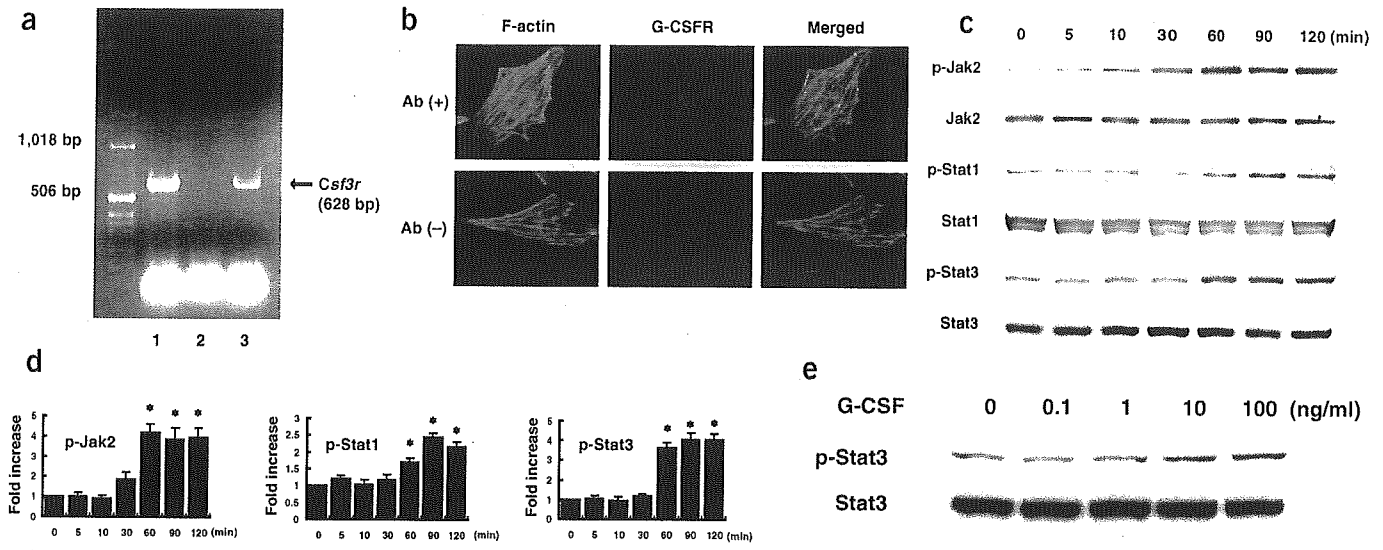

Figure 1 Expression of G-CSFR and the G-CSF-evoked signal transduction in cultured cardiomyocytes. **(a)** RT-PCR for mouse *Csf3r*. Expression of *Csf3r* was detected in the adult mouse heart (lane 1) and cultured cardiomyocytes of neonatal mice (lane 3). In lane 2, reverse transcription products were omitted to exclude the possibility of false-positive results from contamination. **(b)** Immunocytochemical staining for G-CSFR. Cardiomyocytes from neonatal rats were incubated with antibody to G-CSFR (red) and phalloidin (green) (upper panel). In the absence of antibody to G-CSFR, no signal was detected (lower panel). Original magnification, ×1,000. **(c)** G-CSF induces phosphorylation of Jak2, Stat1 and Stat3 in a time-dependent manner in cultured cardiomyocytes. **(d)** Quantification of Jak2, Stat1 and Stat3 activation by G-CSF stimulation as compared with control (time = 0). $^*P < 0.05$ versus control ($n = 3$). **(e)** G-CSF induces phosphorylation and activation of Stat3 in a dose-dependent manner in cultured cardiomyocytes.

has been reported to contribute to G-CSF-induced myeloid differentiation and survival[20,21]. We therefore examined whether G-CSF activates the Jak-Stat signaling pathway in cultured cardiomyocytes. G-CSF (100 ng/ml) significantly induced phosphorylation and activation of Jak2 and Stat3, and to a lesser extent, Stat1 but not Jak1, Tyk2 or Stat5 in a dose-dependent manner (**Fig. 1c–e** and data not shown), suggesting that G-CSFR on cardiomyocytes is functional.

We next examined whether G-CSF confers direct protective effects on cardiomyocytes as it prevents hematopoietic cells from apoptotic death[21]. We exposed cardiomyocytes to 0.1 mM H_2O_2 in the absence or presence of G-CSF and examined cardiomyocyte apoptosis by staining with annexin V[22,23]. Pretreatment with G-CSF significantly reduced the number of H_2O_2-induced annexin V–positive cells compared with cells that were not given the G-CSF pretreatment

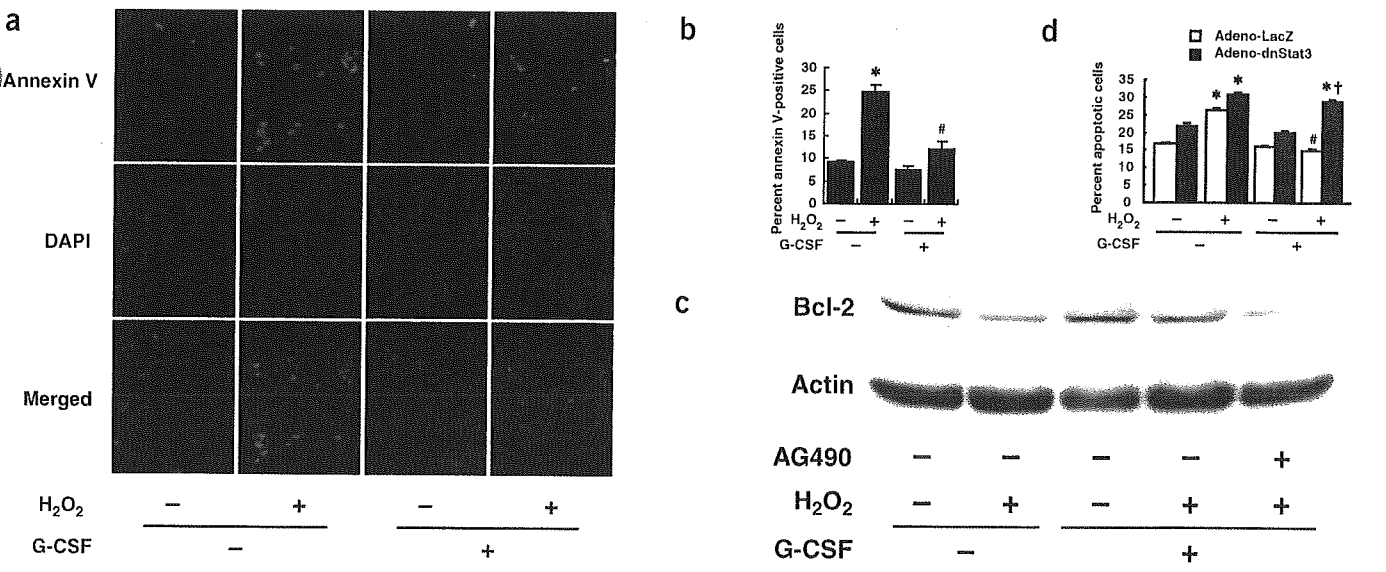

Figure 2 Suppression of H_2O_2-induced cardiomyocyte apoptosis by G-CSF. **(a)** Detection of apoptosis by Cy3-labeled annexin V. Red fluorescence shows apoptotic cardiomyocytes stained with Cy3-labeled annexin V. Nuclei were counterstained with DAPI staining (blue). Original magnification, ×400. **(b)** Quantitative analysis of apoptotic cells. The vertical axis indicates the ratio of the annexin V–positive cell number relative to that of DAPI-positive nuclei. $^*P < 0.01$ versus nontreated cells, $^\#P < 0.05$ versus H_2O_2-treated cells without G-CSF ($n = 3$). **(c)** G-CSF prevents H_2O_2-induced downregulation of Bcl-2 expression ($n = 3$). **(d)** Inhibition of antiapoptotic effects of G-CSF by Adeno-dnStat3. Bar graphs represent quantitative analysis of the apoptotic cell number relative to the total cell number. $^*P < 0.001$ versus H_2O_2 (–)/G-CSF (–), $^\#P < 0.001$ versus H_2O_2 (+)/G-CSF (–), $^\dagger P < 0.001$ versus H_2O_2 (+)/G-CSF (+)/Adeno-LacZ ($n = 3$).

(**Fig. 2a,b**). To investigate the molecular mechanism of how G-CSF exerts an antiapoptotic effect on cultured cardiomyocytes, we examined expression of the Bcl-2 protein family, known target molecules of the Jak-Stat pathway[24], by western blot analysis. Expression levels of antiapoptotic proteins such as Bcl-2 and Bcl-xL were lower when cardiomyocytes were subjected to H_2O_2 (**Fig. 2c** and data not shown), and this reduction was considerably inhibited by G-CSF pretreatment (**Fig. 2c**). AG490, an inhibitor of Jak2, abolished G-CSF-induced Bcl-2 expression (**Fig. 2c**) but did not affect its basal levels (**Supplementary Fig. 3** online), suggesting a crucial role of the Jak-Stat pathway in inducing survival of cardiomyocytes by G-CSF. To further elucidate the involvement of the Jak-Stat pathway in the protective effects of G-CSF on cardiomyocytes, we transduced cultured cardiomyocytes with adenovirus encoding dominant-negative Stat3 (Adeno-dnStat3). G-CSF treatment significantly reduced apoptosis induced by H_2O_2 in Adeno-LacZ-infected cardiomyocytes (**Fig. 2d**). This effect was abolished by introduction of Adeno-dnStat3 (**Fig. 2d**), suggesting that Stat3 mediates the protective effects of G-CSF on H_2O_2-induced cardiomyocyte apoptosis.

Effects of G-CSF on cardiac function after myocardial infarction

Consistent with the *in vitro* data, G-CSF enhanced activation of Stat3 in the infarcted heart (**Fig. 3a**). Notably, the levels of G-CSFR were markedly increased after myocardial infarction in cardiomyocytes (**Supplementary Fig. 4** online), which may enhance the effects of G-CSF on the infarcted heart. To elucidate the role of G-CSF-induced Stat3 activation in cardiac remodeling, we produced myocardial infarction in transgenic mice which express dominant-negative Stat3 in cardiomyocytes under the control of the α-myosin heavy chain promoter (dnStat3-Tg). Administration of G-CSF was started at the time of coronary artery ligation (day 0) until day 4 in transgenic mice; we termed this group Tg-G mice. A control group of dnStat3-Tg mice given myocardial infarction received saline (Tg-cont) instead of G-CSF. We also included two groups of wild-type mice given myocardial infarction treated with G-CSF (Wt-G) or saline (Wt-cont). At 2 weeks after myocardial infarction, we assessed the morphology by histological analysis and measured cardiac function by echocardiography and catheterization analysis. The infarct area was significantly smaller in the Wt-G group than the Wt-cont group (**Fig. 3b**). The Wt-G group also showed less left ventricular end-diastolic dimension (LVEDD) and better fractional shortening as assessed by echocardiography, and lower end-diastolic pressure (LVEDP) and better $+dp/dt$ and $-dp/dt$ as assessed by cardiac catheterization compared with Wt-cont (**Fig. 3c**). The beneficial effects of G-CSF on cardiac function were dose dependent and were significantly reduced by delayed start of the treatment (**Fig. 3d,e** and **Supplementary Fig. 5** online). Moreover, its favorable effects on cardiac function became evident within 1 week after the treatment (**Fig. 3f**). Disruption of the Stat3 signaling pathway in cardiomyocytes abolished the protective effects of G-CSF. There was no significant difference in LVEDD, fractional shortening, LVEDP, $+dp/dt$ and $-dp/dt$ between Tg-G and Tg-cont (**Fig. 3c**). We obtained similar results from infarcted female hearts (**Fig. 3g**). These results suggest that G-CSF protects the heart after myocardial infarction at least in part by directly activating Stat3 in cardiomyocytes, which is a gender-independent effect. We have previously shown that treatment with G-CSF significantly ($P < 0.05$) decreased myocardial infarction–related mortality of wild-type mice[2]. In contrast, there were no significant differences in mortality between G-CSF-treated and saline-treated dnStat3-Tg mice (data not shown).

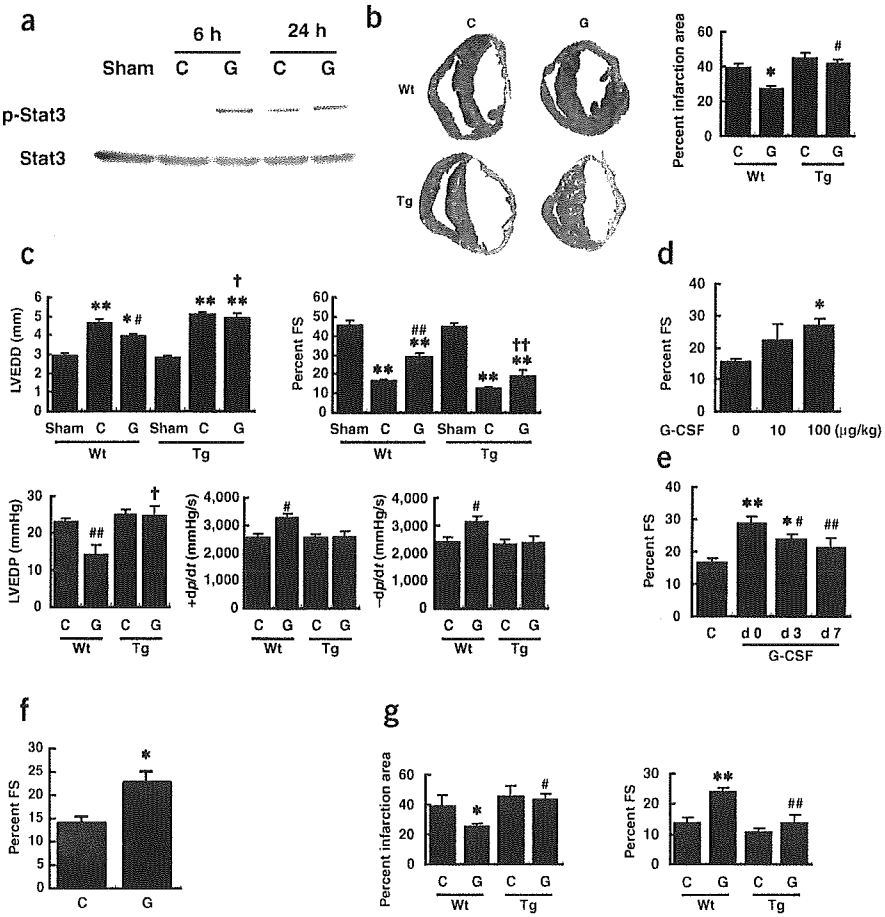

Figure 3 Effects of G-CSF on cardiac function after myocardial infarction. (**a**) Stat3 activation in the infarcted hearts. We operated on wild-type mice to induce myocardial infarction and treated them with G-CSF (G) or saline (C). (**b**) Masson trichrome staining of wild-type (Wt) and dnStat3-Tg (Tg) hearts. $^{*}P < 0.001$ versus Wt-cont, $^{\#}P < 0.001$ versus Wt-G ($n = 11$–15). (**c**) G-CSF treatment preserves cardiac function after myocardial infarction. $^{*}P < 0.01$, $^{**}P < 0.001$ versus sham; $^{\#}P < 0.05$, $^{\#\#}P < 0.001$ versus Wt-cont; $^{\dagger}P < 0.01$, $^{\dagger\dagger}P < 0.001$ versus Wt-G ($n = 10$–15 for echocardiography and $n = 5$ for catheterization analysis). (**d**) Dose-dependent effects of G-CSF. FS, fractional shortening. $^{*}P < 0.01$ versus saline-treated mice (G-CSF = 0)($n = 12$–14). (**e**) Wild-type mice were operated to induce myocardial infarction and G-CSF treatment (100 μg/kg/d) was started from the indicated day for 5 d. $^{*}P < 0.05$, $^{**}P < 0.001$ versus saline-treated mice (C); $^{\#}P < 0.05$, $^{\#\#}P < 0.01$ versus mice treated at day 0 (d 0) ($n = 11$–12). (**f**) Effects of G-CSF on cardiac function at 1 week. $^{*}P < 0.05$ versus control ($n = 3$). (**g**) Effects of G-CSF on cardiac function of female mice. $^{*}P < 0.05$, $^{**}P < 0.001$ versus Wt-cont; $^{\#}P < 0.05$, $^{\#\#}P < 0.005$ versus Wt-G ($n = 4$–5).

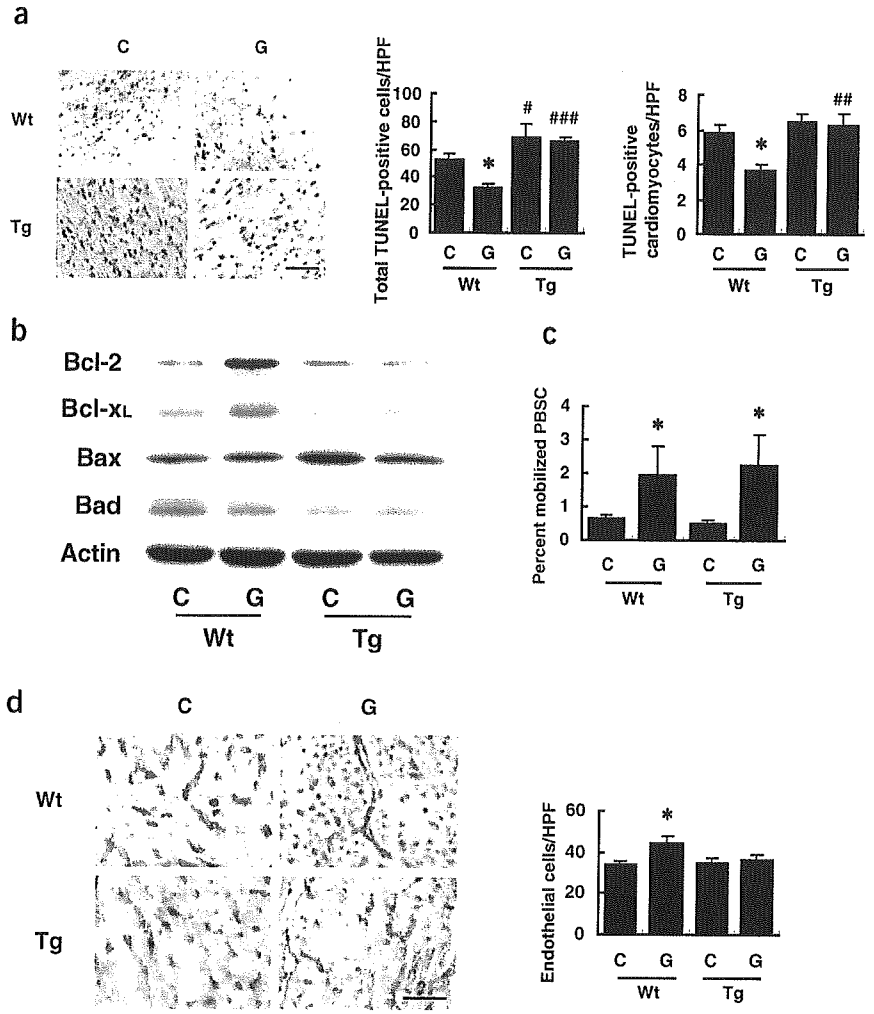

Figure 4 Mechanisms of the protective effects of G-CSF. (**a**) TUNEL staining (brown nuclei) in the infarcted hearts. The graphs show quantitative analyses for total TUNEL-positive cells (left graph) and TUNEL-positive cardiomyocytes (right graph) in infarcted hearts. $^{*}P < 0.01$ versus Wt-cont; $^{\#}P < 0.05$, $^{\#\#}P < 0.005$, $^{\#\#\#}P < 0.001$ versus wild-type mice with the same treatment ($n = 5$–7). Scale bar, 100 μm. (**b**) Infarcted hearts treated with G-CSF (G) or saline (C) were analyzed for expression of Bcl-2, Bcl-xL, Bax and Bad by western blotting ($n = 3$). (**c**) Mobilization of hematopoietic stem cells into peripheral blood (PBSC). $^{*}P < 0.05$ versus saline-treated mice ($n = 4$). (**d**) Capillary endothelial cells were identified by immunohistochemical staining with anti-PECAM antibody in the border zone of the infarcted hearts. Scale bar, 100 μm. The number of endothelial cells was counted and shown in the graph ($n = 6$–8). $^{*}P < 0.05$.

Mechanisms of the protective effects of G-CSF

Our *in vitro* results suggest that the protective effects of G-CSF on cardiac remodeling after myocardial infarction can be attributed in part to reduction of cardiomyocyte apoptosis. To determine whether the Stat3 pathway in cardiomyocytes mediates the antiapoptotic effects of G-CSF on the ischemic myocardium, we carried out TUNEL labeling of left ventricular sections 24 h after myocardial infarction in wild-type mice and dnStat3-Tg mice. Although the number of TUNEL-positive cells was significantly less in the Wt-G group than the Wt-cont group, G-CSF treatment had no effect on cardiomyocyte apoptosis in dnStat3-Tg mice (**Fig. 4a**). The effects of G-CSF on apoptosis after myocardial infarction were also attenuated when mice were treated with AG490 (**Supplementary Fig. 6** online). Myocardial infarction–related apoptosis was significantly increased in the Tg-cont group and AG490-treated wild-type mice compared with Wt-cont mice (**Fig. 4a** and **Supplementary Fig. 6** online), suggesting that endogenous activation of Stat3 has a protective role in the infarcted heart, as reported previously[25]. It is noteworthy that G-CSF treatment inhibited apoptosis of noncardiomyocytes including endothelial cells and that this inhibition was abolished in dnStat3-Tg mice (**Fig. 4a** and data not shown). To investigate the underlying molecular mechanism of the antiapoptotic effects of G-CSF *in vivo*, we examined expression of the Bcl-2 protein family by western blot analysis. Consistent with our *in vitro* results, expression of antiapoptotic proteins such as Bcl-2 and Bcl-xL was significantly increased in the Wt-G group at 24 h after myocardial infarction compared with the Wt-cont group, whereas expression of the proapoptotic proteins Bax and Bad was not affected by the treatment (**Fig. 4b**). In contrast, expression levels of antiapoptotic proteins were not increased by G-CSF in the Tg-G group (**Fig. 4b**). Immunohistochemical analysis also showed increased expression of Bcl-2 in the infarcted heart of the Wt-G group but not of the Tg-G group (**Supplementary Fig. 7** online).

To determine the effects of G-CSF on mobilization of stem cells, we counted the number of cells positive for both Sca-1 and c-kit in peripheral blood samples from mice treated with G-CSF or saline. The G-CSF treatment similarly increased the number of double-positive cells in wild-type mice and dnStat3-Tg mice (**Fig. 4c**). To examine the impact of G-CSF on cardiac homing of bone marrow cells, we transplanted bone marrow cells derived from GFP transgenic mice into wild-type and dnStat3-Tg mice, produced myocardial infarction and treated with G-CSF or saline. FACS analysis showed that G-CSF did not increase cardiac homing of bone marrow cells in wild-type and dnStat3-Tg mice (**Supplementary Fig. 8** online). We have shown that cardiac stem cells, which are able to differentiate into cardiomyocytes, exist in Sca-1-positive populations in the adult myocardium[26]. But G-CSF treatment did not affect the number of Sca-1-positive cells in the infarcted hearts of wild-type or dnStat3-Tg mice (**Supplementary Fig. 9** online). Thus, it is unlikely that G-CSF exerts its beneficial effects through expansion of cardiac stem cells. To determine the effects of G-CSF on proliferation of cardiomyocytes, we carried out immunostaining for Ki67, a marker for cell cycling, in conjunction with a labeling for troponin T. The number of Ki67-positive cardiomyocytes was increased in the infarcted hearts of wild-type mice and dnStat3-Tg mice compared with sham-operated mice (**Supplementary Fig. 10** online). But G-CSF did not alter the number of Ki67-positive cardiomyocytes in wild-type or dnStat3-Tg mice, suggesting that G-CSF does not induce proliferation of cardiomyocytes (**Supplementary Fig. 10** online). The number of Ki67-positive cardiomyocytes was less in infarcted hearts of dnStat3-Tg mice than in those of wild-type mice, suggesting that endogenous Stat3 activity is required

for myocardial regeneration after myocardial infarction and that activation of Stat3 by G-CSF is not sufficient for cardiomyocytes to enter the cell cycle in infarcted hearts of wild-type mice (**Supplementary Fig. 10** online). In contrast, G-CSF treatment significantly increased the number of endothelial cells in the border zone of the infarcted hearts (**Fig. 4d**). This increase was attenuated in dnStat3-Tg mice, indicating that the increased vascularity is mediated by Stat3 activity in cardiomyocytes and may partially account for the beneficial effects of G-CSF on the infarcted hearts. Taken together with the result that G-CSF-induced inhibition of noncardiomyocyte apoptosis was also mediated by the Stat3 signaling pathway in cardiomyocytes (**Fig. 4a**), these findings imply that communication between cardiomyocytes and noncardiomyocytes regulates each others' survival.

To further test whether G-CSF acts directly on the heart, we examined the effects of G-CSF treatment on cardiac function after ischemia-reperfusion injury in a Langendorff perfusion model. The isolated hearts underwent 30 min total ischemia followed by 120 min reperfusion with the perfusate containing G-CSF (300 ng/ml) or vehicle, and left ventricular developed pressure (LVDP, measured as the difference between systolic and diastolic pressures of the left ventricle) and LVEDP were measured. There were no significant differences in basal hemodynamic parameters including heart rate, left ventricular pressure, LVEDP and positive and negative dp/dt, between the control group and G-CSF group (**Table 1**). After reperfusion, however, G-CSF-treated hearts started to beat earlier than those of the control group (**Fig. 5a**). At 120 min after reperfusion, contractile function (LVDP) of G-CSF-treated hearts was significantly better than that of control hearts (**Fig. 5a**). Likewise, diastolic function (LVEDP) of G-CSF-treated hearts was better than that of control hearts (**Fig. 5a**). After ischemia-reperfusion, there was more viable myocardium (red lesion) in G-CSF-treated hearts than control hearts (**Fig. 5b**). The size of the infarct (white lesion) was significantly smaller in G-CSF-treated hearts than in control hearts (**Fig. 5b**).

Table 1 Basal hemodynamic parameters

	Control ($n = 7$)	G-CSF ($n = 7$)
HR (b.p.m.)	326 ± 34	334 ± 24
LVP (mmHg)	121.8 ± 24	117.3 ± 32
LVEDP (mmHg)	4.3 ± 1.3	4.5 ± 1.6
$+dp/dt$ (mmHg/s)	7,554 ± 643	7,657 ± 377
$-dp/dt$ (mmHg/s)	6,504 ± 638	6,670 ± 602

HR, heart rate; b.p.m., beats per minute; LVP, left ventricular pressure; LVEDP, left ventricular end-diastolic pressure; $+dp/dt$ and $-dp/dt$, positive and negative first derivatives for maximal rates of left ventricular pressure development.

DISCUSSION

In the present study, G-CSFR was found to be expressed on cardiomyocytes and cardiac fibroblasts, and G-CSF activated Jak2 and the downstream signaling molecule Stat3 in cultured cardiomyocytes. Treatment with G-CSF protected cultured cardiomyocytes from apoptotic cell death possibly through upregulation of Bcl-2 and Bcl-xL expression, suggesting that G-CSF has direct protective effects on cardiomyocytes through G-CSFR and the Jak-Stat pathway. This idea is further supported by the *in vivo* experiments. G-CSF enhanced Stat3 activity and increased expression of Bcl-2 and Bcl-xL in the infarcted heart where G-CSFR was markedly upregulated, thereby preventing cardiomyocyte apoptosis and cardiac dysfunction. These effects of G-CSF were abolished when Stat3 activation was disrupted in cardiomyocytes, suggesting that a direct action of G-CSF on cardiomyocytes has a crucial role in preventing left ventricular remodeling after myocardial infarction. Because noncardiomyocytes also expressed G-CSFR, the possibility exists that activation of G-CSF receptors on these cells modulates the beneficial effects of G-CSF on infarcted hearts.

The mobilization of bone marrow stem cells (BMSC) to the myocardium has been considered to be the main mechanism by which G-CSF ameliorates cardiac remodeling after myocardial infarction[1,6–8]. In this study, we showed that G-CSF reduces apoptotic cell death and effectively protects the infarcted heart, which is dependent on its direct action on cardiomyocytes through the Stat3 pathway. This antiapoptotic mechanism seems to be more important than induction of BMSC mobilization, because disruption of

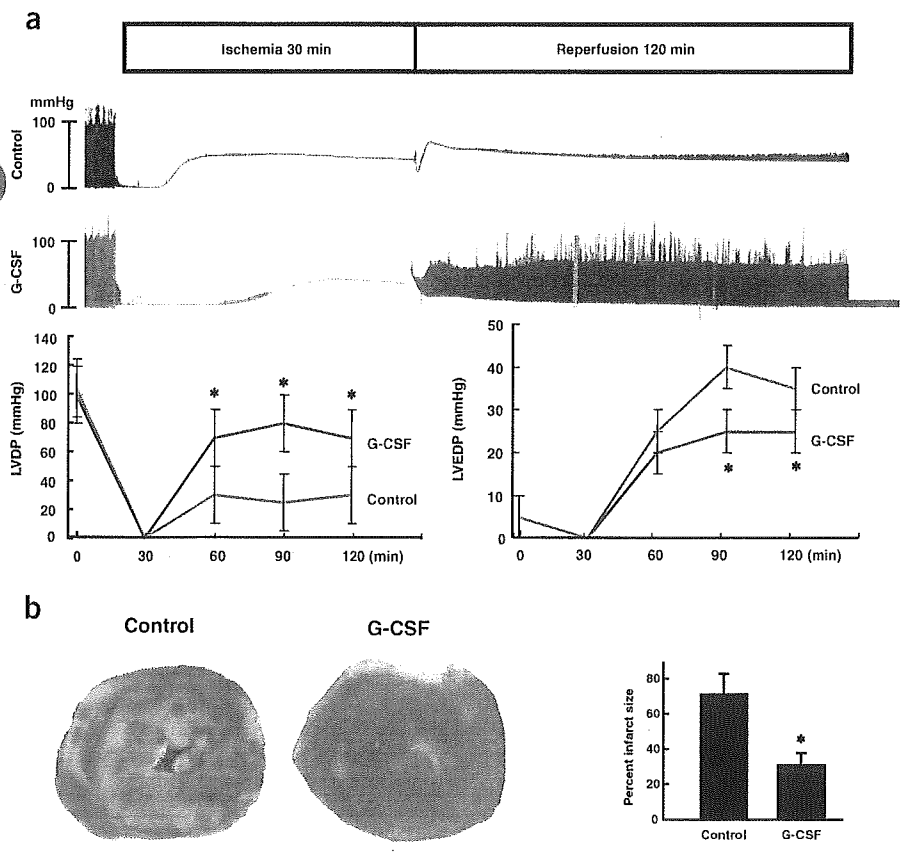

Figure 5 Direct effects of G-CSF on cardiac function after ischemia-reperfusion injury. (**a**) Representative left ventricular pressure records of control and G-CSF-treated hearts are shown (upper panel). The graphs show changes in LVDP (left) and LVEDP (right) during ischemia-reperfusion. $^*P < 0.05$ versus control hearts ($n = 7$). (**b**) The photographs show representative TTC staining of control hearts (Control) and G-CSF-treated hearts (G-CSF) after ischemia-reperfusion. The graph indicates myocardial infarct sizes for control hearts (Control) and G-CSF-treated hearts (G-CSF). Infarct sizes were calculated as described in **Supplementary Methods** online. $^*P < 0.05$ versus control hearts ($n = 7$).

this pathway by expressing dnStat3 in cardiomyocytes almost abolished the protective effects of G-CSF on cardiac remodeling after myocardial infarction. In addition, there was no difference in the effects of G-CSF on mobilization and cardiac homing of bone marrow cells, expansion of cardiac stem cells, and proliferation of cardiomyocytes between wild-type and dnStat3-Tg mice. The beneficial effects of G-CSF and stem cell factor on the infarcted heart has been described, but no evidence indicating that G-CSF induced cardiac homing of bone marrow cells in the infarcted heart has been shown[1]. In this study, we found favorable effects of G-CSF on the infarcted heart as early as 1 week after the treatment even though cardiac homing of bone marrow cells was not increased. Thus, we conclude that increased cardiac homing of bone marrow cells cannot account for improved function of the infarcted heart after G-CSF treatment.

The JAK-STAT pathway has been shown to induce various angiogenic factors besides antiapoptotic proteins[20,21]. The number of endothelial cells in the border zone was increased by G-CSF through Stat3 activation in cardiomyocytes. Consistent with this, we noted that G-CSF induces cardiac expression of angiogenic factors *in vitro* and *in vivo*, which appears to be mediated by cardiac Stat3 activation (M.H., Y.Q., H.T., T.M. & I.K., unpublished data). Moreover, we observed that the majority of apoptotic cells in the infarcted hearts was endothelial cells and that endothelial apoptosis was significantly inhibited by G-CSF treatment in wild-type mice but not in dnStat3-Tg mice (**Fig. 4a** and M.H., T.M. & I.K., unpublished data). Thus, activation of this pathway in cardiomyocytes by G-CSF may also promote angiogenesis and protect against endothelial apoptosis by producing angiogenic factors, resulting in the further prevention of cell death of cardiomyocytes and cardiac remodeling after myocardial infarction. The results in this study provide new mechanistic insights of the G-CSF therapy on infarcted hearts.

METHODS

For further details, please see **Supplementary Methods** online.

Cell culture. Cardiomyocytes prepared from ventricles of 1-d-old Wistar rats[27] were plated onto 60-mm plastic culture dishes at a concentration of 1×10^5 cells/cm^2 and cultured in Dulbecco modified Eagle medium (DMEM) supplemented with 10% fetal bovine serum (FBS) at 37 °C in a mixture of 95% air and 5% CO_2. The culture medium was changed to serum-free DMEM 24 h before stimulation. Generation and infection of recombinant adenovirus were performed as described[28].

Percoll enrichment of adult mouse cardiomyocytes and noncardiomyocytes. Adult mouse cardiomyocytes were prepared from 10-week-old C57BL/6 male mice according to the Alliance for Cellular Signaling protocol. We also prepared cardiomyocytes and noncardiomyocytes from myocardial infarction-operated or sham-operated C57BL/6 male mice. After digestion, cells were dissociated, resuspended in differentiation medium and loaded onto a discontinuous Percoll gradient. Cardiomyocytes or noncardiomyocytes were separately collected as described previously[29] and subsequently washed with 1 × phosphate-buffered saline for RT-PCR.

RNA extraction and RT-PCR analysis. Total RNA from adult mice cardiomyocytes was isolated by the guanidinium thiocyanate-phenol chloroform method. A total of 4 μg RNA was transcribed with MMLV reverse transcriptase and random hexamers. The cDNA was amplified using a mouse *Csf3r* exon 15 forward primer (5′-GTACTCTTGTCCACTACCTGT -3′) and an exon 17 reverse primer (5′-CAAGATACAAGGACCCCCAA -3′). We performed PCR under the following conditions: an initial denaturation at 94 °C for 2 min followed by a cycle of denaturation at 94 °C for 1 min, annealing at 58 °C for 1 min and extension at 72 °C for 1 min. We subjected samples to 40 cycles followed by a final extension at 72 °C for 3 min. The products were analyzed on a 1.5% ethidium bromide stained agarose gel.

Immunocytochemistry. Cardiomyocytes or noncardiomyocytes of neonatal rats cultured on glass cover slips were incubated with or without the antibody to G-CSFR (Santa Cruz Biotechnology) for 1 h, followed by incubation with Cy3-labeled secondary antibodies. After washing, we double-stained the cells with fluorescent phalloidin (Molecular Probes) for 1 h at room temperature.

Western blots. Western blot analysis was performed as described[5]. We probed the membranes with antibodies to phospho-Jak2, phospho-Stat3 (Cell Signaling), phospho-Jak1, phospho-Tyk2, phospho-Stat1, phospho-Stat5, anti-Jak1, Jak2, Tyk2, Stat1, Stat3, Stat5, Bcl-2, Bax, G-CSFR (Santa Cruz Biotechnology), Bcl-xL, Bad (Transduction Laboratories) or actin (Sigma-Aldrich). We used the ECL system (Amersham Biosciences Corp) for detection.

Animals and surgical procedures. Generation and genotyping of dnStat3-Tg mice have been previously described[28]. All mice used in this study were 8–10-week-old males, unless indicated. All experimental procedures were performed according to the guidelines established by Chiba University for experiments in animals and all protocols were approved by our institutional review board. We anesthetized mice by intraperitoneally injecting a mixture of 100 mg/kg ketamine and 5 mg/kg xylazine. Myocardial infarction was produced by ligation of the left anterior descending artery. We operated on dnStat3-Tg mice to induce myocardial infarction and randomly divided them into two groups, the G-CSF-treated group (10–100 μg/kg/d subcutaneously for 5 d consecutively, Kyowa Hakko Kogyo Co.) and the saline-treated group. We operated on nontransgenic mice as control groups using the same procedures and divided them into a G-CSF-treated group and a saline-treated group. Some mice were randomly chosen to be analyzed for initial area at risk by injection of Evans blue dye after producing myocardial infarction. There was no difference in initial area sizes at risk between saline-treated control and G-CSF-treated mice ($n = 5$; **Supplementary Fig. 11** online). We also determined initial infarct size by triphenyltetrazolium chloride staining on day 3. There was no significant difference in initial infarct size between saline-treated control and G-CSF-treated mice ($n = 5$; **Supplementary Fig. 12** online).

Echocardiography and catheterization. Transthoracic echocardiography was performed with an Agilent Sonos 4500 (Agilent Technology Co.) provided with an 11-MHz imaging transducer. For catheterization analysis, the right carotid artery was cannulated under anesthesia by the micro pressure transducers with an outer diameter of 0.42 mm (Samba 3000; Samba Sensors AB), which was then advanced into the left ventricle. Pressure signals were recorded using a MacLab 3.6/s data acquisition system (AD Instruments) with a sampling rate of 2,000 Hz. Mice were anesthetized as described above, and heart rate was kept at approximately 270–300 beats per minute to minimize data deviation when we measured cardiac function.

Histology. Hearts fixed in 10% formalin were embedded in paraffin, sectioned at 4 μm thickness, and stained with Masson trichrome. The extent of fibrosis was measured in three sections from each heart and the value was expressed as the ratio of Masson trichrome stained area to total left ventricular free wall. For apoptosis analysis, infarcted hearts were frozen in cryomolds, sectioned, and TUNEL labeling was performed according to the manufacturer's protocol (*In Situ* Apoptosis Detection kit; Takara) in combination with immunostainings for appropriate cell markers. Digital photographs were taken at magnification ×400, and 25 random high-power fields (HPF) from each heart sample were chosen and quantified in a blinded manner. We examined vascularization by measuring the number of capillary endothelial cells in light-microscopic sections taken from the border zone of the hearts 2 weeks after myocardial infarction. Capillary endothelial cells were identified by immunohistochemical staining with antibody to platelet endothelial cell adhesion molecule (PECAM; Pharmingen). Ten random microscopic fields in the border zone were examined and the number of endothelial cells was expressed as the number of PECAM-positive cells/HPF (magnification, ×400).

Statistical analysis. Data are shown as mean ± s.e.m. Multiple group comparison was performed by one-way analysis of variance (ANOVA) followed by the Bonferroni procedure for comparison of means. Comparison between two groups were analyzed by the two-tailed Student's *t*-test or two-way ANOVA. Values of $P < 0.05$ were considered statistically significant.

URL. Alliance for Cellular Signaling Procedure Protocols
http://www.signaling-gateway.org/data/cgi-bin/Protocols.cgi?cat=0

Note: Supplementary information is available on the Nature Medicine website.

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COMPETING INTERESTS STATEMENTS
The authors declare that they have no competing financial interests.

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Phosphatidylinositol 3-Kinase–Akt Pathway Plays a Critical Role in Early Cardiomyogenesis by Regulating Canonical Wnt Signaling

Atsuhiko T. Naito, Hiroshi Akazawa, Hiroyuki Takano, Tohru Minamino, Toshio Nagai, Hiroyuki Aburatani, Issei Komuro

Abstract—We have recently reported that activation of phosphatidylinositol 3-kinase (PI3K) plays a critical role in the early stage of cardiomyocyte differentiation of P19CL6 cells. We here examined molecular mechanisms of how PI3K is involved in cardiomyocyte differentiation. DNA chip analysis revealed that expression levels of Wnt-3a were markedly increased and that the Wnt/β-catenin pathway was activated temporally during the early stage of cardiomyocyte differentiation of P19CL6 cells. Activation of the Wnt/β-catenin pathway during this period was required and sufficient for cardiomyocyte differentiation of P19CL6 cells. Inhibition of the PI3K/Akt pathway suppressed the Wnt/β-catenin pathway by activation of glycogen synthase kinase-3β (GSK-3β) and degradation of β-catenin. Suppression of cardiomyocyte differentiation by inhibiting the PI3K/Akt pathway was rescued by forced expression of a nonphosphorylated, constitutively active form of β-catenin. These results suggest that the PI3K pathway regulates cardiomyocyte differentiation through suppressing the GSK-3β activity and maintaining the Wnt/β-catenin activity. (*Circ Res.* **2005;97:144-151.**)

Key Words: PI3K ■ Akt ■ Wnt ■ cardiomyocyte differentiation

The heart is the first organ to be formed from mesodermal cells during embryogenesis, and its developmental process consists of multiple steps such as commitment of immature mesodermal cells into cardiac mesodermal cells, subsequent differentiation of cardiac mesodermal cells into cardiomyocytes, and morphogenesis of the chambered heart. The study of cell fate mapping has revealed that the cells committed into cardiac cell fate are delineated in the posterior lateral region of the epiblast of the mouse embryo during the early gastrulation. These progenitor cells migrate through the node and primitive streak to a cranial destination, and start to express cardiac transcription factors such as Nkx-2.5 and GATA-4.[1,2] After gastrulation, these cells move to the anterior lateral part of the embryo and merge at their anterior margins to form cardiac crescent. Then these cells move ventrally and fuse at the midline to create linear heart tube.[3] Advances in molecular biology made it possible to identify many important cardiac transcription factors such as Nkx-2.5, GATA-4, HAND1/2, and MEF2C that serially or synergistically induce the expression of cardiac specific genes and regulate morphogenesis of the developing heart. These genes are also used as a marker for cardiomyocyte differentiation in developing embryos.

Mechanisms of how mesodermal cells are committed to cardiac mesodermal cells, in other words, mechanisms of how expression of these transcription factors are regulated initially, have been largely unknown. Explant cultures of the amphibian and avian embryos revealed that secreted proteins from neighboring endoderm, ectoderm, and the mesoderm itself, play important roles in induction of cardiac transcription factors and differentiation of cardiomyocytes.[4] Among such molecules, bone morphogenetic proteins (BMP) and fibroblast growth factors (FGF) have been reported to induce cardiomyocyte differentiation from noncardiac mesodermal cells.[5,6] However, several recent studies reported that BMP is required for the maintenance but not for the induction of cardiac transcription factors.[7,8] Moreover, FGF expression seems to be downstream of BMP,[6] indicating that molecules other than BMP and FGF are required for initial expression of cardiac transcription factors.

Wnt signaling is involved in the development of many organs of various species.[9] In Drosophila, wingless, a homologue of vertebrate Wnt has been reported to be involved in initial expression of tinman, a Drosophila homologue of Nkx-2.5, through armadillo, a Drosophila homologue of β-catenin, and drives heart development.[10] In vertebrates, however, canonical Wnt pathway, which uses β-catenin as a downstream molecule, has been reported to inhibit cardiomyocyte differentiation from cardiac mesoderm.[11–13] On the

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From the Department of Cardiovascular Science and Medicine (A.T.N., H. Akazawa, H.T., T.M., T.N., I.K.), Chiba University Graduate School of Medicine, Japan; and the Research Center for Advanced Science and Technology (H. Aburatani), University of Tokyo, Japan.

Correspondence to Dr Issei Komuro, Department of Cardiovascular Science and Medicine, Chiba University Graduate School of Medicine, 1-8-1 Inohana, Chuo-ku, Chiba 260-8670, Japan. E-mail komuro-tky@umin.ac.jp

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other hand, Pandur and colleagues reported that Wnt-11, which uses noncanonical Wnt pathway independently of β-catenin,[14] was required and sufficient for cardiomyocyte differentiation.[15] These reports collectively suggest that noncanonical Wnt pathway plays a positive role, whereas canonical Wnt pathway plays a negative role in cardiomyocyte differentiation.

In spite of the well-designed studies using explant cultures in amphibian or avian embryos, it is difficult to dissect the role of various factors such as BMP, FGF, and Wnt in the cardiac development through the whole process. Moreover, it is hard to elucidate the mechanism of commitment of mesodermal cells into cardiomyocytes in mammalians because of difficulty in explant culture using mammalian embryo of a very early stage. From this viewpoint, in vitro differentiation system, in particular P19CL6 cells, a clonal derivative of murine teratocarcinoma P19 cells, is a very useful model. We have recently demonstrated that TAK-1 and Smad proteins play critical roles in cardiomyocyte differentiation downstream of BMP receptor.[16,17] More recently, Nakamura et al have reported that canonical Wnt pathway is required for differentiation of P19CL6 cells into cardiomyocytes.[18]

We have recently reported that phosphatidylinositol 3-kinase (PI3K) pathway is required when mesodermal cells start to express cardiac transcription factors.[19] In this study, we demonstrated that canonical Wnt pathway is required and sufficient for commitment of cardiomyocytes and clarified that PI3K pathway is involved in cardiomyocyte differentiation by crosstalk with canonical Wnt pathway.

Materials and Methods

Plasmids and Reagents

Constitutively active Akt (CA-Akt) and dominant negative Akt (DN-Akt) were described previously.[20] Mutant β-catenin (S33A, S37A, T41A, S45A) was from Dr S. Ishihara (Kyoto University, Japan) and Dr T. Noda (The Cancer Institute of the Japanese Foundation for Cancer Research, Japan). pGK-Wnt-3a was from Dr S. Takada (Center for Integrative Bioscience, Okazaki National Research Institutes, Japan). Constitutively active glycogen synthase kinase-3β (GSK-3β) was from Dr T. Hagen (Wolfson Digestive Diseases Centre, University Hospital Nottingham, United Kingdom). Constitutively active PI3K (myr-p110) was from Drs M. Kasuga and W. Ogawa (Kobe University, Japan). pTOPFLASH and pFOPFLASH were from Upstate biotechnology. pRL-cytomegalovirus (pRL-CMV) was from Promega. LY294002 was purchased from BioMol Research Laboratories. Akt inhibitor III was purchased from Calbiochem. Recombinant mouse Wnt-3a protein, recombinant-mouse Frizzled-8/Fc chimera protein, and recombinant insulin-like growth factor (IGF) II were purchased from R&D systems.

Cell Culture and Transfections

P19CL6 cells were cultured essentially as described previously.[19] Cells were transfected with plasmids on day 0 of differentiation using the lipofection method as previously described.[16,17] Transfection efficiency was ≈60% as examined by GFP expression plasmids (data not shown). Luciferase assay was performed essentially as described previously[21]

Immunofluorescence

For evaluating cardiomyocyte differentiation, cells were immunostained using MF20, a monoclonal antibody against sarcomeric myosin heavy chain (MHC). The cells were viewed and photographed with a confocal laser-scanning microscope (Radiance 2000; Bio-Rad). MF20 positive area was calculated and data are expressed as percentage MF20-positive area (pixel×pixel) compared with control P19CL6 cells cultured in differentiation medium.

RT-PCR

RT-PCR was performed as described previously.[19] To confirm that the obtained bands were not derived from contaminated genomic DNA, a negative experiment was done for each sample without reverse transcriptase before PCR (data not shown).

Western Blotting

Total cell lysates, cytosolic, or nuclear fractions were electrophoresed on SDS-polyacrylamide gels. Western blotting was performed as described previously.[22]

RNA Preparation and High-Density Oligonucleotide Array Hybridization

Total RNA was extracted from P19CL6 cells on days 0, 4, and 6 of DMSO-induced cardiomyocyte differentiation. Expression profiling was performed using Affymetrix GeneChip MU6500 as described previously.[23]

Statistical Analysis

Data are expressed as mean±SE. The significance of differences among means was evaluated using analysis of variance (ANOVA), followed by Fisher PLSD test and Dunnett test for multiple comparisons. Significant differences were defined as $P<0.05$.

Results

Akt Acts Downstream of PI3K in Cardiomyocyte Differentiation of P19CL6 Cells

We have recently reported that activation of PI3K is required for DMSO-induced cardiomyocyte differentiation of P19CL6 cells.[19] Akt is one of the important downstream molecules of PI3K. To clarify whether Akt activation is required for cardiomyocyte differentiation, we first examined the effects of a chemical inhibitor of Akt.[24] When the Akt inhibitor (10 μmol/L) was added to the medium through day 0 to day 4, the rate of cardiomyocyte differentiation shown by MF20 positive area was markedly decreased, although the Akt inhibitor was less effective than the PI3K inhibitor LY294002 (Figure 1A through 1C). To confirm the contribution of Akt to cardiomyocyte differentiation, we transfected a dominant negative form of Akt into P19CL6 cells. When DN-Akt was introduced into P19CL6 cells, cardiomyocyte differentiation was also suppressed (Figure 1A through 1C). We further investigated whether activation of PI3K/Akt pathway is sufficient to drive cardiomyocyte differentiation of P19CL6 cells. Myristoylated p110α, a catalytic subunit of PI3K, leads to constitutive activation of PI3K.[25] Direct activation of PI3K by transfecting this construct increased phosphorylation of Akt on Ser-473 to the same degree as DMSO treatment, indicating that PI3K signaling is activated to the same levels in these cells (Figure 1D). However, cardiomyocyte differentiation was not observed (Figure 1E). Moreover, treatment with IGF II (10 ng/mL) also increased phosphorylation of Akt but failed to induce cardiomyocyte differentiation of P19CL6 cells (Figure 1D and 1E). Furthermore, we confirmed that CA-Akt did not induce cardiomyocyte differentiation in the absence of DMSO (Figure 1C). In collection, these results suggest that PI3K/Akt pathway is necessary, but not sufficient for cardiomyocyte differentiation of P19CL6 cells.

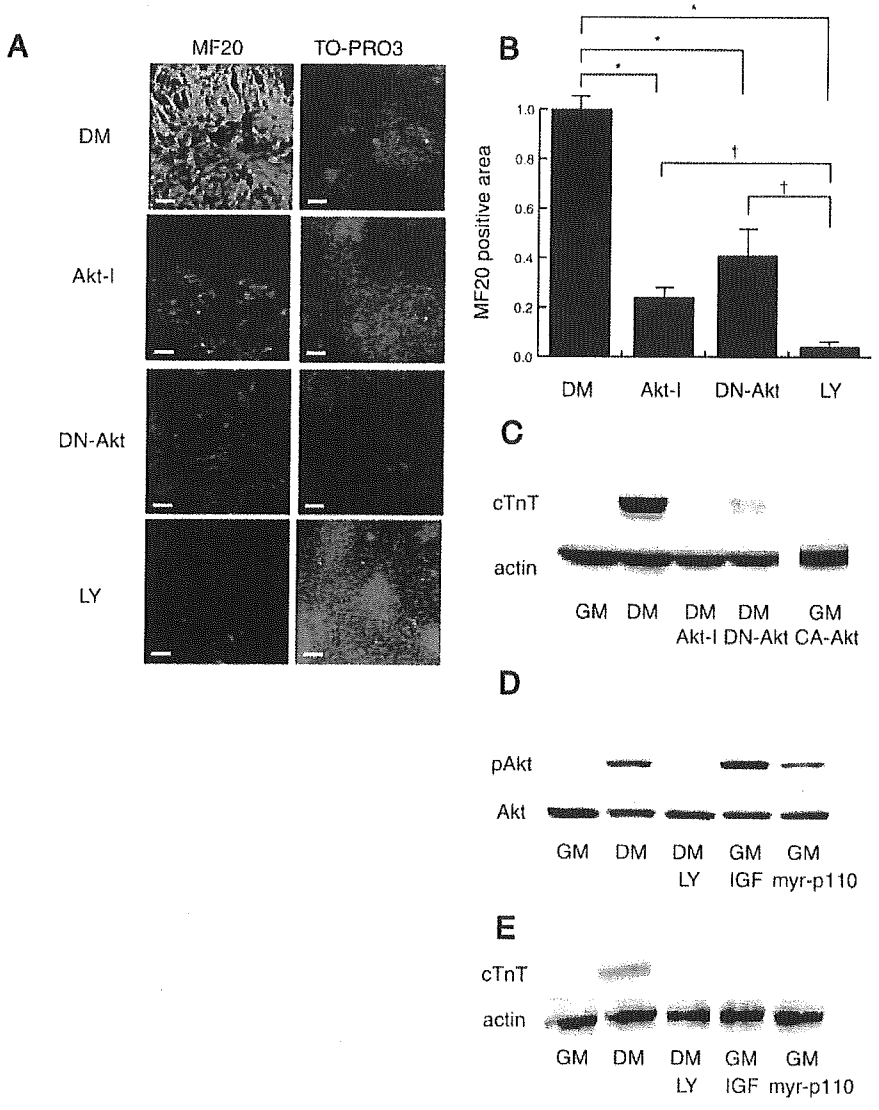

Figure 1. Akt is required, but not sufficient for cardiomyocyte differentiation. A, Suppression of cardiomyocyte differentiation by inhibiting PI3K/Akt signaling. Cells were cultured in differentiation medium (DM) to induce cardiomyocyte differentiation. On day 0, cells were transfected with DN-Akt or pcDNA3.1. LY294002 (LY) or Akt inhibitor III (Akt-I) were added to the medium for the first 4 days. Cells were stained with MF20 on day 16. Scale bars, 50 μmol/L. B, Quantification of MF20 positive area. At least 4 different fields were measured for each dish. *$P<0.001$ compared with DM. †$P<0.05$ compared with LY. C, cTnT expression, cells were cultured in DM or in growth medium (GM). On day 0, cells were transfected with DN-Akt, CA-Akt, or pcDNA3.1. Akt inhibitor III (Akt-I) was added to the medium for the first 4 days. D, Phosphorylation of Akt by IGF treatment, cells were cultured in GM or in DM. On day 0, cells were transfected with constitutively active PI3-kinase (myr-p110) or pcDNA3.1. Next day, IGF or LY294002 were added to the growth medium (IGF) or differentiation medium (LY), respectively. Cell lysates were collected 2 days after, and phosphorylation of Akt was examined by Western blotting. E, cTnT expression. IGFII or LY294002 were added from day 0 to day 4 and cTnT expression was examined on day 16 of culture.

Canonical Wnt Pathway Is Activated Transiently Only During the Early Stage of Cardiomyocyte Differentiation

To elucidate the molecular mechanisms of how PI3K/Akt pathway plays a critical role in cardiomyocyte differentiation during the early stage, we searched for the molecules that are activated during this stage, ie, through day 0 to day 4 of P19CL6 cells. By using a gene chip technology, we found that expression of *Wnt-3a* was increased 12-fold through day 0 to day 4 and decreased 5-fold by day 6 (Table). RT-PCR analysis revealed that *Wnt-3a* and *Wnt-8* but not *Wnt-1* were expressed on days 2 and 4, and TOPFLASH activity, which reflects the activity of canonical Wnt signaling, was elevated from day 0 to day 4, consistent with the expression levels of *Wnt-3a* and *Wnt-8* genes (data not shown). These results are in accordance with the previous study by Nakamura et al[18] and indicate that activation of canonical Wnt signaling occurs at the stage when PI3K/Akt signaling is required for cardiomyocyte differentiation, and suggest that canonical Wnt signaling may be a target of PI3K/Akt pathway.

Temporal Activation of Canonical Wnt Pathway Is Required and Sufficient for Cardiomyocyte Differentiation

The role of Wnt/β-catenin pathway, so-called canonical Wnt pathway, in vertebrate cardiomyocyte differentiation and

Growth Factors Expressed >3-Fold Through Day 0 to Day 4

Genbank	Gene	Days 0 to 4	Days 4 to 6
U26188	Ephrin A1	36.3	D
D12483F	Fibroblast growth factor 8 (FGF-8)	12.3	D
X56842	Wnt-3A for cysteine-rich protein	12.3	D
M22326	Early growth response 1/growth factor-induced protein (zif/268)	11.5	D
M89799	Wnt-5b	11.1	
M84607	Platelet derived growth factor receptor, alpha polypeptide	10.9	D

Growth factors whose expression levels are increased >10-fold in P19CL6 cells during day 0-day 4. D indicates decreased <3.0-fold during day 4 to day 6 or day 0 to day 6.

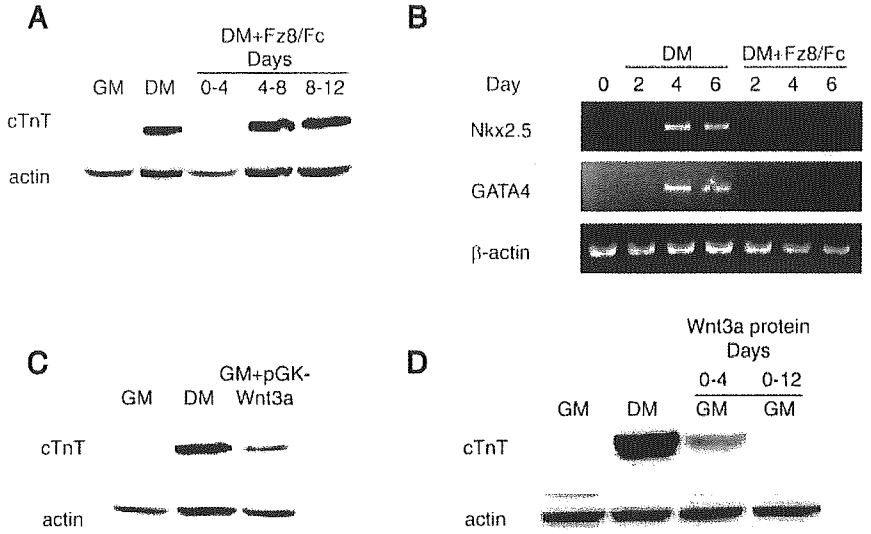

Figure 2. Temporal activation of canonical Wnt pathway is required and sufficient for cardiomyocyte differentiation of P19CL6 cells. A, Canonical Wnt activity is required for cardiomyocyte differentiation. Cells were cultured in GM or in DM. An extracellular Wnt antagonist, Fz8/Fc chimera protein was added through day 0 to 4, (0–4) 4 to 8 (4–8), and 8 to 12. (8–12). B, Changes in the expression of differentiation markers by inhibition of canonical Wnt pathway. Cells were cultured with (DM+Fz8/Fc) or without (DM) Fz8/Fc protein. RNA was collected on days 0, 2, 4, and 6, and RT-PCR analysis was performed. C, Overexpression of Wnt-3a gene induced cardiomyocyte differentiation without DMSO. Cells were cultured in GM or in DM. On day 0, cells were transfected with pGK-Wnt-3a. D, Administration of soluble Wnt protein in a specific time period (days 0 to 4, 0 to 12). Cells were cultured in growth medium and soluble Wnt-3a protein was added through day 0 to day 4 or through day 0 to day 12.

heart development is still controversial.[11–13,18] We first examined the role of canonical Wnt pathway in cardiomyocyte differentiation of P19CL6 cells. To examine whether canonical Wnt pathway is required for cardiomyocyte differentiation, we used extracellular canonical Wnt inhibitor, Fz-8/Fc chimera protein (200 ng/mL), which has been shown to inhibit canonical Wnt signaling.[26] When P19CL6 cells were treated with this protein through day 0 to day 4 of differentiation, cardiac troponin T (cTnT) was not expressed and spontaneous beating was not observed (Figure 2A), in accordance with the previous study.[18] Interestingly, when this protein was administered through day 4 to day 8, or day 8 to day 12 of differentiation, cardiomyocyte differentiation was not inhibited (Figure 2A) but spontaneous beating appeared on day 9, a day earlier than without this protein, although there were no molecular evidence, ie, difference in cTnT expression, for the appearance of earlier beating (Figure 2A and data not shown). RT-PCR analysis revealed that administration of this chimera protein from day 0 to day 4 completely abolished expression of *Nkx-2.5* and *GATA-4* (Figure 2B). These results suggest that activation of canonical Wnt signaling during the early stage is required for DMSO-induced cardiomyocyte differentiation of P19CL6 cells.

To examine whether canonical Wnt pathway is sufficient for cardiomyocyte differentiation, we first overexpressed *Wnt-3a* cDNA in P19CL6 cells and cultured them in growth medium without DMSO. P19CL6 cells expressed cTnT (Figure 2C) and showed spontaneous contraction after 10 days of culture. Next, we cultured P19CL6 cells in growth medium with soluble Wnt-3a protein (100 ng/mL, R&D systems). Surprisingly, when soluble Wnt-3a protein was added to the growth medium continuously, cells never started spontaneous contraction nor expressed cTnT (Figure 2D). However, when the protein was added only during the first 4 days of culture, when canonical Wnt pathway is activated endogenously in DMSO-treated P19CL6 cells, spontaneous contraction was observed from day 10 and cells expressed cTnT (Figure 2D). These results suggest that canonical Wnt signaling has 2 different roles in cardiomyocyte differentiation depending on the differentiation stage of the cells. Although the canonical Wnt pathway promotes commitment into cardiac lineage at the early stage, it inhibits further differentiation into mature cardiomyocytes at the later stage.

PI3K/Akt Pathway Maintains Canonical Wnt Activity Through GSK-3β During DMSO-Induced Cardiomyocyte Differentiation of P19CL6 Cells

Because canonical Wnt pathway plays an essential role in cardiomyocyte differentiation when PI3K/Akt pathway is required for cardiomyocyte differentiation, we hypothesized that PI3K/Akt pathway is required for the activation of canonical Wnt pathway. To test our hypothesis, we first examined whether CA- or DN-Akt could affect canonical Wnt activity in P19CL6 cells. Consistent with previous studies,[27,28] introduction of CA-Akt or DN-Akt did not change canonical Wnt activity (assessed by TOPFLASH activity) in undifferentiated P19CL6 cells (Figure 3A). Introduction of Akt constructs did not change TOPFLASH activity in L-fibroblasts, NIH3T3 cells, and COS-7 cells (data not shown). However, when P19CL6 cells were treated with DMSO and induced to differentiate into cardiomyocytes, TOPFLASH activity was enhanced by CA-Akt and suppressed by DN-Akt (Figure 3A). These observations indicate that it depends on cell types whether PI3K/Akt pathway activates canonical Wnt pathway or not.

GSK-3β, a ubiquitously-expressed constitutively-active serine/threonine kinase, regulates a wide variety of cellular

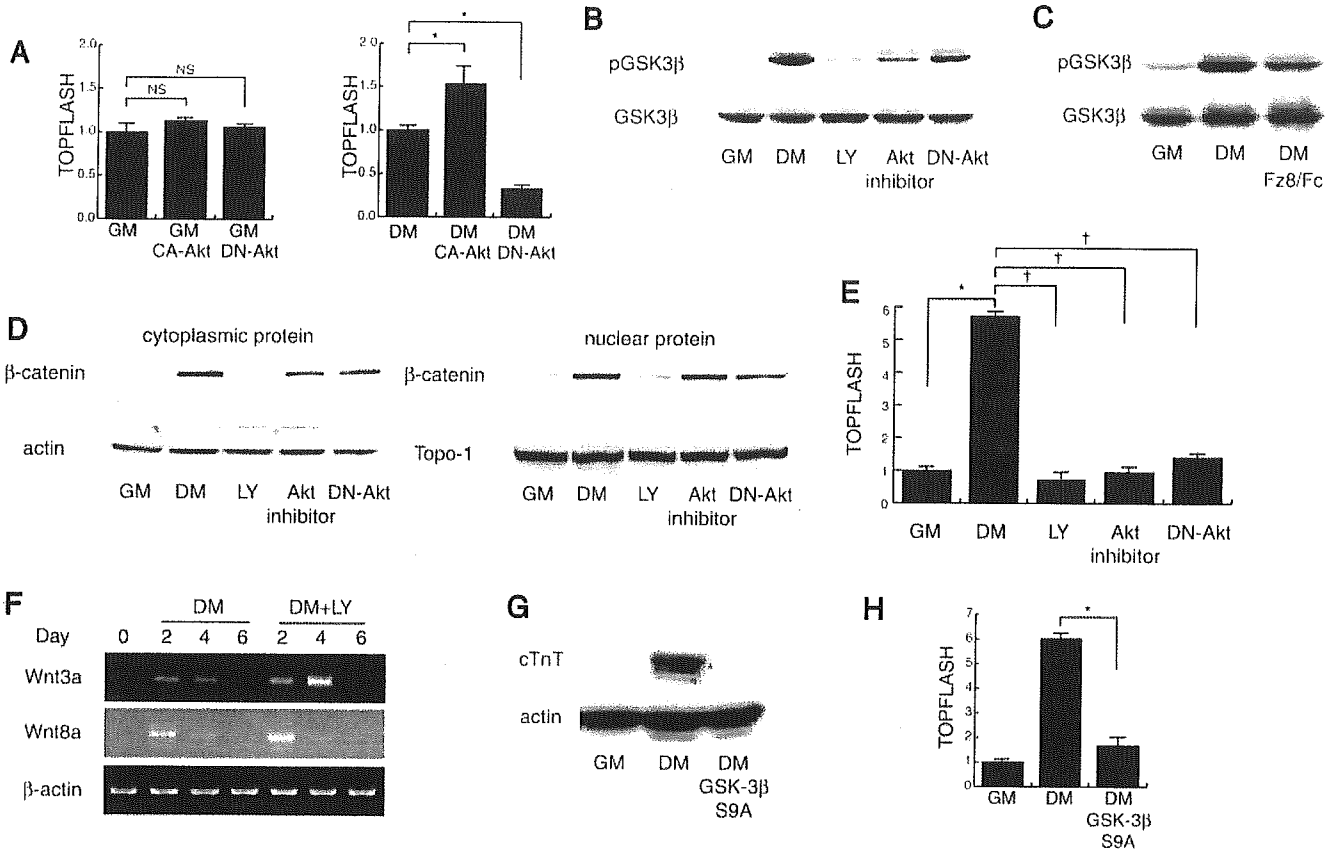

Figure 3. PI3K/Akt pathway changes canonical Wnt activity through GSK-3β in differentiation-induced P19CL6 cells. A, Canonical Wnt activity is altered by PI3K/Akt activity only when cells were treated with DMSO. Cells were cultured in GM or in DM. On day 0, cells were transfected with pTOPFLASH, pRL-CMV, together with or without CA-Akt or DN-Akt. NS, not significant. *$P<0.001$ compared with DM. B, Phosphorylation of GSK-3β in P19CL6 cells by inhibition of PI3K/Akt pathway. Cells were cultured in GM or in DM. On day 0, cells were transfected with DN-Akt or pcDNA3.1. Cells were cultured until day 4, and phosphorylation of GSK-3β was examined by Western blotting. C, Phosphorylation of GSK-3β by addition of Fz8/Fc chimera protein. D, β-catenin expression in P19CL6 cells by inhibition of PI3K/Akt pathway. Cells were cultured as described in Figure 3B and fractionated into cytoplasmic and nuclear fraction. Expression of β-catenin was examined by Western blotting. The same membrane was stripped and labeled with anti-actin (for cytoplasmic fraction) or anti–Topo-1 (nuclear fraction) antibodies to verify even sample loading. D, TOPFLASH activity in P19CL6 cells by inhibition of PI3K/Akt pathway. On day 0, cells were transfected with DN-Akt or pcDNA3.1, pTOPFLASH and pRL-CMV for control. After transfection, medium was changed to GM, DM (DM, DN-Akt), or DM containing LY294002 (LY) or Akt inhibitor III (Akt inhibitor). *$P<0.001$ compared with GM. †$P<0.001$ compared with DM. E, Expression levels of Wnt-3a and Wnt-8 genes after inhibition of PI3K pathway. Cells were cultured in a DM in the presence (DM+LY) or absence (DM) of PI3K inhibitor, LY294002. RNA was extracted on days 0, 2, 4, and 6, and expression of Wnt-3a and Wnt-8 genes was analyzed by RT-PCR. F, Akt phosphorylation-insensitive mutant GSK-3β blocked cardiomyocyte differentiation. Cells were cultured in GM or in DM. On day 0, cells were transfected with constitutively-active GSK-3β (GSK-3β S9A) or with pcDNA3.1. G, TOPFLASH activity in P19CL6 cells by GSK-3β S9A. Cells were cultured as described in Figure 4F. On day 0, cells were transfected with GSK-3β S9A or pcDNA3.1, pTOPFLASH, and pRL-CMV for control. After transfection, medium was changed to GM or DM (DM, GSK-3β S9A). *$P<0.001$ compared with DM.

functions downstream of signaling pathways including PI3K/Akt pathway and canonical Wnt pathway.[29] GSK-3β activity is suppressed by phosphorylation at the Ser-9 by Akt.[30] On the other hand, GSK-3β phosphorylates and promotes degradation of β-catenin and downregulates canonical Wnt signaling. By the treatment with DMSO, phosphorylation of GSK-3β was increased and this increase was suppressed by inhibiting PI3K/Akt pathway both chemically and genetically (Figure 3B). Inhibition of canonical Wnt signaling by Fz-8/Fc protein only slightly decreased GSK-3β phosphorylation that is increased by DMSO treatment (Figure 3C), whereas it severely decreased cardiomyocyte differentiation. This result suggests that canonical Wnt pathway does not directly interact with PI3K/Akt pathway, and thus we speculate that activation of PI3K/Akt and the following phosphorylation of GSK-3β by DMSO is not mediated via canonical Wnt signaling. However, further analyses are required to elucidate whether canonical Wnt pathway and PI3K/Akt pathway interact directly or not. Inhibition of PI3K/Akt pathway and phosphorylation of GSK-3β decreased expression levels of cytoplasmic and nuclear β-catenin (Figure 3D), and the TOPFLASH activity (Figure 3E) in DMSO treated P19CL6 cells. Inhibition of PI3K/Akt pathway did not alter the expression levels of Wnt-3a and Wnt-8 genes (Figure 3F), indicating that the decrease in the canonical Wnt activity is not attributable to decreased expression levels of Wnt-3a or Wnt-8. To further examine whether decreased cardiomyocyte differentiation by PI3K/Akt pathway inhibition is attributable to decreased Ser-9 phosphorylation of GSK-3β, we overexpressed GSK-3β whose Ser-9 is substituted into alanine and

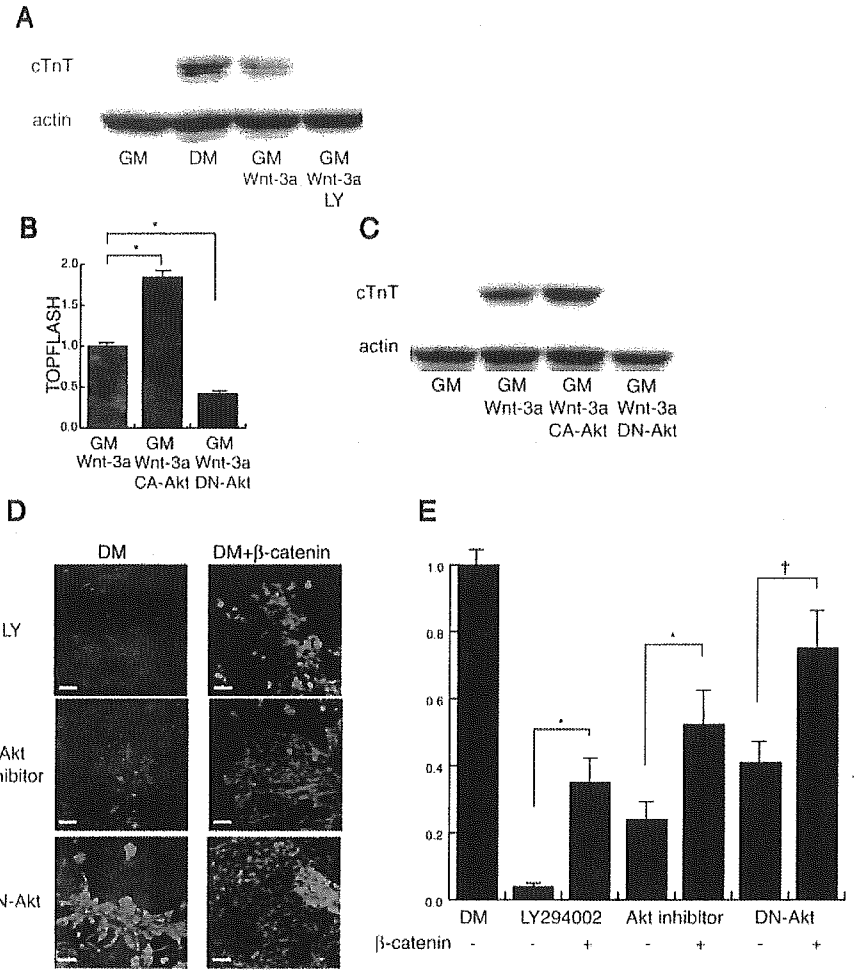

Figure 4. PI3K/Akt pathway and canonical Wnt pathway act synergistically to induce cardiomyocyte differentiation in P19CL6 cells. A, LY294002 inhibited soluble Wnt protein-induced cardiomyocyte differentiation. Cells were cultured in GM or in DM. Soluble Wnt-3a protein was added to the growth medium with or without LY294002 through day 0 to day 4. B, Akt activity correlates with canonical Wnt activity in Wnt-3a transfected P19CL6 cells. Cells were cultured in GM. On day 0, cells were transfected with pTOPFLASH, pRL-SV40, pcDNA3.1 (GM), and pGK-Wnt-3a (Wnt-3a) together with or without CA-Akt or DN-Akt. *$P<0.001$ compared with GM Wnt-3a. C, cTnT expression. Cells were cultured in growth medium. On day 0, cells were transfected with pGK-Wnt-3a (Wnt-3a) together with CA-Akt or DN-Akt. D, Suppression of cardiomyocyte differentiation by inhibiting PI3K/Akt signaling was rescued by activating canonical Wnt pathway. Cells were cultured as described in Figure 1A. On day 0, cells were transfected with DN-Akt or pcDNA3.1, together with or without mutant β-catenin. Cells were stained with MF20 on day 16. Scale bars, 50 μmol/L. E, Quantification of MF20-positive area. At least 4 different fields were measured for each dish. *$P<0.05$, †$P<0.01$ compared with mutant β-catenin nontransfected counterparts.

insensitive to Akt phosphorylation.[31] Introduction of this mutant protein into P19CL6 cells on day 0 completely abrogated DMSO-induced cardiomyocyte differentiation and DMSO-induced elevation of TOPFLASH activity (Figure 3G and 3H). These results suggest that when P19CL6 cells are induced to differentiate into cardiomyocytes, PI3K/Akt pathway, activated independently of canonical Wnt signaling, is required to maintain canonical Wnt activity by suppressing GSK-3β.

PI3K/Akt Pathway and Canonical Wnt Pathway Synergistically Induce Cardiomyocyte Differentiation

If inhibition of PI3K/Akt pathway decreases DMSO-induced cardiomyocyte differentiation in P19CL6 cells by regulating GSK-3β activity, inhibition of PI3K/Akt pathway should also affect Wnt-3a–induced cardiomyocyte differentiation in P19CL6 cells. To test this, we cultured P19CL6 cells in growth medium with soluble Wnt-3a protein and LY294002 for the first 4 days. Cardiomyocyte differentiation induced by soluble Wnt-3a protein was completely blocked by LY294002 treatment (Figure 4A). We next cotransfected CA-Akt or DN-Akt with pGK-Wnt-3a in P19CL6 cells. As expected, cotransfection of CA-Akt and Wnt-3a elevated TOPFLASH activity and expression levels of cTnT. To the contrary, DN-Akt suppressed Wnt-3a–induced increase in TOPFLASH activity and completely blocked cardiomyocyte differentiation (Figure 4B). Finally, we introduced mutant β-catenin, which is insensitive to phosphorylation by GSK-3β, into P19CL6 cells, and examined whether this could rescue cardiomyocyte differentiation of P19CL6 cells. Introduction of the mutant β-catenin restored cardiomyocyte differentiation, which was suppressed by inhibition of PI3K/Akt pathway (Figure 4C through 4E). These results suggest that PI3K/Akt pathway is required to maintain certain levels of canonical Wnt activity that is enough to induce cardiomyocyte differentiation of P19CL6 cells.

Discussion

In this study, we elucidated the molecular mechanism by which PI3K is critically involved in cardiomyocyte differentiation in vitro. Akt, which was activated by the DMSO treatment, was required for cardiomyocyte differentiation of P19CL6 cells as a downstream of PI3K. Canonical Wnt pathway regulated cardiomyocyte differentiation positively and negatively, depending on the stage of differentiation. Inhibition of PI3K/Akt pathway decreased the content of cytoplasmic and nuclear β-catenin and the activity of canonical Wnt pathway through decreased GSK-3β phosphorylation.

Many studies have indicated that PI3K is involved in the differentiation of various kinds of cells such as myoblasts,[32] osteoblasts,[33] and adipocytes.[34] In this study, Akt was in-

volved in cardiomyocyte differentiation downstream of PI3K. However, introduction of myristoylated, constitutively-active form of Akt could not induce cardiomyocyte differentiation of P19CL6 cells in the absence of DMSO (Figure 1E), suggesting that activation of Akt pathway is required, but not sufficient for cardiomyocyte differentiation.

PI3K/Akt pathway affected cardiomyocyte differentiation through maintaining the activity of the canonical Wnt pathway. Activation of the canonical Wnt pathway was required and sufficient for induction of cardiac transcription factors and cardiomyocyte differentiation in P19CL6 cells. It is noteworthy that this positive regulation of cardiomyocyte differentiation by the canonical Wnt pathway is only temporal, and prolonged activation of canonical Wnt pathway rather inhibited full differentiation into spontaneously contracting cardiomyocytes (Figure 3D). Using *Xenopus* and chick embryos, it has been reported that inhibitors of canonical Wnt signaling such as *crescent* and *Dkk-1* are secreted from anterior mesoderm and induce cardiogenesis and that ectopic stimulation of canonical Wnt signaling in this area inhibited cardiomyocyte differentiation.[11–13] In those studies, expression of *Wnt-3a* and *Wnt-8*, which is transiently observed in all embryonic mesoderm,[35] is already limited to posterior mesoderm and is not observed in the anterior mesoderm. The stage when canonical Wnts are expressed corresponds to day 4 or earlier of P19CL6 cell differentiation, indicating that our findings do not contradict with the previous in vivo studies.[11–13] Prolonged exposure to canonical Wnt signaling rather blocked full differentiation into spontaneously contracting cardiomyocyte (Figure 3D). Nakamura et al have reported that canonical Wnt pathway contributes positively to cardiomyocyte differentiation,[18] which is consistent with our results. However, there is some difference between the 2 studies. Activation of the canonical Wnt pathway was sufficient for differentiation into mature spontaneously-contracting cardiomyocytes in our study but not in their study. This discrepancy may come from the duration of Wnt-3a stimulation. We limited the Wnt-3a stimulation to initial 4 days of P19CL6 cell differentiation because thereafter Wnt-3a activation inhibited cardiomyocyte differentiation (Figure 3D). Collectively, our results may explain contradicting results on the requirement of canonical Wnt pathway between in vivo[11–13] and in vitro[18] experiments. Further studies are necessary to elucidate the mechanism of how canonical Wnt pathway shows such biphasic roles in cardiomyocyte differentiation by a differentiation stage-specific manner.

It is still on debate whether canonical Wnt pathway and PI3K/Akt pathway interact with each other through regulation of GSK-3β.[36] Previous reports showed that PI3K/Akt pathway and canonical Wnt pathway is pharmacologically distinct.[27,28] In our study, we observed that PI3K/Akt pathway itself did not activate canonical Wnt pathway but was required for maintenance of canonical Wnt pathway. Our observations do not contradict to previous reports from the point that both signalings are independent and one cannot activate the other pathway. Moreover, Yuan et al[27] showed the synergism between PI3K/Akt pathway and canonical Wnt pathway when both signaling pathways are activated, which

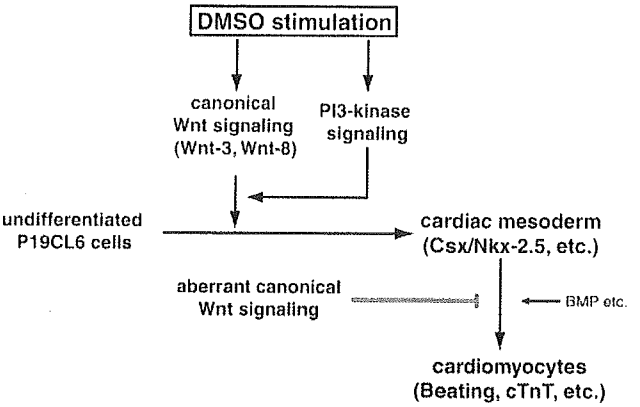

Figure 5. Regulation of early cardiomyogenesis by PI3K and the canonical Wnt pathway. After DMSO treatment, undifferentiated P19CL6 cells start to differentiate into cardiac mesodermal cells and mature cardiomyocytes. DMSO treatment activates both the canonical Wnt pathway and the PI3K pathway independently. Activation of the canonical Wnt pathway is required and sufficient for induction of cardiac mesodermal cells. During cardiac mesoderm induction, PI3K pathway enhances activity of the canonical Wnt pathway and both pathways act together in commitment of cardiac mesodermal cells. Once committed into cardiac mesodermal cells, aberrant activation of canonical Wnt signaling rather suppressed further maturation into functional cardiomyocytes.

is consistent with our study (Figures 4A and 5B). In addition, a growing body of evidence suggests that there is a synergistic effect between PI3K/Akt pathway and canonical Wnt pathway in differentiating neuronal cells,[37] intestinal cells,[38] and myoblasts.[39] We speculate that synergistic action between PI3K/Akt pathway and canonical Wnt pathway exists in certain circumstances such as during differentiation of cells or development of organs.

It should be noted that PI3K/Akt pathway may act as a survival factor for the cardiac mesodermal cells during DMSO- and Wnt-induced cardiomyocyte differentiation in P19CL6 cells in addition to its activity to maintain canonical Wnt activity during cardiomyocyte differentiation.

In summary, we elucidated the molecular mechanisms of how PI3K signaling affects cardiomyocyte differentiation (Figure 5). Canonical Wnt pathway plays a primary and pivotal role in initiation of cardiomyocyte differentiation, and PI3K pathway plays an important role in cardiomyocyte differentiation by maintaining canonical Wnt activity. It is also noteworthy that canonical Wnt pathway is required only temporally and plays both positive and negative roles in cardiomyocyte differentiation by the differentiation stage-dependent manner. Our novel findings in this study could explain contradictory reports between in vitro and in vivo on the role of canonical Wnt pathway in cardiomyocyte differentiation.

Acknowledgments

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Effect of Mental Stress on Coronary Flow Velocity Reserve in Healthy Men

Rei Hasegawa, MD[a], Masao Daimon, MD[a], Tomohiko Toyoda, MD[a], Kiyomi Teramoto, MD[a], Tai Sekine, MD[a], Takayuki Kawata, MD[a], Hiroyuki Watanabe, MD[b], Yoichi Kuwabara, MD[a], Katsuya Yoshida, MD[a], and Issei Komuro, MD, PhD[a,*]

The effect of mental stress on coronary flow velocity reserve (CFVR) was examined in healthy men using transthoracic Doppler echocardiography. In the mental stress group (n = 31), CFVR was significantly reduced at 15 (to 3.3 ± 0.8, p <0.001) and 30 (to 3.7 ± 0.8, p <0.01) minutes after mental stress testing, compared with before mental stress (4.3 ± 0.9), whereas it did not change in each of 3 measurements in control subjects (n = 10). Mental stress impaired coronary circulation even after a certain interval after the stress. **(Am J Cardiol 2005;96:137–140)**

It has been reported that mental stress may induce myocardial ischemia,[1,2] whereas cardiovascular events sometimes occur after a certain interval after mental stress.[3,4] However, the change in coronary circulation after mental stress is unknown. Coronary flow velocity reserve (CFVR), partly endothelium dependent, has been considered a useful physiologic index of coronary microcirculation.[5] Recent developments in transthoracic Doppler echocardiography (TTDE) can provide noninvasive measurements of CFVR in the left anterior descending (LAD) coronary artery.[6–8] This study assessed the response of coronary circulation after mental stress using successive measurements of CFVR by TTDE in healthy men.

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We studied 44 healthy men (mean age 28.6 ± 6.4 years, range 20 to 49). We included only men in this study, because CFVR could be influenced by menstrual status in women.[9] None of subjects had a history of hyperlipidemia, hypertension, or diabetes mellitus or evidence of left ventricular wall motion abnormalities or left ventricular hypertrophy. Informed consent to the protocol, which had been approved by the ethics committee of our hospital, was obtained from all subjects. The 44 volunteers were randomly divided into 2 groups of 34 men with mental stress (the mental stress group) and 10 men without mental stress (the control group). Blood samples were taken immediately before the assessment of CFVR for the determination of the serum concentrations of blood sugar, total cholesterol, triglycerides, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol.

The method of measurement of CFVR with TTDE has been described previously.[5,7–9] Echocardiographic examinations were performed with an Acuson Sequoia 512 (Siemens Medical Solutions USA, Inc., Mountain View, California) using a high-frequency transducer (5 to 7 MHz). For color Doppler echocardiography, the velocity range was set at 11 to 17 cm/s. The acoustic window was around the midclavicular line in the fourth and fifth intercostal spaces in the left lateral decubitus position. After the lower portion of the interventricular sulcus had been located in the long-axis cross-sections, the ultrasound beam was rotated laterally, visualizing the distal portion of the LAD coronary artery under color flow mapping guidance. Blood flow velocity was measured by pulse-wave Doppler echocardiography, using a sample volume (1.5 to 2.0 mm) placed on the color signal in the distal LAD coronary artery. Adenosine triphosphate was administered by intravenous infusion (140 μg/kg/min) for 2 minutes to record spectral Doppler signals during hyperemia. The electrocardiogram and heart rate were monitored continuously during the examination. Blood pressure was recorded at baseline and every minute after the intravenous infusion of adenosine triphosphate. The rate–pressure product was calculated as systolic blood pressure × heart rate. Although we tried to align the ultrasound beam direction with distal LAD coronary artery flow in as parallel a manner as possible, angle correction was needed in each examination because of incident Doppler angle (mean angle 41°, range 25° to 54°). All studies were continuously recorded on S-VHS videotape, and clips of the stopped frame were also stored digitally on a magneto-optical disk (230 MB) for off-line analysis. Each study was analyzed by 2 experienced investigators blinded to the other data. Measurements of mean diastolic flow velocity were performed off-line by contouring the spectral Doppler signals, using the integrated evaluation program in the ultra-

Departments of [a]Cardiovascular Science and Medicine and [b]Psychiatry, Chiba University Graduate School of Medicine, Chiba, Japan. Manuscript received November 3, 2004; revised manuscript received and accepted March 1, 2005.

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* Corresponding author: Tel.: 81-43-226-2097; fax: 81-43-226-2557.
E-mail address: komuro-tky@umin.ac.jp (I. Komuro).

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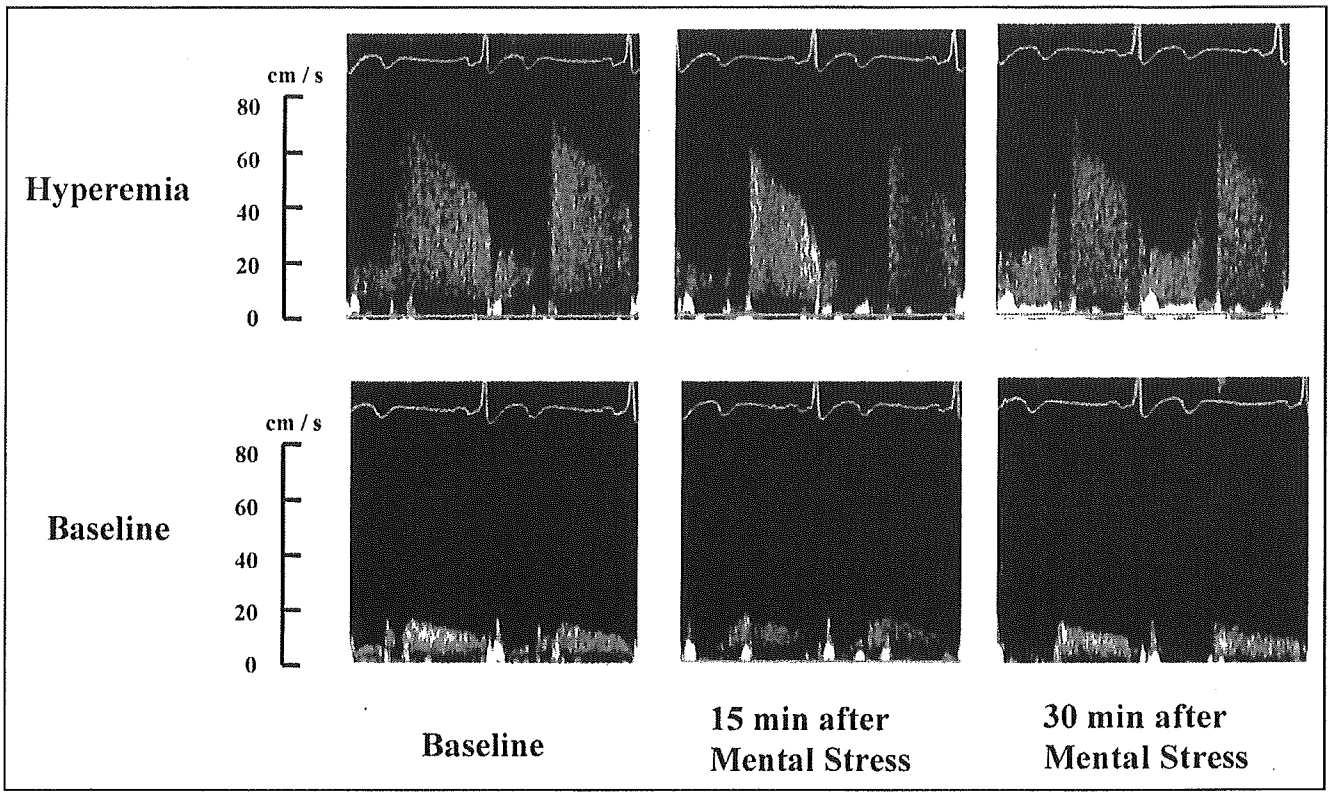

Figure 1. Coronary flow velocity profiles at baseline and hyperemia obtained from 1 patient in the mental stress group. Hyperemic coronary blood flow velocity at 15 minutes after mental stress was significantly less than before stress testing. *Bottom*, coronary flow velocity profile at baseline. *Top*, coronary flow velocity profile at hyperemic condition.

sound system. Each variable was averaged over 3 consecutive cycles. CFVR was calculated as the ratio of hyperemic to basal mean diastolic flow velocity.

All studies were performed in the morning in a quiet, air-conditioned room (22°C to 25°C). During this study, the room lights were dimmed, background noise was maximally reduced, and subjects were encouraged to relax. After 30 minutes of rest, a baseline measurement of CFVR was performed by TTDE immediately before the mental stress test. For mental stress, subjects were forced to add as quickly and accurately as possible using the Uchida-Krapelin psychodiagnostic test for 5 minutes.[10] A metronome was used as an additional distractor. At 15 and 30 minutes of quiet rest after the test, CFVR was assessed in the same manner. The 15-minute interval was chosen on the basis of previous reports[2] that all hemodynamic changes returned to baseline levels at 15 minutes after mental stress testing. In the control group, after 30 minutes of rest, CFVR was measured 3 times at 15-minute intervals by TTDE.

Data are shown as mean ± SD. Baseline characteristics in the 2 groups were compared by the unpaired Student's *t* test. Echocardiographic and hemodynamic variables during adenosine triphosphate infusion in the 2 groups were evaluated by repeated-measures analysis of variance, testing for stress effect, adenosine triphosphate effect, and interaction. Fisher's protested least-significant difference test was used for the post hoc test. A p value <0.05 was considered statistically significant.

Adequate spectral Doppler recordings of coronary flow for assessing CFVR were obtained in 41 (31 in the mental stress group and 10 in the control group) of the 44 study subjects (93%) (Figure 1). The clinical characteristics of the 2 study groups are listed in Table 1. There were no differences between these 2 groups in terms of age, body mass index, smoking status, lipid profile (total cholesterol, low-density lipoprotein cholesterol, high-density lipoprotein

Table 1
Clinical characteristics

Characteristic	Control (n = 10)	Mental Stress (n = 31)
Age (yrs)	29.0 ± 9.2	27.8 ± 5.5
Men	10 (100%)	31 (100%)
Body mass index	23.8 ± 1.9	22.8 ± 2.0
Smoking	2 (20%)	7 (22.5%)
Total cholesterol (mg/dl)	182 ± 38	187 ± 33
Low-density lipoprotein cholesterol (mg/dl)	107 ± 35	113 ± 34
High-density lipoprotein cholesterol (mg/dl)	64 ± 16	58 ± 14
Triglycerides (mg/dl)	128 ± 97	116 ± 85
Blood sugar (mg/dl)	101 ± 14	100 ± 17

Data are presented as mean ± SD.

cholesterol, triglycerides), and blood sugar. None of the subjects experienced any symptoms or presented any electrocardiographic changes during the mental stress test or adenosine triphosphate administration.

Table 2 lists the hemodynamic data at the measurements of CFVR, before and 15 and 30 minutes after mental stress. Mental stress induced significant increases in heart rate, systolic blood pressure, diastolic blood pressure, and the rate–pressure product immediately after mental stress, and these parameters returned to baseline values just before the CFVR measurements after mental stress. No significant differences were observed in hemodynamic data in each of the measurements of CFVR in the same group and between the 2 groups.

In the control group, mean diastolic flow velocity at baseline and CFVR were similar in each of the 3 measurements (Figure 2 and Table 3). In the mental stress group, there was no difference in mean diastolic flow velocity at baseline before and 15 and 30 minutes after mental stress. However, repeated-measures analysis of variance showed a significant interaction in mean diastolic flow velocity at 15 minutes after the stress test between the 2 groups over adenosine triphosphate ($p = 0.02$). Furthermore, there was a significant group effect and interaction in CFVR in the 3 measurements ($p < 0.001$). CFVR significantly decreased at 15 (to 3.3 ± 0.8, $p < 0.001$) and 30 (to 3.7 ± 0.8, $p < 0.01$) minutes after mental stress, compared with before mental stress (4.3 ± 0.9). No significant correlations were observed among decreased CVFR and increased parameters. such as heart rate, blood pressure, and the rate–pressure product during mental stress. Inter- and intraobserver variabilities for measurement of Doppler velocity recording were 5.0% and 3.9%, respectively.

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We have demonstrated for the first time that CFVR was reduced even after a very brief period of mental stress in healthy men without coronary risk factors, even after blood pressure and heart rate returned to baseline levels. This abnormal response of coronary circulation to mental stress may indicate the mechanism by which repetitive mental stress induces coronary circulatory dysfunction, leading to ischemic events in subclinical subjects.

In this study, we measured CFVR with TTDE as an index of coronary microcirculation, which is widely accepted as a surrogate for coronary flow reserve.[5] Although coronary flow reserve is ideal for assessing the function of coronary microcirculation, coronary flow velocity change, but not coronary flow volume, is measured in the epicardial coronary artery. However, it is reported that changes in coronary flow velocity during drug-induced hyperemia closely reflect changes in coronary blood flow.[11] Recent studies have found a good correlation between CFVR assessed with Doppler guidewire and coronary flow assessed by perfusion scintigraphy and positron emission tomography.[12,13] Moreover, the assessment of CFVR with TTDE,

Table 2
Changes in hemodynamics

Variable	Before		During Mental Stress	15 Minutes After		30 Minutes After	
	Baseline	Hyperemia		Baseline	Hyperemia	Baseline	Hyperemia
Mental stress group (n = 31)							
Heart rate (beats/min)	65.5 ± 10.1	70.0 ± 12.4	70.3 ± 10.5*	63.3 ± 9.0	67.0 ± 12.7	62.9 ± 10.4	66.1 ± 12.0
Systolic blood pressure (mm Hg)	115.7 ± 16.0	111.5 ± 15.4	132.1 ± 17.8†	113.3 ± 25.2	112.3 ± 17.0	115.5 ± 165	113.0 ± 16.0
Diastolic blood pressure (mm Hg)	63.2 ± 13.5	56.4 ± 13.8	73.5 ± 12.3†	61.9 ± 12.5	58.4 ± 14.0	61.3 ± 14.8	59.3 ± 14.4
Rate–pressure product (mm Hg × beats/min)	7,666.0 ± 1,958.0	7,872.9 ± 2,016.1	9,382.0 ± 2,418.8†	7,237.3 ± 2,220.1	7,619.1 ± 2,188.3	7,312.0 ± 1,810.7	7,569.1 ± 2,109.2
Control group (n = 10)							
Heart rate (beats/min)	65.2 ± 10.1	69.5 ± 11.1		64.1 ± 9.4	67.1 ± 12.7	65.0 ± 10.5	72.8 ± 16.2
Systolic blood pressure (mm Hg)	102.2 ± 7.5	101.8 ± 8.1		104.9 ± 13.2	103.7 ± 9.8	106.8 ± 11.8	105.3 ± 10.9
Diastolic blood pressure (mm Hg)	52.4 ± 11.3	48.8 ± 12.4		58.0 ± 21.2	50.7 ± 12.1	52.6 ± 12.1	50.6 ± 13.6
Rate–pressure product (mm Hg × beats/min)	6,695.9 ± 1359.7	7,120.7 ± 1,534.1		6,801.2 ± 1,733.0	7,024.4 ± 1,796.3	7,023.3 ± 1,805.6	7,770.5 ± 2,394.9

Values are presented as mean ± SD.
* $p < 0.01$ versus before mental stress; † $p < 0.001$ versus before mental stress.

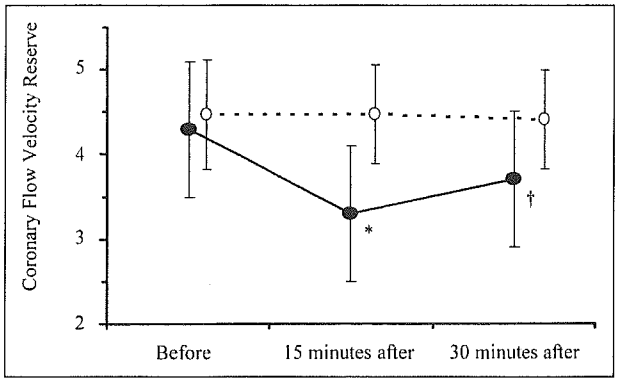

Figure 2. CFVR measurements in the control group *(open circles)* and the mental stress group *(closed circles)*. In the control group, CFVR did not change over 3 measurements. However, in the mental stress group, CFVR was significantly reduced at 15 and 30 minutes after mental stress. Data are presented as mean ± SD. *p <0.001 versus before mental stress; †p <0.01 versus before mental stress.

which has been confirmed to accurately reflect the results of invasive measurement by Doppler guidewire,[7] permits the rapid, reproducible, and totally noninvasive assessment of coronary blood flow at a small cost. Therefore, the noninvasive method we used in the present study permitted the serial evaluation of the physiologic response of coronary circulation after mental stress.

Recently, Ghiadoni et al[14] showed that mental stress resulted in prolonged endothelial dysfunction in brachial arteries for up to 4 hours in healthy subjects, although flow-mediated dilation in the brachial artery does not directly reflect the response of coronary circulation. One limitation of this study is that we did not assess the change of CFVR >30 minutes after mental stress, although this issue would be interesting. Further investigation is needed to address this issue.

Table 3
Coronary flow velocity measurements

Variable	Before	15 Minutes After	30 Minutes After
Mean diastolic flow velocity			
Mental stress group (n = 31)			
Baseline (cm/s)	19.9 ± 6.5	19.9 ± 6.5	21.6 ± 7.9
Hyperemia (cm/s)	83.8 ± 27.6	72.6 ± 28.7*	79.8 ± 27.3
Control group (n = 10)			
Baseline (cm/s)	17.8 ± 6.5	18.2 ± 6.5	19.1 ± 6.6
Hyperemia (cm/s)	79.2 ± 28.1	82.6 ± 29.3	83.5 ± 27.2
CFVR			
Mental stress group (n = 31)	4.3 ± 0.9	3.3 ± 0.8†	3.7 ± 0.8‡
Control group (n = 10)	4.5 ± 0.6	4.5 ± 0.6	4.4 ± 0.6

Values are presented as mean ± SD.
* p <0.05 versus before mental stress; † p <0.001 versus before mental stress; ‡ p <0.01 versus before mental stress.

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Cardiac transcription factor Csx/Nkx2-5: Its role in cardiac development and diseases

Hiroshi Akazawa, Issei Komuro*

Division of Cardiovascular Pathophysiology and Department of Cardiovascular Science and Medicine, Chiba University Graduate School of Medicine, 1-8-1 Inohana, Chuo-ku, Chiba 260-8670, Japan

Abstract

During the past decade, an emerging body of evidence has accumulated that cardiac transcription factors control a cardiac gene program and play a critical role in transcriptional regulation during cardiogenesis and during the adaptive process in adult hearts. Especially, an evolutionally conserved homeobox transcription factor Csx/Nkx2-5 has been in the forefront in the field of cardiac biology, providing molecular insights into the mechanisms of cardiac development and diseases. Csx/Nkx2-5 is indispensable for normal cardiac development, and mutations of the gene are associated with human congenital heart diseases (CHD). In the present review, the regulation of a cardiac gene program by Csx/Nkx2-5 is summarized, with an emphasis on its role in the cardiac development and diseases.

Keywords: Homeobox; Transcriptional regulation; Cardiac development; Congenital heart disease; Cardiac hypertrophy; Cardioprotection

Abbreviations: ANP, atrial natriuretic peptide; ASD, atrial septal defect; AV, atrioventricular; BMP, bone morphogenic protein; BNP, brain natriuretic peptide; CARP, cardiac ankyrin repeat protein; CHD, congenital heart diseases; CKII, casein kinase II; Dpp, decapentaplegic; DMSO, dimethyl sulfoxide; DORV, double-outlet right ventricle; FGF, fibroblast growth factor; HOP, homeodomain-only protein; Irx4, Iroquois homeobox gene 4; MEF2, myocyte enhancer factor 2; MHC, myosin heavy chain; MLC2v, myosin light chain 2v; NES, nuclear export signal; NK2-SD, NK-2-specific domain; PI3-kinase, phosphatidylinositol 3-kinase; Sca-1, stem cell antigen-1; SRF, serum response factor; TAK1, TGF-β-kinase 1; TGF-β, transforming growth factor-β; TOF, tetratology of Fallot; VSD, ventricular septal defect; Wg, wingless.

Contents

* Corresponding author. Tel.: +81 43 222 2097; fax: +81 43 226 2557.
E-mail address: komuro-tky@umin.ac.jp (I. Komuro).

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1. Introduction

The heart is the first functional organ in the developing embryos, and the appropriate delivery of oxygen and nutrients through the circulatory system is prerequisite for embryonic growth and survival. The formation of the heart involves a precisely coordinated process of cellular differentiation and integrated multicellular morphogenesis, and even a minute perturbation of this process gives rise to congenital heart diseases (CHD). The susceptibility of the heart to malformation is reflected by the high incidence of congenital heart disease (nearly 1% of live births; American Heart Association, 2003).

Although the morphological events of heart formation have been described for centuries, it is not until a decade ago that the genetic explorations for cardiac development have started. Cardiogenic progenitors become committed to cardiac lineage in the anterior lateral mesoderm (primary heart filed) of the late gastrulation embryos in response to inducing signals secreted from adjacent endoderm (reviewed in Olson & Srivastava, 1996; Fishman & Olson, 1997; Srivastava & Olson, 2000). These cardiogenic cells, clustering in a form of bilaterally symmetrical crescent, migrate and fuse at the anterior midline to form a linear heart tube. The linear heart tube initiates autonomous contraction and undergoes rightward looping morphogenesis to form a mature four-chambered heart in association with atrioventricular (AV) septations. Maturation of the heart also requires coordinated proliferation and differentiation of myocardium to form functional trabeculated chambers. At the AV canal, mitral and tricuspid valves originate from endocardial cushions, regional swellings forming as a consequence of epithelial–mesenchymal transformation of endocardial cells. Endocardial cushions also participate in the formation of the aortic and pulmonary valves. Migrating neural crest cells populate the outflow tract as well as aortic and pharyngeal arches. Recently, it is proposed that a part of cardiomyocytes in the outflow tract and, possibly, right ventricle is generated from a "secondary (anterior) heart field" situated in splanchnic mesoderm medial and adjacent to the primary heart field (reviewed in Kelly & Buckingham, 2002).

A novel paradigm for heart development originated from the discovery of the *tinman* gene in the fruit fly *Drosophila melanogaster*, which is required for the primitive heart formation in this organism (Azpiazu & Frasch, 1993; Bodmer, 1993). The *tinman* encodes a homeobox-containing transcription factor, and the identification of the *tinman*-related gene *Csx/Nkx2-5* (Komuro & Izumo, 1993; Lints et al., 1993) in mammals attracted much attention to the key regulatory roles of cardiac transcription factors in the intricate program of heart development. Cardiac transcription factors are essential transcriptional activators that are expressed predominantly in hearts and that regulate the expression of the cardiac genes encoding structural proteins or regulatory proteins characteristic of cardiomyocytes (reviewed in Bruneau, 2002). In vertebrates, cardiac transcription factors are represented by the homeobox transcription factor Csx/Nkx2-5, the GATA family transcription factors, and myocyte enhancer factor 2 (MEF2) transcription factors.

Recent data have suggested the significant role of these transcription factors in postnatal hearts as well (reviewed in Akazawa & Komuro, 2003a). Cardiomyocytes are highly differentiated and lose their ability to proliferate soon after birth. Thereafter, cardiomyocytes grow in cell size without cell division to adapt to a demand for an increased workload. In a variety of pathological conditions (e.g., hypertension, valvular disease, myocardial infarction, and cardiomyopathy) that impose overwork on the heart, postnatal cardiomyocytes undergo hypertrophic cell growth. Although cardiac hypertrophy is initially compensatory for an increased workload, the prolongation of this process leads to deleterious outcomes such as congestive heart failure, arrhythmia, and sudden death (Levy et al., 1990; Lorell & Carabello, 2000). Cellular responses characteristic of cardiac hypertrophy include accelerated synthesis of sarcomeric and structural proteins and reprogramming of the fetal cardiac genes (reviewed in Komuro & Yazaki, 1993; Sadoshima & Izumo, 1997). With regard to the transcriptional adaptation induced by hypertrophic stimulation, it is reasonable to assume that cardiac transcription factors play the leading part because they directly regulate a number of cardiac genes that are up-regulated in hypertrophied myocardium. Indeed, the transcriptional activities of GATA and MEF2 transcription factors are enhanced in response to hypertrophic stimulations and they function as essential effectors of divergent intracellular signaling pathways mediating hypertrophic features (reviewed in Akazawa & Komuro, 2003a). However, the role of Csx/Nkx2-5 in the adult hearts remains elusive. Csx/Nkx2-5 is up-regulated in response to hypertrophic stimulations and may have implications in the transcriptional regulation of the cardiac gene program in hypertrophied hearts. In addition, the role of Csx/Nkx2-5 may extend to maintenance of homeostasis in highly differentiated cardiomyocytes.

In line with the involvement in transcriptional regulation of myriad cardiac genes, both during cardiogenesis and during the adaptive process in response to hemodynamic stresses, aberrant expressions of *Csx/Nkx2-5* directly give rise to heart diseases both in mice and humans. This review comprehensively summarizes recent advances in understanding the role of Csx/Nkx2-5 in transcriptional regulation in the heart, especially focusing on its role in cardiac development and diseases.

2. Cardiac homeobox transcription factor Csx/Nkx2-5

2.1. NK-2 class homeobox transcription factor Csx/Nkx2-5

Csx/Nkx2-5 is a member of the NK homeobox gene family that is conserved in evolution and acts as a DNA-