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Regeneration of cardiomyocytes from bone marrow: Use of mesenchymal stem cell for cardiovascular tissue engineering

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Abstract

We have isolated a cardiomyogenic cell line (CMG cell) from murine bone marrow mesenchymal stem cells. The cells showed a fibroblast-like morphology, but the morphology changed after 5-azacytidine exposure. They began spontaneous beating after 2 weeks, and expressed ANP and BNP. Electron microscopy revealed a cardiomyocyte-like ultrastructure. These cells had several types of action potentials; sinus node-like and ventricular cell-like action potentials. The isoform of contractile protein genes indicated that their muscle phenotype was similar to fetal ventricular cardiomyocytes. They expressed α_{1A}, α_{1B}, α_{1D}, β_1, and β_2 adrenergic and M_1 and M_2 muscarinic receptors. Stimulation with phenylephrine, isoproterenol and carbachol increased ERK phosphorylation and second messengers. Isoproterenol increased the beating rate, which was blocked with CGP20712A (β_1-selective blocker). These findings indicated that cell transplantation therapy for the patients with heart failure might possibly be achieved using the regenerated cardiomyocytes from autologous bone marrow cells in the near future.

Introduction

Although heart transplantation is the ultimate therapy for the treatment of severe heart failure, it has not been widely examined due to the lack of donor hearts. The inadequate supply of donor hearts is often a major problem everywhere in the world. As a result, the current challenge in cardiology is how to reserve pump failure by cell transplantation or regenerative medicine. Recent studies have shown that transplanted fetal cardiomyocytes can survive in heart scar tissue and that the transplanted cells limit scar expansion and prevent post-infarction heart failure. Transplantation of cultured cardiomyocytes into the damaged myocardium has been proposed as a future method of treating heart failure (Soonpaa et al., 1997; Delcarpio & Claycomb, 1997). This revolutionary concept remains unfeasible in clinical settings because of the difficulty of obtaining donor fetal hearts. Thus, a cardiomyogenic cell line has long been awaited, and such a line might be capable of substituting for fetal cardiomyocytes in this therapy.

Various studies have demonstrated that cardiomyocytes can differentiate from multipotent stem cells such as embryonic stem (ES) cells (Wobus et al., 1991) and embryonic carcinoma (EC) cells (Wobus et al., 1994). ES cells are an attractive cell source in regenerative medicine, but the recipients must take immunodepressant drugs throughout their lives because the transplanted ES cells are allogeneic. Use of these reagents impairs the quality of life of the recipients, and transplantation of undifferentiated ES cells often causes teratocarcinoma. In addition, the establishment of human ES cells involves ethical problems and is not allowed in every country. Because of these circumstances, the regeneration of cardiomyocytes from adult autologous stem cells has been awaited.

Recent reports have demonstrated the existence of pluripotent stem cells in adult tissues. Roy et al. (2000) reported the existence of neural stem cells in

the brain that can differentiate into neurons, oligodendrocytes, and astrocytes *in vitro*. Marrow stromal cells have been shown to possess many characteristics of mesenchymal stem cells (Prockop, 1997), and pluripotent progenitor marrow stromal cells can differentiate into various types of cell types, including osteoblasts (Rickard et al., 1994; Friedenstein et al., 1987), myocytes (Ferrari et al., 1998), adipocytes, tenocytes, and chondroblasts (Ashton et al., 1980). We recently reported the differentiation of mesenchymal stem cells into cardiomyocytes after exposure to 5-azacytidine and the establishment of cell line CMG (*cardiomyogenic*) that differentiates into cardiomyocytes *in vitro* (Makino et al., 1999). CMG cells exhibit spontaneous beating and express atrial natriuretic peptide (ANP) and brain natriuretic peptide (BNP), and they may provide a useful and powerful tool for cardiomyocyte transplantation after further characterization of their cardiomyocyte phenotype.

This paper describes the characteristics of bone marrow-derived regenerated cardiomyocytes and discusses the possibility of using them for cardiovascular tissue engineering. The expression and function of adrenergic and muscarinic receptors in CMG cells is also described, because these receptors play a critical role in modulating cardiac function (Hakuno et al., 2002).

Mesenchymal marrow stem cells as a possible source of cardiomyocytes: The cardiomyogenic (CMG) cell?

Figure 1 shows the classification of the stem cell system of adults (Fukuda, 2001). Bone marrow stromal cells were previously used as a feeder layer to culture hematopoietic stem cells, and are known to be of mesodermal origin and produce various cytokines and growth factors. In late 1990's, a number of papers reported that bone marrow stromal cells contain multipotent stem cells for non-hematopoietic tissues, called 'marrow mesenchymal stem cells', that could differentiate into osteoblasts, chondroblasts, and adipocytes. All of these cells were known to be of mesodermal origin. If mesenchymal stem cells are multipotent, we hypothesized that they might have the ability to differentiate into cardiomyocytes and instituted this study. We also thought that bone marrow cells could be obtained from patients themselves and that autologous cells would not be rejected after cell transplantation.

Method of establishing bone-marrow derived cardiomyocytes

Female C3H/He mice were anesthetized with ether, their femora were excised, and primary culture of the marrow cells was performed according to Dexter's method. Cells were cultured in Iscove's modified Dulbecco's medium (IMDM) supplemented with 20% fetal bovine serum and penicillin (100 μg ml^{-1})/streptomycin (250 ng ml^{-1})/amphotericin B at 33 °C in humid air containing 5% CO_2. After a series of passages, immortalized cells were obtained by frequent subculture for more than 4 months. Cell lines from different dishes were subcloned by limiting dilution. To induce cell differentiation, cells were treated with 3 μmol l^{-1} of 5-azacytidine for 24 hr. Subclones that included spontaneously beating cells were screened by microscopic observation (first screening), and cells surrounding spontaneous beating cells were subcloned with cloning syringes. Subcloned cells were maintained, exposed to 5-azacytidine again for 24 hr, and clones that showed spontaneous beating most frequently were screened (second screening). The clonal cell line thus obtained was named the CMG cell.

As a result of repeated rounds of limiting dilution, we succeeded in isolating 192 single clones, several of which differentiated into cardiomyocytes and showed spontaneous beating. The experiments were reproducible, but the percentage of cells that differentiated into cardiomyocyte differentiation was specific to each clones. Phase-contrast photography and/or immunostaining with anti-sarcomeric myosin antibodies were used to identify the morphological changes in the CMG cells. CMG cells showed a fibroblast-like morphology before 5-azacytidine treatment (0 week), and this phenotype was retained through repeated subculturing under non-stimulating conditions. After 5-azacytidine treatment, however, the morphology of the cells gradually changed (Figure 2). Approximately 10–30% of the CMG cells gradually increased in size at 1 week, and they formed ball-like appearance, or had lengthened in one direction to exhibit a stick-like morphology. Most of the other non-myocytes had an adipocyte-like appearance.

Regenerated cardiomyocytes display a fetal ventricular phenotype

Various cardiac contractile protein isoforms are differentially expressed in cardiomyocytes at different

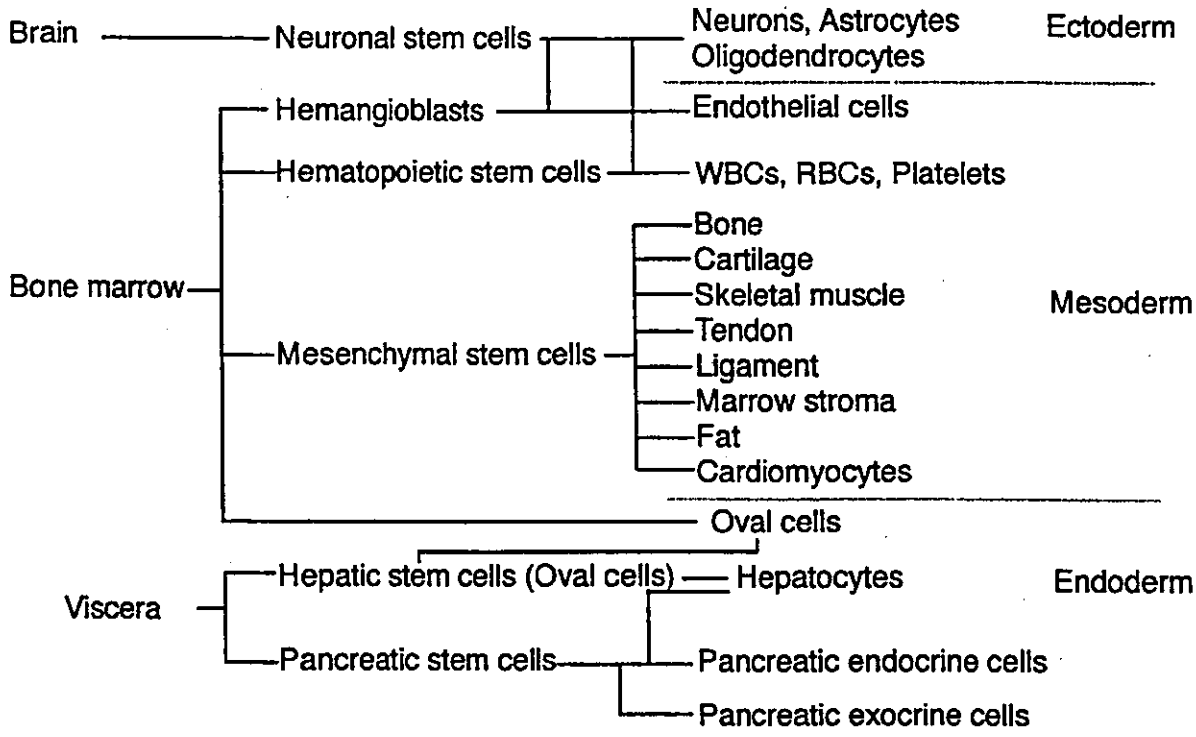

Figure 1. Classification of pluripotent stem cells in adult tissues. Bone marrow contains various kinds of stem cells. Mesenchymal stem cells may differentiate into various mesoderm-derived cells, such as osteoblasts, chondroblasts, adipocytes, skeletal muscle cells and possibly cardiomyocytes.

developmental stages and in different chambers. At around the time of birth there is a developmental switch in the ventricular muscle of small mammals from expression of β-myosin heavy chain (MHC), which is the predominant fetal form, to expression of α-MHC. There is also a developmental switch from expression of α-skeletal actin, which is the predominant fetal and neonatal form, to that of α-cardiac actin, the predominant adult form. We investigated the contractile protein isoforms of bone marrow-derived CMG cells to characterize their phenotype as cardiomyocytes. Table 1 summarizes the results. Fetal, neonatal, and adult ventricle and atrium were used as controls (Fukuda, 2001). Expression of both α- and *β-MHC* was detected in differentiated CMG cells by RT-PCR, but *β-MHC* expression was overwhelmingly greater than that of *α-MHC*. CMG cells expressed both *α-cardiac* and *α-skeletal actin*, but the *α-skeletal actin* gene was expressed at markedly higher levels than the *α-cardiac actin* gene. Interestingly, CMG cells expressed the *myosin light chain (MLC)-2v* gene, but not the *MLC-2a* gene. *MLC-2v* is specifically expressed in ventricular cells, while *MLC-2a* is specifically expressed in atrial cells. Skeletal muscle cells do not express either *α-MHC* or *MLC-2v*. These results indicated that differentiated CMG cells possess the specific phenotype of the fetal ventricular cardiomyocytes (Makino et al., 1999).

Developmental stage of undifferentiated and differentiated CMG cells

Various cardiac specific transcription factors have been cloned, and their genes are serially expressed in the developing heart during myogenesis and morphogenesis. Figure 3 shows the time course of the expression of cardiomyocyte-specific transcription factors in fetal developing heart and CMG cells. The genes coding Nkx2.5 (Linnets et al., 1993) (homeobox type transcription factor specifically expressed beginning in the early developing heart), GATA4 (Arceci et al., 1993) (GATA-motif-binding Zinc finger type transcription factor expressed beginning in the early stage developing heart), HAND1/2 (basic HLH type transcription factor expressed in the heart and autonomic

Table 1. Isoforms of the contractile proteins in differentiated CMG cells

Chamber	Atrium		Ventricle			CMG
Developmental stage	Fetus	Adult	Fetus	Neonate	Adult	
α-Actin	Skeletal	Cardiac	Skeletal > cardiac	Skeletal	Cardiac	Skeletal > cardiac
Myosin heavy chain	$\alpha > \beta$	α	$\beta > \alpha$	$\alpha > \beta$	α	$\beta > \alpha$
Myosin light chain	2a	2a	2v	2v	2v	2v

nervous system), and MEF2-B/C (Edmondson et al., 1994) (muscle enhancement factor: a MADS box family transcription factor expressed in the myocytes) were expressed in the early stage of heart development, and MEF2A and MEF2-D in the middle stage. The CMG cells already expressed *GATA4, TEF-1* (Chen et al., 1994) (transcription enhancement factor 2), *Nkx2.5, HAND*, and *MEF2-C* before exposure to 5-azacytidine, and they expressed *MEF2-A* and *MEF2-D* after exposure to 5-azacytidine. This pattern of gene expression in CMG cells was similar to that of developing cardiomyocytes *in vivo* (Makino et al., 1999), and indicated that the developmental stage of the undifferentiated CMG cells is close to that of cardiomyoblasts or the early stages of heart development. We estimated that the stage of differentiation of the CMG cells lies between the cardiomyocyte-progenitor stage and the differentiated cardiomyocyte stage.

Serial changes in action potential shape in CMG cells simulate those of fetal ventricular cardiomyocytes *in vivo*

CMG cells exhibit at least two types of distinguishable morphological action potentials: sinus-node-like potentials (Figure 4a) and ventricular myocyte-like potentials (Figure 4b) (Makino et al., 1999). The cardiomyocyte-like action potential recorded from these spontaneous beating cells is characterized by (1) a relatively long action potential duration or plateau, (2) a relatively shallow resting membrane potential, and (3) a pacemaker-like late diastolic slow depolarization. Peak-and-dome-like morphology was observed in ventricular-myocyte-like cells. Figure 4c shows the time course of the percentages of the sinus node-like and ventricular-myocyte-like action potentials. All action potentials recorded from CMG cells until 3 weeks were sinus-node-like action potential. The ventricular-myocyte-like action potentials were first recorded after 4 weeks, and their percentage gradually increased thereafter.

The observation of several distinct patterns of action potential in CMG cells may reflect different developmental stages. Yasui et al. studied action potentials and the occurrence of one of the pacemaker currents, I(f), by the whole-cell voltage and current-clamp technique at the stage when a regular heartbeat is first established (9.5 days post coitum) and at 1 day before birth (Yasui et al., 2001). They showed a prominent I(f) in mouse embryonic ventricles in the early stage, and that it decreased by 82% before birth in tandem with the loss of regular spontaneous activity by the ventricular cells. They concluded that the I(f) current of the sinus node type is present in early embryonic mouse ventricular cells. Loss of the I(f) current during the second half of embryonic development is associated with a tendency for the ventricle to lose pacemaker potency. Our findings in CMG cells may reflect the developmental changes in the action potentials that occur in embryonic ventricular cardiomyocytes.

Expression and function of α_1-adrenergic receptors in CMG cells

In the heart *in vivo*, α and β adrenergic receptors play a key role in modulating cardiac hypertrophy and cardiac function, such as heart rate, contractility, and conduction velocity. CMG cells expressed all the α_1 receptor subtypes (α_{1A}, α_{1B}, and α_{1D}) before 5-azacytidine exposure (Figure 5a) (Hakuno et al., 2002), and their expression in undifferentiated CMG cells may be explained by their ubiquitous or wide expression *in vivo* (Alonso-Llamazares et al., 1995). A low level of expression of α_{1A} was observed before 5-azacytidine exposure, and it increased markedly after exposure. Expression of α_{1B} was unaffected by 5-azacytidine. A high level of expression of α_{1D} was detected before 5-azacytidine exposure, but it decreased considerably after exposure. This tran-

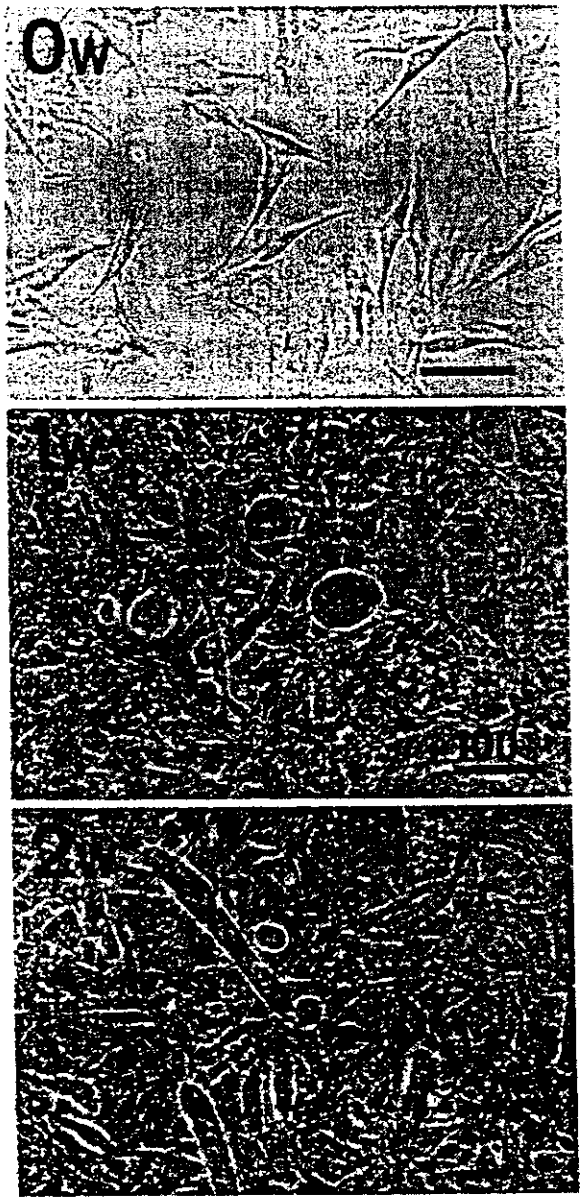

Figure 2. Phase-contrast photographs of CMG cells before and after 5-azacytidine treatment. (Upper panel) CMG cells have a fibroblast-like morphology before 5-azacytidine exposure (0 week). (Middle panel) One week after treatment, some cells gradually increased in size, and developed a ball-like or stick-like appearance. (Lower panel) Two weeks after exposure, the ball-like or stick-like cells began spontaneous beating. Bars indicated 100 μm.

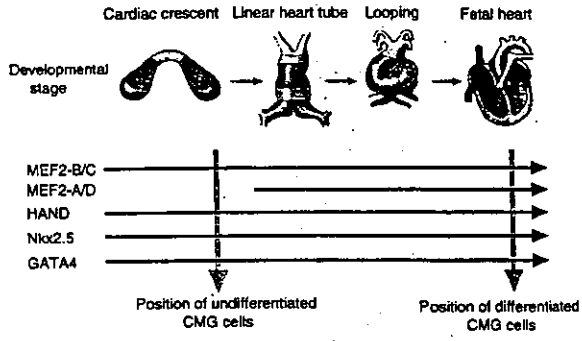

Figure 3. Expression of cardiac-specific transcription factors in the developing heart and in CMG cells. The horizontal arrows indicate the time course of the expression of cardiac-specific transcription factors in the developing fetal heart. The dotted vertical arrows indicate the expression of these factors in undifferentiated and differentiated CMG cells. CMG cells expressed MEF2-A and MEF2-D after 5-azacytidine exposure, when they acquired a cardiomyocyte phenotype.

scriptional switch may be attributable to the CMG cells having acquired the cardiomyocyte phenotype. The ventricular cardiomyocytes *in vivo* mainly expressed α_{1A} and α_{1B}, and expressed a low level of α_{1D} receptor. The temporal changes in expression of α_1 adrenergic receptor subtypes in CMG cells are very similar to the postnatal changes observed in neonatal rat heart (Stewart et al., 1994; Rokosh et al., 1996).

ERK1/2 was activated by phenylephrine, an α_1 stimulant, within as little as 5 min, and the activation peaked at 10 min. The phenylephrine-induced phosphorylation was completely inhibited by prazosin (Figure 5b). Phenylephrine increased the cell area and perimeter of the CMG cardiomyocytes (Figure 5c). These findings indicated that CMG cells express functionally active α_1-adrenergic receptors (Hakuno et al., 2002).

Expression and function of β_1- and β_2-adrenergic receptors in CMG cells

The cardiomyocytes of the mammalian hearts express both β_1 and β_2-adrenergic receptors, the β_1 receptor being the predominant subtype (approximately 75–80% of total β receptors) (Rockman et al., 1997). CMG cells did not express β_1 and β_2 receptor transcripts before 5-azacytidine exposure, but RT-PCR showed expression of their mRNAs after 1 week (Figure 6a) (Hakuno et al., 2002). CMG cells expressed β_1 and β_2 mRNA after acquiring the cardiomyocyte phenotype. The temporal pattern of expression of these receptors differed from that of α_1.

Isoproterenol, a β stimulant, increased the cAMP content of CMG cells, and propranolol completely inhibited the isoproterenol-induced cAMP accumulation (Figures 6b and c). Isoproterenol was applied to the cells to determine whether it would increase the

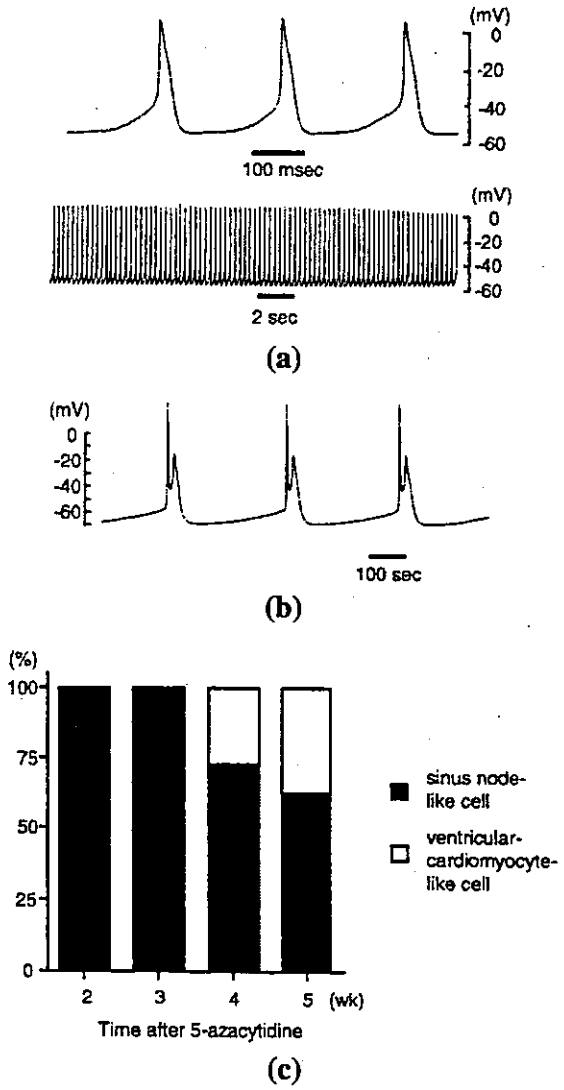

Figure 4. Representative tracing of the action potentials of CMG myotubes. (a, b) Action potential recordings from spontaneous-beating cells were obtained with a conventional microelectrode at day 28 after 5-azacytidine exposure. The action potentials were classified into two groups: (A) sinus-node-like action potentials and (B) ventricular-cardiomyocyte-like action potentials. (c) Percentages of CMG cells exhibiting sinus-node-like and ventricular-cardiomyocyte-like action potentials after 5-azacytidine exposure. A ventricular cardiomyocyte-like action potential was first recorded 4 weeks after 5-azacytidine exposure, and it rapidly became more predominant thereafter.

spontaneous beating rate (Table 2), and the results showed that it increased it significantly to 48% over the rate in the control cells (Hakuno et al., 2002). Preincubation with propranolol (non-selective β blocker), CGP20712A (β_1-selective blocker) strongly reduced the isoproterenol-induced increase in beating rate, and preincubation with ICI118551 (β_2-selective blocker) only slightly decreased the beating rate. The increase in beating rate was similar to that of adult murine cardiomyocytes and ES cell-derived cardiomyocytes.

We also investigated the effect of isoproterenol on the contractile function of CMG cells and found that it increased cell motion distance, %shortening, and contractile velocity. The isoproterenol-induced increase in contractility was almost completely inhibited by both propranolol and CGP20712A. Collectively, these results indicated that the β_1 and β_2-adenergic receptors expressed in CMG cells are functional, and that the isoproterenol-induced increase in spontaneous beating rate and contractility is mainly mediated by β_1 receptors. The β_1 receptor was the predominant subtype that mediated changes in the beating rate in CMG cells, and the beating rate and the contractility were significantly increased by isoproterenol, and completely inhibited by propranolol and CGP20712A. β_1-Receptors played a critical role in mediating the isoproterenol-induced signaling in differentiated CMG cells. This expression pattern was consistent with that of cardiomyocytes *in vivo*.

CMG cells express muscarinic receptor mRNA after 5-azacytidine exposure

Heart rate, conduction velocity, and contractility were negatively regulated by the parasympathetic nervous system in cardiomyocytes, and muscarinic (cholinergic) receptors play an important role in mediating this function. To date, 5 subtypes (M_1-M_5) of muscarinic receptors have been cloned. The expression of the muscarinic receptors is tissue-specific, and cardiomyocytes mainly express M_2 receptors in the mouse and human (Sharma et al., 1997). The M_1 receptor subtype is also expressed in murine neonatal and adult cardiomyocytes. Figure 7a shows the temporal expression pattern of M_1 and M_2 receptor mRNA. Neither receptor was detected prior to 5-azacytidine exposure. CMG cells began to express these receptors when they acquired the cardiomyocyte phenotype.

M_1 receptors coupled to Gq/G_{11} and activated phospholipase C_β via $Gq\alpha$, leading to IP_3 production,

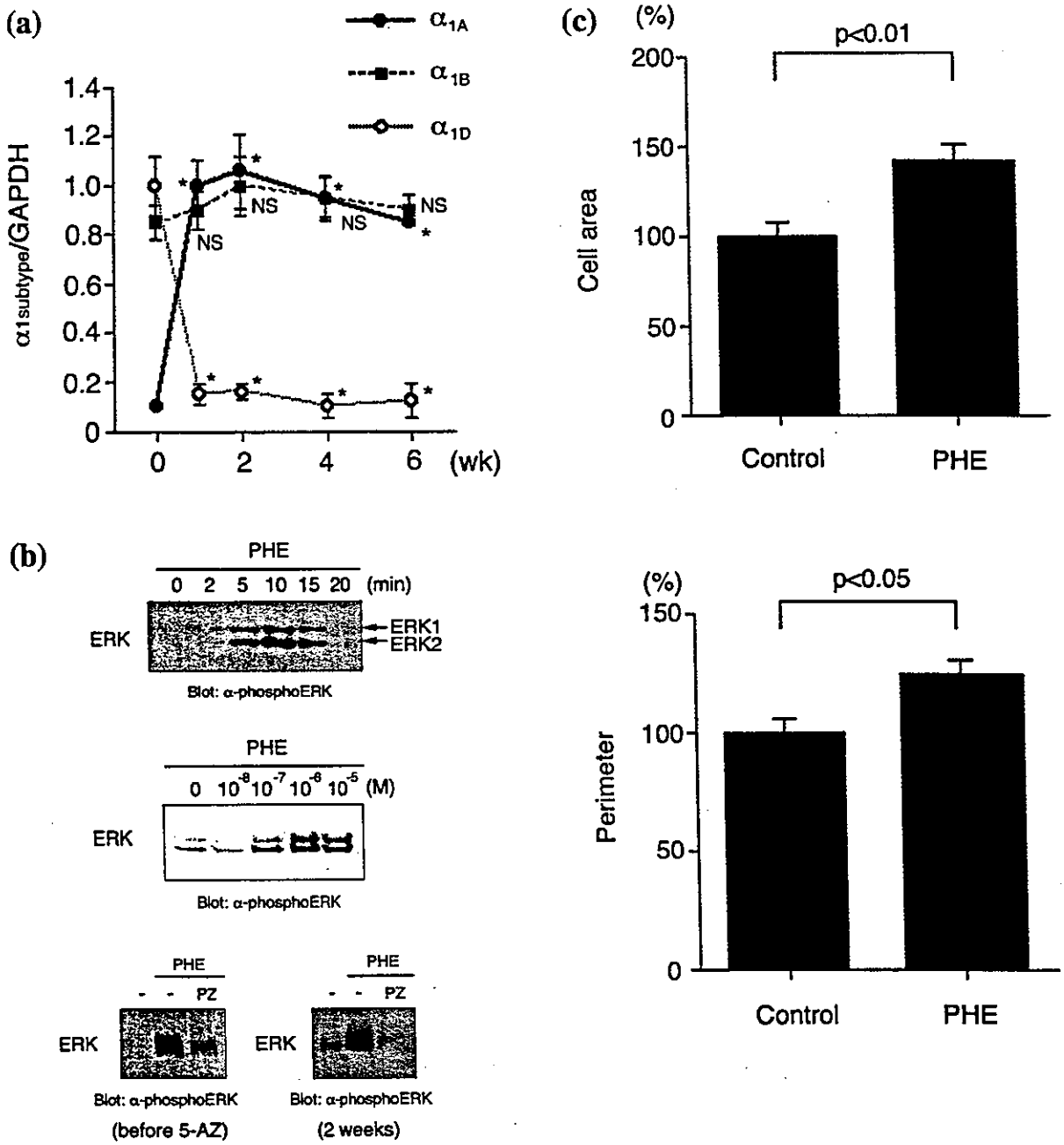

Figure 5. Expression and function of α_1-adrenergic receptor subtype in CMG cells. (a) Densitometric analysis was performed, and the ratio of the RT-PCR product of α_1 subtype (α_{1A}, α_{1B}, α_{1D}) receptors to that of GAPDH is shown. Data were obtained from 5 separate experiments and are shown in arbitrary units compared to the controls. Values are mean±SE. *: $p < 0.01$ vs. controls (before 5-azacytidine exposure). NS: not significant. (b) (Upper panel) Cells at 2 weeks after 5-azacytidine exposure were stimulated with phenylephrine (10^{-4} mol l^{-1}), and Western blot analysis was performed to detect phosphorylation of ERK1/2. (Middle panel) Cells were stimulated with phenylephrine (10^{-7}–10^{-5} mol l^{-1}) for 10 min, and phosphorylation of ERK was detected. (Lower panel) Prazosin (10^{-6} mol l^{-1}) was added to cells 20 min before stimulation with phenylephrine (10^{-6} mol l^{-1}). PHE: phenylephrine, PZ: prazosin. (c) Cells were serum depleted for 24 hr, stimulated with phenylephrine for 24 hr, and stained with anti-sarcomeric myosin antibody. Cell area and perimeter were quantitated with NIH Image software (n = 100) *: $p < 0.01$ vs. control.

Table 2. Isoproterenol increased the spontaneous beating rate and contractility of CMG cells, mainly via β_1 receptors

	Control	Isoproterenol (10^{-7} mol l^{-1})			
		Vehicle	Propranolol (10^{-7} mol l^{-1})	CGP20712A (10^{-7} mol l^{-1})	ICI118551 (10^{-7} mol l^{-1})
% Increase in beating rate	–	47.6±8.4*	10.0±1.9**	13.8±2.4**	37.6±1.9***
cell motion (μm)	5.0±0.3	6.8±0.7*	5.6±0.8***	5.3±0.6***	ND
% Shortening (%)	6.9±0.5	8.5±1.2*	7.2±0.8***	5.6±0.6***	ND
Contractile velocity (μm s^{-1})	71.1±5.2	100.9±11.0*	71.3±8.8***	70.6±6.6***	ND

CMG cells at 4 weeks after 5-azacytidine exposure were initially exposed to prazosin (10^{-6} mol l^{-1}) for 30 min to block α_1-adrenergic receptors. Cells were then preincubated for 20 min with vehicle (PBS), propranolol, CGP20712A, or ICI118551, and then stimulated with isoproterenol. The beating rate was counted 3 min after stimulation. Contractile parameters were analyzed 90 sec after stimulation. Each contractile parameter value was calculated as the mean of 3 randomly selected beats in one cell. PBS was added to the control. Values are means ± SE (n = 100, each). *: $p < 0.05$ vs. control, **: $p < 0.01$ vs. vehicle (isoproterenol only), ***: $p < 0.05$ vs. vehicle, ND: not determined.

and M_2 receptors coupled to Gi/G_0/Gz and activated phospholipase C_β via Giβ_γ, leading to IP_3 production (Nakamura et al., 1995; Berstein et al., 1992). Carbachol, an acetylcholine homologue, increased the content of a second messenger, IP_3 (inositol triphosphate), in CMG cells (Figure 7b), and preincubation with atropine (non-selective muscarinic blocker) and AFDX116 (M_2-selective blocker) inhibited the carbachol-induced IP_3 production (Figure 7c). These findings indicated that muscarinic receptors can transduce their signals, and that M_2 receptors play a critical role in this carbachol-induced IP_3 production in CMG cells. This expression pattern is similar to that of cardiomyocytes *in vivo*.

Significance of expression of adrenergic and muscarinic receptors in CMG cells

Cardiomyocytes *in vivo* respond to stimulation by both sympathetic and parasympathetic nerves, and such stimulation alters the heart rate, conduction velocity, and contractility, enabling the cells to adapt to rapid changes in systemic oxygen demand. To date, and to our knowledge, ES cells and mesenchymal-stem-cell-derived CMG cells are the only possible candidates for regeneration of cardiomyocytes. We have already transplanted these cells into normal adult mouse hearts, and have observed that transplanted cells survived in recipient hearts for at least several weeks. Regenerated cardiomyocytes must express functional adrenergic and muscarinic receptors to be useful for transplantation, and although we did not investigate all signaling pathways and their functions. CMG cells are potential candidates for cardiomyocyte cell transplantation, because they possess such receptors.

Cell transplantation therapy for the treatment of heart failure

We have already transplanted CMG cells into normal adult mouse hearts, and observed that the transplanted cells could survive in the recipient heart for at least several months. Fibroblasts, smooth muscle cells, and skeletal muscle cells were the first cells used for transplantation into scar tissue secondary to experimental myocardial infarction in the heart *in vivo*. While transplantation of these cells into scar tissue might improve cardiac remodeling or diastolic function, it is unlikely to improve systolic function. Transplantation of cardiomyocytes, however, might rescue systolic function. The only potential sources of regenerated cardiomyocytes available to date are embryonic stem (ES) cells and mesenchymal stem cells. ES cells differentiate into cardiomyocytes *in vitro* and have both advantages and disadvantages for cardiomyocyte regeneration. Transplanted ES cells may form teratomas if some undifferentiated totipotent cells are still present, and

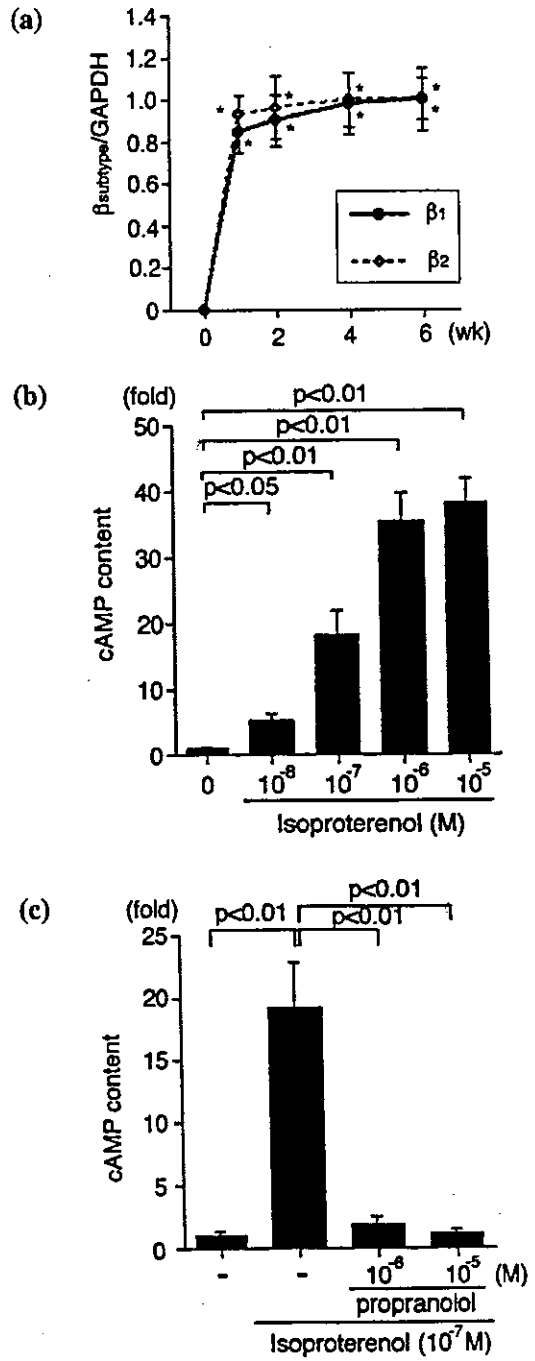

Figure 6. Expression and signal transduction of β_1- and β_2-adrenergic receptor subtype in CMG cells. (a) Densitometric analysis was performed, and the ratio of the RT-PCR product of β subtype (β_1 and β_2 receptors to that of GAPDH is shown. (b) Effect of isoproterenol on cAMP accumulation in CMG cells at 2 weeks after 5-azacytidine exposure. (c) Cells were preincubated with propranolol (10^{-6} or 10^{-5} mol l^{-1}) for 20 min and stimulated with isoproterenol (10^{-7} mol l^{-1}) for 10 min. Data were obtained from 5 separate experiments and are shown as arbitrary units compared with the controls. *: $p < 0.01$, **: $p < 0.05$ vs. controls.

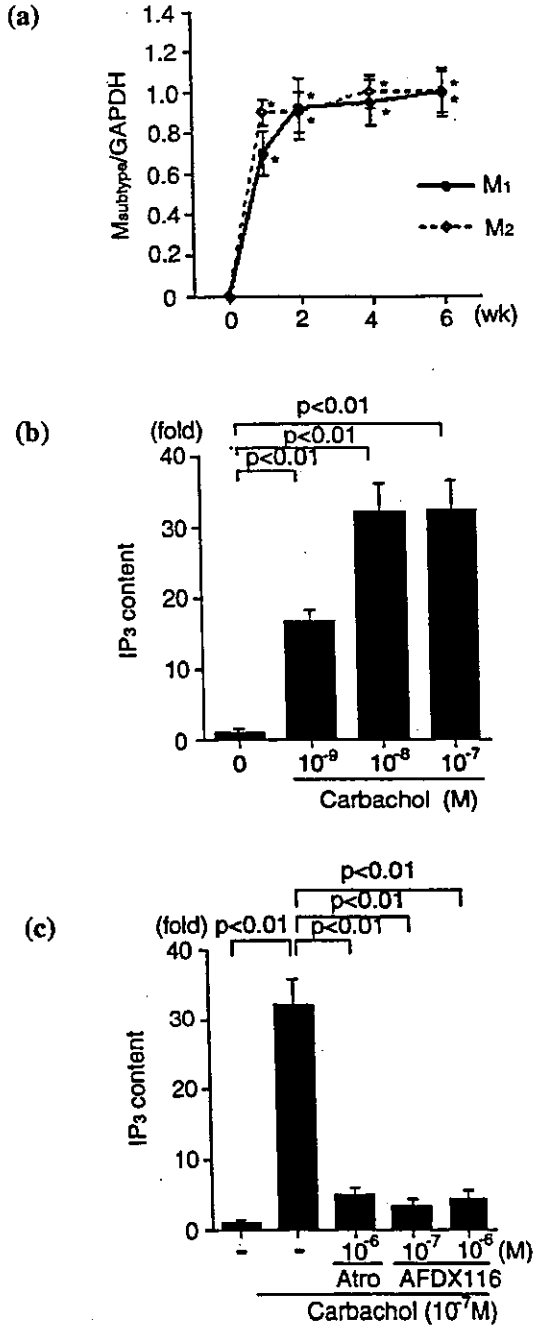

Figure 7. Expression and function of M_1- and M_2-muscarinic receptors in CMG cells. (a) The ratio of the RT-PCR product of muscarinic subtype to that of GAPDH is shown. Data were obtained from 5 separate experiments and are shown as arbitrary units over controls. *: $p < 0.01$ vs. controls. (b) Effect of carbachol on IP_3 production in CMG cells at 2 weeks after 5-azacytidine exposure. (c) Effect of atropine (10^{-6} mol l^{-1}) and AFDX116 (10^{-7} or 10^{-6} mol l^{-1}) on carbachol-induced IP_3 production. Data were obtained from 5 separate experiments and are shown as arbitrary units compared with the controls. *: $p < 0.01$ vs. controls. Atro: atropin.

recipients must take immunosuppressants, because ES cells are allogeneic. By contrast, since mesenchymal stem cells do not carry any inherent risks of tumor formation and are syngeneic, it is reasonable to use autologous mesenchymal stem cell to treat heart disease. Nevertheless, there is a need to improve both the current methods for identification and culture of mesenchymal stem cells, and for induction of CMG cell differentiation, which are still inefficient and slow. Identification of specific growth factors, cytokines, or extracellular matrix factors that regulate cardiomyocyte differentiation may help to accelerate this process faster and make it more efficient.

In vivo evidence that marrow cells can generate functional cardiac tissues

Recent studies have revealed that bone-marrow-derived cells differentiate into various types of cells *in vivo*. Shimizu et al. reported that smooth-muscle-like cells (SMCs) in graft-vs-host arterial lesions could arise from circulating bone-marrow-derived precursors. They used murine aortic transplants to formally identify the source of SMCs in lesions in grafted arteries (Shimizu et al., 2001). Allografts in beta-galactosidase transgenic recipients showed that intimal SMCs arose almost exclusively from host cells, and bone-marrow transplantation of beta-galactosidase-expressing cells into aortic allograft recipients demonstrated that the intimal cells included those of marrow origin.

Kocher et al. (2001) showed that bone marrow from adult humans contains endothelial precursors with phenotypic and functional characteristics of embryonic hemangioblasts and that they can be used to directly induce new blood vessel formation in the infarct-bed (vasculogenesis) and proliferation of preexisting vasculature (angiogenesis) after experimental myocardial infarction. The neoangiogenesis resulted in decreased apoptosis of hypertrophied myocytes in the peri-infarct region, long-term salvage and survival of viable myocardium, reduction in collagen deposition, and sustained improvement in cardiac function.

We also observed that transplanted bone marrow cells differentiated into cardiomyocytes in the recipient heart *in vivo* (unpublished observation). These findings provided direct evidence that bone marrow cells can regenerate various types of cells in cardiac tissue. We expect cardiac tissues damaged by myocardial infarction or other diseases to be repaired by bone-marrow-derived stem cells in the near future, and the precise mechanism should be investigated to achieve this goal.

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Selective Involvement of p130Cas/Crk/Pyk2/c-Src in Endothelin-1–Induced JNK Activation

Hiroaki Kodama, Keiichi Fukuda, Eiichi Takahashi, Satoko Tahara, Yuichi Tomita, Masaki Ieda, Kensuke Kimura, Koji M. Owada, Kristiina Vuori, Satoshi Ogawa

Abstract—Both integrin-based focal adhesion complexes and receptor tyrosine kinases have been proposed as scaffolds on which the G protein–coupled receptor (GPCR)–induced signaling complex might assemble. We have recently reported that Ca^{2+}-sensitive tyrosine kinase, Pyk2, and epidermal growth factor receptor (EGFR) act as independently regulated scaffolds in cardiomyocytes. In this report, we investigated the activation and regulation of p130Cas, Crk, Pyk2, and c-Src by a well-known hypertrophic agonist, endothelin-1 (ET), and determined their contributions to the activation of c-Jun NH_2-terminal kinase (JNK) and extracellular signal–regulated kinase (ERK) in cardiomyocytes. Like Pyk2, ET-induced tyrosine phosphorylation of p130Cas was significantly inhibited by either chelating intracellular Ca^{2+} ($[Ca^{2+}]_i$) or a protein kinase C inhibitor, calphostin C. This activation of p130Cas was also abrogated by the tetrapeptide RGDS, which disrupts integrin heterodimerization; cytochalasin D, which depolymerizes the actin cytoskeleton; or a selective Src family kinase inhibitor, PP2, but not by an EGFR inhibitor, AG1478. We also observed ET-induced temporal associations of Pyk2 with active c-Src, followed by p130Cas with Pyk2, c-Src, and Crk. Overexpression of a dominant-negative mutant of p130Cas (CasΔSD), Crk (CrkSH2m), Pyk2 (PKM), or *C*-terminal Src kinase (Csk), but not of a deletion mutant of EGFR (533delEGFR), attenuated ET-induced JNK activation. Similarly, an ET-induced increase in c-*jun* promoter luciferase activity was inhibited by overexpression of CasΔSD, CrkSH2m, PKM, or Csk. In contrast, ET-induced ERK activation and c-*fos* gene expression were predominantly regulated by EGFR. Collectively, the focal adhesion–dependent p130Cas/Crk/Pyk2/c-Src–mediated pathway is selectively involved in ET-induced JNK activation in cardiomyocytes. (***Hypertension.* 2003;41:1372-1379.**)

Key Words: endothelin-1 ■ cardiac hypertrophy ■ kinase ■ focal adhesion ■ phosphorylation

Cardiac hypertrophy is characterized by both remodeling of the extracellular matrix (ECM) and the hypertrophic growth of cardiomyocytes.[1] Focal adhesions are regions of a cell in direct contact with the ECM, providing anchorage sites linking the ECM to the actin cytoskeleton by way of the integrin family of cell-surface receptors.[2,3] The ECM can regulate reorganization of the cytoskeletal architecture, and ECM-mediated signaling has also been implicated in the growth factor–induced alterations of gene transcription in cardiomyocytes.[4] Mitogen-induced changes in the actin cytoskeleton are accompanied by dramatic changes in several proteins present in focal adhesions.

A 130-kDa Crk-associated substrate, p130Cas, was originally identified as a protein highly tyrosine-phosphorylated in cells transformed by v-Src and v-Crk oncogenes.[5] Molecular cloning of p130Cas revealed a docking protein that contains an SH3 domain, proline-rich regions, and a cluster of 15 putative SH2-binding motifs.[6] This unique structure of p130Cas suggests a role in assembling multiprotein signaling complexes.[7] Indeed, p130Cas localizes to focal adhesions and associates not only with focal adhesion proteins, such as focal adhesion kinases (FAK) and paxillin, but also with other SH2 domain–containing signaling molecules, including Crk.[7,8] p130Cas is also phosphorylated during cell adhesion or after stimulation with various growth factors, such as angiotensin II,[9] platelet-derived growth factor, and endothelin-1 (ET).[10]

One of the prime candidates of tyrosine kinase responsible for p130Cas activation is Pyk2,[8,11] a close relative of FAK. Moreover, Pyk2 has been shown to be responsible for linking c-Src to downstream signaling pathways, such as the activation of extracellular signal–regulated kinases (ERKs)[11,12] and c-Jun NH_2-terminal kinases (JNKs).[13] Recent studies also suggest that the activation of p130Cas is critical in cardiac development, because targeted disruption of the p130Cas gene led to an impaired cardiovascular system demonstrating marked systemic congestion and a poorly developed heart.[14]

Among the many signaling molecules that are activated by hypertrophic stimuli, members of the mitogen-activated pro-

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tein kinase (MAPK) family, including ERK, JNK, and p38 MAPK, are likely to play an important role in cardiac hypertrophic gene expression.[15] However, very little is known about the signals downstream of focal adhesion proteins, including p130Cas, Crk, and Pyk2, which mediate selective activation of the JNK pathway in contrast to the ERK pathway in cardiomyocytes.

In a previous report, we showed that ET activated the 2 distinct tyrosine kinase pathways requiring Pyk2 or epidermal growth factor receptor (EGFR) in cardiomyocytes. EGFR was Ca^{2+}-independently activated, recruited Shc, and predominantly contributed to ERK/c-*fos* activation, whereas Pyk2 or c-Src contributed less to ERK activation.[16] We show here that $[Ca^{2+}]_i$, PKC, c-Src, and focal adhesion integrity are also required for ET-induced tyrosine phosphorylation of p130Cas as well as Pyk2. Furthermore, we demonstrate that ET-induced JNK activation is preferentially regulated by Pyk2, c-Src, and the p130Cas/Crk complex but not by EGFR. Thus, the p130Cas/Crk/Pyk2/c-Src-JNK signaling described here might represent a pathway clearly dissociable from the EGFR-mediated ERK cascade in cardiomyocytes.

Methods

Materials

PP2, AG1478, and AG490 were purchased from Calbiochem. ET, myelin basic protein (MBP), calphostin C, phorbol 12-myristate 13-acetate (PMA), BAPTA, BQ123, A23187, RGDS, and cytochalasin D were purchased from Sigma.

Cell Culture and Transfection

Primary cultured cardiomyocytes were prepared from ventricles of 1-day-old neonatal Wistar rats as described previously.[16] Hemagglutinin (HA)-tagged JNK1 (HA-JNK1) and HA-ERK2 were provided by E. Nishida and M. Karin, respectively. *C*-terminal Src kinase (Csk), the deletion mutant of EGFR (533delEGFR),[17] the dominant-negative mutant of Jak2 (d.n.Jak2), and the kinase-inactive mutant of Pyk2 (PKM)[11] were provided by H. Sabe, H. Matsubara, J. Ihle, and J. Schlessinger, respectively. pSSRα-p130CasΔSD (deletion of 213 to 514 amino acids; CasΔSD) and pSSRα-Crk-SH2m (Crk-SH2 R38V mutant; CrkSH2m) have been described elsewhere.[18,19] Transfection of plasmid was performed with the use of Effectene transfection reagent (Qiagen). After 24 hours of serum depletion, cells were stimulated with ET.

Luciferase Assays

pGVB −438c-*jun*-luc, containing segment −438 to +140 of the rat c-*jun* promoter[20] (c-*jun*-luc), and pGL3-c-*fos*p, containing segment −404 to +41 of the human c-*fos* promoter[21] (c-*fos*-luc), were provided by S. Hata and M. Tsuda, respectively. For each dish, 0.4 μg c-*jun*-luc or c-*fos*-luc together with 2.0 μg CasΔSD, CrkSH2 m, 533delEGFR, Csk, PKM, or d.n.Jak2 were transfected into cardiomyocytes. Cell lysates were processed and assayed for luciferase activity with a luciferase assay system (Promega).

Immunoprecipitation and Immunoblotting

Immunoprecipitation was performed with monoclonal anti-p130Cas and anti-Crk (Transduction Laboratories); polyclonal anti-JNK1, anti-Pyk2, anti-c-Src (SRC2), and anti-EGFR antibodies (Santa Cruz Biotechnology); or monoclonal anti-HA antibodies (Roche Molecular Biochemicals), as described previously.[16] For immunoblot analysis, immunoprecipitates were subjected to sodium dodecyl sulfate–polyacrylamide gel electrophoresis (SDS-PAGE) and then transferred to nitrocellulose membranes. The blots were incubated with anti-phosphotyrosine (4G10), anti-p130Cas, anti-Crk, or monoclonal anti–c-Src (clone 28) antibody, which selectively recognizes the active (Tyr-530–dephosphorylated) form of c-Src.[22] Signals were detected by enhanced chemiluminescence (Amersham).

Kinase Assay of JNK and ERK

JNK and ERK activities were determined by in vitro kinase reactions, as described previously.[16] In brief, JNK1 or ERK2 immunoprecipitates were incubated with glutathione S-transferase (GST)–c-Jun(1-79) for 30 to 45 minutes at 30°C or with MBP for 10 minutes at 25°C. After SDS-PAGE, the gels were dried and subjected to autoradiography. The GST–c-Jun(1-79) construct was provided by M. Hibi.[23]

Reproducibility of Results and Statistical Analysis

Unless stated otherwise, the results are representative of at least 3 separate experiments that gave similar results. Densitometric analysis was performed with Image J, version 1.6. The significance of differences among mean values was determined by ANOVA.

Results

p130Cas Is Tyrosine-Phosphorylated on Cell Adhesion in a Ca^{2+}-, PKC-, and c-Src–Dependent Manner

We first examined the kinetics of tyrosine phosphorylation of p130Cas. As shown in Figure 1A, ET stimulated tyrosine phosphorylation of p130Cas, with peak phosphorylation occurring at 5 minutes. Tyrosine phosphorylation remained above basal levels at 30 minutes. This p130Cas tyrosine phosphorylation was significantly inhibited by pretreatment with the ET-A receptor blocker BQ123, thus suggesting that p130Cas tyrosine phosphorylation was mediated by the ET-A receptor (Figure 1B).

We next studied the dependence of ET-induced p130Cas phosphorylation on changes in $[Ca^{2+}]_i$ or activation of protein kinase C (PKC). ET stimulation causes rapid activation of PKC and an elevation of $[Ca^{2+}]_i$ in cardiomyocytes.[24] Direct stimulation of PKC by PMA or Ca^{2+} ionophore A23187 caused p130Cas tyrosine phosphorylation (Figure 1C). On the other hand, either the chelation of $[Ca^{2+}]_i$ or the inhibition of PKC by calphostin C significantly suppressed the ET-induced p130Cas tyrosine phosphorylation (Figure 1D). These results suggest that activation by both $[Ca^{2+}]_i$ and PKC is required for p130Cas tyrosine phosphorylation in cardiomyocytes.

Because p130Cas colocalizes with Pyk2 or paxillin to the focal adhesion plaques,[25] it has been suggested that p130Cas might be involved in cytoskeletal signaling, dependent on the proper assembly of focal adhesions.[3] The tetrapeptide RGDS, which disrupts integrin heterodimerization,[26] or cytochalasin D, which depolymerizes the actin cytoskeleton,[9,26] fully prevented the ET-induced p130Cas phosphorylation (Figure 1E), thus suggesting that the integrity of the cardiomyocyte cytoskeleton is required for ET-induced p130Cas tyrosine phosphorylation.

ET is known to activate various tyrosine kinases, including c-Src, EGFR, and Jak2.[16,27] To characterize the tyrosine kinase responsible for p130Cas phosphorylation by ET, we used selective tyrosine kinase inhibitors; AG1478, an EGFR inhibitor; PP2, a Src family kinase inhibitor;[9,27] and AG490, a Jak2 inhibitor. PP2 abolished ET-induced p130Cas tyrosine phosphorylation, whereas AG1478 or AG490 had no effect, thus suggesting that activation of c-Src might lie upstream of p130Cas in ET-induced signaling (Figure 1F).

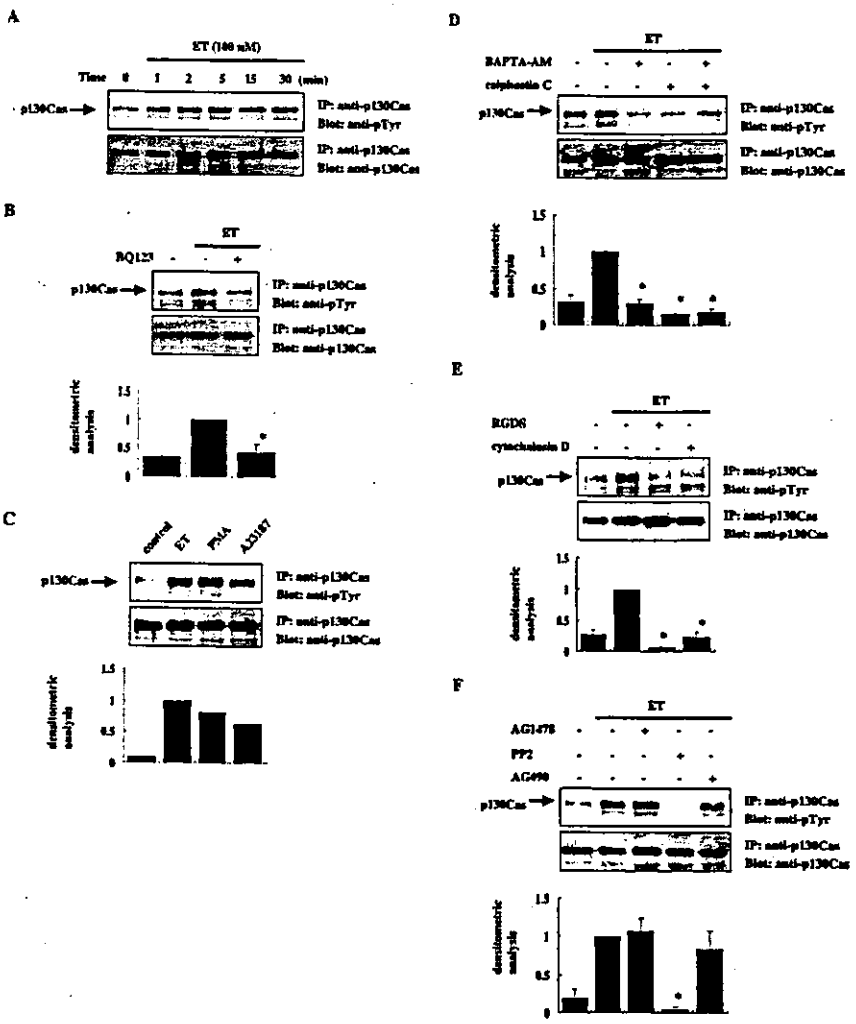

Figure 1. ET-induced tyrosine phosphorylation of p130Cas is dependent on focal adhesion, PKC, Ca^{2+}, and c-Src in cardiomyocytes. A, Cells were stimulated with ET (100 nmol/L) for the indicated times. p130Cas was immunoprecipitated (IP) with anti-p130Cas monoclonal antibody (mAb) and immunoblotted (Blot) with an anti-phosphotyrosine (pTyr) mAb. The same membrane was immunoblotted with an anti-p130Cas mAb to confirm the equal expression of p130Cas. B, Cells were pretreated with or without BQ123 (2 μmol/L) for 30 minutes and stimulated with ET (100 nmol/L) for 15 minutes. C, Cells were left unstimulated (control) or stimulated with ET (100 nmol/L), PMA (1 μmol/L), or A23187 (10 μmol/L) for 15 minutes. D, Cells were pretreated with BAPTA-AM (50 μmol/L) for 30 minutes or calphostin C (1 μmol/L) for 1 hour and stimulated with ET (100 nmol/L) for 15 minutes. E, Cells were pretreated with vehicle (−, DMSO), RGDS (1 mmol/L) overnight, or cytochalasin D (10 μmol/L) for 30 minutes and stimulated with ET. F, Cells were pretreated with vehicle (−, DMSO), AG1478 (250 nmol/L), PP2 (50 μmol/L), or AG490 (20 μmol/L) for 30 minutes and stimulated with ET. All data were quantified by densitometric analysis and expressed as the fold increase compared with ET-stimulated cells (lower panel). *$P<0.05$, significant difference compared with ET-stimulated cells.

p130Cas Forms Temporal Associations With Pyk2, Active c-Src, and Crk in Response to ET

The protein sequence of p130Cas suggests that it might serve as an adapter protein, and p130Cas is thought to recruit cytoskeletal signaling molecules or other SH2 domain–containing molecules.[6,7] We attempted to identify some of the proteins that were observed in p130Cas or Pyk2 immune-complex assays. ET induced a rapid, temporal association of Pyk2 with active c-Src as early as 1 minute (Figure 2A), and thereafter the autokinase activity of Pyk2 gradually increased, peaked at 5 minutes, and then returned to near basal levels at 60 minutes (Figure 2B). After Pyk2 binds to SH2 domains of Src family tyrosine kinases, c-Src is then known to phosphorylate several other sites in Pyk2, which in turn function as binding sites for signaling molecules containing SH2 domains.[12] We next observed that ET increased a transient association of Pyk2 with p130Cas after the increased autokinase activity of Pyk2 (Figure 2C). ET also increased the association of p130Cas with active c-Src (Figure 2D). Moreover, ET enhanced the association of p130Cas with Crk (Figure 2E).

ET-Induced JNK Activation Requires Both Ca^{2+} and PKC and a c-Src–Dependent Signal in Cardiomyocytes

Kudoh et al[28] reported that G protein–coupled receptor (GPCR) stimulation by angiotensin II activated JNK in cardiomyocytes and that the activation of JNK was suppressed by downregulation of PKC or by chelating $[Ca^{2+}]_i$. We confirmed that another GPCR ligand, ET, activated JNK in a time-dependent manner, and ET-induced JNK activation was significantly attenuated by chelating $[Ca^{2+}]_i$ or by calphostin C (Figures 3A and 3B).

Furthermore, JNK activation was abrogated by PP2, whereas AG1478 or AG490 had no effect (Figure 3C). The results of the inhibitory effect of PP2 suggested that Src family kinases were selectively involved in the activation of JNK. Either RGDS or cytochalasin D significantly inhibited JNK activation (Figure 3D). Because activation of p130Cas or Pyk2[16] is also dependent on PKC, $[Ca^{2+}]_i$, and c-Src, it is possible to speculate that JNK activation by ET might be at least partly mediated through the focal adhesion proteins p130Cas or Pyk2 associated with c-Src.

CasΔSD, CrkSH2m, Pyk2, or Csk Significantly Inhibits ET-Induced Activation of JNK but Not of ERK

To confirm that the p130Cas/Crk complex or Pyk2 is critically involved in ET-induced JNK activation, we transfected the cells with HA-JNK1 or HA-ERK2, together with CasΔSD, CrkSH2m, 533delEGFR, Csk, PKM, or d.n.Jak2

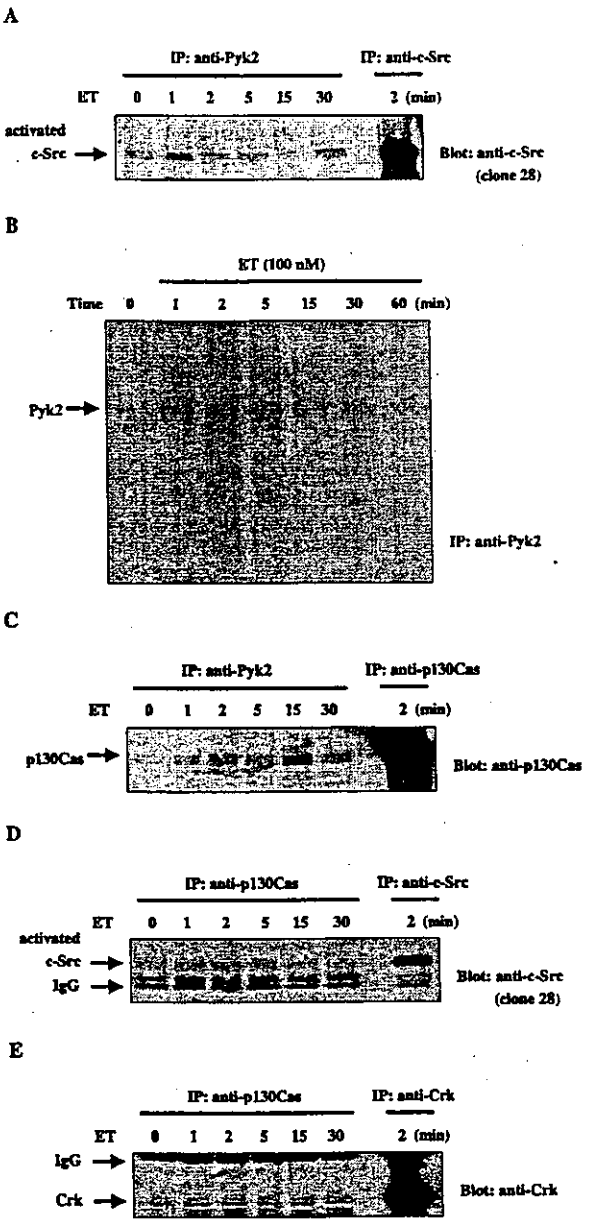

Figure 2. ET augmented p130Cas protein/protein complex formation. Cells were stimulated with ET (100 nmol/L) for the indicated times. A, Pyk2 or c-Src was immunoprecipitated (IP) with an anti-Pyk2 polyclonal antibody (pAb) or an anti-c-Src (SRC2) pAb and immunoblotted (Blot) with an anti-c-Src (clone 28) monoclonal antibody (mAb). B, Pyk2 was immunoprecipitated with an anti-Pyk2 pAb and incubated with γ-[^{32}P]ATP for 30 minutes. After SDS-PAGE, the gels were dried and subjected to autoradiography. C, Pyk2 or p130Cas was immunoprecipitated with an anti-Pyk2 pAb or an anti-p130Cas mAb and immunoblotted with an anti-p130Cas mAb. D, p130Cas or c-Src was immunoprecipitated with an anti-p130Cas pAb or an anti-c-Src (SRC2) pAb and immunoblotted with anti-c-Src (clone 28). E, p130Cas or Crk was immunoprecipitated with an anti-p130Cas pAb or an anti-Crk mAb and immunoblotted with an anti-Crk mAb.

and stimulated them with ET. Overexpression of CasΔSD or CrkSH2m had been previously shown to interfere with p130Cas/Crk signaling.[18] ET-induced JNK activation was strongly attenuated by CasΔSD, CrkSH2m, Csk or PKM, but it was not noticeably inhibited by 533delEGFR or d.n.Jak2

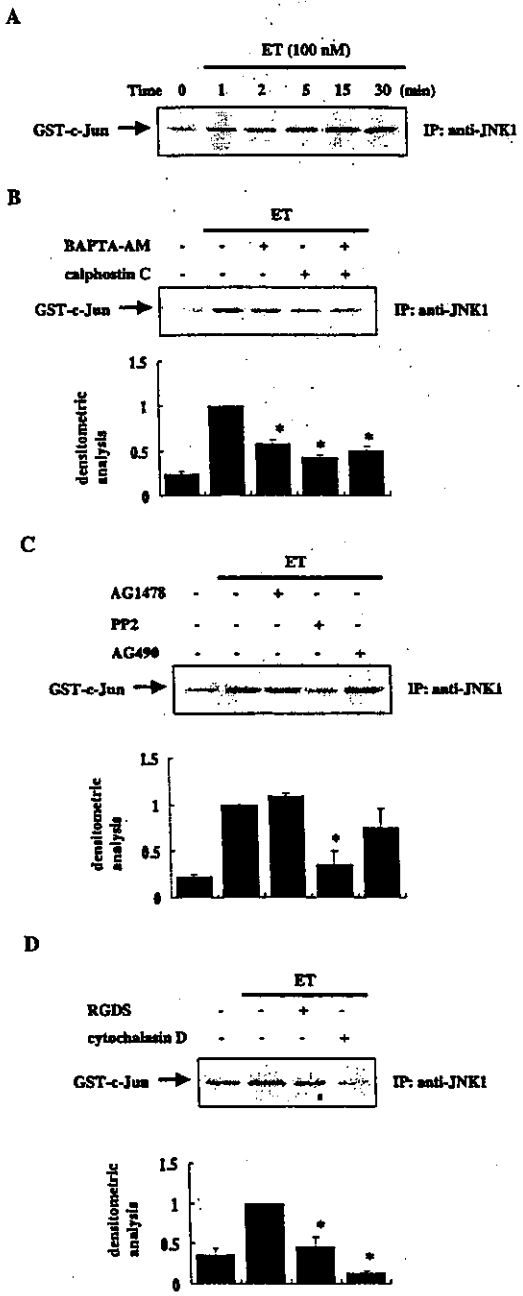

Figure 3. ET-induced activation of JNK required both Ca^{2+} and PKC and c-Src. A, Cells were stimulated with ET (100 nmol/L) for the indicated times. JNK1 was immunoprecipitated (IP) with an anti-JNK1 polyclonal antibody and incubated with GST-c-Jun(1-79) as a substrate. The immunoprecipitates were electrophoresed and subjected to autoradiography. B, Cells were pretreated with BAPTA-AM (50 μmol/L) for 30 minutes or calphostin C (1 μmol/L) for 1 hour and stimulated with ET (100 nmol/L) for 15 minutes. C, Cells were pretreated with vehicle (−, DMSO), AG1478 (250 nmol/L), PP2 (50 μmol/L), or AG490 (20 μmol/L) for 30 minutes and stimulated with ET. D, Cells were pretreated with vehicle (−, DMSO), RGDS (1 mmol/L) overnight, or cytochalasin D (10 μmol/L) for 30 minutes and stimulated with ET. The amount of ^{32}P incorporated into GST-c-Jun(1-79) was determined by densitometry. Graph indicates the fold increase in JNK activity relative to values obtained in ET-stimulated cells (lower panel). Shown is the mean±SD, n=4, *$P<0.05$.

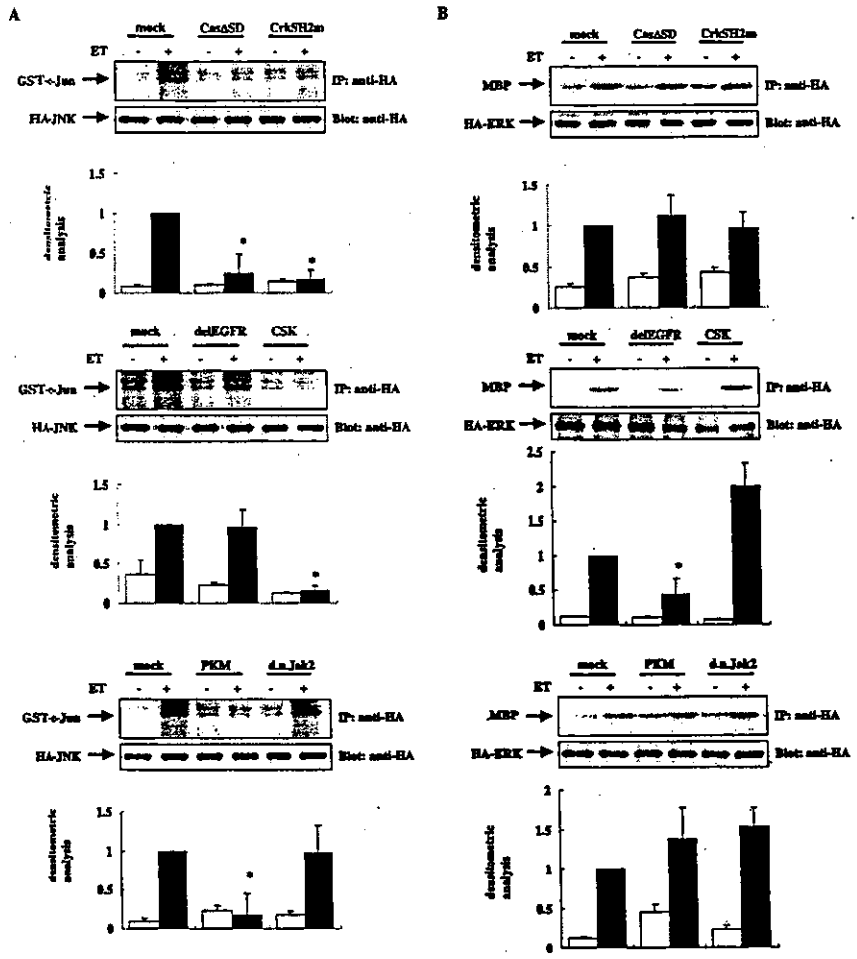

Figure 4. Effect of CasΔSD, CrkSH2m, 533delEGFR, PKM, Csk, or d.n.Jak2 on ET-induced activation of JNK and ERK in cardiomyocytes. A, Cells were transfected with 2 μg HA-JNK1 together with 10 μg of mock plasmid, CasΔSD, CrkSH2m, 533delEGFR, Csk, PKM, or d.n.Jak2. B, Cells were transfected with 2 μg HA-ERK2 together with 10 μg of mock plasmid, CasΔSD, CrkSH2m, 533delEGFR, Csk, PKM, or d.n.Jak2. Cells were incubated with ET (100 nmol/L) for 15 minutes. HA-JNK1 or HA-ERK2 was immunoprecipitated (IP), and activity was measured by in vitro kinase reactions with GST–c-Jun(1-79) or MBP as a substrate. Shown are GST–c-Jun(1-79) or MBP phosphorylation on an autoradiogram, together with levels of HA-JNK1 or HA-ERK2 expression analyzed by immunoblotting with an anti-HA monoclonal antibody (upper panel). The amount of ^{32}P incorporated into GST–c-Jun(1-79) or MBP was determined by densitometry. Graph indicates the fold increase in JNK or ERK activity relative to values obtained in mock-transfected cells (lower panel). Shown is the mean±SD, n=3, $^*P<0.05$.

(Figure 4A). In contrast, ERK activation was attenuated solely by 533delEGFR (Figure 4B). These results, taken together with the inhibitor experiment, indicated that the p130Cas/Crk/Pyk2/c-Src–mediated pathway was selectively involved in ET-induced JNK activation in cardiomyocytes.

ET-Induced Increase in c-*jun* but Not c-*fos* Promoter Activity Is Significantly Inhibited by CasΔSD, CrkSH2 m, PKM, or Csk

It had been demonstrated that JNK phosphorylates c-Jun at the putative regulatory *N*-terminal serine residues and increases their transcriptional activities.[23,29] The phosphorylated c-Jun forms a homodimer or a heterodimer with itself or c-Fos, thus forming the transcription factor activator protein-1, and transactivate many genes, including c-*jun* itself. We further analyzed the involvement of p130Cas, Crkl, Pyk2, c-Src, and EGFR in ET-induced c-*jun* or c-*fos* gene expression by transfecting the cells with c-*jun*-luc or c-*fos*-luc, together with CasΔSD, CrkSH2m, 533delEGFR, Csk, PKM, or d.n.Jak2. The ET-induced increase in c-*jun* promoter activity was significantly suppressed by CasΔSD, CrkSH2m, PKM, and Csk but was not inhibited by 533delEGFR (Figure 5A). On the other hand, the ET-induced increase in c-*fos* promoter activity was significantly suppressed by 533delEGFR and partially suppressed by PKM but was not significantly inhibited by CasΔSD, CrkSH2m, or Csk (Figure 5B). The results shown are also consistent with our previous observation that the ET-induced increase in c-*fos* mRNA levels was attenuated by inhibition of EGFR; however, activation of c-Src or focal adhesion integrity was not required.[16]

Discussion

Tyrosine phosphorylation and protein/protein complex formation of diverse signaling molecules have been identified as prominent early events in cells stimulated by growth factors to regulate cell proliferation, migration, and apoptosis.[2,3] There is considerable evidence that both FAK family kinases and p130Cas/Crk complex formation play a critical role in integrin-mediated signaling. However, most of the studies supporting the role of p130Cas, Crk, or Pyk2 have used immortalized cells, especially fibroblasts, plated on fibronectin-coated dishes, and the significance of integrin-mediated signaling in cardiomyocytes remained to be clarified.

Earlier studies from our laboratory indicated that cytoskeletal protein Pyk2 was tyrosine-phosphorylated in a Ca^{2+}- and PKC-dependent manner after ET stimulation and that the signaling pathways involving Pyk2 or c-Src and EGFR-mediated Shc/ERK activation were distinct pathways.[16] In the present study, we found that p130Cas, like Pyk2, was regulated by both $[Ca^{2+}]_i$ and PKC, independent of transac-

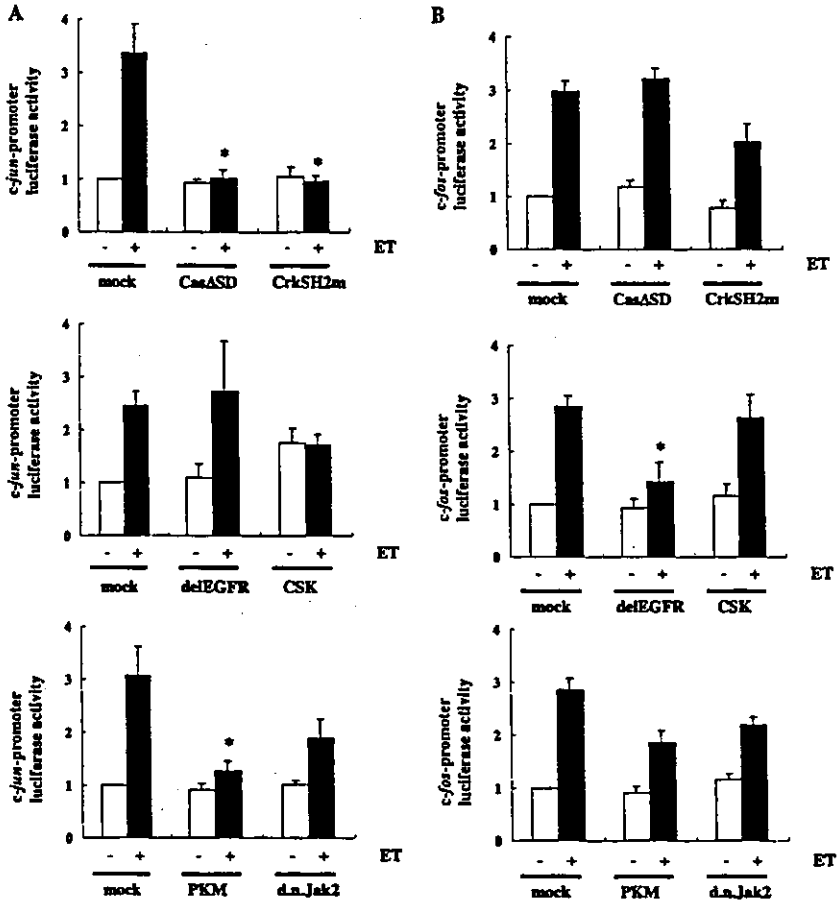

Figure 5. Effect of CasΔSD, CrkSH2m, 533delEGFR, PKM, Csk, or d.n.Jak2 on ET-induced increase in c-*jun* and c-*fos* promoter activity in cardiomyocytes. A, After transfection of c-*jun*-luc together with mock plasmid, CasΔSD, CrkSH2m, 533delEGFR, Csk, PKM, or d.n.Jak2, cells were treated with ET (100 nmol/L) for 10 hours. B, After transfection of c-*fos*-luc together with mock plasmid, CasΔSD, CrkSH2m, 533delEGFR, Csk, PKM, or d.n.Jak2, cells were treated with ET (100 nmol/L) for 3 hours. Cells were harvested and lysed for luciferase assay. Graph indicates the fold increase in c-*jun* or c-*fos* promoter luciferase activity relative to values obtained in mock-transfected cells. Shown is the mean±SD, n=5, $^*P<0.05$.

tivation of the EGFR. Furthermore, both c-Src and focal adhesion integrity are relevant for its activation. Our data also demonstrated that p130Cas/Crk/Pyk2/c-Src signaling was a predominant pathway leading to JNK/c-*jun* activation, in contrast with the prominent EGFR-mediated ERK/c-*fos* activation observed in cardiomyocytes (Figure 6). Many lines of evidence suggest that focal adhesion and receptor tyrosine kinases can function as independently regulated scaffolds, especially in GPCR signaling. Della Rocca et al[26] showed the preference of signaling to be determined by the cell itself,

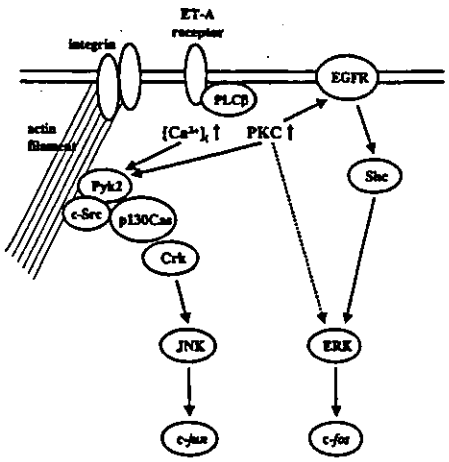

Figure 6. Scheme showing sequence of events in ET signaling.

because the expressed cellular context was significantly different among cell types. In Rat-1 cells, which do not detectably express Pyk2, GPCR-induced FAK phosphorylation is dissociable from ERK activation. Conversely, in Pyk2-expressing cells, Pyk2 can serve as a link from c-Src to the downstream ERK and JNK cascade.[11-13,30] Recent data have also shown that Pyk2 expression and activation can enhance the tyrosine phosphorylation of p130Cas. Thus, in cardiomyocytes abundantly expressing both Pyk2 and p130Cas, Pyk2 can recruit p130Cas and thereby efficiently transduce signaling to the downstream effectors.

Src family tyrosine kinases have been implicated in GPCR signaling, including the ET-A receptor.[27] In vascular smooth muscle cells, angiotensin II stimulation has been shown to induce an association of active c-Src with EGFR, the recruitment of Shc, and EGFR-mediated ERK activation.[22] Overexpression of Csk impairs lysophosphatidic acid (LPA)-induced EGFR phosphorylation in COS-7 cells.[31] In cardiomyocytes, however, overexpression of Csk or a selective Src family kinase inhibitor did not affect ET-induced tyrosine phosphorylation of EGFR, the recruitment of Shc, or ERK activation, as described previously.[16] Dikic et al[12] demonstrated GPCR-induced association of Pyk2 with c-Src through the binding of autophosphorylated Tyr-402 of Pyk2 to the SH2 domain of c-Src, thereby leading to c-Src activation, thus suggesting that Pyk2 phosphorylation mediated by c-Src might generate a docking site for an additional signaling protein recruited by

Pyk2. The functional significance and mechanisms behind the formation of the Pyk2/c-Src complex resemble those described for interactions between FAK and c-Src.[11] The phosphorylation of Tyr-579 and 580 of Pyk2 by c-Src appears to be necessary for maximal Pyk2 kinase activity. Activated c-Src bound to Pyk2 might directly phosphorylate adjacent cellular proteins, such as p130Cas, and thus amplify signals from Pyk2 to downstream effectors. These scenarios are also supported by the present observation that the ET-induced association of Pyk2 with an active c-Src preceded the autophosphorylation of Pyk2, the association of Pyk2 with p130Cas, and that of p130Cas with c-Src and Crk. Furthermore, ET-induced p130Cas tyrosine phosphorylation was significantly inhibited by PP2. Once tyrosine-phosphorylated, p130Cas has been shown to act as a docking protein to recruit Crk and its effectors.[6,7] The SH3 domains of Crk bind to several effectors able to activate JNK, including C3G and DOCK180.[32,33] Dolfi et al[18] reported that JNK activation by the transient expression of p130Cas or Crk was effectively blocked by a dominant-negative mutant of Rac, thus suggesting a linear pathway from the p130Cas/Crk complex to the Rac-mediated JNK pathway. Furthermore, either the SH2 or SH3 mutant of Crk efficiently blocked v-Src–induced JNK activation. Recent studies have demonstrated that c-Src was specifically involved in H_2O_2-mediated JNK activation by way of the p130Cas/Crk signaling pathway in vascular smooth muscle cells and fibroblasts.[34] We also found that c-Src played a critical role not only in the phosphorylation and complex formation of Pyk2 or p130Cas but also in the activation of JNK, which was independent of EGFR-mediated signaling in cardiomyocytes. These data further indicate that p130Cas/Crk signaling involving Pyk2 and c-Src might be selectively recruited in ET-induced JNK activation in cardiomyocytes.

We demonstrated that overexpression of CasΔSD, CrkSH2m, PKM, or Csk could significantly attenuate ET-induced JNK activation, whereas 533delEGFR had no such effect. It is interesting to find that the MAPK subfamily, including ERKs and JNKs, are mediated through different scaffolds, receptor tyrosine kinases and focal adhesion complexes, respectively. The reason for this differential regulation in the MAPK subfamily is largely unknown. It might be partly due to the fact that tissue-specific expression and/or mutual interactions of Pyk2 or p130Cas/Crk with adaptor proteins, including Shc, Grb2, or Sos, will critically regulate the threshold activation of a target pathway, ERK or JNK, in a given cell type.[26,30]

The physiological significance of cytoskeleton-dependent signaling in cardiac hypertrophy has yet to be clarified. Because ET-induced c-*fos* and c-*jun* gene expression was also differentially regulated by independently regulated scaffolds in a similar manner as ERK and JNK activation in cardiomyocytes, one could anticipate that a predominant scaffold will selectively regulate specific cardiac hypertrophic gene induction in response to specific stimuli. Further examination of the functional significance of these cytoskeletal molecules will ultimately improve our understanding of the diversity and heterogeneity in cardiac hypertrophy.

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