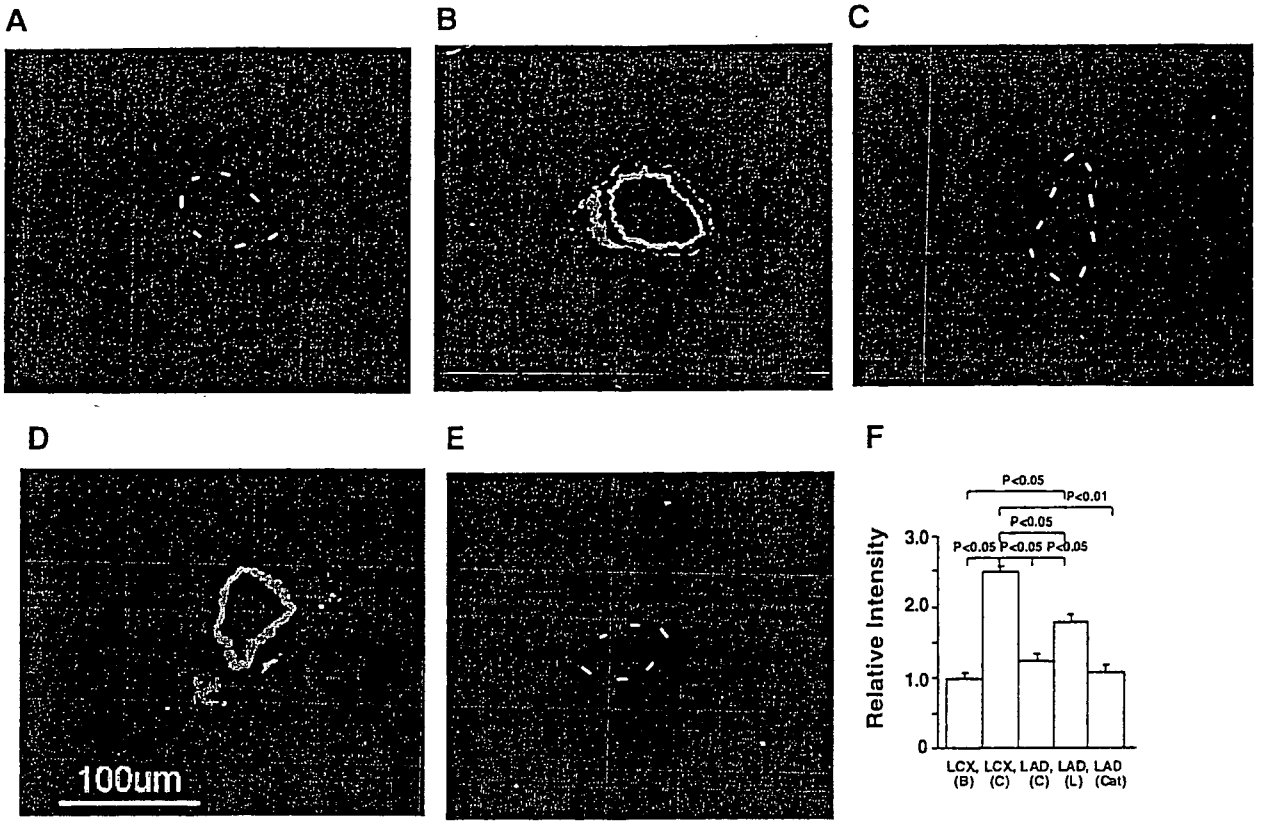

Fig. 5. Detection of H_2O_2 production. *A*: left circumflex artery (LCX; baseline without ACh). *B*: LCX (control). *C*: left anterior descending coronary artery (LAD; control). *D*: LAD (L-NMMA). *E*: LAD (catalase). *F*: fluorescent intensity (B, baseline without ACh; C, control, L, L-NMMA; Cat, catalase). No. of arterioles per animals used was 5/5 for each group. Dashed line, outline of vessels. Bar, 100 μm.

pletely abolish the ACh-induced vasodilatation in both sized arteries, whereas L-NMMA plus catalase markedly attenuated the residual vasodilatation in vivo as did TEA, indicating that H_2O_2 exerts important vasodilator effects during I/R injury in canine coronary microcirculation in vivo (Figs. 3 and 4). Furthermore, in the present study, endogenous H_2O_2-mediated coronary vasodilatation was noted to a greater extent in arterioles than in small arteries (Figs. 3 and 4), confirming the predominant role of H_2O_2 in microvessels and that of NO in relatively large arteries in vivo (25).

Compensatory vasodilator mechanism among H_2O_2, NO, and adenosine. It is well known that coronary vascular tone is regulated by the interactions among several endogenous vasodilators, including NO, H_2O_2, and adenosine (33). These vasodilators play an important role in compensatory vasodilatation of coronary microvessels during myocardial ischemia (35). In the present study (Figs. 3 and 4), endothelium-dependent arteriolar vasodilatation to ACh during coronary I/R was significantly increased by L-NMMA while small arterial vasodilatation to ACh was increased by catalase and 8-SPT, and the residual arteriolar dilation was further inhibited by both of them (L-NMMA plus catalase or TEA). Furthermore, fluorescent microscopy with DCF and DAR, respectively, showed that H_2O_2 and NO production after I/R were enhanced in small coronary arteries and arterioles by L-NMMA [fluorescent intensity (FI) 1.8] and catalase (FI 1.9) compared with those in the LAD of control group (Figs. 5 and 6, FI: DAR 1.2 and DCF 1.1). The residual small arteriolar dilatation after combined administration of L-NMMA + catalase was completely blocked by 8-SPT, an adenosine receptor blocker, indicating that adenosine also compensated for the loss of action of NO and H_2O_2. Taken together, these results indicate the compensatory vasodilator effects among NO, H_2O_2, and adenosine to maintain coronary blood flow during coronary I/R injury in vivo. H_2O_2 and NO were mutually compensatory in both small arteries and arterioles, and in the presence of their inhibitors (catalase and L-NMMA), adenosine also caused arteriolar vasodilatation, as we reported previously (35). This finding is consistent with our finding that NO, H_2O_2, and adenosine play an important compensatory role in coronary autoregulation in canine coronary microcirculation in vivo (35). It was reported that TEA inhibited adenosine-induced vasodilatation of canine subepicardial coronary arteries in vitro (3). Furthermore, H_2O_2 stimulates protein kinase C, phospholipase A_2, and arachidonic acid release and increases intracellular cAMP levels (10). These findings suggest that cAMP-mediated pathway is involved, at least in part, during coronary vasodilatation through K_{Ca} channels after I/R injury.

Role of H_2O_2 during coronary I/R. It is known that K_{Ca} channels substantially contribute to coronary vasodilatation in myocardial ischemia (22) and that H_2O_2 also activates K_{Ca} channels (11). However, it remains to be examined whether H_2O_2 contributes to coronary vasodilatation during I/R in vivo. The present results demonstrate that H_2O_2

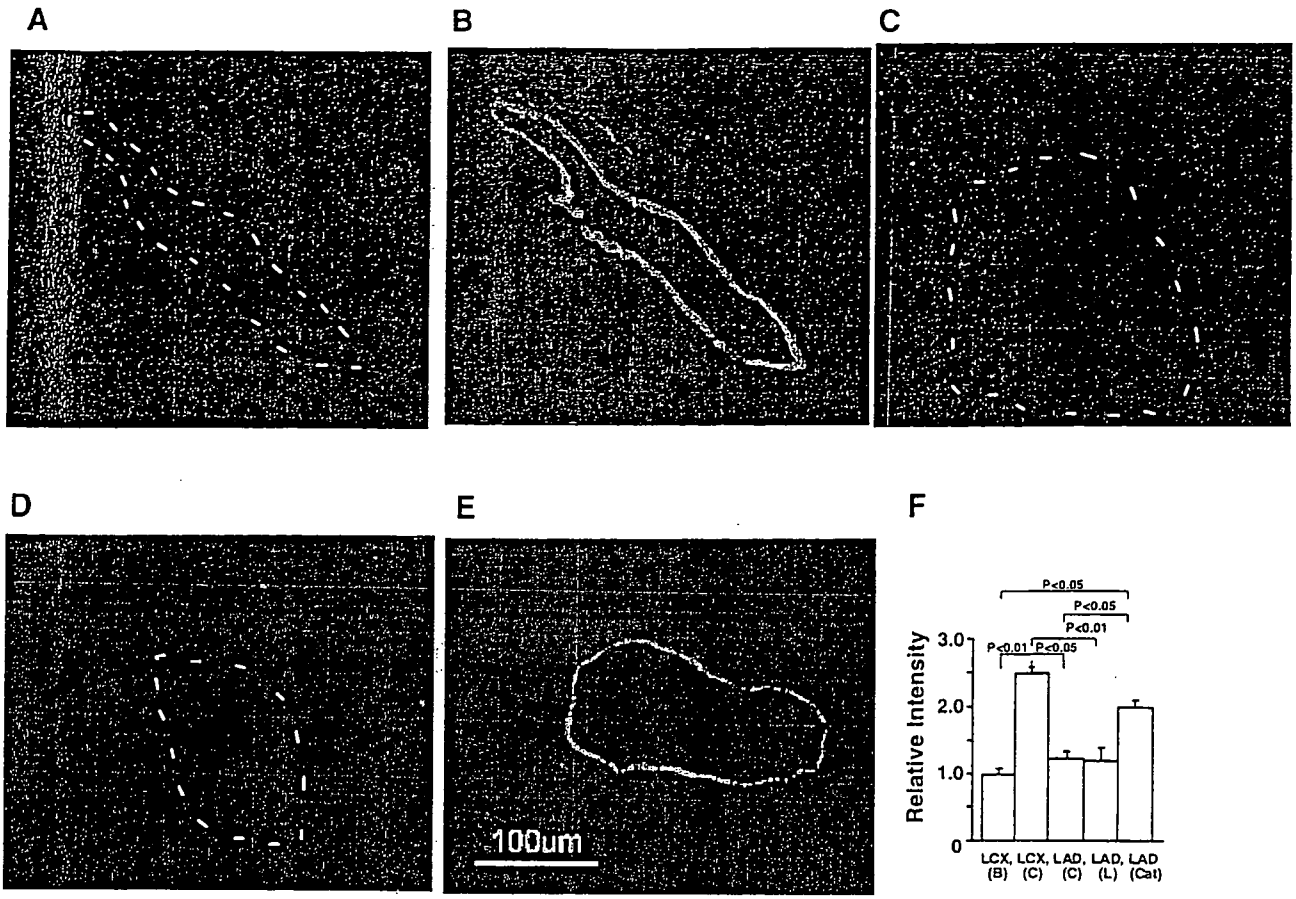

Fig. 6. Detection of nitric oxide (NO) production. *A*: LCX (baseline without ACh). *B*: LCX (control). *C*: LAD (control). *D*: LAD (L-NMMA). *E*: LAD (catalase). *F*: fluorescent intensity (B, baseline without ACh; C, control, L, L-NMMA; Cat, catalase). No. of small arteries per animals used was 5/5 for each group. Dashed line, outline of vessels.

substantially contributes to coronary vasodilatation during I/R in vivo as a compensatory mechanism for the loss of NO. Several mechanisms have been proposed for K_{Ca} channel opening during coronary I/R, including cellular acidosis

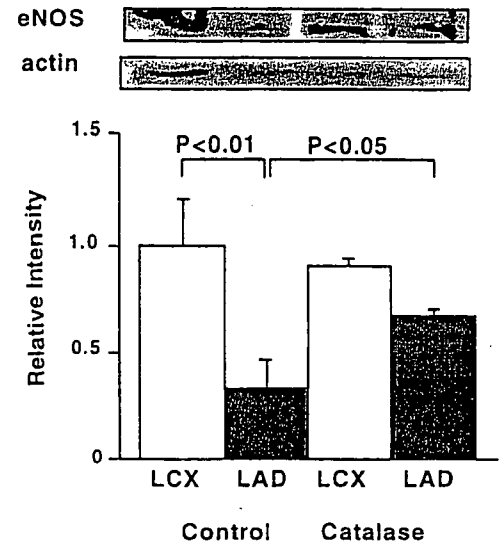

Fig. 7. Western blotting showing the effects of catalase on endothelial nitric oxide synthase (eNOS) protein expression in the myocardium of LAD and LCX. No. of animals used was 3 for each group.

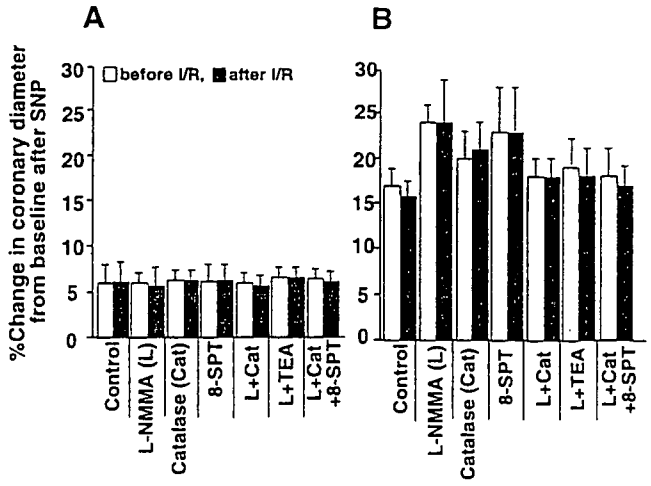

Fig. 8. Endothelium-independent coronary vasodilatation before and after coronary I/R injury in dogs in vivo. *A*: small artery (≥100 μm). *B*: arteriole (<100 μm). No. of small arteries and arterioles per animals used (*n*/*n*) was 7/5 for control, 8/5 for L-NMMA, 10/5 for catalase, 6/5 for 8-SPT, 8/5 for L-NMMA plus catalase, 5/5 for L-NMMA plus TEA, and 5/5 for L-NMMA plus catalase plus 8-SPT in small arteries; and 12/5 for control, 16/5 for L-NMMA, 12/5 for catalase, 5/5 for 8-SPT, 10/5 for L-NMMA plus catalase, 8/5 for L-NMMA plus TEA, and 7/5 for L-NMMA plus catalase plus 8-SPT in arterioles.

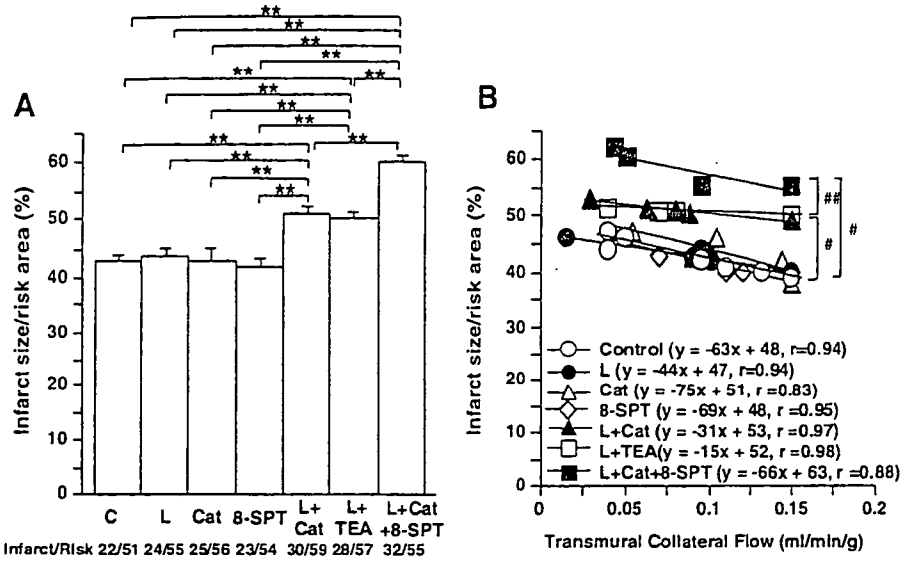

Fig. 9. Effects of H_2O_2, NO, and adenosine on I/R-induced MI in dogs in vivo. *A*: I/R-induced left ventricular infarct size in dogs in vivo. C, control. *B*: plot of infarct size expressed as a percentage of the risk area and regional collateral flow during I/R. $^{**}P < 0.01$, $\#P < 0.05$ vs. L-NMMA (L) or Cat or 8-SPT; $\#\#P < 0.01$ vs. L + TEA or L + Cat.

(27), increase in intracellular Ca^{2+} concentration after ischemia (28), and H_2O_2 production by inflammatory cells (5). Furthermore, an inhibitor of NO synthesis [N^G-nitro-L-arginine methyl ester (L-NAME)] or that of K_{Ca} channels (charybdotoxin) partly inhibits the protective effect on myocardial infarct size (22). Liu et al. (14) demonstrated that peroxynitrite inhibits K_{Ca} channel activity in human coronary arterioles during I/R. This mechanism might contribute to impaired H_2O_2-mediated dilation in I/R where NO synthase activity is increased in the presence of excess of O_2^-. In the present study, inhibition of H_2O_2 or NO alone did not significantly increase myocardial infarct size compared with control conditions (Fig. 9). These results suggest that H_2O_2 and NO exert cardioprotective effects against the development of myocardial infarction in a compensatory manner.

Recently, we have demonstrated that the expression of eNOS protein is decreased in the ischemic myocardium, which is improved by a selective Rho-kinase inhibitor, hydroxyfasudil, during coronary I/R injury in dogs in vivo (36). Furthermore, a physiological concentration (2 μmol/l) of H_2O_2 improved the recovery of both cardiac contractile function and energy metabolism after I/R in perfused rat heart (37). In the present study, the expression of eNOS protein was decreased in the ischemic myocardium, which was increased by catalase during I/R injury (Fig. 7). All these mechanisms may be involved in the beneficial effects of H_2O_2 on the I/R-induced myocardial injury. It also is conceivable that I/R reduces endothelial tetrahydrobiopterin levels in coronary vessels and impairs eNOS function (30).

Limitations of the study. Several limitations should be mentioned for the present study. First, we did not examine coronary vasodilatation in response to SOD/SOD mimetic (e.g., Tempol) or peroxynitrite inhibitor (e.g., ebselen) after I/R. However, because of the complex interactions among the oxygen species, we consider that both Tempol and ebselen also affect H_2O_2 metabolism by scavenging superoxide anions and peroxynitrite, respectively. Second, in addition to catalase, endogenous glutathione peroxidase (GSH) also plays an important role in removing H_2O_2, and NO also could be a substrate for endogenous catalase (1). However, in the present study, we used exogenous catalase to remove H_2O_2 to examine the role of the reactive oxygen species. Third, the exact source of vascular H_2O_2 production remains to be elucidated (e.g., the endothelium, smooth muscle, or cardiomyocytes). Fourth, while we were able to demonstrate the production of H_2O_2 using fluorescent microscopy with DCF, we were unable to quantitatively measure the H_2O_2 production because DCF detects H_2O_2, $ONOO^-$, and HOCl as well. Fifth, we were unable to find smaller arterioles because of the limited spatial resolution of our CCD intravital microscope. If we had an intravital camera with higher resolution, we would be able to observe coronary vasodilator responses of smaller arterioles.

Clinical implications and conclusions. During coronary I/R, microemboli of atherosclerosis debris and platelet plugs are released into the coronary microcirculation, particularly at revascularization with thrombolysis and/or percutaneous coronary intervention. Thus preexisting coronary endothelial dysfunction with various risk factors may be an important determinant for I/R injury in acute myocardial infarction. The synthesis and/or action of endothelium-derived NO are impaired under various pathological conditions, such as hypertension, hyperlipidemia, and diabetes mellitus (26, 34). In hypertension, K channel activities are increased in a compensatory manner with reduced NO activity (13). The present results suggest that NO and H_2O_2 compensate each other to cause coronary vasodilatation during I/R injury in vivo.

In conclusion, we were able to demonstrate that endogenous H_2O_2, in cooperation with NO, plays an important cardioprotective role in coronary I/R injury in vivo. The present findings may have important clinical implications because H_2O_2-mediated mechanisms substantially contribute to endothelium-dependent vasodilatation in coronary I/R in vivo.

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Beraprost sodium enhances neovascularization in ischemic myocardium by mobilizing bone marrow cells in rats

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Abstract

Beraprost sodium, an orally active prostacyclin analogue, has vasoprotective effects such as vasodilation and antiplatelet activities. We investigated the therapeutic potential of beraprost for myocardial ischemia. Immediately after coronary ligation of Sprague–Dawley rats, beraprost (200 μg/kg/day) or saline was subcutaneously administered for 28 days. Four weeks after coronary ligation, administration of beraprost increased capillary density in ischemic myocardium, decreased infarct size, and improved cardiac function in rats with myocardial infarction. Beraprost markedly increased the number of CD34-positive cells and c-kit-positive cells in plasma. Also, four weeks after coronary ligation of chimeric rats with GFP-expressing bone marrow, bone marrow-derived cells were incorporated into the infarcted region and its border zone. Treatment with beraprost increased the number of GFP/von Willebrand factor-double-positive cells in the ischemic myocardium. These results suggest that beraprost has beneficial effects on ischemic myocardium partly by its ability to enhance neovascularization in ischemic myocardium by mobilizing bone marrow cells.

Keywords: Prostacyclin analogue; Myocardial infarction; Neovascularization; Bone marrow mobilization

Interruption of myocardial blood flow leads to rapid death of cardiomyocytes and vascular structures, resulting in the development of heart failure [1]. Stem or progenitor cells are mobilized from bone marrow into the peripheral blood in response to tissue ischemia, migrate to sites of injured tissues, and differentiate into endothelial cells and cardiomyocytes [2–4]. However, the compensatory mechanisms are insufficient to heal infarcted myocardium. Earlier studies have shown that bone marrow cells artificially mobilized by cytokines repair the infarcted heart and improve cardiac function after acute myocardial infarction [5,6]. Therefore, enhancement of bone marrow cell mobilization leading to neovascularization following revascularization would be beneficial for the treatment of acute myocardial infarction.

Beraprost sodium (BPS) is a chemically stable prostacyclin analogue owing to its cyclo-pentabenzofuranyl structure [7]. It has been well established that BPS has vasoprotective effects such as vasodilation and antiplatelet activities [8–11]. Thus, BPS has been used in the treatment of peripheral arterial disease [12,13] and pulmonary arterial hypertension [14,15]. Although a limited number of studies suggest therapeutic potential of prostacyclin for the treatment of myocardial ischemia [16–18], the underlying mechanisms still remain unclear. In addition, little information is available regarding the therapeutic potential of prostacyclin analogues such as BPS for myocardial ischemia. A recent study has shown that BPS activates endothelial

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nitric oxide synthase (eNOS) through the c-AMP/protein kinase A pathway [19]. Activation of eNOS is known to contribute to bone marrow cell mobilization, leading to neovascularization [20]. These results raise the possibility that BPS may have beneficial effects on the ischemic myocardium through enhancement of bone marrow cell mobilization.

Thus, the purposes of this study were: (1) to examine the effect of BPS on mobilization and recruitment of bone marrow cells after acute myocardial infarction, (2) to investigate whether BPS induces neovascularization in the ischemic myocardium, and (3) to investigate whether treatment with BPS improves cardiac function in rats with myocardial infarction.

Methods

Model of myocardial infarction. We used male Sprague–Dawley rats (Japan SLC Inc., Hamamatsu, Japan) weighing 185–215 g. Myocardial infarction was produced by left coronary ligation, as described previously [21]. Briefly, after rats were anesthetized with sodium pentobarbital (30 mg/kg), they were artificially ventilated with a volume-regulated respirator. The heart was exposed via a left thoracotomy incision. Then, the left coronary artery was ligated 2–3 mm from its origin between the pulmonary artery conus and the left atrium with a 6-0 Prolene suture. Finally, the heart was restored to its normal position, and the chest was closed. Experimental protocols were performed in accordance with the "Guidelines of the Animal Care Ethics Committee of the National Cardiovascular Center Research Institute", which complies NIH Guidelines.

Administration of BPS. Immediately after coronary ligation, BPS (200 μg/kg/day, Astellas Pharma Inc., Tokyo, Japan) was subcutaneously administered to surviving rats using an osmotic mini-pump for 4 weeks (BPS group, $n = 12$). As a control, saline was similarly administered to rats receiving coronary ligation (Control group, $n = 12$).

Echocardiographic studies. Echocardiographic studies were performed 4 weeks after coronary ligation. M-mode tracings were obtained at the level of the papillary muscles using an echocardiographic system equipped with a 7.5-MHz phased-array transducer (HP SONOS 5500; Hewlett Packard Co., Andover, MA). Anterior and posterior end-diastolic and end-systolic wall thickness, LV end-diastolic and end-systolic dimensions, and LV fractional shortening were measured by the American Society for Echocardiography leading-edge method in three consecutive cardiac cycles. LV meridional wall stress was estimated as $0.344 \times \text{LV pressure} \times \{\text{LV dimension}/(1 + \text{PWT}/\text{LV dimension})\}$, where PWT is posterior wall thickness [22].

Hemodynamic studies. Hemodynamic studies were performed 4 weeks after coronary ligation, following echocardiography. After anesthesia with pentobarbital sodium, a 1.5F micromanometer-tipped catheter (Millar Instruments Inc., Houston, TX) was advanced into the LV through the right common carotid artery. Hemodynamic variables were measured with a pressure transducer connected to a polygraph. After completion of these measurements, the left and right ventricles and the lungs were excised and weighed. Infarct size was determined as a percentage of the entire LV area ($n = 5$ in each group), as reported previously [23]. Briefly, incisions were made in the posterior LV so that the tissue could be pressed flat. The circumference of the entire flat LV and of the visualized infarcted area, as judged from both the epicardial and endocardial sides, was outlined on a clear plastic sheet. The difference in weight between the two marked areas on the sheet was used to determine infarct size and was expressed as a percentage of LV surface area.

Measurement of plasma ANP level. Blood samples were obtained 4 weeks after coronary ligation. Plasma atrial natriuretic peptide (ANP), a marker for heart failure, was measured by enzyme immunoassay (Peninsula Laboratories Inc., San Carlos, CA).

Mononuclear cell mobilization and FACS analysis. To investigate whether administration of BPS mobilizes bone marrow cells, an additional 12 rats were randomized to receive BPS (200 μg/kg/day, BPS group, $n = 6$) or saline (Control group, $n = 6$). On the third day of BPS or saline treatment, 4 ml of blood was drawn from the inferior vena cava of each rat. Peripheral blood was obtained at the end of infusion. After mononuclear cells were counted, they were incubated for 30 min at 4 °C with fluorescein isothiocyanate (FITC)-conjugated mouse monoclonal antibodies against rat CD34 (clone ICO-115, Santa Cruz) and CD45 (clone OX-1), and FITC-conjugated rabbit anti-rat c-Kit polyclonal antibody (clone C-19, Santa Cruz). Immunofluorescence-labeled cells were analyzed by quantitative flow cytometry with a FACSCalibur flow cytometer (BD Biosciences, Mountain View, CA). Isotype-identical antibodies served as controls.

RT-PCR assay. To investigate whether bone marrow cells express the prostacyclin receptor (IP receptor), we analyzed expression of its mRNA by reverse transcription-polymerase chain reaction (RT-PCR). In brief, total RNA of bone marrow cells was extracted with guanidine isothiocyanate (RNeasy Mini Kit, Qiagen). Then, reverse-transcribed single-stranded cDNA was subjected to PCR (PCR Amplification Kit, Takara) using primer sets for the IP receptor (Hokkaido System Science Co., Ltd., Sapporo, Japan, forward, 5′-GGCACGAGAGGATGAAGTTTACC-3′; reverse, 5′-GTCAGAGGCACAGCAGTCAATGG-3′) and G3PDH (Clonetech Laboratories Inc., Mountain View, CA, forward, 5′-TG AAGGTCGGTGTCAACGGATTTGGC-3′; reverse, 5′-CATGTAGG CCATGAGGTCCACCAC-3′).

Creation of bone marrow-chimeric rats. To assess recruitment of bone marrow cells after BPS administration, bone marrow transplantation was performed by using male normal Sprague–Dawley rats as recipients and male Green fluorescent protein (GFP)-transgenic rats (SD-Tg [Act-EGFP] CZ-004Osb, Japan SLC Inc.) as donors, using a previously described method [24]. Briefly, bone marrow was harvested by flushing the cavity of femurs and tibias from GFP-transgenic rats with phosphate-buffered saline. Then, 3×10^7 GFP-positive bone marrow cells were individually administered to 12 lethally irradiated (900c Gray) rats via the tail vein. Four weeks after transplantation, flowcytometric analysis determined that 90% of peripheral blood mononuclear cells from both donors and 8 of 12 chimeric rats were GFP-positive, suggesting the establishment of stable chimerism. These chimeric rats were subjected to left coronary ligation, followed by administration of BPS (200 μg/kg/day, BPS group, $n = 4$) or saline (Control group, $n = 4$) using an osmotic mini-pump for 4 weeks.

Histological examination. To detect fibrosis in the cardiac muscle, the LV myocardium ($n = 5$, each group) was fixed in 10% formalin, cut transversely in three sections, embedded in paraffin, and stained with Masson's trichrome. To detect capillary endothelial cells in the peri-infarct area, we performed DAB staining (LSAB2 System HRP, Dako Cytomation Co., Denmark) using rabbit polyclonal anti-von Willebrand factor (vWF) antibody (Dako). A total of 10 different fields from three different sections were randomly selected, and the number of capillaries was counted in the peri-infarct area using a light microscope at 200× magnification. Capillary density was expressed as the mean number of capillaries per square millimeter. Also, 4 weeks after coronary ligation in bone marrow-chimeric rats ($n = 4$ in each group), the LV myocardium was excised, embedded in OCT compound, snap-frozen in liquid nitrogen, and cut transversely into 6-μm-thick sections from base to apex. Immunofluorescent staining was performed using rabbit polyclonal anti-vWF antibody (Dako), mouse monoclonal anti-cardiac troponin T antibody (Neomarkers, Fremont, CA), and rabbit polyclonal Alexa 488-conjugated anti-GFP antibody (Molecular Probes Inc., Eugene, OR). The nuclei were counterstained with 4′,6′-diamidino-2-phenylindole (DAPI). We measured the number of GFP/vWF-double-positive cells incorporated into vascular structures in 10 randomly selected fields in the peri-infarct area per section in a blinded fashion using a fluorescence microscope.

Statistical analysis. Numerical values are expressed as means ± SEM. Comparisons of parameters between two groups were made by unpaired Student's t test. A value of $p < 0.05$ was considered significant.

Results

Cardiac structure

Body weight at 4 weeks after coronary ligation was significantly greater in the BPS group than in the Control group (Table 1). Right ventricular weight and lung weight in the BPS group were significantly smaller than those in the Control group, although LV weight did not differ between the two groups. Moderate to large infarcts were observed in the Control group (Fig. 1A). However, administration of BPS significantly decreased infarct size in rats with myocardial infarction (Fig. 1A and B). BPS significantly decreased LV end-diastolic dimension (LVDD) (Fig. 1C).

Table 1
Physiological profiles of experimental groups

	Control	BPS
Number	12	12
Body weight (g)		
Baseline	198 ± 3	204 ± 3
After treatment	319 ± 6	352 ± 9*
LV wt/body wt (g/kg)	2.28 ± 0.04	2.27 ± 0.04
RV wt/body wt (g/kg)	0.99 ± 0.05	0.61 ± 0.02**
Lung wt/body wt (g/kg)	6.55 ± 0.62	3.88 ± 0.1**
Plasma AND level (pg/ml)	798 ± 99	498 ± 57*

Control, infarct rats without treatment; BPS, infarct rats treated with BPS administration; AND, atrial natriuretic protein. Data are expressed as means ± SEM. $^{*}p < 0.05$, $^{**}p < 0.01$ vs. Control group.

Cardiac function

Neither heart rate nor mean arterial pressure differed between the BPS and Control groups (Table 2). LV fractional shortening and LV maximum dP/dt in the BPS group were significantly greater than those in the Control group (Fig. 2A and B). LV end-diastolic pressure (LVEDP) in the BPS group was significantly lower than that in the Control group (Fig. 2C). LV minimum dP/dt was also improved by BPS (Fig. 2D). Treatment with BPS attenuated the increase in plasma ANP level after myocardial infarction (Table 1). BPS significantly increased anterior wall thickening, although it did not significantly alter posterior wall thickening (Table 2). Thickness of the anterior and posterior walls tended to be greater in the BPS group, but these changes did not reach statistical significance. LV diastolic wall stress in the BPS group was significantly lower than that in the Control group.

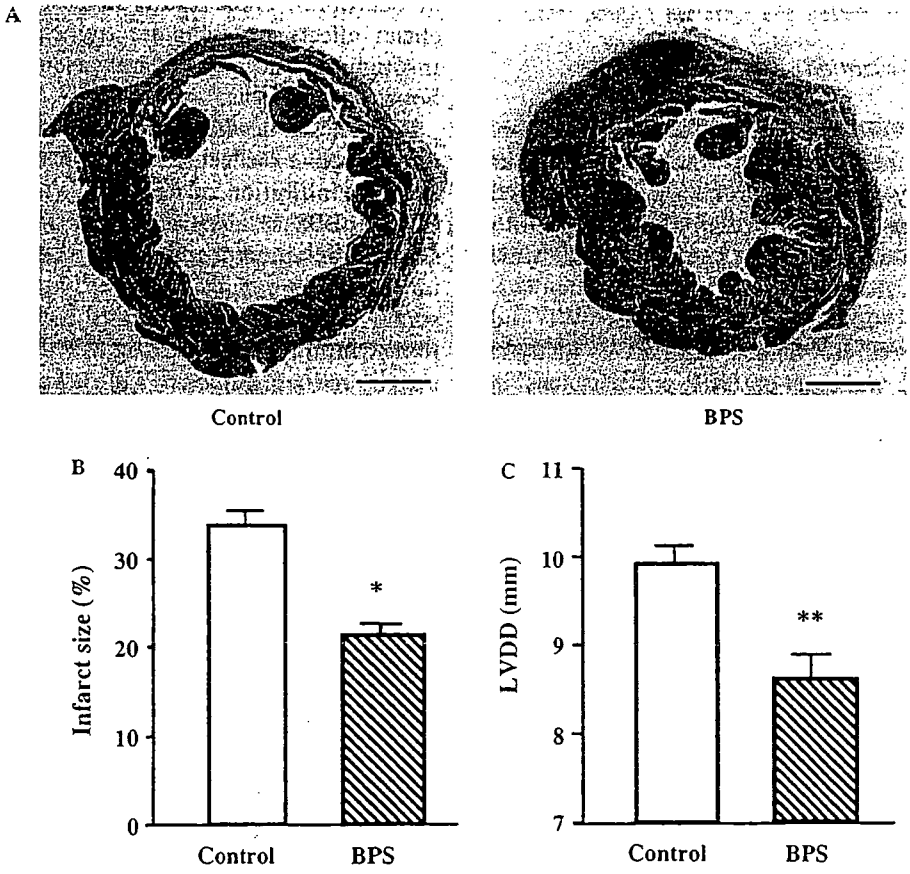

Fig. 1. (A) Representative examples of Masson's trichrome staining of transverse sections of LV myocardium 4 weeks after coronary ligation. Scale bars = 2 mm. (B,C) Quantitative analysis of infarct size and LV end-diastolic dimension (LVDD). Infarcted area and LVDD in the BPS group were significantly smaller than those in the Control group. Data are expressed as means ± SEM. $^{*}p < 0.05$, $^{**}p < 0.01$ vs. Control group.

Table 2
Echocardiographic and hemodynamic data

	Control	BPS
AWT diastole (mm)	0.62 ± 0.04	0.74 ± 0.05
AW thickening (%)	17 ± 3	34 ± 6*
PWT diastole (mm)	1.55 ± 0.07	1.70 ± 0.04
PW thickening (%)	43 ± 4	49 ± 3
Heart rate (bpm)	458 ± 7	471 ± 10
Mean arterial pressure (mmHg)	103 ± 5	115 ± 4
LV systolic pressure (mmHg)	113 ± 4	127 ± 5*
LV diastolic wall stress (kdyne/cm^2)	24 ± 4	5 ± 1**
LV systolic wall stress (kdyne/cm^2)	267 ± 18	225 ± 14

AWT, anterior wall thickness; AW, anterior wall; PWT, posterior wall thickness; PW, posterior wall. Data are expressed as means ± SEM. *$p < 0.05$, **$p < 0.01$ vs. Control group.

Mobilization of bone marrow cells

RT-PCR demonstrated that IP receptor mRNA was expressed in bone marrow cells (Fig. 3A), indicating a direct effect of BPS on these cells. Three-day administration of BPS significantly increased the number of peripheral blood mononuclear cells compared to saline administration (Fig. 3B). Administration of BPS markedly increased the number of circulating progenitor cells such as CD34-positive cells and c-kit-positive cells (Fig. 3C and D). BPS also increased the number of CD45-positive hematopoietic lineage cells (Fig. 3E).

BPS-induced neovascularization

Chimeric rats with GFP-expressing bone marrow were used to assess recruitment of bone marrow cells. Four weeks after coronary ligation, bone marrow-derived GFP-positive cells were incorporated predominantly into the infarcted region and its border zone (Fig. 4A), while these cells were rarely detected in the noninfarcted myocardium. Some of the GFP-positive cells stained for vWF and formed vascular structures. Semi-quantitative analysis demonstrated that the number of GFP-positive cells in the myocardium was significantly greater in the BPS group than in the Control group (Fig. 4B). The number of GFP-vWF double-positive cells (bone marrow-derived endothelial cells) in the ischemic myocardium was significantly greater in the BPS group than in the Control group (Fig. 4C). In addition, a small number of GFP-troponin T-double-positive cells were observed in the BPS group (Fig. 4D).

Capillary density

In the peri-infarct area, clustering of relatively small vessels was seen in BPS-treated hearts, which is indicative of recent endothelial regeneration (Fig. 5A). Semi-quantitative analysis also demonstrated that administration of BPS significantly increased the capillary density in the peri-infarct area compared to the Control group (Fig. 5B).

Discussion

In the present study, we demonstrated that treatment with BPS (1) decreased infarct size and improved cardiac structure and function in rats with acute myocardial infarction, (2) increased the number of circulating progenitor cells such as CD34-positive cells and c-kit-positive cells in rats, and (3) increased the number of bone marrow-derived endothelial cells and the capillary density in the ischemic myocardium. These results suggest that BPS may have beneficial effects on ischemic myocardium at least in part through enhancement of neovascularization by mobilizing bone marrow cells.

Earlier studies have reported that prostacyclin has cardioprotective effects in ischemia–reperfusion injury through inhibition of neutrophil activation and migration [25,26]. BPS is also reported to inhibit chemotaxis and superoxide anion production of neutrophils which contribute to tissue damage by releasing tissue destructive lysosomal enzymes [27]. Infusion of BPS has been shown to reduce infarct size in the dog heart with left coronary occlusion by reducing myocardial oxygen demand and by inhibition of the migration of neutrophils [28]. However, these

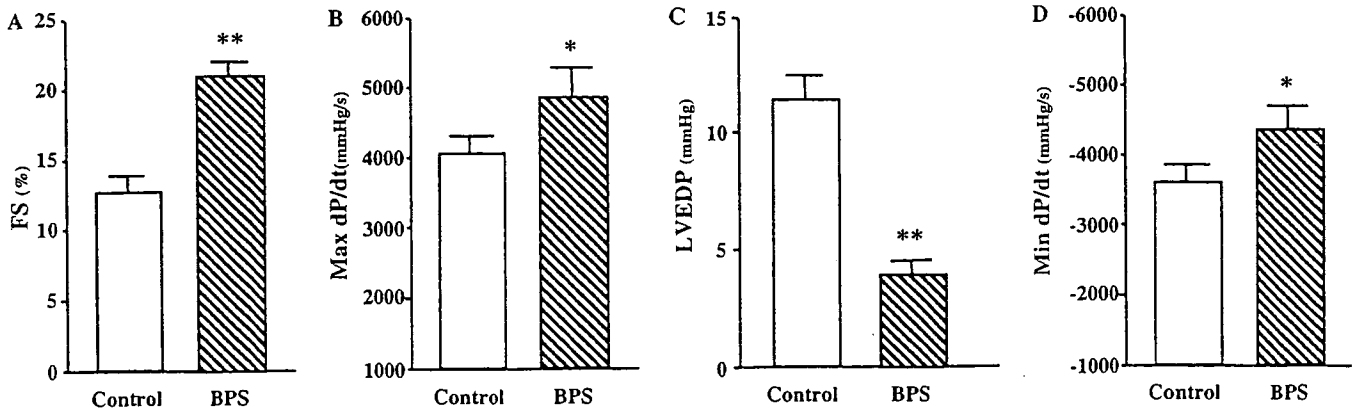

Fig. 2. Cardioprotective effects of BPS on echocardiographic and hemodynamic parameters. FS, fractional shortening; LVEDP, LV end-diastolic pressure; Max and Min dP/dt, maximum and minimum dP/dt. Data are expressed as means ± SEM. *$p < 0.05$, **$p < 0.01$ vs. Control group.

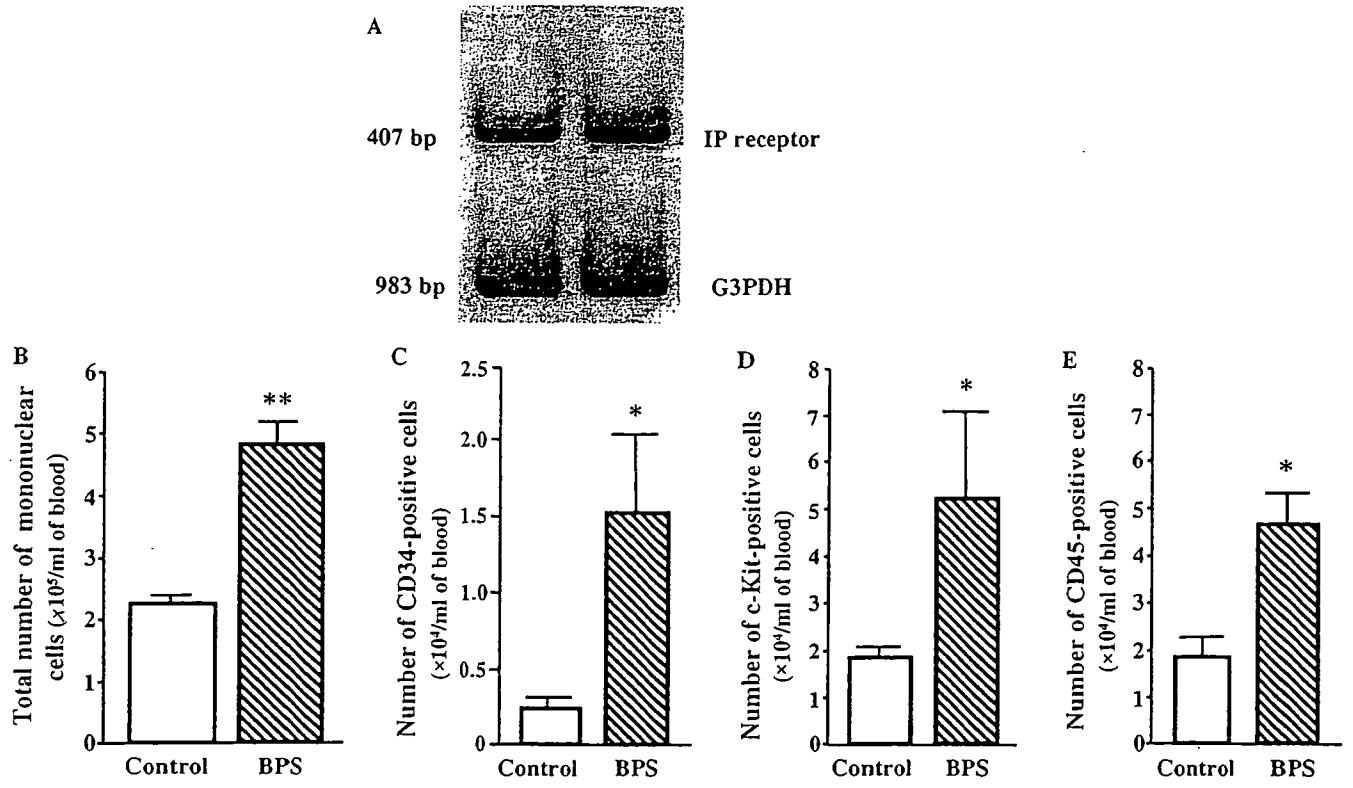

Fig. 3. BPS-induced mobilization of bone marrow cells. (A) Expression of prostacyclin receptor (IP receptor) on bone marrow cells. (B–E) Quantification of BPS-induced MNC mobilization by FACS analysis. Administration of BPS markedly increased the number of circulating progenitor cells such as CD34-positive cells and c-kit-positive cells. BPS also increased the number of CD45-positive hematopoietic lineage cells. Data are expressed as means ± SEM. $^{*}p < 0.05$, $^{**}p < 0.01$ vs. Control group.

biological activities of BPS appear to be insufficient to explain the decrease in infarct size as well as suppression of LV remodeling.

Recent studies have shown that mobilization of bone marrow cells by cytokines promotes myocardial repair and regeneration after acute myocardial infarction [5,6]. In the present study, three-day administration of BPS markedly increased the number of circulating progenitor cells such as CD34-positive cells and c-kit-positive cells in rats. In addition, treatment with BPS enhanced recruitment of bone marrow cells to the ischemic myocardium and increased capillary density in the peri-infarct area. Earlier studies have shown that CD34-positive cells have angiogenic potential to treat ischemic heart [29–31]. Also, another stem cell fraction, c-kit-positive cells have ability to repair ischemic myocardium by differentiating into vascular endothelial cells [32,33]. These findings suggest that administered BPS induces neovascularization partly via enhancement of bone marrow cell mobilization. RT-PCR demonstrated that IP receptor mRNA was expressed in bone marrow cells, indicating a direct effect of BPS on these cells. A recent study has shown that BPS increases eNOS expression in cultured endothelial cells through activation of c-AMP/Protein kinase A signal transduction [19]. Also, earlier studies have shown that eNOS plays essential role in the recruitment of EPCs to the ischemic myocardium [20]. Taken together, administered BPS may act as a potent stimulator of cell mobilization from bone marrow, although further studies are necessary to examine the underlying mechanisms.

In the present study, treatment with BPS significantly attenuated infarct size after myocardial infarction. BPS improved cardiac function and attenuated the development of LV remodeling after acute myocardial infarction, as indicated by increases in LV fractional shortening and maximum dP/dt, and decreases in LVEDP and LVDD. Taken together, BPS may attenuate myocardial infarction through enhancement of neovascularization via modification of bone marrow kinetics. Interestingly, a small fraction of mobilized bone marrow cells expressed cardiac troponin T in the ischemic myocardium in the BPS group, suggesting that BPS may partially contribute to myocardial regeneration after acute myocardial infarction. Earlier studies have demonstrated that BPS has other beneficial effects for ischemic heart disease including anti-thrombotic activity [34], inhibition of reperfusion injury [35], and prevention of coronary spasm [36], and re-stenosis [37]. These findings suggest that administration of BPS may be a promising therapy for acute myocardial infarction.

Granulocyte colony stimulating factor (G-CSF) is currently used agent for mobilization of bone marrow. Infusion of G-CSF after myocardial infarction improves LV function increasing peripheral stem cell fraction [5,38]. A recent clinical trial, however, claimed the G-CSF therapy

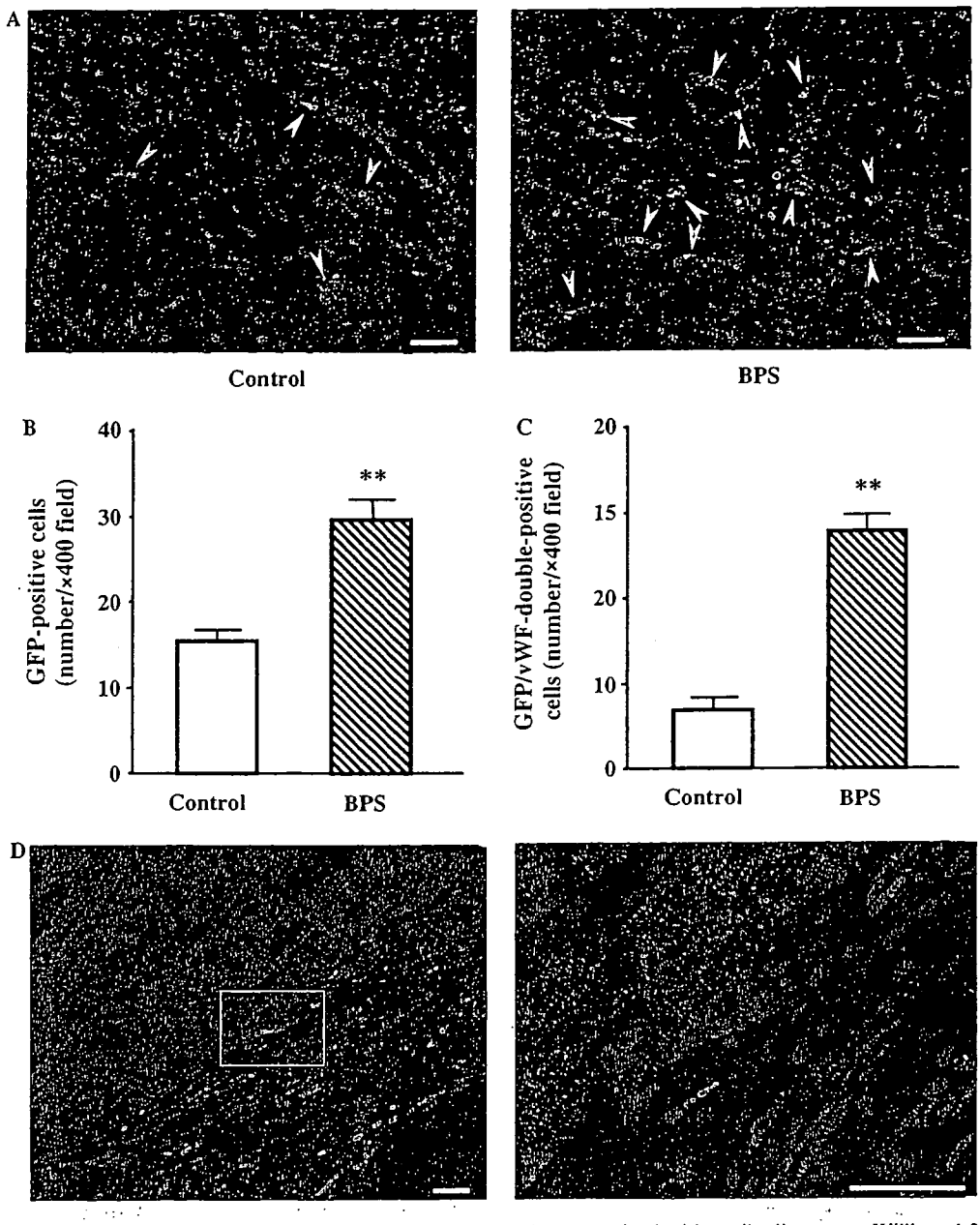

Fig. 4. BPS-induced neovascularization. (A) Representative immunofluorescent images stained with antibodies to von-Willbrand factor (vWF, red) and green fluorescent protein (GFP, green). Nuclei were counterstained with DAPI (blue). (B,C) Semi-quantitative analyses of numbers of GFP-positive cells and GFP-vWF double-positive cells in the peri-infarct area. (D) Representative immunofluorescent image of GFP-positive cells (green) expressing cardiac troponin T (red) observed in the BPS group. Scale bars = 50 μm. Data are expressed as means ± SEM. $^{**}p < 0.01$ vs. Control group.

has serious problem with re-stenosis after recanalization [39]. On the other hand, the safety of BPS has been identified in the treatment of peripheral arterial disease [12,13] and pulmonary arterial hypertension [14,15]. A randomized, controlled clinical trial failed to demonstrate therapeutic potential of prostacyclin for the treatment of severe congestive heart failure [40], which has long discouraged the pursuit of prostacyclin as a therapeutic option for the treatment of acute myocardial infarction. Interestingly, however, double-blinded, randomized, placebo-controlled, large-scale studies showed that treatment with BPS decreased vascular events in patients with peripheral arterial disease [41,42]. Thus, adequate use of BPS for only acute myocardial infarction may have beneficial effects on ischemic myocardium, although further preclinical trials are required to verify the safety and efficacy of BPS.

Conclusion

In summary, administration of BPS improved cardiac structure and function in rats with acute myocardial infarction. This beneficial effect of BPS may be mediated partly by its ability to enhance neovascularization in ischemic myocardium by mobilizing bone marrow cells.

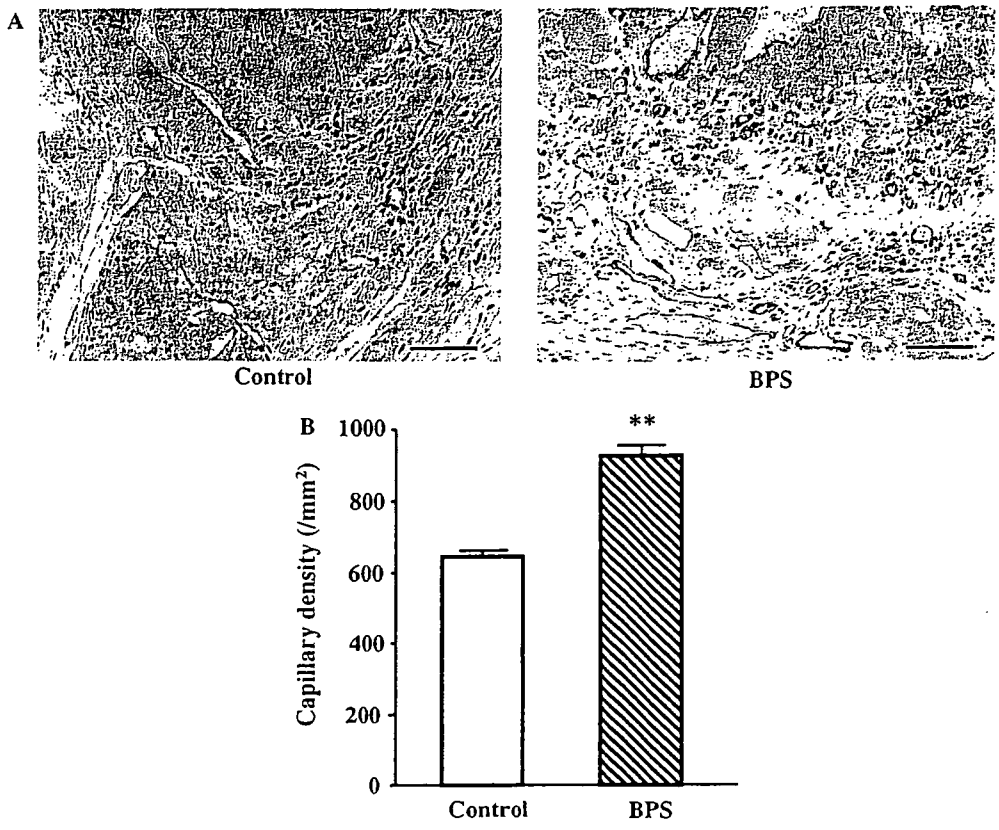

Fig. 5. (A) Representative samples stained with antibody to von Willebrand factor by bright-field DAB. (B) Quantitative analysis of capillary density in peri-infarct area. Administration of BPS increased capillary density by 37%. Scale bars = 50 μm. Data are expressed as means ± SEM. $^{**}p < 0.01$ vs. Control group.

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BASIC RESEARCH

Granulocyte Colony-Stimulating Factor Mediates Cardioprotection Against Ischemia/Reperfusion Injury via Phosphatidylinositol-3-Kinase/Akt Pathway in Canine Hearts

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Abstract
Purpose Recent studies suggest that G-CSF prevents cardiac remodeling following myocardial infarction (MI) likely through regeneration of the myocardium and coronary vessels. However, it remains unclear whether G-CSF administered at the onset of reperfusion prevents ischemia/reperfusion injury in the acute phase. We investigated acute effects of G-CSF on myocardial infarct size and the incidence of lethal arrhythmia and evaluated the involvement of the phosphatidylinositol-3 kinase (PI3K) in the *in vivo* canine models.
Methods In open-chest dogs, left anterior descending coronary artery (LAD) was occluded for 90 minutes followed by 6 hours of reperfusion. We intravenously administered G-CSF (0.33 μ/kg/min) for 30 minutes from the onset of reperfusion. Wortmannin, a PI3K inhibitor, was selectively administered into the LAD after the onset of reperfusion.
Results G-CSF significantly ($p < 0.05$) reduced myocardial infarct size (38.7±4.3% to 15.7±5.3%) and the incidence of ventricular fibrillation during reperfusion periods (50% to 0%) compared with the control. G-CSF enhanced Akt phospholylation in ischemic canine myocardium. Wortmannin blunted both the infarct size-limiting and anti-arrhythmic effects of G-CSF. G-CSF did not change myeloperoxidase activity, a marker of neutrophil accumulation, in the infarcted myocardium.
Conclusion An intravenous administration of G-CSF at the onset of reperfusion attenuates ischemia/reperfusion injury through PI3K/Akt pathway in the *in vivo* model. G-CSF administration can be a promising candidate for the adjunctive therapy for patients with acute myocardial infarction.

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Key words G-CSF · myocardial infarction · ischemia-reperfusion injury · ventricular fibrillation · phosphatidylinositol-3 kinase · Akt

Abbreviations

VF	ventricular fibrillation.
G-CSF	granulocyte colony-stimulating factor
WTMN	wortmannin

Introduction

Granulocyte colony-stimulating factor (G-CSF), a 20-kDa glycoprotein, promotes the proliferation, survival and differentiation of hematopoietic cells [1]. Furthermore, G-CSF can mobilize hematopoietic stem cells from bone marrow [2, 3]. Thus, G-CSF is believed to improve cardiac remodeling after myocardial infarction (MI) through regeneration of the myocardium and angiogenesis [4, 5]. In addition to these effects of G-CSF, Komuro and colleagues clearly demonstrated that the high dose of G-CSF acutely reduces infarct size by preventing apoptosis in the isolated hearts [6]. However, it remains unclear whether clinically relevant dosages of G-CSF can reduce the infarct size in the in vivo model and, if so, it is not clear which downstream signaling pathway is involved in the acute cardioprotective effects of G-CSF. Furthermore, although lethal arrhythmias are a major cause of death in patients with acute myocardial infarction [7, 8], anti-arrhythmic effects of G-CSF have not been determined.

Thus, we investigated the acute effects of a clinical relevant dose of G-CSF on ischemia/reperfusion injury including both lethal arrhythmias and infarct size in canine hearts. We also examined a role of the PI3K/Akt pathway, a down stream of G-CSF receptors, in the cardioprotective effects of G-CSF. In the present study, we adopted ischemia/reperfusion protocols that have not been tested in previous studies [4, 5], because coronary revascularization has been established as a standard therapy to attenuate cardiac damage after MI.

Materials and methods

Materials

G-CSF was provided by Kirin brewery company (Tokyo, Japan). Recombinant human G-CSF can increase the number of white blood cells in dogs [9]. Wortmannin was obtained from Sigma (St. Louis, MO), and antibodies against Phospho-Akt and Akt were obtained from Cell signaling technologies (Beverly, MA).

Instrumentation

Twenty-nine beagle dogs (Kitayama Labes, Gifu, Japan) weighing 8 to 12 kg were anesthetized by an intravenous injection of sodium pentobarbital (30 mg/kg), intubated and ventilated with room air mixed with oxygen (100% O_2 at flow rate of 1.0 to 1.5 l/min). Thoracotomy was done at the fifth left intercostal space, and the heart was suspended in a pericardial cradle. After intravenous administration of heparin (500 U/kg), the left anterior descending coronary artery (LAD) was cannulated for perfusion with blood from the left carotid artery through an extracorporeal bypass tube. This allows the selective infusion of drugs into the LAD-perfused areas through this bypass tube. The left atrium was catheterized for microsphere injection to measure myocardial collateral blood flow during ischemia as described previously [10]. Hydration was maintained by a slow normal saline infusion. Both systemic blood pressure (SBP) and heart rate (HR) were monitored continuously during the study. All procedures were performed in conformity with the Guide for the care and use of laboratory animals (NIH Publication No. 85–23, 1996 revision), and were approved by the *Osaka University Committee for Laboratory Animal Use.*

Experimental protocols

Protocol 1. Acute effects of G-CSF on infarct size and lethal arrhythmias in canine hearts

After hemodynamic stabilization, we intravenously administered either saline (Control group; $n = 9$) or G-CSF (0.33 μg/kg/min) (G-CSF group; $n = 6$) for 30 min following the onset of reperfusion. An intracoronary administration of wortmannin (WTMN), a PI3K inhibitor, was selectively administered into the LAD (1.5 μg/kg/min) for 60 min after the onset of reperfusion (GCSF + WTMN group, $n = 7$; WTMN group, $n = 7$) (Fig. 1). We have previously confirmed that the dose of wortmannin used prevents the phosphorylation of Akt in myocardium [10]. We measured infarct size and myocardial collateral blood flow during ischemia. In brief, infarct size was evaluated at the end of the protocol by Evans blue/TTC staining. Collateral blood flow during 90 min of ischemia was assessed by the non-radioactive microsphere method [10]. We also counted

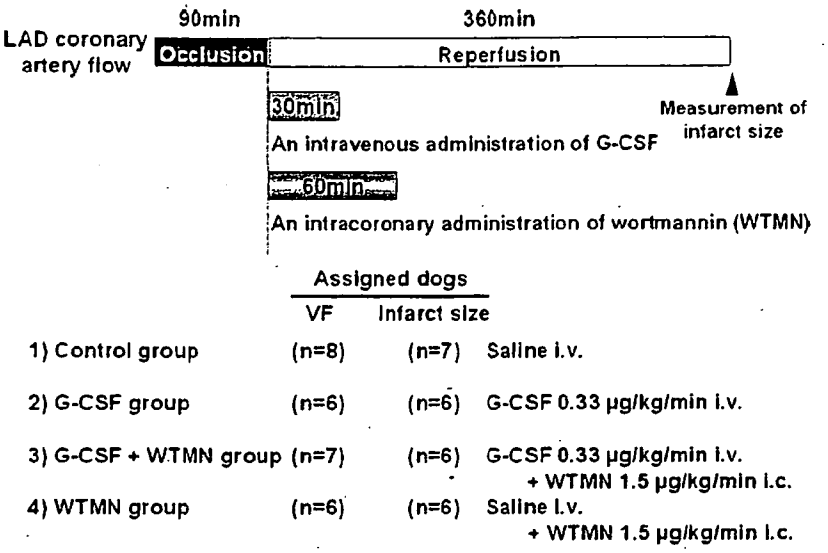

Fig. 1 Experimental protocols to assess myocardial infarct size and ventricular fibrillation (VF) in canine hearts. Myocardial infarct size was measured after 90 min of left anterior descending coronary artery (LAD) occlusion followed by 360 min of reperfusion. The incidence of VF was evaluated during reperfusion for 360 min. Intravenous administration of granulocyte colony-stimulating factor (G-CSF) was started at the onset of reperfusion and continued for 30 min. Intracoronary administration of wortmannin (WTMN) was started at the onset of reperfusion and continued for 60 min.

the incidence of VF during the 6 h reperfusion period (Fig. 1).

Finally, we measured myeloperoxidase (MPO) activity in LAD-perfused myocardium to check the accumulation of neutrophils in infarcted myocardium.

Protocol 2. Phosphorylation of Akt in ischemic myocardium

In this protocol, we used 11 dogs in Control group (n = 3), G-CSF group (n = 4), and G-CSF + WTMN group (n = 4). After 90 min of ischemia followed by 30 min of reperfusion, hearts were excised. The myocardial tissue in the ischemic zone, which was identified as the edge of the region showing necrosis, and non-ischemic zone were quickly placed into liquid nitrogen and stored at −80°C. Phosphorylation of Akt and total content of Akt were evaluated by immunoblotting as reported previously [10].

Immunoblotting

Immunoblotting was performed as described previously [11], and the immunoreactive bands were quantified by densitometry (Molecular Dynamics).

MPO activity

Several myocardial tissue samples were taken from the ischemic area in the dogs studied, frozen in liquid nitrogen and stored at −80°C until assay. The technical procedure has been described previously [12]. One unit of MPO activity was defined as that which degrades 1 μmol hydrogen peroxide per minute at 25°C.

Statistical analysis

Results are expressed as the mean ± SEM. Comparisons of the time course of the change in mean SBP and HR between groups were performed using two-way repeated measures analysis of variance (ANOVA). Comparisons of other data between groups were performed using one-way factional ANOVA. The Bonferroni-Holm procedure was used for correction of multiple comparisons [13]. The incidence of VF was compared using the χ^2-test and Fisher's exact probability test. A p value < 0.05 was considered to represent statistical significance.

Results

Criteria for exclusion

Since there was a negative correlation between myocardial collateral blood flow during ischemia and the incidence of VF [14, 15], it was important to assess myocardial collateral blood flow and exclude the dogs with high myocardial collateral blood flow. We excluded two dogs with excessive collateral blood flow (>15 ml/100 g/min) (Control group: 1, WTMN group: 1) among 29 dogs tested. Thus, 27 dogs were

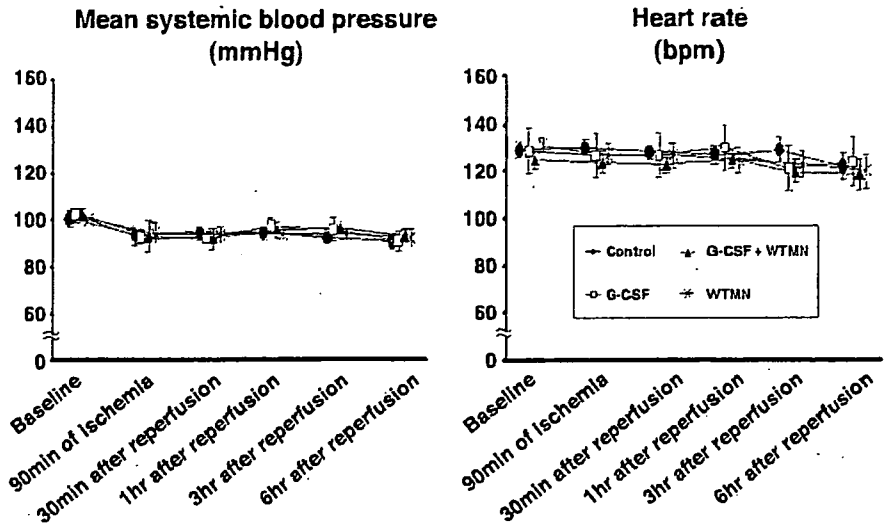

Fig. 2 The changes in mean systemic blood pressure (SBP) and heart rate (HR) during the experiment in groups tested. Neither SBP nor HR differed between the groups tested at baseline, 90 min of ischemia, at 30 min and 1, 3, and 6 h after reperfusion.

evaluated for VF analysis. Among these 27 dogs, we further excluded two dogs (Control group: 1, G-CSF + WTMN group: 1) from infarct size analysis that matched the exclusion criteria of lethal arrhythmia (more than two consecutive attempts required to convert VF with low-energy DC pulses applied directly to the heart) [10].

Effects of G-CSF on infarct size and VF during the reperfusion period

Throughout the study, neither SBP nor HR differed among the four groups (Fig. 2). The area at risk and myocardial collateral blood flow during myocardial ischemia were also comparable in the groups tested (Fig. 3). Figure 4 shows infarct size in the groups tested. G-CSF reduced ($p < 0.05$) infarct size compared with the control group. The intracoronary administration of wortmannin for 60 min after the onset of reperfusion abrogated the infarct size-limiting effects of G-CSF, although wortmannin alone did not affect infarct size.

G-CSF reduced ($p < 0.05$) the incidence of VF during the reperfusion period compared with the control group (Table 1). The antiarrhythmic effects of G-CSF were abolished by wortmannin.

Effect of G-CSF on MPO activity in infarcted myocardium

MPO activity in infarcted myocardium 6 h after reperfusion in G-CSF group did not differ from that in the control group. (10.0 ± 2.6 versus 10.7 ± 2.1 U/g protein).

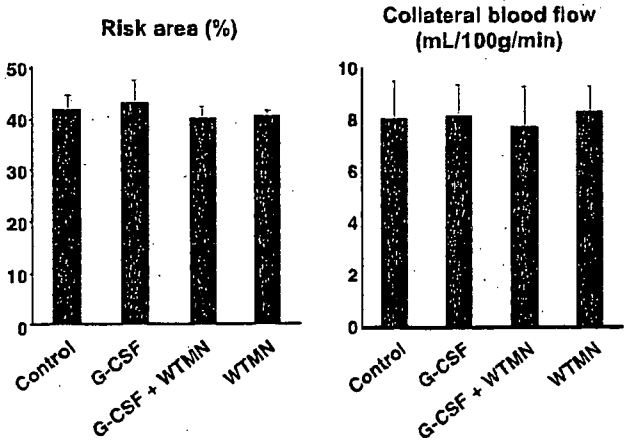

Fig. 3 Area at risk and myocardial collateral blood flow during ischemia in groups tested. Neither the area at risk nor myocardial collateral blood flow differed between the groups tested.

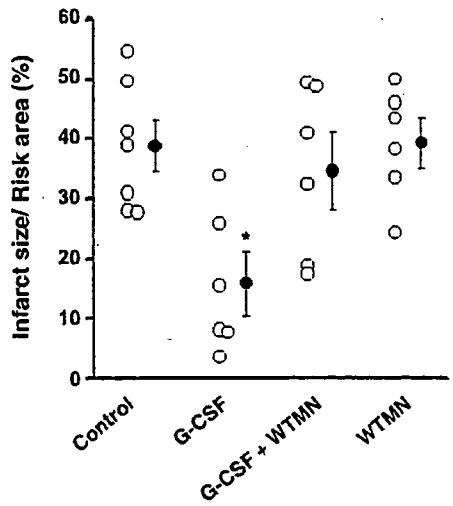

Fig. 4 Infarct size as a percentage of the area at risk in groups tested. Intravenous administration of G-CSF limited infarct size. The infarct-size limiting effect of G-CSF was blunted by the intracoronary administration of WTMN during reperfusion. *$p <$ 0.05 vs. control group.

Table 1 Effects of G-CSF on the incidence of VF during reperfusion periods

Group	Incidence of VF (%)	
Control	50.0	(4/8)
G-CSF	0*	(0/6)
G-CSF + WTMN	42.9	(3/7)
WTMN	50.0	(3/6)

*$p < 0.05$ vs. control group

Effect of G-CSF on Akt phosphorylation in ischemic myocardium

G-CSF augmented Akt phosphrylation in the LAD-perfused myocardium. The increase in Akt phosphorylation was attenuated by wortmannin (Fig. 5).

Discussion

The present study demonstrated that administration of G-CSF following the onset of reperfusion limited infarct size in acute phase and reduced the incidence of lethal arrhythmia. The intracoronary administration of wortmannin abrogated these cardioprotective effects of G-CSF, suggesting that G-CSF mediated cardioprotection via the PI3K/Akt pathway. To our knowledge, this is the first study to reveal the acute effect of G-CSF against ischemia/reperfusion injury via the PI3K/Akt pathway in in vivo canine hearts.

Previous studies have reported that G-CSF improves cardiac remodeling after MI in the chronic ligation model of coronary artery [4, 5, 16]. It has been believed that G-CSF exerts cardioprotective effects through regeneration of myocardium and angiogenesis. Recently, Komuro and colleagues clearly demonstrated that the high dose of G-CSF limits infarct size in the acute phase in the isolated hearts [6]. To translate their remarkable findings into the clinical setting, we need to consider the dose of G-CSF and experimental models in their study. They used a perfusate containing 300 ng/ml G-CSF in the isolated heart model. This dose is relatively high compared with the dose used in clinical settings [17, 18]. In addition, effects of G-CSF on neutrophil function cannot be tested in the isolated heart model. In the present study, we demonstrated that a clinical relevant dose of G-CSF acutely limits infarct size in the in vivo model. In contrast with previous studies [4, 5, 16], we examined the effects of G-CSF in the ischemia/reperfusion model, because coronary revascularization is principally applied for patients with acute MI to attenuate ischemia/reperfusion injury. We found that G-CSF following the onset of reperfusion effectively limited infarct size. Our findings strongly support that G-CSF would be a promising candidate as an adjunctive therapy for patients with acute MI. Indeed, two recent publications by the FIRSTLINE-AMI trial clearly demonstrated that subcutaneous administration of G-CSF after percutaneous coronary intervention improved cardiac function and prevented cardiac remodeling [19, 20]. Considering our present data, the improvement of cardiac function by G-CSF in clinical studies will be due to limiting infarct size in the acute phase as well as preventing cardiac remodeling.

G-CSF can provoke multiple intracellular signal transductions including Jak/Stat, ERK and PI3K/Akt [16, 21]. Recently, we and others demonstrated that post-interventions which activate PI3K/Akt during the reperfusion protect against ischemia/reprfusion injury [10, 22]. Thus, we investigated a role of PI3K/Akt in G-CSF-mediated cardioprotection. WTMN significantly blunted the infarct size-limiting effects of G-CSF, and G-CSF enhanced Akt phosphorylation in the ischemic myocardium, indicating that G-CSF reduces infarct size via PI3K/Akt-dependent pathway. Further investigations will be needed to clarify the molecular target of PI3K/Akt and the role of other signals activated by G-CSF in this condition.

Although we demonstrated that G-CSF mediated cardioprotection, one small clinical study showed that G-CSF may induce coronary re-stenosis [23]. In contrast, other large-scale studies did not show that G-CSF induced coronary restenosis [19, 20]. Since there is still controversy about the restenosis effects of G-

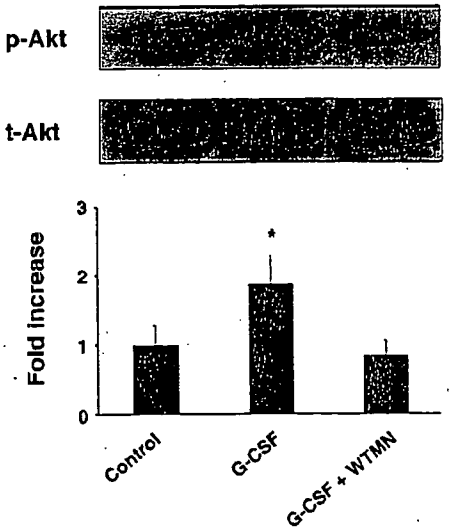

Fig. 5 Akt phosphorylation in LAD-perfused areas. G-CSF phosphorylated Akt in LAD-perfused myocardium. Akt phosphorylation by G-CSF was prevented by co-treatment with WTMN. Akt phosphorylation was normalized by total Akt. *$p < 0.05$ vs. control group.

CSF, this issue will be minimized by the concomitant use of a drug-eluting stent and G-CSF. Another possible adverse effect of G-CSF will be enhancement of neutrophil function. G-CSF appears not only to stimulate the formation of granulocyte colonies from bone marrow-derived precursors, but also to enhance the function of mature neutrophils [24] and elevates the number of white blood cells, which may predict adverse prognosis in the patients of acute MI [25]. Consistent with previous studies [26, 27], we also showed that G-CSF did not change MPO activity, a marker of neutrophil accumulation, in the infarcted myocardium. These findings suggest that G-CSF exerted cardioprotective effects independent of white blood cells. Although our findings suggest that the overall effect of G-CSF may be beneficial for ischemia/reperfused myocardium, we need to be cautious about these potential adverse effects of G-CSF.

Importantly, we clearly demonstrated that G-CSF reduced the incidence of VF during reperfusion via the PI3/Akt-dependent pathway. Since lethal arrhythmias are one of the major causes of death in patients with acute MI [8], the anti-arrhythmic effects of G-CSF have great clinical impact. We have previously demonstrated that another cytokine, erythropoietin, also reduced the incidence of lethal arrhythmia via the PI3/Akt pathway [10]. Although our findings suggest that the PI3K/Akt-dependent pathway will play an important role in the generation of lethal arrhythmias, further investigation will be needed to clarify the potential mechanism by which G-CSF exerts anti-arrhythmic effects. We need to consider whether G-CSF exerts anti-arrhythmic effects by the reduction of myocardial infarct size or by some other actions of G-CSF.

In conclusion, the intravenous administration of a clinically relevant dose of G-CSF will be a promising strategy to treat patients with acute MI. Further controlled studies will be warranted to check the safety and efficacy of G-CSF treatment in the acute phase after MI.

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Heavy ion radiation up-regulates Cx43 and ameliorates arrhythmogenic substrates in hearts after myocardial infarction

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Abstract

Objective: Radiation has been shown to enhance intercellular communication in the skin and lungs through an increase of connexin43 (Cx43) expression. If analogous Cx43 up-regulation is induced in the diseased heart, it would provide a new perspective in radiation therapy for arrhythmias. The aim of the present study is to test this hypothesis.
Methods: Non-transmural myocardial infarction (MI) was created in 24 rabbits by microsphere injection into the coronary arteries. Twenty-four rabbits without MI were used as controls. Targeted external heavy ion beam irradiation (THIR; 15 Gy) was applied 2 weeks after MI with an accelerator (HIMAC, Chiba, Japan).
Results: The THIR was associated with an increase of Cx43 mRNA and protein levels in the left ventricle in control as well as in MI rabbits. THIR also increased lateralization of Cx43, which was no longer colocalized with cadherins. In MI hearts, immunoreactive Cx43 signals were reduced in the peri-infarct zone, and the reduction was reversed by THIR. *In-vivo* epicardial potential mapping on the free wall (64 unipolar electrodes to cover 7 × 7 mm) in MI hearts revealed reduced conduction velocity, whereas dispersion of the activation-recovery interval (ARI) was increased compared with controls, and these changes were reversed by THIR. The vulnerability for ventricular tachyarrhythmias (VT/VF), which was estimated by programmed stimulation, was increased in MI hearts, and this increased vulnerability to arrhythmias was reversed by THIR.
Conclusions: THIR increases Cx43 expression, improves the conductivity, decreases the spatial heterogeneity of repolarization, and reduces the vulnerability of rabbit hearts to ventricular arrhythmias after MI. THIR could have an antiarrhythmic potential through an improvement of electrical coupling.

Keywords: Gap junctions; Connexin43; Heavy ion radiaton; Myocardial infarction; Ventricular arrhythmias; Arrhythmia (mechanisms); Epicardial mapping

1. Introduction

Modalities currently available for treatment and prevention of life-threatening ventricular tachyarrhythmias (VT/VF) are antiarrhythmic drugs, catheter ablation and implantable cardioverter/defibrillator (ICD). The usefulness of these therapeutic options is limited by either low efficiency, intolerable side

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