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Relationship between Albuminuria, Low eGFR, and Carotid Atherosclerosis in Japanese Women

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Key Words
Chronic kidney disease · Carotid atherosclerosis · Carotid atherosclerosis, women · Health screening

Abstract
In this cross-sectional study, we have investigated whether chronic kidney disease components were associated with carotid plaque and carotid intima-media thickening in women. Between April 2005 and May 2006, 830 women underwent general health screening including carotid ultrasonography and urinary albumin excretion, and were enrolled in the study. Of these individuals examined, 83 (10%) had albuminuria, 203 (24%) had low estimated GFR (eGFR), and 24 (3%) had both albuminuria and low eGFR. Univariate analysis showed that albuminuria, but not low eGFR, was associated with carotid plaque, and that both albuminuria and low eGFR were positively associated with carotid intima-media thickening. Age-adjusted logistic regression analysis showed that albuminuria was positively associated with carotid plaque with an odds ratio of 2.48 (95% CI 1.49–4.11, $p < 0.001$). On the other hand, association between albuminuria and carotid intima-media thickening was not statistically significant after age adjustment. Positive association between albuminuria and carotid plaque was present when either hypertension or high fasting glucose was absent. In conclusion, in Japanese women who underwent general health screening, albuminuria, but not low eGFR, was positively associated with carotid plaque.

Introduction

Increasing evidence indicates that an early stage of chronic kidney disease (CKD), reflected by either reduced glomerular filtration rate (GFR) and albuminuria/proteinuria, may increase the incidence of not only end-stage renal disease, but also ischemic cardiac and cerebrovascular diseases [1, 2]. In addition, it has been reported that prevalence carotid artery intima-media thickening and carotid plaque, both of which are risk factors for stroke [3] and coronary artery disease [4, 5], are more common in subjects with CKD than those without [6, 7]. We previously reported that both albuminuria and low estimated GFR (eGFR) were a risk factor for carotid intima-media thickening in Japanese men. In the present study, we have addressed the relationship between CKD components and carotid atherosclerosis in Japanese women.

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Subjects and Methods

Study Population

Between April 2005 and May 2006, 830 women underwent general health screening (Ningen Dock) including carotid ultrasonography as a part of the health screening course, and were enrolled in the present study. The study was approved by The Ethical Committee of Mitsui Memorial Hospital and University of Tokyo, Faculty of Medicine.

Laboratory Analysis

Blood samples were taken from the subjects after an overnight fast. Serum levels of total cholesterol, HDL-cholesterol, and triglycerides were determined enzymatically. Serum uric acid was measured by the uricase-peroxidase method, hemoglobin A_{1C} was determined using the latex agglutination immunoassay, and creatinine was determined by the enzymatic method. Plasma glucose was measured by the hexokinase method and serum insulin was measured by enzyme immunoassay. Homeostasis model assessment insulin resistance (HOMA-IR) was calculated in these individuals according to the following formula: HOMA-IR = [fasting immunoreactive insulin (μU/ml) × fasting plasma glucose (FPG; mg/dl)]/405.

Creatinine and urine albumin were measured by TBA-200FR (Toshiba Medical Systems, Tochigi, Japan) and by Accute (Toshiba Medical Systems), respectively, using commercially available kits, Accuras Auto CRE (Shino-test, Tokyo, Japan) and IATRO U-ALB (TIA) (Mitsubishi Kagaku Iatron, Tokyo, Japan), respectively. Serum creatinine was calibrated using the following formula: serum creatinine (Jaffe method) = 0.2 + serum creatinine (enzyme method). GFR was estimated by equations of a simplified version of Modification of Diet in Renal Disease [8], where 0.881 is a coefficient for eGFR specific to the Japanese population [9], $eGFR = 186.3 \times (\text{serum creatinine})^{-1.154} \times (\text{age})^{-0.203} \times 0.881 \times 0.742$ (for female). Individuals were classified as having low eGFR when their eGFR values were <60 ml/min/1.73 m^2 [10]. For the diagnosis of albuminuria, spot urine samples were collected and analyzed; albuminuria was defined to be present when the urinary albumin excretion ratio (UAER), expressed as milligrams as per gram creatinine, was ≥30 mg/g. Normo-, micro-, and macroalbuminuria were defined as an UAER of <30, 30–299, and 300 mg/g or more, respectively. Albuminuria and low eGFR are the components of CKD [10].

Carotid Ultrasonography

Carotid artery status was studied and analyzed as described previously [11]. In brief, carotid artery status was assessed by high-resolution B-mode ultrasonography, using a machine (Sonolayer SSA270A, Toshiba, Japan) equipped with a 7.5-MHz transducer (PLF-703ST, Toshiba). The carotid arteries were examined bilaterally at the levels of the common carotid, the bifurcation, and the internal carotid arteries from transverse and longitudinal orientations by trained sonographers. Carotid intima-media wall thickening was said to occur when the intima-media thickness which was measured at the far wall of the distal 10 mm of the common carotid artery was ≥1.0 mm. Carotid plaque was defined when there is portion that shows the thickness of intima-media complex ≥1.1 mm [12] with the focal protrusion or point(s) of inflexion.

Statistical Analysis

Skewed variables (triglycerides, HOMA-IR, UAER) are presented as median (interquartile range). Other data are expressed as the mean ± SD unless stated otherwise. Analyses of variance, the Mann-Whitney U test, χ^2 tests, and logistic regression analysis were conducted as appropriate to assess the statistical significance of differences between groups using computer software, StatView (Version 5.0; SAS Institute, Cary, N.C., USA) and Dr. SPSS II (Chicago, Ill., USA). A value of $p < 0.05$ was taken to be statistically significant.

Results

Baseline Characteristics

The mean age ± SD of the individuals enrolled was 57.3 ± 11.0 years. Of the 830 individuals examined, 83 (10.0%) had albuminuria, 203 (24.5%) had low eGFR, and 24 (2.9%) had both albuminuria and low eGFR. Therefore, 262 (31.6%) subjects were said to have CKD in our study population. Among 83 who had albuminuria, 75 (9.0%) had microalbuminuria and the remaining 8 (1.0%) had macroalbuminuria. Prevalence of low eGFR in individuals who did not have albuminuria [179/747 (24.0%)] and that in those who had albuminuria [24/83 (28.9%)] did not significantly differ ($p = 0.389$, by the χ^2 test). Individuals with albuminuria had a greater HOMA-IR value than those without CKD (table 1). After adjusting for age and smoking status, logistic regression analysis showed that the odds ratios of albuminuria and low eGFR for increased insulin resistance (defined here as HOMA-IR of ≥2.0) was 4.17 (95% CI 2.22–7.83, $p < 0.001$) and 0.86 (95% CI 0.53–1.40, $p = 0.543$), respectively. When only 630 individuals who had an FPG level of <126 mg/dl and were not taking antidiabetic medication were analyzed, association between albuminuria and increased insulin resistance was still significant with an odds ratio of 2.63 (95% CI 1.49–4.69, $p < 0.001$).

Association between CKD Components and Carotid Plaque

Carotid plaque was more frequently found in individuals with albuminuria than in non-CKD subjects (fig. 1). On the other hand, prevalence of carotid plaque was not significantly different between individuals with low eGFR and those without CKD. Logistic regression analysis showed that, as compared with the no-CKD group, albuminuria was associated with a higher prevalence of carotid plaque after adjusting for age only and after adjustment for age, systolic blood pressure (SBP), FPG, and smoking status (table 2). When HOMA-IR was added as

Table 1. Clinical characteristic and laboratory data in subjects with and without albuminuria and/or low eGFR

	No CKD (n = 568)	CKD (n = 262)	p value	Albuminuria (n = 83)	Low eGFR (n = 203)
Age, years	54.5 ± 10.4	63.4 ± 9.8	<0.001	62.3 ± 11.2	64.1 ± 8.9
Body mass index	21.4 ± 3.0	22.0 ± 3.4	0.016	22.3 ± 4.4	21.8 ± 2.8
Systolic blood pressure, mm Hg	119 ± 19	125 ± 21	<0.001	136 ± 23	122 ± 20
Diastolic blood pressure, mm Hg	74 ± 12	77 ± 13	0.006	82 ± 14	75 ± 12
Antihypertensive medication, n (%)	43 (7.6)	41 (15.6)	<0.001	25 (30.1)	24 (11.8)
Antidiabetic medication, n (%)	4 (0.7)	2 (0.7)	>0.999	1 (1.2)	2 (1.0)
Laboratory data					
Serum calcium, mg/dl	9.3 ± 0.3	9.4 ± 0.3	<0.001	9.4 ± 0.4	9.4 ± 0.3
Serum phosphate, mg/dl	3.7 ± 0.4	3.7 ± 0.4	0.850	3.7 ± 0.4	3.8 ± 0.4
Serum albumin, g/dl	4.5 ± 0.2	4.5 ± 0.2	0.162	4.5 ± 0.2	4.5 ± 0.2
Serum urea nitrogen, mg/dl	13.7 ± 3.3	15.8 ± 4.0	<0.001	15.9 ± 5.4	16.4 ± 4.0
Serum creatinine, mg/dl	0.6 ± 0.1	0.7 ± 0.2	<0.001	0.7 ± 0.3	0.8 ± 0.2
eGFR, ml/min/1.73 m^2	71 ± 8	59 ± 10	<0.001	67 ± 15	55 ± 6
UAER, mg/g	8.0 (5.2–13.1)	11.7 (6.5–37.5)	<0.001	55.8 (39.1–101.2)	8.7 (5.5–15.0)
Uric acid, mg/dl	4.5 ± 0.9	5.1 ± 1.1	<0.001	5.0 ± 1.3	5.2 ± 1.1
Total cholesterol, mg/dl	219 ± 36	230 ± 34	<0.001	227 ± 41	232 ± 32
HDL cholesterol, mg/dl	68 ± 15	67 ± 16	0.841	66 ± 16	68 ± 16
Triglycerides, mg/dl	75 (56–104)	86 (65–119)	<0.001	87 (64–120)	86 (65–119)
Fasting glucose, mg/dl	92 ± 13	96 ± 23	<0.001	105 ± 36	93 ± 11
Hemoglobin A_{1C}, %	5.2 ± 0.5	5.4 ± 0.7	<0.001	5.5 ± 1.0	5.3 ± 0.5
Carotid ultrasonography					
IMT, mm	0.67 ± 0.17	0.75 ± 0.19	<0.001	0.76 ± 0.21	0.75 ± 0.20
max. IMT, mm	1.19 ± 0.54	1.31 ± 0.56	0.003	1.40 ± 0.58	1.27 ± 0.54
Plaque, n (%)	226 (40)	129 (49)	0.013	56 (67)	89 (44)
HOMA-IR	1.04 (0.74–1.47)	1.16 (0.81–1.80)	0.004	1.44 (0.85–2.35)	1.13 (0.81–1.62)
Smoking status					
Never, n (%)	490 (86.3)	234 (89.3)	0.122	71 (85.5)	186 (91.6)
Former, n (%)	34 (6.0)	7 (2.7)		3 (3.6)	5 (2.5)
Current, n (%)	44 (7.7)	21 (8.0)		9 (10.8)	12 (5.9)

Data are means ± SD, median (interquartile range), n, or percentage. UAER indicates the urinary albumin excretion rate. The Mann-Whitney U test was used to evaluate differences in triglycerides, fasting insulin, HOMA-IR, and UAER between no-CKD and CKD groups.

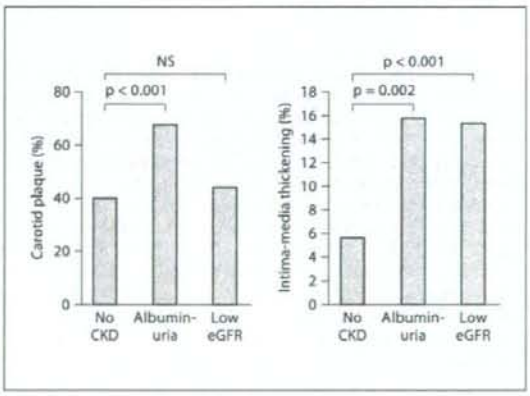

Fig. 1. Prevalence of carotid plaque and carotid artery intima-media thickening and in individuals with or without CKD components.

Table 2. Logistic regression analysis for carotid plaque as a dependent variable

	Odds ratio (95% CI) of albuminuria	p value	Odds ratio (95% CI) of low eGFR	p value
Whole				
Unadjusted	3.11 (1.92–5.03)	<0.001	1.06 (0.77–1.46)	0.723
Adjusted for age	2.48 (1.49–4.11)	<0.001	0.54 (0.37–0.78)	0.001
Adjusted for age, SBP, FPG, and smoking status	2.13 (1.26–3.61)	0.005	0.56 (0.39–0.81)	0.002
Subjects with hypertension (n = 204)				
Unadjusted	1.88 (0.93–3.80)	0.079	0.67 (0.36–1.26)	0.216
Adjusted for age	1.65 (0.80–3.39)	0.173	0.45 (0.22–0.90)	0.025
Adjusted for age, SBP, FPG, and smoking status	1.69 (0.78–3.65)	0.182	0.45 (0.22–0.92)	0.028
Subjects without hypertension (n = 626)				
Unadjusted	3.39 (1.70–6.76)	<0.001	1.23 (0.85–1.78)	0.282
Adjusted for age	3.08 (1.48–6.42)	0.003	0.60 (0.39–0.93)	0.021
Adjusted for age, SBP, FPG, and smoking status	2.83 (1.34–5.96)	0.006	0.61 (0.40–0.95)	0.027
Subjects with high fasting glucose (n = 57)				
Unadjusted	1.36 (0.42–4.39)	0.613	0.87 (0.26–2.96)	0.826
Adjusted for age	1.23 (0.36–4.25)	0.742	0.52 (0.13–2.05)	0.353
Adjusted for age, SBP, and smoking status	1.30 (0.26–6.58)	0.751	0.46 (0.11–1.87)	0.275
Subjects without high fasting glucose (n = 773)				
Unadjusted	3.35 (1.95–5.74)	<0.001	1.08 (0.77–1.50)	0.669
Adjusted for age	2.68 (1.52–4.73)	<0.001	0.55 (0.37–0.80)	0.002
Adjusted for age, SBP, and smoking status	2.39 (1.34–4.24)	0.003	0.57 (0.38–0.82)	0.003

an additional covariate to this statistical mode, albuminuria was still associated with carotid plaque with an odds ratio of 2.12 (95% CI 1.25–3.60, p = 0.005). Positive association between albuminuria and carotid plaque was statistically significant also in individuals without hypertension, defined here as SBP of ≥140 mm Hg, diastolic blood pressure of ≥90 mm Hg or taking antihypertensive medication, and was also statistically significant in those without high fasting glucose, defined here as an FPG level of ≥110 mg/dl or taking antidiabetic medication (table 2). By contrast, low eGFR was associated with a lower prevalence of carotid plaque after adjusting for age or after adjustment for age, SBP, FPG, and smoking status.

Association between CKD Components and Carotid Intima-Media Thickening

Carotid intima-media thickening was more frequently found in individuals with albuminuria or in those with low eGFR than non-CKD subjects (fig. 1). After adjusting for age, association between either of these two CKD components and intima-media thickening lost statistical significance, irrespective of the status of hypertension or high fasting glucose (table 3).

We also analyzed the database which contained 3,318 women who underwent general health screening between 2003 and 2007; not all of them had data of urinary albumin excretion. Age-adjusted logistic regression analysis showed that odds ratio of low eGFR for carotid plaque was 0.67 (95% CI 0.56–0.82, $p < 0.001$) and that for carotid intima-media thickening was 1.11 (95% CI 0.80–1.54, p = 0.54). Therefore, the inverse association between low eGFR and carotid plaque and no significant association between low eGFR and carotid intima-media thickening were observed also in the database containing a female population of larger size.

In addition, after adding the data of men (n = 1,705), we investigated the interaction between gender and CKD components. When carotid plaque was used as a dependent variable, gender showed a significant interaction with both albuminuria and low eGFR ($p < 0.05$). On the other hand, when carotid intima-media thickening was used as a dependent variable, gender showed a significant interaction with albuminuria ($p < 0.05$), but not with low eGFR (p = 0.83).

Serum Levels of Calcium and Phosphorus and Carotid Atherosclerosis in CKD Subjects

We then investigated whether serum levels of calcium and phosphorus were associated with carotid atherosclerosis in individuals with CKD. In individuals with CKD, age-adjusted logistic regression analysis showed that an

Table 3. Logistic regression analysis for carotid intima-media thickening as a dependent variable

	Odds ratio (95% CI) of albuminuria	p value	Odds ratio (95% CI) of low eGFR	p value
Whole				
Unadjusted	2.21 (1.15–4.23)	0.017	2.64 (1.61–4.36)	<0.001
Adjusted for age	1.26 (0.61–2.61)	0.534	1.25 (0.73–2.15)	0.416
Adjusted for age, SBP, FPG, and smoking status	0.74 (0.33–1.66)	0.469	1.34 (0.77–2.33)	0.304
Subjects with hypertension (n = 204)				
Unadjusted	1.28 (0.55–2.97)	0.079	2.68 (1.25–5.74)	0.011
Adjusted for age	0.93 (0.38–2.30)	0.882	1.81 (0.81–4.05)	0.148
Adjusted for age, SBP, FPG, and smoking status	0.89 (0.34–2.32)	0.806	1.82 (0.81–4.11)	0.149
Subjects without hypertension (n = 626)				
Unadjusted	2.04 (0.68–6.11)	0.201	2.70 (1.36–5.35)	0.005
Adjusted for age	1.17 (0.32–4.26)	0.816	1.04 (0.49–2.21)	0.915
Adjusted for age, SBP, FPG, and smoking status	0.69 (0.16–2.97)	0.621	1.09 (0.51–2.36)	0.822
Subjects with high fasting glucose (n = 57)				
Unadjusted	0.53 (0.10–2.82)	0.460	1.40 (0.31–6.36)	0.661
Adjusted for age	0.39 (0.06–2.33)	0.300	0.84 (0.17–4.32)	0.838
Adjusted for age, SBP, and smoking status	0.33 (0.04–2.76)	0.304	0.76 (0.15–3.91)	0.743
Subjects without high fasting glucose (n = 773)				
Unadjusted	2.63 (1.29–5.34)	0.008	2.90 (1.70–4.95)	<0.001
Adjusted for age	1.47 (0.66–3.28)	0.350	1.47 (0.66–3.28)	0.350
Adjusted for age, SBP, and smoking status	1.10 (0.48–2.54)	0.280	1.39 (0.77–2.50)	0.280

odds ratio of serum calcium (per 1 mg/dl increase) was 1.18 (95% CI 0.54–2.57, p = 0.680) for carotid plaque, and 1.51 (95% CI 0.48–4.73, p = 0.477) for carotid intima-media thickening. In these individuals, age-adjusted logistic regression analysis showed that an odds ratio of serum phosphorus (per 1 mg/dl increase) was 0.79 (95% CI 0.42–1.51, p = 0.476) for carotid plaque, and 0.41 (95% CI 0.16–1.06, p = 0.066) for carotid intima-media thickening.

Discussion

In the current study, we have investigated the association between components of CKD (low eGFR and albuminuria) and carotid atherosclerosis in women who underwent general health screening. Univariate analysis showed that albuminuria, but not low eGFR, was significantly positively associated with carotid plaque. The association between albuminuria and carotid plaque remained statistically significant after adjustment for age, SBP, FPG, and smoking status. In addition, positive association between albuminuria and carotid plaque was observed in women without hypertension or in those without high fasting glucose. Although both albuminuria and low eGFR was associated with carotid intima-media thickening by univariate analysis, statistical significance was lost after multivariate adjustment, irrespective of the status of hypertension or high fasting glucose.

Evidence is accumulating that presence of early-phase renal disease may increase the risk of atherosclerotic diseases; however, information over the possible relationship between CKD, especially low eGFR, and carotid artery atherosclerosis seems to be limited. Zhang et al. [6] analyzed the data of 1,264 invited Chinese residents (543 men, 721 women) aged 40 years or older. They found that GFR was negatively associated with carotid intima-media thickness in univariate analysis; however, the observed association lost its statistical significance after adjusting for other atherogenic risk factors. Briet et al. [2] reported that carotid intima-media thickness did not differ significantly between individuals with decreased eGFR and those without. In the previous paper, we reported that low eGFR was associated with carotid intima-media thickening in male individuals when individuals had other atherogenic risk factors, such as hypertension, impaired glucose metabolism, or cigarette smoking [13]. Together with these previous observations, findings in the current study suggested that risk factor properties of low eGFR on carotid atherosclerosis might be different according to the gender. Low eGFR was found to be, although unexpectedly, inversely associated with carotid

plaque in the current study; however, whether there is truly such a relationship or not needs to be further addressed in future studies after increasing the number of enrolled subjects.

Compared to low eGFR, the association of albuminuria with carotid atherosclerosis has more consistently demonstrated by cross-sectional and prospective studies [14–16]. It is possible that impaired glucose/lipid metabolism may represent a mechanism underlying this observed link because albuminuria is known to be associated metabolic syndrome and increased insulin resistance. Consistent with this idea, in the current study, albuminuria was associated with increased insulin resistance (HOMA-IR of ≥2.0) with an odds ratio of 4.17. It is of note, however, that association between albuminuria and carotid plaque was found to be independent of SBP, FPG, and HOMA-IR.

It has been reported that serum phosphorus concentration was associated with coronary arterial wall calcification and carotid intima-media thickening in patients with end-stage renal disease [17, 18]. Therefore, here we examined whether serum phosphorus levels were associated with carotid atherosclerosis in individuals with CKD. Serum phosphorus levels were not significantly different between CKD-positive and -negative individuals (table 1). Serum phosphorus levels were found not to be significantly associated with carotid plaque or intima-media thickening by age-adjusted logistic regression analysis, which was in agreement with the observation of Maeda et al. [19]. On the other hand, we previously showed both serum calcium and phosphorus were associated with carotid plaque by analyzing 5,732 subjects [20]. Therefore, the findings in the current study should be re-evaluated after increasing the number of individuals enrolled.

There are several study limitations in the current study. We used the Modification of Diet in Renal Disease formula with the Japanese coefficient of 0.881 for the estimation of GFR [9], which may not be very accurate for values >60 ml/min/1.73 m^2. We could not find a significant association between serum levels of calcium/phosphorus and carotid atherosclerosis in individuals with CKD. It is possible that there may be closer association between these variables when eGFR is much lower. In the current study population, however, only a small fraction of subjects (n = 3) had eGFR level <30 ml/min/1.73 m^2.

In conclusion, by analyzing cross-sectional data from Japanese women who underwent general health screening, we found that albuminuria, but not low eGFR, was positively associated with carotid plaque in univariate analysis. Association between albuminuria and carotid plaque remained statistically significant after multivariate adjustment. It was found to be significant also in individuals without hypertension or in those without high fasting glucose. It may be proposed that, when assessing a possible association between CKD and carotid atherosclerosis, albuminuria and low eGFR should be analyzed separately in women undergoing general health screening, or Ningen Dock.

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Comparison of vasculoprotective effects of benidipine and losartan in a rat model of metabolic syndrome

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ABSTRACT

Although antihypertensive drugs confer improvement in endothelial dysfunction and protection from atherogenesis in hypertension, different classes of antihypertensive drugs may elicit different degrees of vasculoprotective effects. We have investigated the effects of a long-acting calcium antagonist, benidipine, and an angiotensin AT_1 receptor antagonist, losartan, on the vascular damage observed in OLETF rats, an animal model of metabolic syndrome. At 34 weeks of age, OLETF rats were treated with either benidipine (3 mg/kg/day, per os) or losartan (25 mg/kg/day, per os) for 8 weeks. The extent of blood pressure reduction, restoration endothelium-dependent aortic relaxation, and elevation of serum nitrite/nitrate concentration did not differ significantly between benidipine- and losartan-treated OLETF rats. Benidipine and losartan also reduced the aortic expression of transforming growth factor-β1 mRNA and thickening of the vascular wall to a similar extent. Increased cardiac fibrosis was also inhibited by both benidipine and losartan. These data suggest that, when used in an antihypertensive dose, benidipine is as effective as losartan in restoring vascular endothelial function and in suppressing of cardiovascular remodeling in an animal model of metabolic syndrome.

1. Introduction

It has been shown that antihypertensive agents that belong to several different classes are effective in ameliorating endothelial dysfunction, an early feature of vascular damage, in the condition of hypertension (Dohi et al., 1994, Perticone et al., 1999, Taddei et al., 2001, Tschudi et al., 1994, Yao et al., 2003, Zhou et al., 2004). Although controlling blood pressure per se is postulated to largely account for cardiovascular outcome (Wang et al., 2007), blockers of the renin-angiotensin system may be more potent in protecting vascular function in the context of diabetes than other classes of antihypertensive drugs (Cheetham et al., 2000, Cheng et al., 2001, Lindholm et al., 2002, Oniki et al., 2006), including calcium channel blockers (Candido et al., 2004). On the other hand, in the Valsartan Antihypertensive Long-term Use Evaluation (VALUE) trial, it was found that the outcome of cardiac morbidity and mortality did not differ between a treatment group given an angiotensin AT_1 receptor antagonist and one given a calcium channel blocker-based treatment groups in the subgroup of hypertensive patients with diabetes (Zanchetti et al., 2006). This finding supports the concept that intensive control of blood pressure is the most important factor for the reduction of cardiovascular morbidity and mortality even in diabetic patients, regardless of the class of antihypertensive drugs administered (Messerli et al., 2001).

The Otsuka Long-Evans Tokushima Fatty (OLETF) rat is characterized as having increased insulin resistance, diabetes, obesity, hypertension, and dyslipidemia; in other words, metabolic syndrome. In the current study, we aimed to compare the effectiveness of two classes of antihypertensive agents, a long-acting dihydropyridine-calcium channel blocker (benidipine) and an angiotensin AT_1 receptor antagonist (losartan), on the restoration of vascular function and vessel morphology in this rat model of metabolic syndrome.

2. Materials and methods

2.1. Animal models

The experiments were performed in accordance with the guidelines for animal experimentation approved by the Animal Center for Biomedical Research, Faculty of Medicine, University of Tokyo. Male OLETF and age-matched Long-Evans Tokushima Otsuka (LETO) rats were obtained from the Tokushima Research Institute, Otsuka Pharmaceutical (Tokushima, Japan) and maintained under constant temperature and lighting conditions with free access to food and water. At 34 weeks of age, some OLETF rats were given benidipine at a dose of 3 mg/kg/day or losartan at a dose of 25 mg/kg/day per os, which was

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continued for 8 weeks. One day before the sacrifice, rats were kept in the metabolic cage, and urine was collected for 24 h under fasting condition. Systolic blood pressure and heart rate were measured in conscious rats by tail-cuff plethysmography (BP-98A, Softron, Tokyo, Japan).

2.2. Isolated vascular ring experiments

Ring segments (5 mm in length) of the thoracic aorta were suspended in individual organ chambers filled with Krebs buffer of the following composition (mmol/L): NaCl, 118.3; KCl, 4.7; CaCl2, 2.5; MgSO4, 1.2; KH2PO4, 1.2; NaHCO3, 25.0; and glucose, 10, pH 7.4. The solution was continuously aerated with a 95% O2, 5% CO2 mixture which was maintained at 37°C. Isometric tension was recorded by using an isometric force displacement transducer (NIHON KOHDEN, Tokyo, Japan) connected to a data acquisition system (Power Lab Chart 5, ADInstruments Japan Inc., Nagoya, Japan). The vessels were then precontracted with phenylephrine (3×10^{-6} mol/l). After a stable contraction plateau was reached, the rings were exposed to either acetylcholine or sodium nitroprusside (SNP).

2.3. Real time polymerase chain reaction

Real time reverse transcription polymerase chain reaction (RT-PCR) with gene-specific hybriprobes was performed by LightCycler (Roche Diagnostics, Basel, Switzerland) as described previously (Saito et al., 2005). We examined the three isozymes nitric oxide synthase (NOS). The following primers and probes were used: for transforming growth factor (TGF) -β1: forward 5′ GCAACAACGCAATCTATGAC 3′, reverse 5′ CCTGTATTCCGTCTCCTT 3′ (Nihon Gene Research Lab's Inc., Sendai, Japan); for endothelial NOS (eNOS): forward 5′ CTGGCAAGACCGATTAC-AC 3′, reverse 5′ GTCCAAACACTCCACGCT 3′ (Nihon Gene Research Lab's Inc.); for inducible NOS (iNOS): forward 5′ ACCCAAGGTCTACGTTCAAG 3′, reverse 5′ AAGACCGCACCGAAGATATC 3′ (Nihon Gene Research Lab's Inc.); and for neuronal NOS (nNOS): forward 5′ TGAGCTTTGCGGACAG-GA 3′, reverse 5′ TACGTGAGGCGGAACTTGT 3′. After normalization to the expression of GAPDH mRNA levels, eNOS expression was presented as the percentages of the data from aortas of OLETF rats without benidipine treatment.

2.4. Remodeling of aortic wall and heart

Remodeling of aortic wall was examined as described previously (Ishizaka et al., 2005). Briefly, the paraffin-embedded specimens of thoracic aorta in the 3 μm of thickness were stained with hematoxylin and eosin and Masson's trichrome staining. Vascular wall thickness and perivascular fibrosis were taken as indicators of structural abnormalities of aorta. Quantification of cardiac fibrous areas was performed on the Masson's trichorme stained samples as described previously (Ishizaka et al., 2002). Histopathology and morphometry were performed by investigators who were unaware of the treatment being administered.

2.5. Measurement of serum nitrite/nitrate

After protein-free filtrate of the serum was prepared with the Centricon YM-10 (Millipore, Billerica, MA), concentrations of nitrite/nitrate were measured by the Griess method with the NO2/NO3 Assay Kit-C II (Dojin Chemical Laboratory, Japan). The absorbance of the solution was determined at 540 nm with a micro plate reader, Biotrak II (GE Healthcare, Buckinghamshire, England).

2.6. Statistical analysis

Data are expressed as the mean ± S.E.M. We used ANOVA followed by a multiple comparison test to compare raw data, before expressing the results as a percentage of the control value using the statistical analysis software Statistica version 5.1 J for Windows (StatSoft Inc, Tulsa, OK). A value of $P<0.05$ was considered to be statistically significant.

3. Results

3.1. Characteristics of experimental animals

OLETF rats aged 42 weeks were significantly heavier than LETO rats of the same age. Neither antihypertensive agent significantly modified the body weight of OLETF rats (Table 1). Systolic blood pressure was significantly higher in OLETF rats than in LETO rats, and treatment of OLETF rats with either benidipine or losartan lowered blood pressure to a range comparable to that in LETO rats. The plasma fasting glucose level was significantly higher in untreated OLETF rats than in LETO rats, and was affected by neither benidipine nor losartan.

3.2. Relaxations of aortic segments

As compared to the aortas from LETO rats, peak relaxation produced by acetylcholine in the aorta from untreated OLETF rats was significantly reduced, whereas that produced by SNP was not significantly different between LETO and OLETF rats (Fig. 1, Table 2). Both benidipine and losartan reversed, albeit partially, the impaired vascular relaxation in response to acetylcholine in OLETF rats. Neither peak relaxation ($P=0.288$) nor the ED50 ($P=0.128$) in response to acetylcholine was significantly different between the aorta of the OLETF/Ben group and that of the OLETF/Los group.

3.3. Remodeling of aortic wall

As compared to LETO rats, the wall-to-lumen ratio and area of perivascular fibrosis were increased in OLETF rats (Fig. 2). As compared to

Table 1
Characteristics of the experimental animals

Variables	LETO	OLETF	P value (vs. LETO)	OLETF/Ben	P value (vs. OLETF)	OLETF/LOS	P value (vs. OLETF)
n	11	11		11		6	
Body weight (g)	445±8	481±13	0.014	476±11	0.394	470±15	0.311
Systolic blood pressure (mm Hg)	136±2	149±4	0.012	138±3	0.027	135±3	0.015
Heart rate (bpm)	406±21	409±16	0.447	418±15	0.359	408±14	0.482
Heart weight (g)	1.46±0.03	1.85±0.05	<0.001	1.69±0.04	0.010	1.62±0.11	0.049
Heart weight (g/100 g BW)	0.33±0.01	0.40±0.02	0.001	0.36±0.01	0.047	0.34±0.01	0.036
Total cholesterol (mg/dl)	78.7±2.6	78.6±3.0	0.487	79.2±4.5	0.461	78.5±4.3	0.495
Triglyceride (mg/dl)	17.2±2.3	41.0±9.1	0.005	28.5±6.1	0.461	22.8±5.0	0.098
Plasma fasting glucose (mg/dl)	159±4	203±22	0.028	184±16	0.238	187±16	0.288

Values are mean ± S.E.M. Both benidipine and losartan lowered the blood pressure of OLETF rats to levels comparable to those of LETO rats. Both hypertensive drugs lowered the heart weight significantly. Levels of serum triglyceride and plasma glucose were also slightly lowered by either antihypertensive drug, although the reduction did not reach statistical significance.

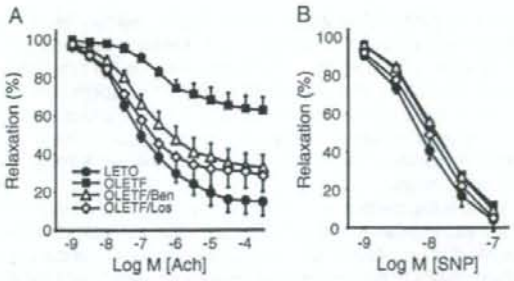

Fig. 1. Endothelium-dependent vascular relaxations in response to acetylcholine (Ach) and endothelium-independent sodium nitroprusside (SNP) in aortic segments from LETO, untreated OLETF, and benidipine and losartan-treated OLETF rats. Vessels were studied as ring segments in organ chambers, and relaxations in response to Ach and SNP were studied after the vessels had been pre-constricted with phenylephrine, 3×10^{-6} mol/l.

LETO rats (100.0±2.9, $n=6$), the luminal area was significantly greater in OLETF rats (138.3±.3, $P<0.001$, $n=6$), OLETF/Ben rats (122.5±5.4, $P<0.001$, $n=6$), and OLETF/Los rats (128.0±5.3, $P<0.001$, $n=6$). Both benidipine and losartan reduced these variables to levels comparable to those in LETO rats. Between the OLETF/Ben and OLETF/Los rats, the difference in the wall-to-lumen ratio ($P=0.336$) and in the area of perivascular fibrosis ($P=0.479$) was not statistically significant. Expression of TGF-β1 mRNA was greater in the aorta of OLETF rats than in that of LETO rats, and both benidipine and losartan reduced the expression of TGF-β1 mRNA in the aorta of OLETF rats (Fig. 3A).

3.4. Serum level of nitrite/nitrate and mRNA expression of NOS isoforms

As compared with the aorta of LETO rats, expression of eNOS and nNOS mRNA was significantly lower, whereas that of iNOS mRNA was significantly higher, in the aorta of OLETF rats (Fig. 3B–D). Both benidipine and losartan reduced the expression eNOS and nNOS mRNA, and increased that of iNOS mRNA, in the aorta of OLETF rats to levels comparable to those in the aorta of LETO rats. The serum nitrite/nitrate level was significantly lower in OLETF rats than in LETO rats; however, it was again increased to a level comparable to that in LETO rats by either benidipine or losartan (Fig. 4).

3.5. Fibrosis of the heart

As compared to the heart of LETO rats, interstitial fibrosis was enhanced in the heart of OLETF rats. Losartan and benidipine suppressed the increase in fibrosis in the heart of OLETF rats to a similar extent (Fig. 5).

4. Discussion

In the current study, we showed that acetylcholine-induced endothelium-dependent vascular relaxation was attenuated in OLETF rats as compared with age-matched LETO rats. Treatment of OLETF rats with an antipressor dose of either losartan or benidipine restored depressed endothelium-dependent vascular relaxation and increased

Table 2
Responses of isolated vessels to acetylcholine and sodium nitroprusside (SNP)

Variables	LETO	OLETF	*P* value (vs. LETO)	OLETF/ Ben	*P* value (vs. OLETF)	OLETF/ LOS	*P* value (vs. OLETF)
n	6	7		7		9	
Ach ED_{50}	7.0±0.3	6.5±0.1	0.037	7.0±0.1	<0.001	7.1±0.2	0.006
Ach peak relaxation	95±4	38±7	<0.001	74±5	0.001	73±7	0.003
SNP ED_{50}	7.6±0.1	7.3±0.1	0.104	7.1±0.0	0.075	7.5±0.2	0.184
SNP peak relaxation	94±8	89±4	0.333	91±2	0.190	95±6	0.169

Values are mean±S.E.M. ED_{50}s are −log[M]. Relaxations are the peak response given as a percentage of the pre-constricted tension. Ach indicates acetylcholine and SNP indicates sodium nitroprusside.

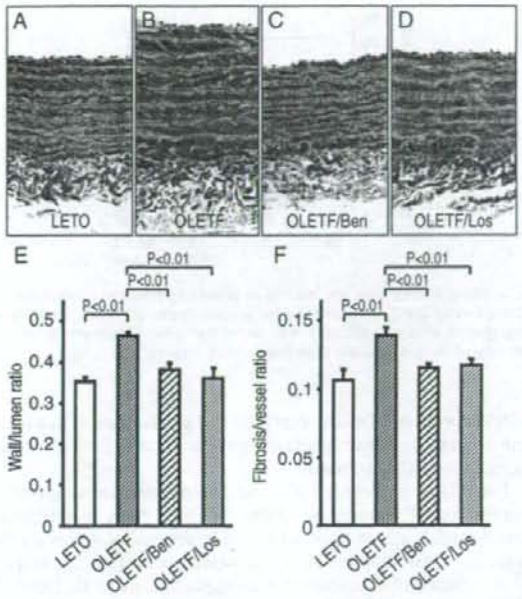

Fig. 2. Effects of benidipine and losartan on vascular remodeling in OLETF rats. (A–D) Masson trichrome staining of the aorta of the LETO rat (A), untreated OLETF rat (B), and benidipine (C) and losartan (D) treated OLETF rat. Both antihypertensive agents significantly reduced the wall/lumen ratio and fibrosis area in the aorta of OLETF rats. Original magnification, ×200. E, F. Values are mean±S.E.M. Summary of the wall-to-lumen ratio (E) and perivascular fibrosis (F) data of the aortas from 4–6 experiments for each group.

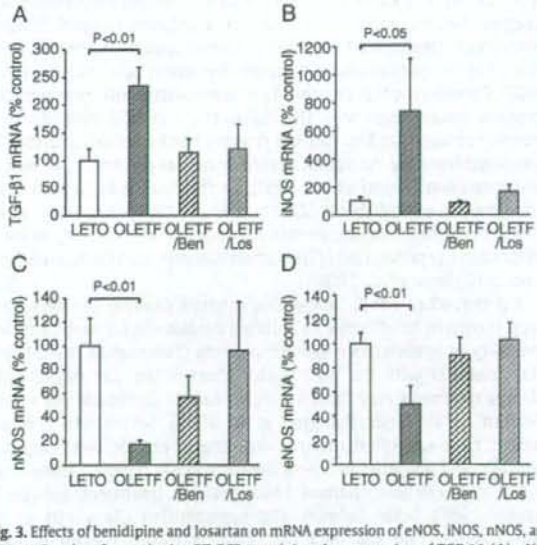

Fig. 3. Effects of benidipine and losartan on mRNA expression of eNOS, iNOS, nNOS, and TGF-β1 Results of quantitative RT-PCR examining the expression of TGF-β1 (A), eNOS (B), iNOS (C), and nNOS (D) mRNA in the aorta of LETO, untreated OLETF, and benidipine and losartan-treated OLETF. Values are mean±S.E.M. Summary of the data from 4–6 experiments for each group.

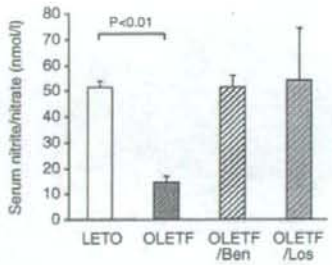

Fig. 4. Effects of benidipine and losartan on serum concentration of nitrite/nitrate in LETO, untreated OLETF, and benidipine and losartan-treated OLETF rats. Serum samples were filtered with a Centricon YM-10 before the assay. Values are mean±S.E.M. Summary of the data from 4–6 experiments for each group.

mRNA expression of eNOS and nNOS to a similar extent. In addition, both of these depressor agents improved aortic and cardiac remodeling, again, to a similar extent.

The effects of various classes of antihypertensive drugs on the preservation of endothelial dysfunction have been investigated in animal models and in human cases of hypertension. Although there might be some differences in the vasculoprotection conferred by various classes of antihypertensive drugs (Bennett et al., 1996), ACE inhibitors, angiotensin AT_1 receptor antagonists (Bennett et al., 1996, Clozel et al., 1990, Dohi et al., 1996), and calcium channel blockers, especially the long-acting ones (Krenek et al., 2001; Tschudi et al., 1994; Wang et al., 2007; Yao et al., 2003; Zhou et al., 2004) are all effective in restoring vascular function in hypertension. In this sense, it is noteworthy that a regiment that based on angiotensin AT_1 receptor antagonist, candesartan and that based on calcium channel blocker, amlodipine, produced no statistical differences in terms of the primary cardiovascular end point in 4728 Japanese hypertensive patients (Ogihara et al., 2008).

In the condition of hypertension with diabetes, however, ACE inhibitors (Baluchnejadmojarad et al., 2004, Oltman et al., 2008) and angiotensin AT_1 receptor antagonists (Cheng et al., 2001; Schafer et al., 2007) may be more effective in cardiovascular protection (Candido et al., 2004). Kagota et al. (2007) reported that an angiotensin AT_1 receptor blocker, telmisartan, but not a calcium channel blocker, amlodipine, ameliorated the impaired endothelium-dependent vasodilatation in spontaneously hypertensive obese rats (Kagota et al., 2007). Considering that certain AT_1 receptor antagonists may potently improve insulin sensitivity, the effectiveness of ACE inhibitors, AT_1 receptor antagonists and calcium channel blockers should further be compared from the viewpoint of cardiovascular protection, as well as renoprotection (Fogari et al., 2007), in the setting of hypertension accompanied with diabetes (Zanchetti et al., 2006) (Kawamori et al., 2006). In addition, an angiotensin AT_1 receptor blocker may be more effective in the prevention of new-onset diabetes than calcium channel blocker (Ogihara et al., 2008).

On the other hand, long-acting calcium channel blockers have been shown to be effective in reducing cardiovascular morbidity and mortality in hypertensive diabetic patients (Tuomilehto et al., 1999). This contrasts with the finding that short-acting, calcium channel blocker treatment may induce a higher rate of cardiovascular events (Borhani et al., 1996; Byington et al., 1998). Several other recent studies have suggested that the outcome of cardiac morbidity and mortality did not differ between angiotensin AT_1 receptor antagonist-based and calcium channel blocker-based treatment groups in patients with both diabetes and hypertension (Zanchetti et al., 2006), supporting the idea that blood pressure control is most important for the reduction of cardiovascular morbidity and mortality in diabetic hypertensive patients regardless of the classes of antihypertensive drugs (Messerli et al., 2001). Therefore, the finding that benidipine and losartan showed similar efficacy in restoring vascular function and cardiovascular morphology in the current study would seem to be in agreement with this idea. On the other hand, as we did not compare the subdepressor dose of antihypertensive drugs, we could not conclude that there may not be a difference in the vasculoprotective effects between the two classes of antihypertensive agents tested when used at a subdepressor dose or in combination with other drugs.

What is the mechanism underlying the preferable effects of benidipine and losartan in the current study? Many studies have shown that eNOS plays a crucial role in vasculoprotection (Forstermann and Munzel, 2006). In the current study, expression of eNOS and nNOS was found to be significantly lower in OLETF rats than in LETO rats; however, both benidipine and losartan preserved eNOS/nNOS expression and increased the serum nitrite/nitrate concentrations. It has also been reported that angiotensin AT_1 receptor antagonist (Yamamoto et al., 2007) and long-acting calcium channel blockers (Ding and Vaziri, 2000; Kobayashi et al., 1999; Toba et al., 2005) can upregulate vascular eNOS expression in hypertension. It has been reported that nNOS is also expressed in vascular cells, especially in certain pathological conditions, such as atherosclerosis and hypertension (Boulanger et al., 1998; Kishi et al., 2003), and nNOS, like eNOS, may also exert important vasculoprotective actions against vascular lesion formation (Channon et al., 1998). It has been reported that ACE inhibitors and angiotensin AT_1 receptor antagonists increase nNOS expression in the adrenal glands (Qadri et al., 2001). In addition, it has been proposed that iNOS induction may be involved in the pathophysiological process leading to inflammation, endothelial dysfunction, and atherosclerosis (Nagareddy et al., 2005, Vane et al., 1994). Therefore, benidipine- and losartan-mediated reduction of iNOS expression, which is enhanced in the aorta of OLETF rats, may be a preferable phenomenon in terms of vasculoprotection. Reduction of iNOS expression might be independent of the antipressor effects of benidipine or losartan, because it has been reported that calcium channel blockers and angiotensin AT_1 receptor antagonists may reduce iNOS expression in cultured cells (Chou et al., 2002, Neri Serneri et al., 2004). This point should be examined in future studies. We also showed that benidipine reduced the cardiac fibrosis in the heart of OLETF rats at 42 weeks of age. This finding is in agreement with a previous report that benidipine is also effective in inhibiting the cardiac remodeling, seen in the pressure-overload model (Liao et al., 2005) and in OELTF rats (Jesmin et al., 2006).

In conclusion, we showed here that, when used in an antihypertensive dose, a long-acting calcium channel blocker, benidipine and an angiotensin AT_1 receptor antagonist, losartan, were equally effective in restoring vascular function and in suppressing cardiovascular remodeling in an animal model of metabolic syndrome. The mechanisms

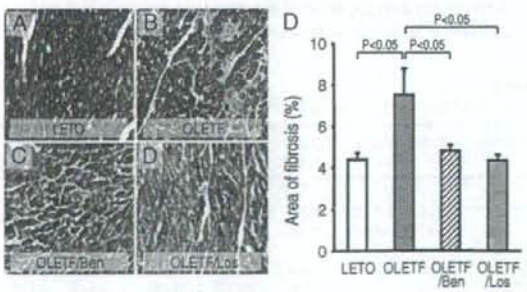

Fig. 5. Effects of benidipine and losartan on cardiac fibrosis. (A–D) Representative image of Masson trichrome staining of the heart of the LETO (A), untreated OLETF (B), and benidipine (C) and losartan (D) treated OLETF rats. (D) Values are mean±S.E.M. Summary of the fibrosis area data from 4–6 experiments for each group.

underlying these preferable effects may include upregulation of vascular expression of eNOS and nNOS, and downregulation of fibrosis-related genes, such as TGF-β1.

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Administration of angiotensin II, but not catecholamines, induces accumulation of lipids in the rat heart

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ABSTRACT

Accumulation of lipids in the heart may cause cardiac dysfunction in various disorders, such as obesity and diabetes. In the current study, we have investigated whether administration of angiotensin II or norepinephrine induces accumulation of lipids and/or changes in the expression of genes related to lipid metabolism in the rat heart. Lipid deposition was found in myocardial, vascular wall, and perivascular cells of the angiotensin II-infused rat heart, and superoxide generation was increased in these lipid-positive cells. By contrast, intracardiac lipid deposition was not found in the heart of norepinephrine-induced hypertensive rats. Triglyceride content in the heart tissue of angiotensin II-infused rats increased more than 3-fold as compared with untreated controls. Losartan completely, but hydralazine only partially, suppressed the angiotensin II-induced intracardiac lipid deposition and increase in tissue triglyceride content. Administration of angiotensin II upregulated the mRNA expression of sterol regulatory element-binding protein-1c and fatty acid synthase, but downregulated that of uncoupling protein 2 and 3, in a manner dependent on the angiotensin AT_1 receptor. Collectively, these results suggest that angiotensin II may be involved in modulating both intracardiac lipid content and lipid metabolism-related gene expression, in part via an angiotensin AT_1 receptor-dependent and pressor-independent mechanism.

1. Introduction

Accumulation of lipids in non-adipose tissues can occur in certain disease conditions, including aging, over-nutrition, obesity, and diabetes, and may play a crucial role in the pathogenesis of tissue damage (Schaffer, 2003), a phenomenon referred to as lipotoxicity (Unger, 2002). Inappropriate accumulation of free fatty acids and neutral lipids can also be observed in the myocardium; this accumulation may result in both functional and morphological damage, such as systolic and/or diastolic dysfunction of the left ventricle (Chiu et al., 2005, Zhou et al., 2000), ventricular wall hypertrophy (Finck et al., 2003, Horiuchi et al., 1993), and interstitial fibrosis (Lee et al., 2004). In previous studies, we found that administration of angiotensin II to rats causes deposition of lipids in tubular epithelial and vascular wall cells in the kidney (Ishizaka et al., 2006, Saito et al., 2005), where cellular proliferation may be promoted. In the current study, we have investigated whether administration of two different pressor agents, angiotensin II and a catecholamine, causes intracardiac accumulation of lipids, and modulates the expression of genes related to lipid metabolism.

2. Materials and methods

2.1. Animal models

The experiments were performed in accordance with the guidelines for animal experimentation approved by the Animal Center for Biomedical Research, Faculty of Medicine, University of Tokyo. Angiotensin II-induced hypertension was induced in male Sprague-Dawley rats (250 to 300 g) by subcutaneous implantation of an osmotic minipump (Alza Pharmaceutical) as described previously (Ishizaka et al., 1997). Briefly, Val^5-angiotensin II (Sigma Chemical) was infused at doses of 0.7 mg/kg/day. Norepinephrine (Sigma Chemical) was infused at a dose of 2.8 mg/kg/day for 7 days using the same system. In some angiotensin II-infused rats, angiotensin AT_1 receptor antagonist, losartan (25 mg/kg/day), or the nonspecific vasodilator, hydralazine (15 mg/kg/day) (Sigma Chemical), both of which normalized the blood pressure of angiotensin II-infused rats, was given in the drinking water (Ishizaka et al., 2002).

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Table 1
Oligonucleotide primers used in this study

Gene	GenBank no.	Forward primer	Reverse primer
PPAR-α	NM_013196	GTGGCTGCTATAATTTGCTG	TGAAGGAGTTTTGGGAAGAG
PPAR-γ	NM_013124	ATCAGCTCTGTGGACCTCTC	AGGCTCTACTTTGATCGCAC
SREBP-1c	XM_213329	CTGATGGAGACAGGGAGTTC	ATCACCACGGCTGTCAGT
FAS	M76767	CTGGAACGTGAACATGATCT	TTCACCAGCAGGATACTCAG
HMG-CoA reductase	NM_013134	GACACTTACAATCTGTATGATG	CTTGGAGAGGTAAAACTGCCA
CPT-1	NM_031559	ATCGACCGCCATCTCTTC	CTCAAAGTCAAAGAGCTCCAC
CPT-2	NM_012930	TGACCAAAGAAGCAGCGAT	TTGTGGTTCATCTGCTGGTA
DGAT-1	NM_053437	TCTTCCTACCCGGGATGTCAATC	TCCCTGCAGACACAGCTTTG
PGC-1α	AY237127	TCATTACCTACCGTTACACCT	CATACTTGCTCTTGGTGGAA
UCP2	BC062230	TGGTCGGAGATACCAGAG	GTCTGTCATGAGGTTGGCT
UCP3	AF035973	GTCCGATTTCAAGCCATGAT	CTTGTGATGTTGGGCCAAGT
Nox1	MN_053683	TGGACGAATTAGGCAAACCG	TTGGGGTGGGCAGTAGCTAT
Nox4	AY027527	AACACTGGTGAAGATTTGC	CTGAGGGATGATTGATTACTG
GAPDH	NM_017008	TGAACGGGAAGCTCACTGG	TCCACCACCCTGTTGCTGTA

PPAR, peroxisome proliferator-activated receptor; SREBP, sterol regulatory element-binding protein; FAS, fatty acid synthase; HMG-CoAR, 3-hydroxy-3-methylglutaryl coenzyme A reductase; CPT, carnitine palmitoyltransferase; DGAT, diacylglycerol acyltransferase; PGC, PPAR-γ coactivator; UCP, uncoupling protein; and GAPDH, glyceraldehyde-3-phosphate dehydrogenase.

2.2. Measurement of lipid contents in the serum and the heart

Serum levels of total cholesterol, triglycerides, and nonesterified fatty acid were measured by enzymatic methods (SRL). Contents of triglycerides, total cholesterol, and free cholesterol in the heart tissue were measured from homogenate extracts by enzymatic colorimetric determination using Triglyceride-E Test, Cholesterol-E Test, and Free cholesterol-E Test Wako, respectively (Wako Pure Chemicals).

2.3. Histological analysis

Oil red O staining was performed on sections of unfixed, freshly frozen heart samples (3 μm in thickness). The areas of lipid deposition were calculated by using the image analysis software, Photoshop (Adobe), and semiquantification of the lipid deposition was performed as described elsewhere (Ishizaka et al., 2006). Staining with the oxidative fluorescent dye dihydroethidium (DHE) was performed as described previously (Saito et al., 2004). Images were obtained with a fluorescent microscope BX51 (Olympus), and the fluorescence intensity, obtained from at least five fields for each section, was presented as the percentage of that of untreated control.

2.4. Western blot analysis

Western blot analysis was performed as described previously (Aizawa et al., 2000). Antibodies against total and phosphorylated forms AMP-activated protein kinase (Cell Signaling), sterol regulatory element-binding protein (SREBP)-1 (Santa Cruz Biotechnology), SREBP-2 (Santa Cruz Biotechnology), ATP-binding cassette transporter subfamily A1 (ABCA1) (Novus Biologicals), scavenger receptor class B type 1 (SR-B1) (Novus Biologicals), and mitochondrial superoxide dismutase (mt SOD) (Upstate) were used at a dilution of 1/1000.

2.5. Real time reverse transcription-polymerase chain reaction (RT-PCR)

Expression of lipid metabolism-related gene mRNA was analyzed by real time quantitative PCR performed by LightCycler together with hybriprobe technology (Roche Diagnostics). Expression of target genes was normalized to the mRNA expression of endogenous control, glyceraldehyde-3-phosphate dehydrogenase (GAPDH). The target genes were as follows: peroxisome proliferator-activated receptor (PPAR)-α (Nihon Gene Research Lab's Inc., Sendai, Japan), PPAR-γ, SREBP-1c, fatty acid synthase (FAS), 3-hydroxy-3-methylglutaryl coenzyme A reductase (HMG-CoAR), carnitine palmitoyltransferase (CPT)-1, CPT-2, diacylglycerol acyltransferase (DGAT)-1, PPAR-γ coactivator (PGC)-1α, uncoupling protein (UCP)2, UCP3, Nox1, and Nox4. The forward and backward primers used are described in Table 1.

2.6. Statistical analysis

Data are expressed as the mean±S. E. M. We used ANOVA followed by a multiple comparison test to compare raw data, before expressing the results as a percentage of the control value using the statistical analysis software StatView ver. 5.0 (SAS Institute). A value of $P<0.05$ was considered to be statistically significant.

3. Results

3.1. Characteristics of experimental animals

The hemodynamic parameters in each group have been reported elsewhere (Aizawa et al., 2000). Angiotensin II and norepinephrine elevated the blood pressure to a similar extent, and both hydralazine and losartan completely suppressed the blood pressure elevation induced by angiotensin II. Angiotensin II, but not norepinephrine, significantly increased the serum levels of triglycerides and non-esterified fatty acids, and these increases were inhibited by losartan, but not by hydralazine (Fig. 1A–C).

3.2. Tissue contents of lipids

The tissue content of triglycerides, total cholesterol, and free cholesterol was found to be increased in the heart of angiotensin II-

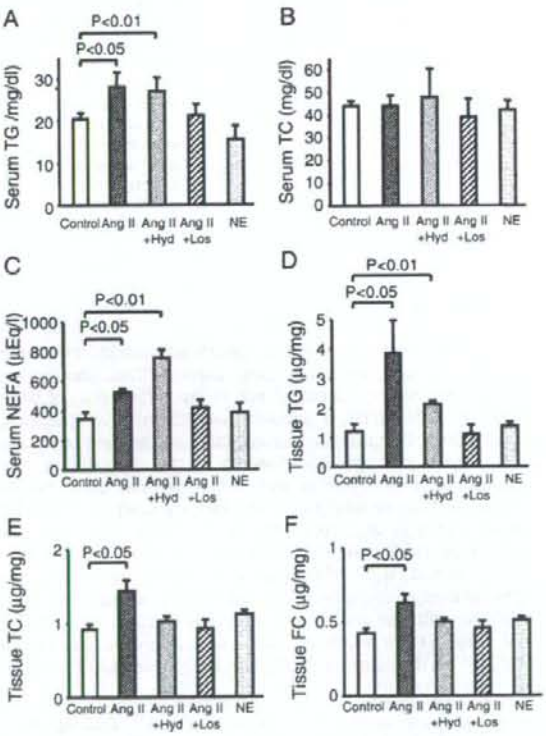

Fig. 1. Serum levels and tissue content of lipids. A–C. Serum levels of triglycerides (TG) (A), total cholesterol (TC) (B), and non-esterified fatty acids (NEFA) (C). D–E. Content of triglycerides (D), total cholesterol (E), free cholesterol (FC) (F) in the heart tissue. Shown in a summary of data from 4–6 rats in each group. Ang II, angiotensin II; Hyd, hydralazine; Los, losartan; and NE, norepinephrine.

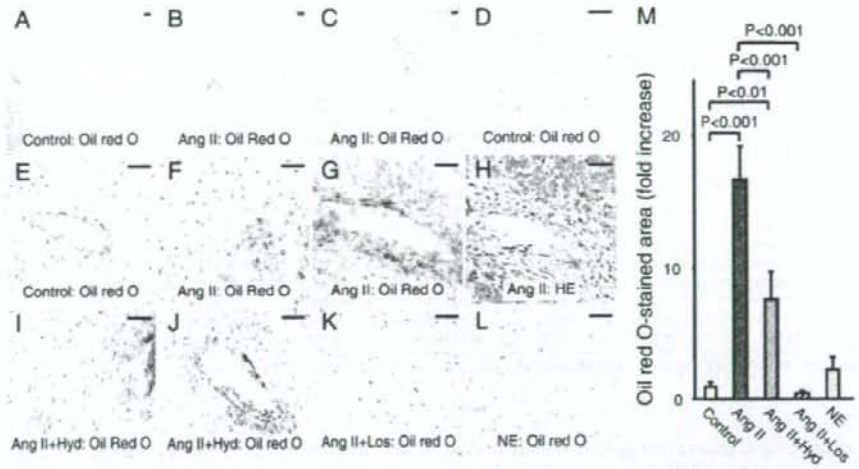

Fig. 2. Accumulation of lipids in the heart. A, D, E. Heart section from a control rat. B, C, F–H. Heart sections from angiotensin II (Ang II)-infused rats. I, J. Heart section from a rat given both angiotensin II and hydralazine (Hyd). K. Heart section from a rat given both angiotensin II and losartan (Los). L. Heart section from a rat given norepinephrine (NE). F and G are serial sections. A–G, I–L. Oil red O staining. H. Hematoxylin eosin (HE) staining. Lipid droplets were not observed in the myocardium or vascular regions (A, D, E) of control rats. Lipid droplets were present in both the myocardium (B, C, F) and perivascular regions (G) in the heart of angiotensin II-infused rats. Lipid droplets in the myocardium (I) and perivascular regions (J) were observed in the heart of rats given both angiotensin II and hydralazine, but not in the heart of rats given angiotensin II plus losartan (K) or those given norepinephrine (L). Original magnification, ×100 (A–C), and ×200 (D–L). Scale bars indicate 50 μm. M. Semiquantification of the oil red O-stained area. Shown is a summary of data from 5–7 experiments in each group.

infused rats, but not norepinephrine-infused rats (Fig. 1). Hydralazine only partially suppressed the angiotensin II-induced increase in intracardiac triglyceride content, but it completely suppressed the increase in intracardiac total cholesterol and free cholesterol content (Fig. 1D–F). Losartan suppressed the angiotensin II-induced increase in all three lipid fractions tested. Administration of losartan alone or hydralazine alone did not significantly alter the lipid content of the heart (losartan: triglycerides, 1.53±0.12 μg/mg, $n=4$; total cholesterol, 1.16±0.07 μg/mg, $n=3$; free cholesterol, 0.53±0.04 μg/mg, $n=4$; hydralazine: triglycerides, 1.40±0.14 μg/mg, $n=4$; total cholesterol, 1.09±0.14 μg/mg, $n=4$; free cholesterol, 0.43±0.04 μg/mg, $n=5$).

3.3. Staining for lipids

Oil red O staining of heart sections showed no apparent lipid deposition in the heart of untreated rats (Fig. 2A, D, E). By contrast, accumulation of oil red O-stainable lipid was observed in the myocardium as well as the arterial wall of angiotensin II-infused rats (Fig. 2B, C, F, G). In the angiotensin II-infused rat heart, lipid accumulation was also observed in perivascular regions, especially where remodeling of perivascular regions was apparent (Fig. 2G, H), and in granulation regions (data not shown). Lipid deposition remained present in the heart when angiotensin II-infused rats were concomitantly treated with hydralazine (Fig. 2I, J). On the other hand, lipid deposition was not apparent, or was very minor when present, in heart sections from rats treated with both angiotensin II and losartan or from rats treated with norepinephrine infusion (Fig. 2K, L). Semiquantitative measurements of the oil red O-stained areas are summarized in Fig. 2M.

3.4. Co-localization of lipid deposition and superoxide

As compared with untreated controls, DHE staining-positive signals were increased in the heart of angiotensin II-infused rats, and

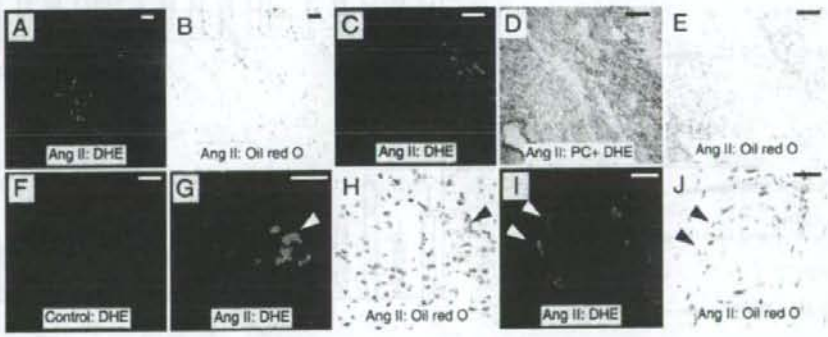

Fig. 3. Lipid and superoxide staining of the heart section. A–E, F–J. Heart sections from angiotensin (Ang) II-infused rats. F. Heart section from a control rat. A, C, F, G, I Dihydroethidium (DHE) staining. D. Phase contrast (PC) microscopic image overlaid with DHE staining image. B, E, H, J. Oil red O staining. C and D are the same section. C (=D)–E, G–H, and I–J are serial sections. Some cells with intense DHE staining (arrowheads in G and I) contained lipid deposits (arrowheads in H and J). Original magnification, ×100 (A–C), ×200 (C–H), and ×400 (I, J). Scale bars indicate 50 μm.

Table 2
mRNA levels of genes related to lipid metabolism

Gene	Control (n=6)	Ang II (n=6)	P	Ang II+Hyd (n=5)	P	Ang II+Los (n=6)	P	NE (n=7)	P
PPAR-α	1±0.17	1.88±0.34	0.030	2.99±0.64	0.005	1.41±0.20	0.080	2.00±0.18	0.001
PPAR-γ	1±0.17	3.30±0.98	0.019	4.25±1.13	0.032	0.83±0.09	0.19	3.56±0.44	<0.001
SREBP-1c	1±0.24	3.66±1.02	0.008	2.67±0.96	0.039	0.71±0.12	0.14	0.77±0.17	0.21
FAS	1±0.17	2.97±0.32	<0.001	3.46±1.00	<0.001	1.30±0.17	0.18	1.28±0.13	0.18
HMG-CoA reductase	1±0.20	2.29±0.30	<0.001	2.50±0.66	0.009	0.99±0.23	0.49	0.98±0.33	0.48
CPT-1	1±0.06	0.55±0.09	<0.001	1.08±0.29	0.395	0.82±0.15	0.154	0.16±0.03	<0.001
CPT-2	1±0.04	0.63±0.06	<0.001	0.67±0.10	<0.001	0.66±0.06	<0.001	0.67±0.05	<0.001
DGAT-1	1±0.04	1.20±0.12	0.071	0.58±0.18	0.003	0.60±0.04	<0.001	0.87±0.12	0.14
PGC-1α	1±0.09	0.52±0.06	<0.001	0.59±0.18	<0.005	0.94±0.18	0.395	1.34±0.31	0.17
UCP2	1±0.08	0.51±0.08	<0.001	0.39±0.08	<0.001	0.80±0.09	0.055	1.53±0.79	0.276
UCP3	1±0.06	0.75±0.09	0.020	0.50±0.11	<0.001	0.74±0.14	0.037	2.10±0.49	0.038
Nox1	1±0.21	3.31±0.61	0.006	4.87±1.82	0.026	0.90±0.19	0.378	1.17±0.42	0.367
Nox4	1±0.21	5.25±2.22	0.047	0.72±0.10	0.093	1.17±0.12	0.199	1.17±0.14	0.206

P values are versus untreated control. Ang II, angiotensin II; Hyd, hydralazine; Los, losartan; and NE, norepinephrine. Other abbreviations were same as Table 1.

semiquantitative measurements showed that the DHE-stained area was significantly greater after angiotensin II infusion (control 100±37%, n=5, versus angiotensin II 342±125%, n=5; P<0.05). In the heart of angiotensin II-infused rats, some myocardial cells that had increased superoxide staining were found to be positive for lipid deposition (lower magnification in Fig. 3A, B, and higher magnification in Fig. 3C–D). Similarly, some vascular wall and perivascular cells with increased superoxide staining were found to contain lipid deposits (Fig. 3G–J).

3.5. Regulation of genes related to lipid metabolism

Next, we examined the expression of lipid metabolism-related genes after infusion of the pressor agents (Table 2). mRNA expression of PPAR-α, PPAR-γ, SREBP-1c, FAS, and HMG-CoAR was found to be increased in the heart of rats that received angiotensin II infusion. Of the genes tested, mRNA expression of PPAR-α and PPAR-γ was also increased in the heart of the norepinephrine-infused rat. The expression of PGC-1α, UCP2 and UCP3 was decreased after angiotensin II infusion, but not after norepinephrine infusion. The angiotensin II-induced regulation of these genes (PPAR-α, PPAR-γ, SREBP-1c, FAS, HMG-CoAR, PGC-1α, UCP2, and UCP3) was suppressed by losartan, but not by hydralazine. On the other hand, mRNA expression of CPT-1 and CPT-2 was downregulated by angiotensin II. We found that the angiotensin II-induced CPT-1 downregulation was suppressed by depressor agents, and that norepinephrine also downregulated CPT-1 mRNA expression; therefore, the angiotensin II-induced CPT-1 mRNA downregulation might be induced by hypertension per se. Angiotensin II increased the mRNA expression of two components of NAD(P)H oxidase, Nox1 and Nox4.

Angiotensin II did not alter the protein expression of AMPKα; however, it increased the levels of phosphorylated AMPKα, and this increase was inhibited by either depressor agent (Fig. 4). Protein expression of matured SREBP-1 was increased by angiotensin II, and this increase was suppressed by losartan, but not by hydralazine.

We also examined the expression of several other lipid metabolism-related proteins. In the heart of control (n=4) and angiotensin II-

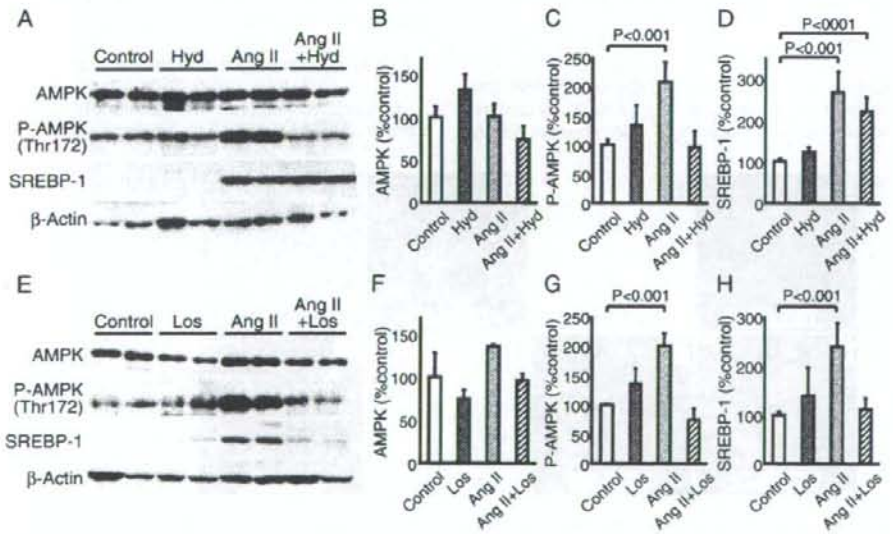

Fig. 4. Western blot analysis of AMP-activated protein kinase (AMPK), phosphorylated (activated) form of AMPKα (P-AMPK), and SREPB-1. A, E. Representative blots. B–D, F–H. Summary of data from 4–6 experiments in each group. Abbreviations are same as Table 1.

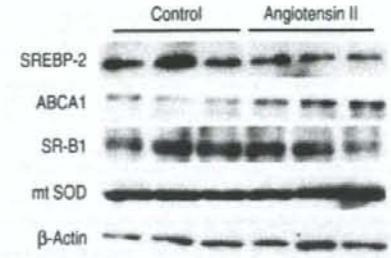

Fig. 5. Western blot analysis of proteins related to lipid metabolism. Shown are the results of the expression in the heart of control and angiotensin II-infused rats of the following proteins: Sterol regulatory element-binding protein (SREBP)-2, ATP-binding cassette transporter subfamily A-1 (ABCA1), scavenger receptor class B type 1 (SR-B1), mitochondrial superoxide dismutase (mt SOD).

infused ($n=4$) rats, the expression of these proteins was, respectively (% control): SREBP-2: 100±17 versus 78±14 (P=NS); ABCA1: 100±10 versus 172±7 ($P<0.001$); SR-B1: 100±17 versus 127±18 (P=NS); mit SOD: 100±5 versus 110±18 (P=NS) (Fig. 5).

4. Discussion

In the present study, we showed that administration of angiotensin II, but not catecholamines, caused accumulation of lipids in myocardial, vascular wall, and perivascular cells in the rat heart. Such angiotensin II-induced lipid deposition, as well as the increases in tissue triglyceride content in the heart, was suppressed completely by losartan, but only partially by hydralazine. These findings collectively indicate that the accumulation of intracardiac lipids induced by angiotensin II was, at least in part, independent of the pressor properties of angiotensin II.

Intracardiac lipid accumulation, which is sometimes designated 'cardiac steatosis' (McGavock et al., 2007), is known to occur in humans in certain diseased conditions, such as diabetes and heart failure (McGavock et al., 2007, Sharma et al., 2004). By means of genetic engineering, several animal models showing an amount of intracardiac lipids have been generated; these models include mice with cardiac-specific overexpression of acyl CoA synthase (Lee et al., 2004), fatty acid transport protein 1(Chiu et al., 2005), and PPAR-α (Finck et al., 2003), and mice with cardiac-restricted deletion of PPAR-delta (Cheng et al., 2004). The observation that accumulation of excessive fatty acids aggravates, whereas reduction of cardiac lipid content ameliorates, the structural and functional damage in these models supports the notion that accumulation of excessive lipid may indeed be cardiotoxic. In our previous studies, we found that administration of angiotensin II, but not catecholamines, caused marked accumulation of neutral lipids in the kidney (Ishizaka et al., 2006, Saito et al., 2005), leading us to investigate whether these two pressor agents affect cardiac lipid content differently in the current study.

What would be the mechanism underlying angiotensin II-induced intracardiac lipid deposition? We found that angiotensin II upregulated the expression of SREBP-1c, FAS, and HMG-CoAR, and downregulated that of UCP2, and UCP3; in addition, the pattern of regulation paralleled intracardiac lipid accumulation. It has been reported that angiotensin II upregulates the expression of SREBP-1c and FAS, resulting in increased lipogenesis in adipocytes in vitro (Jones et al., 1997, Kim et al., 2001). In addition, although the physiological functions of UCP2 and UCP3 are not well-established, downregulation of these new UCPs may augment the production of reactive oxygen species and decrease the catalysis of transported fatty acids (Affourtit et al., 2007). We also found that angiotensin II upregulated PPAR-α mRNA expression. Overexpression of PPAR-α in the heart may also cause lipotoxic cardiomyopathy (Finck et al., 2003, Vikramadithyan et al., 2005), suggesting that PPAR-α upregulation might be an underlying mechanism linking angiotensin II administration and cardiac lipid deposition.

Several previous studies have shown that PPAR-α activator may ameliorate myocardial damage induced by angiotensin II (Fujita et al., 2008, Ichihara et al., 2006). In the current study, we also found that PPAR-α expression was increased by norepinephrine infusion, which did not cause apparent cardiac lipid accumulation, indicating that upregulation of cardiac PPAR-α may not solely account for lipid accumulation in the heart. Whether or not PPAR-α activator acts to enhance or to suppress angiotensin II-induced lipid accumulation in the heart should be examined in future studies.

Activation of AMPK may result in the phosphorylation of acetyl CoA carboxylase, followed by the reduction of malonyl CoA and the subsequent activation and upregulation of CPT-1, leading to the stimulation of fatty acid oxidation (Affourtit et al., 2007). In the current study, we found that angiotensin II activated cardiac AMPK; however, it downregulated CPT-1 mRNA expression. Tian et al. (2001) have recently reported that pressure overload-induced cardiac hypertrophy causes a significant increase in AMPK activity in the heart that is, unexpectedly, accompanied by a downregulation of CPT-1 expression. They presumed that, unlike short-term activation, prolonged activation of AMPK might result in a downregulation of the enzymes that would be critical to fatty acid oxidation. With regard to this, it may be of note that, in the current study, both AMPK activation and CPT-1 downregulation by angiotensin II were suppressed not only by losartan, but also by hydralazine, and that CPT-1 mRNA downregulation was also induced by norepinephrine-induced hypertension, suggesting that these events were induced not in an angiotensin II-specific manner, but rather by hypertension itself.

It has been reported that UCP2 may reduce the generation of ROS, and conversely, downregulation of uncoupling proteins may increase the generation of ROS (Arsenijevic et al., 2000). On the other hand, enhanced oxidative stress or increased amounts of ROS may activate or upregulate SREBP-1 and FAS (Furuta et al., 2008, Gharavi et al., 2006). In addition, CuZn-SOD deficiency has been reported to increase lipid accumulation in the liver (Uchiyama et al., 2006). We found in our previous study (Saito et al., 2005) and the current one that superoxide is histologically co-localized with lipid deposition in the heart and kidney of angiotensin II-infused rats. Taken together, these findings may collectively suggest that angiotensin II-induced deposition of lipid in the heart may be evoked, at least in part, by enhanced oxidative stress (Fig. 5). This hypothesis should be examined in future studies (Fig. 6).

In conclusion, administration of angiotensin II to rats induced intracardiac lipid accumulation in regions where superoxide

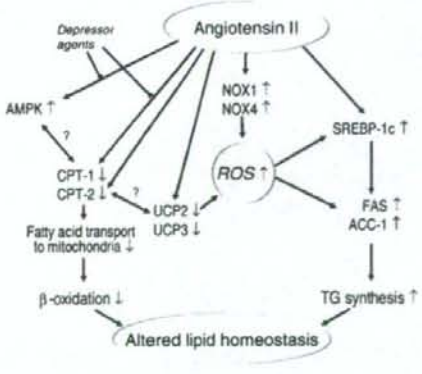

Fig. 6. Working hypothesis on angiotensin II-induced altered lipid homeostasis. Abbreviations are same as in Table 1. ROS indicates reactive oxygen species.

production was found to be increased. The angiotensin II-induced accumulation of intracardiac lipids, in addition to regulation of the expression of several lipid metabolism-related genes (SREBP-1c, FAS, HMG-CoAR, PGC-1α, UCP2, and UCP3), events that were not mimicked by catecholamine infusion, were found to be dependent on the angiotensin AT_1 receptor. The physiological significance of angiotensin II-induced cardiac lipid accumulation and the role of enhanced oxidative stress on this phenomenon await further investigation.

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Intramembrane Processing by Signal Peptide Peptidase Regulates the Membrane Localization of Hepatitis C Virus Core Protein and Viral Propagation▽

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Hepatitis C virus (HCV) core protein has shown to be localized in the detergent-resistant membrane (DRM), which is distinct from the classical raft fraction including caveolin, although the biological significance of the DRM localization of the core protein has not been determined. The HCV core protein is cleaved off from a precursor polyprotein at the lumen side of Ala[191] by signal peptidase and is then further processed by signal peptide peptidase (SPP) within the transmembrane region. In this study, we examined the role of SPP in the localization of the HCV core protein in the DRM and in viral propagation. The C terminus of the HCV core protein cleaved by SPP in 293T cells was identified as Phe[177] by mass spectrometry. Mutations introduced into two residues (Ile[176] and Phe[177]) upstream of the cleavage site of the core protein abrogated processing by SPP and localization in the DRM fraction. Expression of a dominant-negative SPP or treatment with an SPP inhibitor, L685,458, resulted in reductions in the levels of processed core protein localized in the DRM fraction. The production of HCV RNA in cells persistently infected with strain JFH-1 was impaired by treatment with the SPP inhibitor. Furthermore, mutant JFH-1 viruses bearing SPP-resistant mutations in the core protein failed to propagate in a permissive cell line. These results suggest that intramembrane processing of HCV core protein by SPP is required for the localization of the HCV core protein in the DRM and for viral propagation.

The hepatitis C virus (HCV), which has infected an estimated 170 million people worldwide, leads to chronic hepatitis, which in turn causes severe liver diseases, including steatosis, cirrhosis, and eventually hepatocellular carcinoma (47). HCV possesses a positive-sense single-stranded RNA with a nucleotide length of 9.6 kb, which encodes a single large precursor polyprotein composed of about 3,000 amino acids. The viral polyprotein is processed by cellular and viral proteases into structural and nonstructural proteins (24). The development of efficient therapies for hepatitis C had been hampered by the lack of a reliable cell culture system, as well as by the absence of a small-animal model. Lohmann et al. established an HCV replicon, which consisted of an antibiotic selection marker and a genotype 1b HCV RNA, and showed that it replicated autonomously in the intracellular compartments of a human hepatoma cell line, Huh7 (16). The replicon system has been used as an important tool in the investigation of HCV replication, and it has served as a cell-based assay system for the evaluation of antiviral compounds. Recently, cell culture systems for in vitro replication and infectious-virus production were established based on the full-length HCV genome of a genotype 2a isolate, which was recovered from a fulminant hepatitis C patient (15, 45, 50). However, the molecular mechanism of the HCV life cycle in host cells has not been well characterized.

Several viruses have been reported to utilize a lipid raft composed of cholesterol and sphingolipids upon entry (34). The lipid raft is characterized by resistance to nonionic detergents at 4°C and includes caveolin, glycolipids, and other substances (40). Several nonenveloped viruses enter cells through a caveola/raft-mediated endosome, designated the caveosome, and then translocate to the endoplasmic reticulum (ER), endosome, or nucleus (34, 35), although enveloped viruses generally enter host cells through a clathrin-dependent pathway (18). HCV is enclosed by a host cell-derived membrane and belongs to the family *Flaviviridae*. Several reports suggest that HCV enters host cells through general endocytosis, such as by a clathrin-mediated pathway (5, 6, 22). However, HCV has been suggested to replicate on a detergent-resistant membrane (DRM), including some characteristic membrane structures such as lipid rafts and membranous webs (8, 9, 38). In a previous report, an HCV replication complex prepared from a cell fraction treated with a nonionic detergent was shown to be enzymatically active (2). HCV nonstructural proteins remodel the intracellular membrane to form a replication complex that includes several host proteins (8, 46). The HCV core protein has a C-terminal transmembrane region that is anchored on intracellular compartments such as the ER and mitochondria and on the surfaces of lipid droplets (10, 30, 42). Recent studies have indicated that assembly of HCV particles occurs around lipid droplets that are surrounded by the remodeled membranes (23). Although the HCV core protein functions as a capsid protein, it is found in the DRM fraction, which is

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