonary vascular resistance, right ventricular hypertrophy, dysfunction and uncompensated right heart failure, and ultimately death.\(^1\) Vascular remodeling occurs as a result of pulmonary vascular endothelial dysfunction, PASMC proliferation and migration, medial hypertrophy, inflammation, and thrombosis in \textit{in situ} leading to the formation of plexiform lesions, which are a hallmark of the disease.\(^2\)\(^3\) These remodeled vessels, together with an imbalance in vasodilators and vasoconstrictors, contribute to increase pulmonary vascular resistance, which, in turn, strains and remolds the right heart. Despite our understanding of these pathobiological processes, pharmacotherapies to treat the disease are limited and survival outcomes have improved little over the past few decades.\(^4\)

\textit{In} vascular smooth muscle cells, SERCA2a modulates calcium homeostasis. Under basal conditions, SERCA2a sequesters calcium in the endoplasmic reticulum; when SERCA2a is downregulated, intracellular calcium \([\text{Ca}^{2+}]_i\) levels are increased. In rat vascular injury models, SERCA2a expression is downregulated in the vascular media leading to increased \([\text{Ca}^{2+}]_i\) and activation of calcineurin (protein phosphatase 2B)/cytoplasmic nuclear factor of activated T cells (NFAT) signaling to stimulate vascular smooth muscle cell proliferation and promote neointima formation.\(^5\) Similar findings have also been observed in human coronary artery smooth muscle cells \textit{in vitro} and balloon-injured human internal mammary arteries \textit{ex vivo}.\(^6\)\(^7\)

Akin to what is observed in the systemic vasculature, there is evidence to indicate that SERCA2a is downregulated in PAH. In PASMCs isolated from PAH patients and animal models of PAH, \([\text{Ca}^{2+}]_i\) levels are elevated and this stimulates PASMC proliferation and migration. Furthermore, PASMCs isolated from patients with idiopathic PAH demonstrate increased
activation of the signal transducer and activator of transcription-3 (STAT3) and nuclear localization of NFATc2 suggesting that [Ca^{2+}]i-dependent NFAT activation is associated with vascular remodeling in PAH.\textsuperscript{8-10} Thus, strategies to maintain SERCA2a expression and regulate [Ca^{2+}]i should offer a therapeutic benefit in PAH by limiting pulmonary vascular cell proliferation and, thereby, vessel remodeling.

Gene transfer of SERCA2a has demonstrated \textit{in vivo} therapeutic efficacy in small and large animal models of vascular injury. Forced expression of SERCA2a in vascular smooth muscle cells restores sarco/endoplasmic reticulum Ca\textsuperscript{2+} handling, decreases [Ca^{2+}]i, and inhibits NFAT transcriptional activity to limit proliferation, migration, and neointima formation.

SERCA2a gene transfer has also been shown to abrogate endothelial dysfunction by increasing endothelial nitric oxide synthase (eNOS) expression and activity.\textsuperscript{5,7} SERCA2a gene transfer using adeno-associated virus serotype 1 (AAV1.SERCA2a) has been validated extensively in the ventricular myocardium and shown to improve left ventricular systolic function and ventricular remodeling in rat and swine preclinical models of heart failure and in a phase 2 clinical trial of patients with New York Heart Association Stage III/IV congestive heart failure.\textsuperscript{11} The therapeutic potential of SERCA2a gene transfer to target pulmonary vascular dysfunction in PAH has not been tested to date. We, therefore, hypothesized that SERCA2a is downregulated in pulmonary arterioles in PAH and that gene transfer of SERCA2a via intratracheal administration of aerosolized AAV1.SERCA2a would provide selective gene transfer to the pulmonary circulation to prevent or ameliorate pulmonary vascular remodeling and right ventricular myocardial dysfunction in PAH.

\textbf{Methods}

Please refer to the expanded Methods section in the online-only Data Supplement.
Human lung tissue samples

Lung tissue specimens were obtained at the time of lung transplantation from 8 patients with idiopathic PAH, and at the time of thoracic surgery (lobectomy or pneumonectomy for localized lung cancer) from 5 patients without PAH that served as controls. Preoperative echocardiography was performed in the control patients to rule out pulmonary hypertension. Lung tissue from the control patients was collected at a site remote from tumor foci. The study was approved by the local ethics committee (Comité de Protection des Personnes, CPP Ile de France VII, Le Kremlin Bicêtre, France) and patients gave informed consent.

Cell culture

Human pulmonary artery smooth muscle cells (PASMC) and pulmonary artery endothelial cells (PAEC) were purchased from Lonza, Inc. (Allendale, NJ). PASMC were cultured in SmBM medium supplemented with 5% fetal bovine serum (FBS) and SmGM-2 SingleQuots (Lonza). PAEC were grown in EBM-2 medium supplemented with 5% fetal bovine serum supplemented with EGM-2 SingleQuots (Lonza). Cells were grown in 5% CO₂ at 37°C and passaged at confluence.

Adenovirus and adeno-associated virus (AAV1) vectors

Ad-SERCA2a encoding human SERCA2a and green fluorescence protein (GFP) under control of the cytomegalovirus (CMV) promoter;¹² Ad-βGal, encoding β-Galactosidase and GFP under control of the CMV promoter;¹² and Ad-VIVIT, encoding the NFAT competing peptide VIVIT and GFP under control of the CMV promoter were produced as described previously.¹³,¹⁴ Cells were infected with adenovirus at 100 pfu/cell. The efficiency of infection was assessed by GFP fluorescence.

Human AAV1-SERCA2a and AAV1.βGal were produced as described previously.¹⁵ The
rAAV1.SERCA2a vector used in this study contains an AAV serotype 1 viral capsid and a single-stranded ~4.5 kb DNA containing the human SERCA2a cDNA driven by a CMV immediate-early promoter/enhancer, a hybrid intron, and a bovine growth hormone polyadenylation signal, all flanked by 145 nt AAV2 inverted terminal repeat sequences necessary for replication and packaging of the vector DNA in the capsid. The vector was manufactured using standard calcium phosphate transfection methods in adherent 293 cells. Three plasmids were used, one containing helper functions from adenovirus, one containing the AAV rep2 and cap1 genes, and the third containing the vector genome. AAV1.βGal was constructed in a similar fashion using the β–Galactosidase gene.

**Rat monocrotaline-PAH model**

All animal experiments were approved by the Icahn School of Medicine at Mount Sinai institutional animal use and care committee and were in accordance with the National Institutes of Health Guide for the Care and Use of Laboratory Animals. Adult male Sprague-Dawley rats (Charles River, MA) weighing 350-400 g were fed standard chow and administered an intraperitoneal injection of monocrotaline (MCT) 60 mg/kg (Sigma–Aldrich, St. Louis, MO) (MCT group) or 0.9% saline as a control group (sham, n=6). In the treatment protocol, 15 days after the MCT or vehicle control injection, rats from the MCT group (n=30) were randomized to one of three treatment groups: saline (n =10); AAV1.βgal (3.5 x10^11 vg/ml, n=10) or AAV1.SERCA2a (3.5x10^11 vg/ml, n=10). Treatments were aerosolized in 300 µl for single dose intratracheal delivery using an IA-1C Microsprayer (PennCentury, Wyndmoor, PA). In the prevention protocol, immediately after MCT or vehicle control (n=6) injection, rats were randomized into the three treatment groups: Saline (n=15); AAV1.SERCA2a (n=15) or AAV1.βgal (n=6) delivered as described for the treatment protocol. Hemodynamic studies were
conducted 45 days after the administration of MCT or vehicle control after which the rats were sacrificed for tissue collection.

**Right and left heart hemodynamic studies**

Rats were anesthetized with 1% isoflurane, intubated via a tracheotomy, and mechanically ventilated (tidal volume=10 mL/kg; respiratory rate=30 breaths per minute). The thoracic cavity was opened using a midsternal approach, a Scisense catheter was inserted directly into the right or left ventricle and an ultrasonic flow probe (flow probe 2.5S176; Transonic Systems Inc., Ithaca, NY) was placed on the ascending root of the aorta. The heart rate, mean pulmonary artery pressure (mPAP), aortic systolic arterial pressure, right and left ventricular end-systolic and diastolic pressures (RVESP, LVESP, RVEDP and LVEDP, respectively) were measured directly. Hemodynamic data were recorded using a Scisense P–V Control Unit (Scisense, Ontario, Canada).

**Statistical Analysis**

Results are presented as mean±SEM. Normality of the data was assumed based on prior study of the outcome variables subjected to Shapiro-Wilk testing. Data were analyzed using an unpaired t test for comparisons between two means or a one-way ANOVA with the Bonferroni correction for comparisons between >2 means. Data comparison between the AAV1.SERCA2a and AAV1.βgal groups was analyzed by using a *post-hoc* Tukey test. P<0.05 was considered significant. Statistical analysis was performed using GraphPad Prism software (GraphPad Software, Inc., La Jolla, CA).

**Results**

**SERCA2a expression is decreased in human PAH**

To determine if SERCA2a expression is decreased in PAH, we examined pulmonary vessels and
lung tissue from patients with documented PAH (n=6) and compared them to tissues from patients without PAH (n=5) harvested at the time of thoracic surgery (Supplemental Tables 1, 2). Tissue sections from PAH patients were typical for the disease with hypertrophy of small pulmonary arteries, which was not observed in vessels of non-PAH patients. Hypertrophied PAH vessels demonstrated decreased expression of SERCA2 in the vessel intima and media layers consistent with downregulation of SERCA2 in PAEC and PASMC (Figure 1A). Decreased expression of SERCA2 was also confirmed in whole lung tissue lysates in PAH compared to non-PAH patients (Figure 1B). Taken together, these findings indicate that SERCA2 expression is decreased in small hypertrophied pulmonary arteries in PAH and suggest that downregulation of SERCA2 may play a role in the pathologic vascular remodeling that is characteristic of the disease.

SERCA2a modulates NFAT and STAT3 to regulate human PASMC proliferation and migration

To understand the role of SERCA2a in pulmonary vascular remodeling, we first examined the effect of modulating SERCA2a expression on PASMC proliferation and migration. PASMC were infected for 48 h with a control adenovirus encoding β-Galactosidase (Ad.βGal) or an adenovirus encoding human SERCA2a (Ad.SERCA2a) to increase expression by 95% and stimulated with 5% FBS. Serum stimulation increased proliferation of PASMCs by 2.25±0.39-fold (p<0.001 vs. 0.1% FBS) while forced expression of SERCA2a by gene transfer diminished this response significantly (0.61±0.30-fold, p<0.03 vs. 5% FBS) (Figure 2A). Serum stimulation also increased cell migration (1.61±0.11-fold, p<0.001 vs. 0.1% FBS), an effect that was abrogated by SERCA2a overexpression (0.92 ±0.13, p=0.027 vs. CTL, 5% FBS) (Supplemental Figure 1). These findings correlated with the SERCA2a expression profile in serum-stimulated
PASMCs: SERCA2a was undetectable in non-infected or Ad.βGal-infected cells but highly expressed in Ad.SERCA2a-infected PASMCs (Figure 2B). Increased SERCA2a expression was associated with a significant decrease in calcineurin/protein phosphatase 2B (PP2B) and Cyclin D1 expression compared to control or Ad.βGal-infected cells (Figure 2B). Similarly, inhibition of PP2B signaling by adenovirus-mediated expression of VIVIT, a peptide that competes with NFAT for binding to PP2B, decreased PASMC proliferation significantly, suggesting that SERCA2a inhibits proliferation by regulating NFAT activity (Figure 2A). Therefore, we assessed the effect of SERCA2a on NFAT transcriptional activity. Compared to Ad.βGal-infected or non-infected cells, SERCA2a overexpression decreased NFAT transcriptional activity by 2.5-fold (p=0.0008) (Figure 2C). We next examined the effect of SERCA2a on STAT3, which has been shown to regulate NFAT and is activated in PAH.10 Overexpression of SERCA2a decreased phosphorylation and activation of STAT3 (Figure 2D). Thus, these findings indicate that SERCA2a inhibits PASMC proliferation through a mechanism that involves decreased activation of STAT3 and NFAT.

SERCA2a limits proliferation and migration of PAECs and restores activation of eNOS

As remodeled vessels demonstrate intimal hypertrophy, we also examined the effect of modulating SERCA2a expression on proliferation and migration of PAEC. Similar to what was observed in PASMC, SERCA2a overexpression decreased Cyclin D1 expression compared to Ad.βGal-infected cells, consistent with inhibition of proliferation. SERCA2a overexpression also prevented the serum-stimulated increase in PAEC migration (0.93 ±0.04, p<0.02 vs. CTL, 5% FBS). We also observed that increased SERCA2a expression was associated with a concomitant 1.5-fold (p<0.03 vs. CTL) increase in eNOS activation as demonstrated by increased phosphorylation of eNOS at Ser1177 (Supplemental Figure 2). These findings suggest that
SERCA2a regulates PAEC proliferation and migration, which may occur as a result of enhanced eNOS activation.

**SERCA2a gene transfer via intratracheal delivery of AAV1.SERCA2a reverses established pulmonary hypertension in the MCT-PAH rat model**

Having found that SERCA2a is downregulated in PAH, we next evaluated the effect of targeted vascular gene transfer of SERCA2a on pulmonary hemodynamics and vascular remodeling in the rat monocrotaline (MCT) model of PAH. This model develops elevated pulmonary pressures with evidence of pulmonary vascular remodeling 15 days after a single injection of MCT.\(^{16-19}\) To determine the therapeutic efficacy of forced pulmonary vascular SERCA2a expression in a model of established PAH, rats received a single subcutaneous injection of MCT and 15 days later were randomized to receive intratracheal aerosolized saline, adeno-associated virus serotype 1 (AAV1) carrying LacZ encoding for \(\beta\)-Galactosidase (AAV1.\(\beta\)Gal) or AAV1.SERCA2a. Sham rats that were injected with vehicle only served as the controls (Figure 3A).

We first assessed the efficiency of AAV1-mediated gene transfer by performing X-Gal staining to corroborate transduction in lung tissue harvested 30 days after the intratracheal delivery of AAV1.\(\beta\)Gal in MCT rats. \(\beta\)-Galactosidase was expressed abundantly throughout the intima and media of small pulmonary arteries indicating successful gene transfer to the pulmonary vessels using AAV1 and aerosolized intratracheal delivery. \(\beta\)-Galactosidase was also detected in bronchial smooth muscle cells (Supplemental Figure 3A). We also examined SERCA2a mRNA levels and protein expression in the lungs at the end of the 30-day treatment period; human SERCA2a mRNA levels were detected only in MCT-PAH rats randomized to aerosolized AAV1.SERCA2a (Supplemental Figure 3B). Next, SERCA2a protein levels were assessed in lung homogenates using an antibody that recognized both the human and the rat
SERCA2a isoform. SERCA2a expression was downregulated in MCT-PAH rats treated with aerosolized saline or AAV1.βGal but was highly expressed in AAV1.SERCA2a-treated MCT-PAH rats (Figure 3B). These findings were confirmed by immunofluorescent staining of remodeled pulmonary arteries. SERCA2a expression was downregulated in MCT-PAH rats treated with saline or AAV1.βGal but detectable in rats treated with AAV1.SERCA2a (Figure 3C). These findings confirm that SERCA2a is downregulated in pulmonary vessels from rats with MCT-induced PAH and intratracheal aerosol delivery of AAV1.SERCA2a is sufficient to transduce pulmonary vessels and increase pulmonary arteriole SERCA2a expression.

To determine the effect of increased pulmonary vascular SERCA2a expression on pulmonary hemodynamics, we measured pulmonary artery pressures on day 45. Compared to the Sham rats, MCT-PAH rats treated with aerosolized saline or AAV1.βGal demonstrated increased pulmonary artery systolic (PAs), pulmonary artery diastolic (PAd), and mean pulmonary artery (mPA) pressures consistent with PAH. By contrast, PAs, PAd, and mPA were decreased in MCT-PAH rats treated with aerosolized AAV1.SERCA2a (Figure 3D). In addition, while there was an increase in pulmonary vascular resistance in the Saline- and AAV1.βGal-treated MCT rats compared to the Sham controls (0.03±0.01 vs. 0.24±0.01 vs. 0.18±0.03 mmHg*min/ml, p<0.001), treatment with AAV1.SERCA2a decreased pulmonary vascular resistance (0.07±0.01 mmHg*min/ml, p<0.001 vs. Saline, AAV1.βGal) to levels observed in Sham rats. These findings indicate that a reduction in pulmonary pressures in AAV1.SERCA2a-treated MCT-PAH rats is an effect of SERCA2a and not the viral gene transduction process as pulmonary pressures remained elevated in AAV1.βGal-treated MCT-PAH rats.

**SERCA2a gene transfer limits pulmonary artery remodeling in PAH**

Vascular gene transfer of SERCA2 in MCT-PAH rats also reversed or limited pulmonary
vascular remodeling compared to the saline- or AAV1.βGal-treated groups. Morphometric analysis of distal pulmonary arteries demonstrated a significant increase in medial thickness in both saline- and AAV1.βGal-treated MCT-PAH rats compared to sham controls, regardless of vessel diameter (small <50μm, medium 51-100μm, or large >100μm). By contrast, vessel hypertrophy was attenuated significantly in the SERCA2a-treated animals resulting in a decrease in the number of muscularized small vessels of all sizes compared to the control groups. This finding was confirmed by demonstrating a decrease in the presence of α-smooth muscle actin-positive cells in the medial layer of vessels from AAV1.SERCA2a-treated MCT-PAH rats compared to the other treatment groups (Figure 4A).

Pulmonary arteriole perivascular collagen deposition and fibrosis was increased in saline- and AAV1.βGal-treated MCT rats while treatment with AAV1.SERCA2a-treated MCT-PAH rats decreased the profibrotic response (Figure 4B). SERCA2a gene transfer was also associated with a decrease in the infiltration of inflammatory cells in the MCT-injured lungs. Immunohistochemistry for the macrophage/monocyte marker CD68 revealed a marked infiltration of macrophages/monocytes in lung samples from the saline and AAV1.βGal-treated groups compared to Sham rats, with decreased recruitment of macrophages in AAV1.SERCA2a-treated MCT-PAH rats (Figure 4C).

**SERCA2a overexpression inhibits PASMC proliferation and apoptosis resistance in vivo**

Our *in vitro* studies demonstrated that forced expression of SERCA2a inhibited PASMC proliferation. To determine if SERCA2a-mediated inhibition of proliferation limited pulmonary artery remodeling in PAH, we next examined proliferation *in vivo*. Vascular gene transfer of SERCA2a decreased the number of proliferating PASMCs identified as BrdU positive cells in the medial layer of remodeled pulmonary arteries (Figure 5A). Consistent with the decrease in
PASMC proliferation, treatment with AAV1.SERCA2a in MCT-PAH rats decreased phosphorylation and activation of STAT3 and downregulated expression of Cyclin D1 compared to what was observed in saline- and AAV1.βGal-treated MCT-PAH rats (Figure 5B). Treatment with AAV1.SERCA2a also restored eNOS expression levels to those observed in Sham controls (Supplemental Figure 4) suggesting that improved endothelial function may also participate in inhibiting PASMC proliferation in vivo.

In PAH, pulmonary vascular remodeling is characterized by apoptosis-resistant smooth muscle cells that contribute to vessel hypertrophy.20 We, therefore, next sought to determine if SERCA2a overexpression decreased the number of medial smooth muscle cells by promoting apoptosis. Using an in situ TUNEL assay, we observed that the number of TUNEL positive cells was significantly higher in AAV1.SERCA2a-treated MCT-PAH rats compared to animals treated with saline, AAV1.βGal and the Sham control group. Interestingly, SERCA2a overexpression in Sham rats by delivery of AAV1.SERCA2a did not induce apoptosis in normal distal pulmonary arteries (Figure 5C). This indicates that SERCA2a overexpression modified pulmonary vascular remodeling by increasing apoptosis in a limited number of proliferating cells in addition to inhibiting directly proliferation of pulmonary vascular cells.

**Right ventricular remodeling in PAH is improved by vascular SERCA2a gene transfer**

In PAH, elevated pulmonary vascular pressures result in right ventricular (RV) hypertrophy and ultimately the development of right heart failure. As it is known that SERCA2a expression is downregulated in the left ventricle (LV) in heart failure,18,19 we first examined SERCA2a protein expression in RV tissue homogenates. Immunoblot analysis showed a significant downregulation of SERCA2a in the RV of saline- or AAV1.βGal-treated rats compared to the Sham control group. By contrast, SERCA2a expression in the RV of MCT rats treated with AAV1.SERCA2a
was not downregulated and was similar to that observed in Sham controls (Figure 6A).

SERCA2a levels in the LV were similar in the Sham control and MCT-PAH rats and treatment with saline, AAV1.βGal, or AAV1.SERCA2a (Supplemental Figure 5A).

Next, we assessed the distribution of SERCA2a gene transduction by aerosolized AAV1.SERCA2a to determine if RV SERCA2a expression was altered following AAV1.SERCA2a-treatment by off-target gene transfer. We analyzed viral genome copies in tissue samples from the lung, RV and LV in MCT-PAH rats treated with aerosolized AAV1.SERCA2a; AAV1.βGal-treated MCT-PAH rats served as the control. The number of exogenous SERCA2a genome copies (specific to the SERCA2a in the AAV1 vector) in the lung tissue samples was increased in AAV1.SERCA2a-treated MCT-PAH rats compared to the AAV1.βGal group. There was no viral genome detected in the RV or LV of the AAV1.SERCA2a-treated group, demonstrating the specificity of the intratracheal aerosol delivery method for the lung and that RV SERCA2a expression in AAV1.SERCA2a-treated rats did not result from transduction of RV cardiomyocytes (Figure 6B).

SERCA2a gene transfer also had beneficial effects on RV hemodynamics. Compared to Sham rats, there was a significant increase in RV systolic pressure in the saline- (24.5±1 vs. 58±6.8 mmHg, P<0.001) and AAV1.βGal-treated MCT-PAH rats (50.4±3.6 mmHg, P<0.001) compared to Sham controls. In AAV1.SERCA2a-treated rats, RV systolic pressure was not significantly different from that observed in the Sham controls (Figure 7A, Supplemental Figure 5A). There were no differences between treatment groups in the RV diastolic pressure or the LV systolic and diastolic pressures (Figure 7A, Supplemental Figure 5B-E). These findings support our hypothesis that intratracheal delivery of aerosolized AAV1.SERCA2a restores vascular SERCA2a expression to limit pulmonary vascular remodeling and pulmonary
hypertension to decrease the pressure load on the RV and prevent RV remodeling.

Right ventricular hypertrophy, assessed by RV/LV + septum weight, was present in MCT-PAH rats treated with saline or AAV1.βGal as compared to Sham control rats. MCT-PAH rats treated with AAV1.SERCA2a, however, had a significant reduction in RV hypertrophy (Figure 7B). Similarly, RV cardiomyocyte cross-sectional area was enlarged in saline- or AAV1.βGal-treated rats compared to Sham controls, a finding that was not observed in AAV1.SERCA2a-treated rats (Figure 7C). RV hypertrophy was associated with an increase in RV collagen content in saline- and AAV1.βGal-treated MCT-PAH rats compared to Sham rats but not in the AAV1.SERCA2a-treated group (Figure 7D). There was also evidence of increased RV perivascular and interstitial inflammatory cell infiltrates as well as CD68+ cells in the saline- and AAV1.βGal-treated groups compared to Sham rats or the AAV1.SERCA2a-treated group (Figure 7E).

**Prevention of MCT-induced PAH by intratracheal delivery of AAV1.SERCA2a**

Given that AAV1.SERCA2a had therapeutic efficacy in established PAH, we also sought to determine whether gene transfer of SERCA2a via AAV1.SERCA2a could prevent the development of PAH. To examine this hypothesis, we administered aerosolized saline, AAV1.βGal, or AAV1.SERCA2a immediately following injection with MCT (Figure 8A). After 45 days, as expected, pulmonary SERCA2a expression was decreased in MCT-PAH rats treated with AAV1.βGal compared to Sham rats; however, SERCA2a was not downregulated in MCT-PAH rats treated with AAV1.SERCA2a. This was associated with a concomitant decrease in pulmonary Cyclin D1 expression consistent with a decrease in cell proliferation (Figure 8B). Hemodynamic assessment demonstrated that treatment with AAV1.SERCA2a prevented an increase in pulmonary artery systolic and diastolic filling pressures (Figure 8C). Treatment with
AAV1.SERCA2a also prevented the increase in pulmonary vascular resistance observed in AAV1.βGal-treated rats (0.25±0.05 vs. 0.08±0.01 mmHg*min/ml, p<0.001). Similarly, treatment with AAV1.SERCA2a prevented RVH as evidenced by a decrease in RV weight and RV systolic pressure compared to the saline- or AAV1.βGal-treated groups (Figure 8D, E). As noted in the treatment protocol, there was no difference between treatment groups with respect to LV filling pressures or weight (Supplemental Figure 6). Thus, a single intratracheal injection of aerosolized AAV1.SERCA2a can prevent PAH in the MCT-PAH rat model.

Discussion

This study provides the first evidence that SERCA2 protein expression levels are downregulated in lung samples from patients with PAH and in cultured proliferating human PASMC and PAECs. Similarly, in the rat MCT model of PAH, we observed a decrease in pulmonary vascular SERCA2a protein expression 45 days after MCT injection. Impaired SERCA2a activity resulting from a decrease in SERCA2a expression may therefore be implicated in the pathogenesis of PAH. Herein, we show that a single intratracheal delivery of aerosolized AAV1.SERCA2a has therapeutic efficacy in PAH. Four weeks after gene transfer, the SERCA2a mRNA transcript was still detectable in the pulmonary tissue of animals transduced with SERCA2a, demonstrating persistent transgene expression. In addition, AAV1.SERCA2a gene transfer reduced the severity of pulmonary vascular remodeling accompanied by anti-inflammatory and anti-fibrotic effects. Pulmonary vascular gene transfer of AAV1.SERCA2a also diminished RV hypertrophy and fibrosis and prevented the decrease in RV SERCA2a expression seen in control animals with RVH and failure, likely as a result of the reduction in right heart load.

In PAH, hypertensive pulmonary vascular disease and pulmonary artery hypertrophy is
characterized by proliferation and migration of both PAECs and PASMCs, which is associated with downregulation of SERCA2a in the systemic vasculature. In our study, gene transfer of SERCA2a to restore or maintain SERCA2a levels in proliferating cells exerted beneficial effects by inhibiting activation of the STAT3-NFAT pathway and, thereby, cell proliferation that resulted in near normal vessel morphology. This is consistent with our prior reports that indicated that SERCA2a overexpression inhibits human coronary artery smooth muscle cell proliferation and migration by restoring Ca\textsuperscript{2+} homeostasis and increasing the rate of Ca\textsuperscript{2+}-store refilling to inhibit store-operated channel-stimulation of PP2B/NFAT signaling. This phenomenon may be supported by the observation that SERCA2a is localized near the nucleus in PASMCs, suggesting that its location may favor a regulatory role for nuclear trafficking of transcription factors such as STAT3 and NFAT. Other studies have found that SERCA2 expression level was diminished in the airway smooth muscle cells in patients with moderately severe asthma, and that SERCA2a downregulation contributed to the airway secretory and hyperproliferative phenotype.

Dysregulated proliferation of PASMCs may also be driven by a decrease in PAEC eNOS expression and activation. Our findings confirm prior reports that described a decrease in eNOS expression in MCT PAH rats and are in accordance with observations in lung tissue of patients with PAH patients as compared to control subjects. It is plausible that decreased pulmonary vascular eNOS expression may contribute to pulmonary vasoconstriction and to the excessive medial hypertrophy observed in this PAH. In this study, SERCA2a gene transfer restored eNOS expression in pulmonary arteries compared to what was observed in controls. This finding is also consistent with our prior study that demonstrated that intracoronary AAV1.SERCA2a gene transfer increased endothelial cell eNOS protein expression and activity and improved coronary
blood flow and in a preclinical porcine model of heart failure.\textsuperscript{26} Taken together, these observations suggest that SERCA2a gene transfer may play an important role in the control of pulmonary vascular cell proliferation and vessel remodeling.

Recombinant AAV vectors have attracted much interest for clinical gene therapy owing to their safety profile (no known pathology has been found to be associated with AAV in humans), broad tissue tropism, and more importantly, prolonged gene expression without the integration of their DNA into the host chromosome.\textsuperscript{27-30} These vectors have been shown to exhibit less inflammatory and immune reactions than the adenovirus. In this study, we used an AAV serotype 1 vector based on our prior work that demonstrated effective and efficient transduction of endothelial and smooth muscle cells of coronary arteries \textit{in vitro} and \textit{in vivo} and long-term expression of our therapeutic protein in heart tissue in human failing hearts.\textsuperscript{26,28,31} This feature of AAV vectors may be advantageous in investigating the effects of transgenes on chronic disease processes as PAH.

Because AAV1 has tropism for the heart (cardiomyocytes) as well as the endothelium and vascular smooth muscle and we were interested in gene transfer only to the pulmonary vessels, we rationalized that local delivery of AAV1.SERCA2a via a single aerosolized intratracheal instillation would limit off-target transduction of the heart. The use of intratracheal aerosol delivery for pulmonary gene transfer has been described previously using adenovirus.\textsuperscript{32} The use of recombinant adenovirus, however, is limited by the poor long-term expression of the transgene with a peak in expression after 7 days and loss of transgene expression by 21 days making adenovirus an inadequate vector platform to trial therapeutic gene transfer in experimental PAH. However previous clinical studies have demonstrated that repeated aerosolized delivery of AAV1 encoding the human cystic fibrosis transmembrane regulator to
the lungs of subjects with cystic fibrosis was safe and well tolerated. There are few experimental studies that have trialed adeno-associated virus (AAV) for therapeutic gene transfer in pulmonary hypertension with only 2 prior studies using an intranasal or intratracheal aerosol route for AAV delivery in PAH models. In these studies, however, the AAV serotype was not divulged and it is, therefore, difficult to interpret the findings reported without this information. Other studies that have performed gene transfer of AAV1 or AAV2 in rodent models of PAH have utilized an intramuscular injection delivery approach. In these studies, there is likely off-target gene transfer throughout the cardiovascular system and it would be difficult to determine if favorable pulmonary hemodynamics resulted from an improvement in pulmonary vascular remodeling and/or direct transduction of the RV.

Although gene transfer of SERCA2a to the RV was not an aim of this study, it is plausible that future therapeutic interventions in established PAH with RV failure may combine directed pulmonary vascular and RV transduction. It has been shown that in isolated cardiomyocytes and animal models of left heart failure that restoring SERCA2a expression by gene transfer corrects contractile abnormalities, improves energetic and electrical remodeling, and improves hemodynamic function along with survival in rodent and large animal models of heart failure. The overall beneficial profile of SERCA2a targeting has led to the initiation and successful completion of a first-in-human gene therapy trial (CUPID) to investigate the effects of AAV1-SERCA2a gene transfer in patients with heart failure.

In conclusion, our study demonstrates that selective pulmonary vascular gene transfer of SERCA2a with aerosolized AAV1.SERCA2a modulates hypertrophic vascular remodeling in established PAH to lower pulmonary pressures and adverse right ventricular remodeling. Furthermore, maintaining pulmonary vascular SERCA2a expression prevents pulmonary arterial
remodeling to prevent the development of PAH. Our findings have important clinical implications, as at the time of PAH diagnosis, the majority of patients have already developed some form of pathological pulmonary arterial remodeling, which based on our findings correlates with a marked downregulation of SERCA2a expression. Therefore, in this setting, and supported by an already successful application in heart failure patients and clinical feasibility of aerosolized AAV1, maintaining or restoring SERCA2a expression by AAV1.SERCA2a gene transfer during the pathogenesis of PAH or once PAH is established holds promise as a therapeutic approach for the disease.

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**Conflict of Interest Disclosures:** RJH and KZ have ownership interest in Celladon Corporation, which is developing AAV1.SERCA2a for the treatment of heart failure. RJH, YK, and DL hold intellectual property around SERCA2a gene transfer as a treatment modality for PAH. BAM receives funding from Gilead Sciences, Inc. to study experimental pulmonary hypertension. The other authors have no conflict of interest to declare.

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Figure Legends:

Figure 1. SERCA2a expression in decreased in pulmonary vessels from patients with PAH.
Lung tissue was harvested from patients with confirmed PAH (n=6) and control non-PAH
patients. (n=5). (A) SERCA2a expression in pulmonary arterioles and bronchial smooth muscle
was assessed by immunohistochemistry. SERCA2a was expressed in the endothelial and smooth
muscle cell layers of control vessels (top left) but decreased in remodeled pulmonary vessels
(right top and bottom). SERCA2a expression was also detected in bronchial smooth muscle cells
(bottom left). Representative images are shown. Scale bar = 100 μm. (B) Downregulation of
SERCA2a in PAH was confirmed by Western blot of lung tissue homogenates. *P=0.034 vs
Non-PAH.
Figure 2. SERCA2a gene transfer inhibits proliferation of PASMCs. PASMCs were infected for 48 h with Ad.SERCA2a, Ad.βgal, or Ad.VIVIT and then cultured for 48 h in virus-free medium. (A) Proliferation was determined by labeling cells with BrdU and supplementing the medium with 5% FBS to stimulate proliferation. Non-infected PASMCs and PASMCs cultured with 0.1% FBS to maintain quiescence cultured under the same conditions served as controls (n=6) *p=0.03 vs. CTL. **p<0.005 vs. CTL. ***p<0.001 vs. CTL or 0.1% FBS. CTL, control. (B) Western immunoblotting was performed to evaluate SERCA2a, protein phosphatase 2B (PP2B), and Cyclin D1 expression (n=3). Protein expression was normalized to GAPDH. *p<0.03 vs. CTL. **p<0.008 vs. CTL. (C) NFAT transcriptional activity was assessed using a luciferase promoter-reporter assay. Data are expressed in relative luciferase units (RLU) (n=5) ***p<0.001 vs. CTL. (D) Phosphorylated and total STAT3 expression were determined by immunoblotting. Phosphorylated STAT3 was normalized to total STAT3. GAPDH was used as the loading control (n=3). Representative blots are shown. *p=0.04 vs. CTL

Figure 3. Intratracheal delivery of aerosolized AAV1.SERCA2a improves pulmonary hemodynamics in the rat MCT model of PAH. (A) Schematic of the treatment protocol to assess the therapeutic efficacy of AAV1.SERCA2a gene therapy when given after PAH is established. (B) SERCA2a protein expression in lung homogenates from the Sham (n=6) and MCT-PAH rats treated with aerosolized saline (n=5), AAV1.βgal (n=5), or AAV1.SERCA2a (n=7) treated-animals was examined by Western blot. GAPDH was used as a loading control. A representative blot (n=3) is shown. ***p<0.001 vs. Saline, AAV1.SERCA2a. (C) SERCA2a expression (red) in pulmonary arterioles was detected by immunofluorescence. Nuclei were counterstained with DAPI (blue). * in lower right panel refers to airway with visible SERCA2a expression in the
smooth muscle layer. Scale bar = 100 μm. (D) The effect of AAV1.SERCA2a gene therapy on pulmonary artery systolic pressure (PASP), diastolic pressure (PADP), and mean pulmonary pressure (mPAP) was measured invasively at Day 45. *p<0.04 vs. Sham or AAV1.βgal, **p<0.004 vs. AAV1.βgal, ***p<0.001 vs. Sham or AAV1.βgal. MCT, monocrotaline

Figure 4. AAV1.SERCA2a gene therapy decreases pulmonary artery hypertrophy. Lung sections from Sham (n=6) and MCT-PAH rats treated with aerosolized saline (n=5), AAV1.βgal (n=5), or AAV1.SERCA2a (n=7) treated-animals were (A) stained with H&E and distal pulmonary arterioles were examined by microscopy for morphometric analysis and assessment of medial thickness (top left). Sections were also immunostained with α-smooth muscle cell actin to confirm medial hypertrophy (bottom left). Representative images are shown (n=5 sections per rat). Scale bar=100 μm. Morphometric analysis was used to categorize vessels as small (<50 μm), medium (51-100 μm) or large (>100 μm) (right). **p<0.005 vs. Sham, AAV1.SERCA2a, ***p<0.001 vs. Sham, AAV1.SERCA2a. (B) Perivascular fibrosis was examined in lung sections stained with Masson’s trichrome to visualize collagen deposition. Representative images are shown (n=3 sections per rat). Scale bar=100 μm. *p<0.02 vs. Sham, AAV1.SERCA2a, **p<0.005 vs. Sham, AAV1.SERCA2a. (C) Inflammatory cell infiltrate was visualized by CD68 immunostaining to identify monocytes/macrophage infiltrates in lung tissue from Sham (n=3) or MCT-PAH rats treated with saline (n=3), AAV1-βgal (n=3) or AAV1-SERCA2a (n=4). Representative photomicrographs are shown (n=3). Scale bar = 100 μm. ***p<0.0001 vs. Sham, AAV1.SERCA2a.

Figure 5. AAV1.SERCA2a decreases proliferation and increases apoptosis in pulmonary
arterioles. Lung sections from Sham (n=6) and MCT-PAH rats treated with aerosolized saline (n=5), AAV1.βgal (n=5), or AAV1.SERCA2a (n=7) treated-animals were (A) immunostained for Bromodeoxyuridine (BrdU) (green) in the vessel wall of pulmonary arterioles. Sections were counterstained with anti-smooth muscle cell α-actin (αSMC) (red) and DAPI (blue). Representative images are shown (n=3 per rat). Scale bar=100 μm. **p<0.005 vs. Sham, AAV1.SERCA2a, ***p<0.001 vs. Sham, AAV1.SERCA2a. (B) Cyclin D1, phosphorylated STAT3, and total STAT3 levels were examined in lung homogenates by Western immunoblotting. GAPDH was used as a loading control. Representative blots are shown (n=3). *p<0.02 vs. Sham, AAV1.SERCA2a, **p=0.003 vs. Sham, AAV1.SERCA2a, ***p<0.001 vs. Sham, AAV1.SERCA2a. (C) Apoptosis was evaluated by TUNEL staining of pulmonary arterioles. TUNEL-positive nuclei are green. Nuclei are counterstained with DAPI (blue). Representative images are shown (n=3). Scale bar=100 μm. The % TUNEL positive cells were determined for 10 vessels per section, 12 sections per animal. ***p<0.001 vs. Sham, Sham+AAV1.SERCA2a, Saline, AAV1.βgal.

**Figure 6.** SERCA2a expression in the RV in PAH. (A) The RV was harvested from Sham (n=6) and MCT-PAH rats treated with aerosolized saline (n=5), AAV1.βgal (n=5), or AAV1.SERCA2a (n=7) and homogenates were used to examine SERCA2a expression by Western blotting. A representative blot is shown (n=3). *p<0.02 vs. Sham, AAV1.SERCA2a, **p=0.003 vs. Sham, AAV1.SERCA2a. (B) Levels of human SERCA2a and viral genome copies were assessed in the rat RV, LV, and lungs to determine the specificity of AAV1.SERCA2a gene transfer to lungs with aerosol delivery (n=3). ***p<0.001 vs. RV, LV, and AAV1.βgal-injected lung. RV, right ventricle; LV, left ventricle.
Figure 7. AAV1.SERCA2a improves RV hemodynamics and decreases RV hypertrophy and fibrosis. (A) Cardiac hemodynamics were measured invasively in Sham (n=6) and MCT-PAH rats treated with aerosolized saline (n=5), AAV1.βgal (n=5), or AAV1.SERCA2a (n=7) treated-animals at day 45. ***p<0.001 vs. Sham, AAV1.SERCA2a. **p<0.005 vs. AAV1.βgal. MCT, monocrotaline, RV, right ventricle; LV, left ventricle. (B) RV hypertrophy was determined by the RV/LV+septum weight ratio (Fulton index). *p<0.04 vs. Sham, AAV1.SERCA2a, **p=0.006 vs. AAV1.βgal. (C) RV sections were stained with fluorescence-tagged wheat germ agglutinin to examine RV cardiomyocyte cross sectional area (CSA)(n=3 per animal) ***p<0.0001 vs. Sham, AAV1.SERCA2a. (D) Collagen deposition and fibrosis was examined in RV tissue sections using Masson's trichrome stain (n=3 per animal) ***p<0.001 vs. Sham, AAV1.SERCA2a. (E) Infiltration of the RV by macrophages/monocytes was evaluated by CD68-immunostaining (n=3 per animal). Representative images are shown. Scale bar =100 μm. *p=0.04 vs. Sham, AAV1.SERCA2a **p=0.002. Sham, AAV1.SERCA2a.

Figure 8. AAV1.SERCA2a prevents the development of PAH. (A) Schematic of the protocol to assess the role of AAV1.SERCA2a gene therapy in the prevention of MCT-induced PAH. On day 0, rats were injected with MCT and co-administered aerosolized saline (n=15), AAV1.βgal (n=6), or AAV1.SERCA2a (n=15). (B) SERCA2a and CyclinD1 protein expression was examined by Western blotting in lung homogenates (n=3). Protein expression was normalized to GAPDH. Representative blots are shown. *p<0.04 vs. Saline, AAV1.SERCA2a, **p=0.008 vs. Saline, AAV1.SERCA2a. (C) AAV1.SERCA2a limited the increase in pulmonary artery systolic (PASP) and diastolic (PADP) pressures observed in control group rats. Hemodynamics were measured invasively at day 45. *p<0.04 vs. Saline, AAV1.SERCA2a, **p=0.002 vs.
AAV1.SERCA2a. (D) SERCA2a overexpression also limited the increase in RV systolic (RVSP) and diastolic (RVDP) pressures at day 45. *p<0.03 vs. Saline, AAV1.SERCA2a. (E) RV hypertrophy was determined by the RV/LV+septum weight ratio (Fulton index). *p<0.02 vs. Saline, AAV1.SERCA2a. (F) SERCA2a overexpression had no effect on LV systolic (LVSP) and diastolic (LVEDP) pressures or cardiac output (CO). ***p<0.001 vs. MCT+Saline, MCT+AAV1.SERCA2a. MCT, monocrotaline; RV, right ventricle; LC, left ventricle; CO, cardiac output.
Figure 1
Figure 2
A

Day 0

Day 15

Day 45

MCT (60mg/kg) or Sham (n=6)

Intratracheal aerosolized AAV1 delivery

AAV1.SERCA2a (n=10)
AAV1.βGal (n=10)

Saline (n=10)

Hemodynamics

Tissue harvest

AAV1.SERCA2a (n=7)
AAV1.βGal (n=5)

Saline (n=5)

B

SERCA2a expression (fold increase)

Sham Saline AAV1.βGal AAV1.SERCA2a

C

Figure 3

Sham Saline AAV1.βGal AAV1.SERCA2a

D

PASp (mmHg)

PAPd (mmHg)

mPAP (mmHg)
Figure 4
Figure 5
Figure 6
**A**

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<th>MCT+ AAV1.βGal</th>
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<td>50.4±3.6***</td>
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<td>LVEDP (mmHg)</td>
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<td>CO (ml/min)</td>
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<td>144.8±36.8</td>
<td>178.9±34.8</td>
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</table>

**B**

![Graph showing RV weight (g) vs. treatment groups](image)

**C**

![Images showing fibrosis and CD68 expression](image)

**D**

![Images showing fibrosis and CD68 expression](image)

**E**

![Images showing fibrosis and CD68 expression](image)

Figure 7
A) Rats 400g
Injection of MCT (60mg/Kg) SubQ
Intratracheal AAV1 delivery Microsprayer®
AAV1-SERCA2a (n=15)
Saline (n=15)
AAV1.βGal (n=6)

B) Hemodynamics
Sacrifice
Tissue harvesting
AAV1-SERCA2a (n=8)
Saline (n=8)
AAV1.βGal (n=3)

Sham
SERCA2a
Cyclin 1
GAPDH

\[ \text{SERCA2a/GAPDH ratio (X fold of Sham)} \]

\[ \text{Cyclin D1/GAPDH ratio (X fold of Sham)} \]

PASP (mmHg)
RVSP (mmHg)
RVDP (mmHg)

CO (ml/min)

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<td>LVEESP (mmHg)</td>
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<td>LVEDP (mmHg)</td>
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<td>CO (ml/min)</td>
<td>220.3±11</td>
<td>124.8±6.4***</td>
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Figure 8
Therapeutic Efficacy of AAV1.SERCA2a in Monocrotaline-Induced Pulmonary Arterial Hypertension
Lahouaria Hadri, Razmig G. Kratlian, Ludovic Benard, Bradley A. Maron, Peter Dorfmüller, Dennis Ladage, Christophe Guignabert, Kiyotake Ishikawa, Jaume Aguero, Borja Ibanez, Irene C. Turnbull, Erik Kohlbrenner, Lifan Liang, Krisztina Zsebo, Marc Humbert, Jean-Sébastien Hulot, Yoshiaki Kawase, Roger J. Hajjar and Jane A. Leopold

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SUPPLEMENTAL MATERIAL
Supplemental Methods:

**Cell proliferation.** Proliferation of PASMCs and PAECs was measured by 5-bromo-2'-deoxyuridine (BrdU) incorporation for 48 h using the Cell Proliferation ELISA, BrdU (colorimetric) assay (Roche, Indianapolis, IN), according to the manufacturer’s instructions.¹

**Cell Migration.** Migration of PASMC and PAEC was assessed using a micro Boyden Chamber QCM™ 24-Well Colorimetric Cell Migration assay (ECDM 508, Millipore, Billerica, MA) according to the manufacturer’s instructions.¹ Migrated cells were quantified using a microplate reader at 560 nm by colorimetric assay. All experiments were performed in triplicate and data is expressed as % migrated cells/βgal-infected cells.

**Western immunoblotting.** Protein lysates (30 μg) were size-fractionated electrophoretically using SDS-PAGE, transferred onto a nitrocellulose membrane, blocked, and incubated with primary antibodies overnight at 4°C. The membranes were incubated with anti-SERCA2a (21st Century Biochemicals, Marlborough, MA), anti-phospho-eNOS Ser1177 and total eNOS (BD Biosciences, San Jose, CA), anti-Cyclin D1 (BD Biosciences, San Jose, CA), anti-phospho-STAT3, anti-STAT3 (Cell Signaling, Beverly, MA), anti-glyceraldehyde 3-phosphate dehydrogenase (GAPDH) (Sigma, St. Louis, MO), or anti-PP2B (Santa Cruz, Dallas, TX). Levels of proteins and phosphoproteins were detected by using horseradish peroxide-linked secondary antibodies (Cell Signaling, Beverly, MA) and the ECL System (Thermo Scientific, Rockford, IL) or the Odyssey CLx infrared imaging system (LI-COR, Lincoln, NE). GAPDH protein expression was used as the loading control.

**Lung tissue histology.** Rat lungs were inflated with OCT/PBS (50/50) at a pressure of 20 cm H₂O injected through the trachea prior to tissue harvest. The lungs were then frozen, embedded in OCT, sectioned, and 8 μm sections were fixed with ice cold acetone. Sections were stained using hematoxylin and eosin and examined by light microscopy. Smooth muscle α-actin immunohistochemical staining was performed as described previously.² Pulmonary arterioles located distal to terminal bronchioles were identified. The external diameter and the cross-sectional medial wall thickness were measured in 30 muscular arteries per rat ranging in size from 25-50, 51-100, 101-150 μm and up to 150 μm in external diameter. Percent wall thickness was calculated as [(medial thickness x 2)/external diameter] x100. Fibrosis and collagen deposition was examined in lung tissue frozen sections (8μm) that were fixed in 1% paraformaldehyde and stained with Masson’s trichrome stain. Sections were visualized and collagen deposition was quantified using ImageJ software (http://rsbweb.nih.gov/ij/).

**NFAT-reporter gene assay.** Cells were transfected with a NFAT-promoter-luciferase construct using FuGENE 6 as the transfection reagent (Roche, Indianapolis, IN). After 24 h, luciferase activity was measured using the Luciferase Assay System (Promega, Madison, WI). Results were normalized to total protein, and expressed as % control non-infected cells in relative luciferase units (RLU).

**Right ventricular weight and right and left ventricular histology.** The heart was dissected immediately after sacrifice and weighed. The weight ratio of the right ventricle
(RV) to the left ventricle (LV) plus septum [RV/(LV+S)] was calculated as an index of right ventricular hypertrophy (RVH). The RV and LV sections were then fixed with ice-cold acetone, embedded in OCT, and hematoxylin and eosin staining was performed on 8 μm–thick sections that were subsequently examined using light microscopy. Fibrosis and collagen deposition was examined in frozen sections (8μm) that were fixed in 1% paraformaldehyde and stained with Masson’s trichrome stain. Sections were visualized and collagen deposition was quantified using ImageJ software. Cardiomyocyte cross-sectional area was measured using fluorescence-tagged wheat germ agglutinin (Invitrogen) that binds to saccharides of cellular membranes. Images of RV cardiomyocyte cell membranes were captured digitally and analyzed by image analysis using ImageJ software.

**X-gal staining.** The efficiency of intratracheal AAV1 gene transfer was determined by X-Gal staining. Lung tissue sections transduced with AAV1.Adβgal were fixed for 30 min at 4°C in 2% formaldehyde/0.2% glutaraldehyde in PBS, pH 7.4. An X-Gal solution (Thermo Scientific, Pittsburgh PA) was added to the tissue sections and incubated at 37°C for 2 h.

**Quantitative real-time PCR.** Total RNA was isolated from the lung and RV using Trizol reagent and the RNeasy Protect Mini kit (Qiagen, Valencia, CA). First-strand cDNA was reverse-transcribed from 2.0 μg of total RNA using a high capacity cDNA archive kit (Applied Biosystems, Foster City, CA). Real-time PCR was performed using an ABI PRISM Sequence Detector System 7500 (Applied Biosystems, Foster City, CA) with SYBR Green (BioRad, Hercules, CA) as the fluorophore and ROX (Takara, Otsu, Japan) as a passive reference dye. To determine exogenous human SERCA2a mRNA expression, the following primer was used: forward 5’-AGACCCAAGCTGGCTAGCTTA-3’, reverse 5’-TTCTTCAGCCGTAACCTCGTGGA-3’. The primers 18S-F, 5’-TGCGGAAGGATCATTAACGGA-3 and 18S-R, 5’-AGTAGGAGAGCGCGGACC-3’ was used as an endogenous loading control. Fold changes in gene expression were determined using the relative comparison method with normalization to 18S rRNA.

**Immunohistochemistry.** Frozen sections (8 μm) were incubated in 3% hydrogen peroxide for 30 min to block endogenous peroxidase activity. Sections were blocked with 10% normal goat serum and incubated overnight at 4°C with a rabbit antibody against SERCA2 (1:100; Thermo Scientific, Pittsburgh, PA) or CD68 (1:50; BD Bioscience, San Jose, CA). Sections were then incubated with a biotinylated goat anti-rabbit IgG (Dako, Japan) for 30 min, followed by peroxidase labeling with streptavidin (LSAB kit, Dako, Japan) for an additional 20 min at 25°C. Protein expression or presence of macrophages/microcytes was quantified using Image J software.

**In vivo proliferation and apoptosis.** Apoptosis was determined by TUNEL staining of lung tissue sections fixed in 1% paraformaldehyde using the DeadEnd™ Fluorometric TUNEL System (Promega, Madison, WI) according to manufacturer’s instructions. Images were visualized on a Nikon Eclipse TE2000-U microscope at 20X and images captured using Openlab software (Improvement, Waltham, MA). Results were quantitated...
by determining % TUNEL positive nuclei per vessel for 10 vessels per section, 2 sections per rat, and 3 rats per treatment. To measure proliferation, BrdU (100 mg/kg) was delivered by intraperitoneal injection before sacrifice, and proliferation was assessed using an anti- BrdU antibody (Abcam, Cambridge, MA) according to the manufacturer’s instructions. The number of TUNEL- or BrdU-positive PASMCs was divided per the total number of DAPI-positive nuclei and expressed as a percentage.

Supplemental References:


Supplemental Table 1. PAH patient pulmonary hemodynamics pre-lung transplant

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Lung Transplantation (LTx); pulmonary arterial pressure (PAP); Total pulmonary vascular resistance (TPR); Cardiac index (CI)

Supplemental Table 2. Control subjects diagnosis at time of surgery

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Supplemental Figure 1. SERCA2a gene transfer inhibits serum-stimulated PASMC migration. PASMCs were infected for 48 h with Ad.SERCA2a, Ad.βgal, or Ad.VIVIT and then cultured for 48 h in virus-free medium. Cell migration was determined using a micro-Boyden chamber assay. Cells were stimulated by supplementing the medium with 5% FBS. Non-infected PASMCs and PASMCs cultured with 0.1% FBS to maintain quiescence cultured under the same conditions served as controls (n=3). *p<0.03 vs. CTL. **p<0.005 vs CTL.
Supplemental Figure 2. SERCA2a gene transfer increases PAEC eNOS activation and inhibits serum-stimulated cell migration. (A) Representative immunoblot of SERCA2a, Cyclin D1, and phosphorylated and total eNOS in PAECs infected with Ad.βgal or Ad.SERCA2a. The relative ratio of phosphorylated eNOS at Ser1177 was normalized to total eNOS (n=3). GAPDH was used as a loading control. Representative blots are shown. *p<0.03 vs. CTL. (B) Effect of SERCA2a overexpression on PAEC migration was assessed using a micro-Boyden chamber assay. Cells were stimulated with 5% FBS. *p<0.02 vs. CTL. CTL, control; FBS, fetal bovine serum.
Supplemental Figure 3. Efficiency of intratracheal targeted delivery of AAV vectors and SERCA2a gene transfer to the lung vasculature. (A) X-Gal staining of lung tissue sections was performed 30 days after intratracheal delivery of AAV1.βgal in MCT–treated animals. Arrows indicate the localization of βgal protein in a pulmonary arteriole (right) and evidence of X-Gal staining in bronchial smooth muscle cells (left). Scale bar=50 µm for the upper panels, 20 µm for the lower panels. Representative photomicrographs are shown. (B) To demonstrate transduction of the lungs with AAV1.SERCA2a, 15 days after MCT injection, rats were randomized to receive intratracheal administration of AAV1-SERCA2a, AAV1.βgal or saline, and total mRNA was isolated from lung samples. Real-time PCR using primers selective for exogenous human SERCA2a was performed. Results are expressed as average fold change in gene expression levels relative to sham; ***P < 0.001 vs. Sham, Saline, AAV1.βgal.
Supplemental Figure 4. AAV1.SERCA2a gene transfer increases pulmonary vascular eNOS expression. Expression of eNOS in lung homogenates from Sham (n=6) and MCT-PAH rats treated with aerosolized saline (n=5), AAV1.βgal (n=5), or AAV1.SERCA2a (n=7). GAPDH was used as a loading control. A representative blot (n=3) is shown. *p<0.03 vs. Sham, AAV1.SERCA2a, **p=0.003 vs. Sham, AAV1.SERCA2a.
Supplemental Figure 5. SERCA2a expression in the heart and the effect of AAV1.SERCA2a on cardiac hemodynamics. (A) SERCA2a expression was examined in LV homogenates. A representative blot is shown (n=3). GAPDH was used as a loading control. (B) Effect of AAV1.SERCA2a treatment on right ventricular systolic (RVSP) and end diastolic pressure (RVEDP) in sham and MCT-injected rats treated with saline, AAV1.βgal or AAV1.SERCA2a. (C) Left ventricular end-systolic (LVSP) and end-diastolic (LVEDP) pressures in Sham and Saline-, AAV1.βgal- and AAV1.SERCA2a-treated rats. **p<0.005, ***p<0.001.
Supplemental Figure 6. AAV1.SERCA2a did not influence LV hemodynamics in the prevention protocol. On day 0, rats were injected with MCT and co-administered aerosolized saline (n=15), AAV1.βgal (n=6), or AAV1.SERCA2a (n=15). LV hemodynamics were measured invasively. (A) LV end-systolic pressure (LVESP), (B) LV end-diastolic pressure (LVEDP), and (C) LV weight were determined.