and mineralocorticoid receptor-independent γENaC enhancement in AB-R mice and AB-H mice. The amount of βENaC did not differ between groups. Although it is generally accepted that ENaC activation occurs through mineralocorticoid receptor activation [7,8], mineralocorticoid receptor-independent ENaC activation has been reported [30]. The mechanisms of mineralocorticoid receptor-independent γENaC activation, however, are unknown. We did not measure Na concentration in the CSF in the present study because of technical difficulties, and we did not directly evaluate the effects of ENaC activity on Na transport. Furthermore, ENaC expression levels may reflect both epithelial components and neural components [6]. We did not address these issues in the present study, and further studies are needed.

In conclusion, the present findings strongly suggest that activation of brain αENaC and AT1R through mineralocorticoid receptor contributes to the acquisition of Na sensitivity to induce sympathoexcitation. High salt intake accelerates sympathetic activation and LV systolic dysfunction in a pressure overload model.

Acknowledgements

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There are no conflicts of interest.

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Nanoparticle-mediated endothelial cell-selective delivery of pitavastatin induces functional collateral arteries (therapeutic arteriogenesis) in a rabbit model of chronic hind limb ischemia

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Objectives: We recently demonstrated in a murine model that nanoparticle-mediated delivery of pitavastatin into vascular endothelial cells effectively increased therapeutic neovascularization. For the development of a clinically applicable approach, further investigations are necessary to assess whether this novel system can induce the development of collateral arteries (arteriogenesis) in a chronic ischemia setting in larger animals.
Methods: Chronic hind limb ischemia was induced in rabbits. They were administered single injections of nanoparticles loaded with pitavastatin (0.05, 0.15, and 0.5 mg/kg) into ischemic muscle.
Results: Treatment with pitavastatin nanoparticles (0.5 mg/kg), but not other nanoparticles, induced angiographically visible arteriogenesis. The effects of intramuscular injections of phosphate-buffered saline, fluorescein isothiocyanate (FITC)-loaded nanoparticles, pitavastatin (0.5 mg/kg), or pitavastatin (0.5 mg/kg) nanoparticles were examined. FITC nanoparticles were detected mainly in endothelial cells of the ischemic muscles for up to 4 weeks. Treatment with pitavastatin nanoparticles, but not other treatments, induced therapeutic arteriogenesis and ameliorated exercise-induced ischemia, suggesting the development of functional collateral arteries. Pretreatment with nanoparticles loaded with vatalanib, a vascular endothelial growth factor receptor (VEGF) tyrosine kinase inhibitor, abrogated the therapeutic effects of pitavastatin nanoparticles. Separate experiments with mice deficient for VEGF receptor tyrosine kinase demonstrated a crucial role of VEGF receptor signals in the therapeutic angiogenic effects.
Conclusions: The nanotechnology platform assessed in this study (nanoparticle-mediated endothelial cell-selective delivery of pitavastatin) may be developed as a clinically feasible and promising strategy for therapeutic arteriogenesis in patients. (J Vasc Surg 2010;52:412-20.)

Clinical Relevance: Restoration of tissue perfusion in patients with critical limb ischemia is a major therapeutic goal. Recent clinical trials designed to induce neovascularization by administering exogenous angiogenic growth factors or cells failed to demonstrate a decisive clinical benefit. A controlled drug delivery system for a new approach to therapeutic neovascularization therefore would be more favorable. In the present study, we applied nanoparticle-mediated delivery system and report that endothelial cell-selective delivery of pitavastatin increased the development of collateral arteries and improved exercise-induced ischemia in a rabbit model of chronic hind limb ischemia. This nanotechnology platform is a promising strategy for the treatment of patients with severe organ ischemia and represents a significant advance in therapeutic arteriogenesis over current approaches.

The vascular endothelium is a major target for the pleiotropic (nonlipid-related) vascular protective effects of the 3-hydroxy-3-methylglutaryl-CoA reductase inhibitors (statins).[1] Statins improve endothelial dysfunction[1-3] and exert multiple vascular protective properties, mainly by enhancing the activity of endothelial nitric oxide synthase. Statins increase the angiogenic activity of mature endothelial cells, as well as that of endothelial progenitor cells, and augment neovascularization (arteriogenesis, vasculogenesis, and angiogenesis) in the ischemic hearts and limbs of

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Competition of interest: Dr Egashira holds a patent on the results reported in the present study.

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experimental animals.[4-6] Statins also attenuate atherosclerosis formation[7] and pose little potential risk for tumor angiogenesis, in contrast to angiogenic growth factors.[8]

Most of these beneficial effects of statins on therapeutic neovascularization, however, were observed after the daily administration of high doses in experimental animals, a regimen that could lead to serious adverse side effects in a clinical setting. A clinical study of 500 patients with coronary artery disease reported no effects of statins within the clinical dose range on indices of functional collateral development (arteriogenesis).[9]

To optimize the therapeutic effects of statins in the induction of therapeutic neovascularization, we recently applied nanotechnology and reported that nanoparticle (NP)-mediated pitavastatin delivery into vascular endothelial cells effectively increased therapeutic neovascularization with no serious side effects in a murine model of acute hind limb ischemia.[10] The beneficial effects induced by pitavastatin-NP were mediated by increased activity of endothelial nitric oxide synthase (eNOS) and multiple endogenous angiogenic growth factors, suggesting that this NP-mediated cell-selective delivery produces a well-harmonized integrative system for therapeutic neovascularization. Importantly, this NP-mediated delivery system was as effective at a dose that is approximately 100 to 300 times lower than the cumulative systemic dose. To translate our experimental findings in the murine model of acute hind limb ischemia to clinically applicable approaches, it is desirable to determine whether NP-mediated statin delivery into vascular endothelial cells induces the development of collateral arteries (arteriogenesis) and thus restores tissue perfusion in a setting of chronic ischemia in larger animals.

Recent evidence suggests that arteriogenesis is a very important adaptive mechanism for the restoration of perfusion to critically ischemic tissue.[11] Arteriogenesis is the process whereby a preexisting arteriole from the resistance vessel class matures into an artery of the conductance vessel class, whereas angiogenesis is the process by which a sprouting capillary originates from a preexisting capillary. Vasculogenesis represents the differentiation of bone marrow-derived endothelial progenitor cells to form a primitive vasculature. The structure and molecular interactions of arteriogenesis differ from those of angiogenesis and vasculogenesis.

Contrary to conventional paradigms,[12] angiogenesis and vasculogenesis by themselves cannot replace the conductance capacity of collateral arteries in the absence of arteriogenesis.[11,13] According to the results of clinical trials, the question has been raised about whether the angiogenesis/vasculogenesis induced by single angiogenic growth factors can induce functional collateral arteries.[14,15] A high local concentration of angiogenic growth factors increases the risk of atherosclerosis[16-18] and tumor angiogenesis.[19] Therefore, an attempt to stimulate the development of functional collateral arteries through the process of arteriogenesis represents an evolution toward a new therapeutic strategy for patients with severe ischemia due to atherosclerotic vascular disease.

The primary aim of this study was to test the hypothesis that NP-mediated delivery of pitavastatin to endothelial cells can be a realistic strategy for promoting functional collateral arteries and for improving exercise-induced ischemia in a rabbit model of chronic hind limb ischemia.

MATERIALS AND METHODS

The study protocol was reviewed and approved by the Committee on Ethics in Animal Experiments, Kyushu University Faculty of Medicine. The experiments were conducted according to the Guidelines of the American Physiological Society.

Preparation of NP. Anionic poly(lactic-co-glycolic acid) (PLGA) NP incorporated with fluorescein-isothiocyanate (FITC), pitavastatin, or vatalanib[20] (an inhibitor of receptor tyrosine kinase of vascular endothelial cell growth factor [VEGF] receptors 1-3; a gift of Novartis Pharma) were prepared by a emulsion solvent diffusion method.[10] The FITC-, pitavastatin-, and vatalanib-incorporated NP contained (w/v) 5% FITC, 6.3% pitavastatin, and 6.1% vatalanib, respectively. The diameter of PLGA NP was 196 ± 29 nm. Additional details are provided in the Appendix (online only).

Angiogenesis activity of human endothelial cells. Angiogenesis of human endothelial cells (HECs) was tested by 2-dimensional Matrigel assay, as previously described.[10] Additional details are provided in the Appendix (online only).

Rabbit model of chronic hind limb ischemia and treatments. Male Japanese White rabbits were used. To induce chronic hind limb ischemia, the left femoral artery was completely excised from its proximal origin at the branchpoint of the external iliac artery to the bifurcation of the saphenous and popliteal arteries.[21,22] For intramuscular injection, drugs incorporated with or without NP were suspended in 5 mL of phosphate-buffered saline (PBS) and injected into 10 different sites in the left medial thigh muscles with a 27-gauge needle 7 days after femoral artery excision (Appendix Fig I, online only). To define the dose-response relationship of the proarteriogenic effects of pitavastatin-NP, animals were randomly divided into a PBS group and three other treatment groups that received an intramuscular injection of pitavastatin-NP containing the three different doses of pitavastatin (0.05, 0.15, and 0.5 mg/kg).

In another set of experiments, animals were randomly distributed in groups receiving intramuscular injections of PBS, pitavastatin (0.5 mg/kg), FITC-NP, or pitavastatin (0.5 mg/kg)-NP. The effect of vatalanib-NP on arteriogenesis induced by pitavastatin-NP was also examined in another set of animals treated intramuscularly with vatalanib-NP or with vatalanib-NP and pitavastatin-NP. Additional details are provided in the Appendix (on-line only).

Effects of pitavastatin-NP on collateral arterial development 28 days after treatment

Internal iliac angiography. A 4Fr end-hole infusion catheter was introduced into the right common carotid

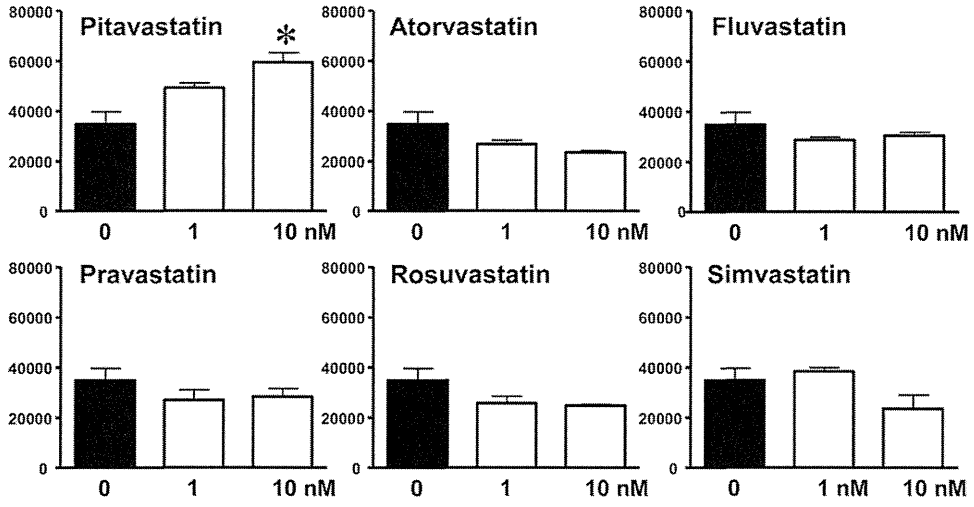

Fig 1. Effects of six statins on angiogenic capacity of human endothelial cells in vitro is shown by quantitative analysis of tube formation (tube length in mm per well) in six independent experiments. $*P < .01$ vs control by one-way analysis of variance with the Dunnett multiple comparison test.

artery and advanced to the left internal iliac artery at the level of the interspaces between the seventh lumbar and the first sacral vertebrae. After an intra-arterial injection of nitroglycerin (0.25 mg), 5 mL of contrast medium was injected at a rate of 1 mL/s. The 3-second angiogram was used for analysis of the angiographic score. A composite of 5-mm^2 grids was placed over the angiogram. The total number of grids that were crossed by visible arteries was divided by the total number of grids in the area of the medial thigh, as previously described.[21,22]

Capillary and arteriolar density. Histologic evaluation was performed for 5-μm frozen sections or 5-μm paraffin-embedded sections of the adductor skeletal muscles of the ischemic limb. CD31$^+$ (Dako, Tokyo, Japan) capillary endothelial cells were counted. Arterioles were determined by immunostaining with α-smooth muscle actin (α-SMA; Dako) and anti-mouse immunoglobulin G secondary antibody (Alexa 546; Molecular Probes, Invitrogen, Carlsbad, Calif), and vessels surrounded by smooth muscle cells were counted. Nuclei were counterstained with 4′,6-diamidino-2-phenylindole (Vector Shield, Vector Laboratories, Burlingame, Calif). Capillary and arteriolar density were calculated as capillaries/mm^2 and arterioles/mm^2 averaged from five randomly selected fields.[21,22] To ensure that the density was not overestimated or underestimated as a consequence of myocyte atrophy or edema, the capillary/muscle and arteriolar/muscle fiber ratios were also evaluated.

Tissue oximetry. Tissue oxygen content was measured by fluorescence quenching technique using an OxyLab PO_2 monitor (Oxford Optronix Ltd, Oxfordshire, UK) fiberoptic probe mounted to a micromanipulator, as previously described.[23] Ischemic limb was exposed on an anesthetized animal, and a 18-gauge needle was used to insert the fiberoptic probe to the adductor skeletal muscles of the ischemic limb at a 90° angle to contact the adductor skeletal muscles. The stable Po_2 reading, before a rapid rise to at least 60 mm Hg that signaled loss of tissue contact, was used as the tissue oxygen partial pressure.

Effects of pitavastatin-NP on forced ischemia induced by electrical pulses. The functional status of collateral arterial development was examined 28 days after treatment with PBS, FITC-NP, pitavastatin only, and pitavastatin-NP. After anesthesia, 21-gauge catheters were inserted into the right femoral artery and the left femoral vein for blood sampling. Two 21-gauge needles were inserted into the left medial thigh and the left gastrocnemius muscle. The electrode wires were then connected to the needles and plugged into the stimulator (Electronic Stimulator, Model SEN-7203, NIHON KOHDEN, Tokyo, Japan). The stimulating voltage was set at 5 V for 1 millisecond to cause noticeable contraction of the left hind limb. The stimulation frequency was 3 Hz, and the left hind limb was electrically stimulated for 30 minutes. Arterial and venous blood was sampled to measure the oxygen saturation before stimulation and at 15 and 30 minutes after stimulation.

A mouse model of hind limb ischemia and treatments. Male wild-type and Flt-1 tyrosine kinase deficient (Flt-1 TK$^{-/-}$) mice[24] were used. After anesthesia, unilateral hind limb ischemia was induced in the mice as previously described.[10,25] Additional details are provided in the Appendix (online only).

Statistical analyses. Data are expressed as mean ± standard error of the mean. Statistical analysis was assessed by one-way or two-way analysis of variance with post hoc test. Values of $P < .05$ were considered statistically significant.

RESULTS

Effects of statins and pitavastatin-NP on the angiogenic capacity of HECs in vitro. Treatment with pitavastatin increased angiogenic activity in HECs, whereas other statins had no effect (Fig 1). Treatment with pitavastatin-

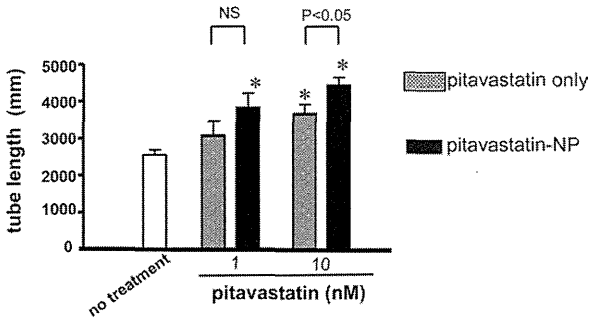

Fig 2. Effects of pitavastatin and pitavastatin nanoparticles *(NP)* are shown on the angiogenic capacity of human endothelial cells in vitro by quantitative analysis of tube formation (tube length per well) of six independent experiments. $*P < .01$ vs control by two-way analysis of variance with the Dunnett multiple comparison test.

NP increased angiogenic activity in HECs. The angiogenic activity of statin-NP was greater than that of 10 nM pitavastatin alone (Fig 2).

Effects of pitavastatin-NP on angiographically visible collateral arterial development. Because only a single dose of pitavastatin (0.4 mg/kg)-NP was previously examined in the mouse model,[13] the dose-response relationship of pitavastatin-NP with angiographically visible collateral arterial development (arteriogenesis) was examined in the present study. Treatment with pitavastatin (0.5 mg/kg)-NP, but not with those with pitavastatin at 0.05 or 0.15 mg/kg, increased the arteriogenic response, as assessed by the angiographic score (Fig 3, *A*). Representative angiograms 28 days after treatment demonstrate corkscrew-like collateral arterial development only in the pitavastatin-NP group (Fig 3, *B*). Treatment with pitavastatin (0.5 mg/kg)-NP significantly increased the angiographic score (Fig 3, *C*). In contrast, no treatment effects on the angiographic score were noted in the FITC-NP or pitavastatin-only groups.

Effects of pitavastatin-NP on histopathologic angiogenesis and arteriogenesis. Treatment with pitavastatin (0.5 mg/kg)-NP, but not with FITC-NP or statin only, significantly increased the capillary density and capillary/muscle fiber ratio, which are indices of angiogenesis (Fig 4, *A*). The beneficial effects of pitavastatin-NP were not associated with significant changes in serum biochemical markers (Table). Treatment with pitavastatin-NP also significantly increased the α-SMA$^+$ arteriolar density and arteriole/muscle fiber ratio, which are indices of arteriogenesis (Fig 4, *B*), indicating that pitavastatin-NP treatment induced angiogenesis and arteriogenesis.

Examination of hematoxylin-eosin-stained sections revealed no abnormal histopathologic findings (inflammation and fibrosis) among the four groups (data not shown). There was no significant difference in muscle fiber density among the four groups (PBS groups: 129 ± 8, 145 ± 4/mm^2; FITC-NP groups: 130 ± 3 and 129 ± 6/mm^2).

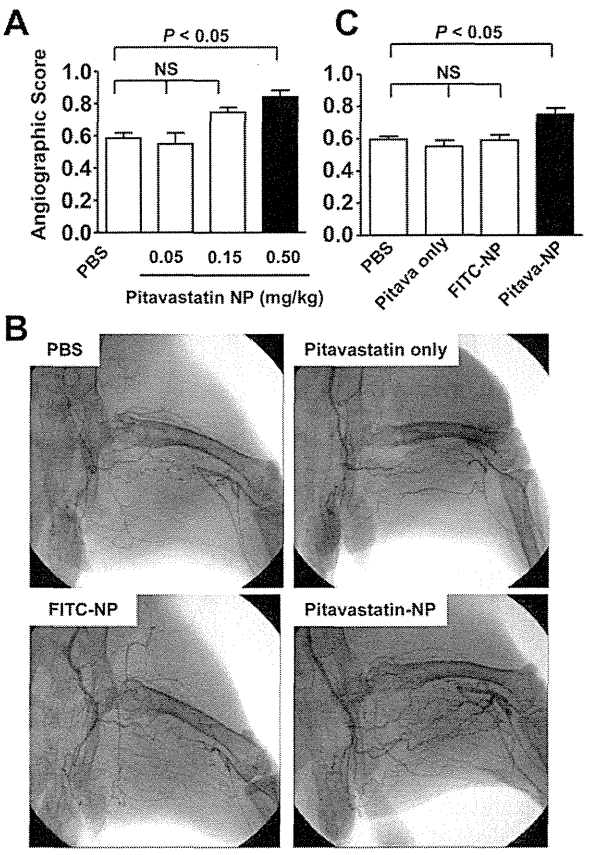

Fig 3. Effects of pitavastatin nanoparticles (*NP*) on angiographically visible collateral arterial development are shown 28 days after treatment. **A,** Effects of pitavastatin-NP containing 0.05, 0.15, or 0.5 mg/kg pitavastatin on the angiographic score (n = 3 each). **B,** Representative angiograms are shown of the phosphate buffered saline *(PBS)*, pitavastatin-only, fluorescein isothiocyanate *(FITC)*-NP, and pitavastatin-NP groups at 28 days after treatment. Corkscrew-like collateral arteries were observed only in the pitavastatin-NP group. **C,** Summary of the angiographic scores obtained for the four groups in panel **B** (n = 6 each).

Effects of pitavastatin-NP on tissue oxygen saturation. The tissue oxygen pressure in adductor skeletal muscles of the ischemic limb was measured 28 days after treatment. Treatment with pitavastatin (0.5 mg/kg)-NP significantly increased tissue oxygen pressure compared with the other groups (Appendix Fig II, online only).

Endothelial cell-selective delivery of NP. The cellular distribution of FITC was examined 3, 7, and 28 days after the intramuscular injection of FITC-NP or FITC only. On day 3 after injection, strong FITC signals were detected in FITC-NP–injected ischemic muscle (Fig 5, *A*), whereas no FITC signals were observed in control nonischemic muscle (Fig 5, *A*) or in ischemic muscle injected with FITC only (data not shown). The FITC signals were localized predominantly to the capillaries and arterioles. Weak FITC signals were also detected in myocytes at day 3t. On day 7 and 28, FITC signals remained localized predomi-

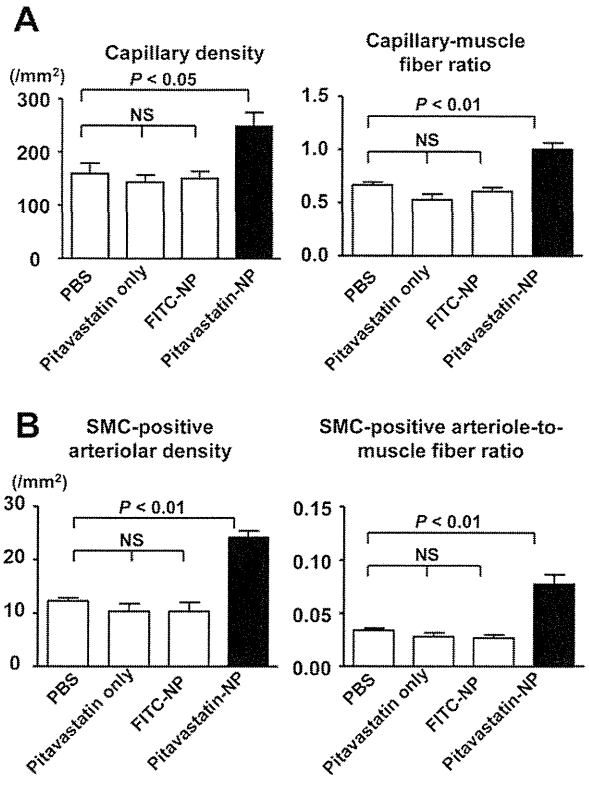

Fig 4. Effects of pitavastatin nanoparticles (*NP*) on angiogenesis and arteriogenesis are shown 28 days after treatment. **A,** CD-31$^+$ capillary density and capillary/muscle fiber ratio (indices of angiogenesis) is shown in ischemic muscles (n = 6 each). **B,** α-Smooth muscle actin (α-SMA)-positive arteriolar density and arteriole/muscle fiber ratio is shown in ischemic muscles (indices of arteriogenesis; n = 8 each). *FITC,* Fluorescein isothiocyanate; *PBS,* phosphate-buffered saline; *SMC,* smooth muscle cells.

nantly to capillaries and arterioles (Fig 5, *A*). Immunofluorescent staining revealed that FITC signals localized mainly to CD31$^+$ endothelial cells in FITC-NP–injected ischemic muscle 28 days after ischemia (Fig 5, *B*). In contrast, no FITC signals were observed in skeletal muscle myocytes on day 7 and 28 or in contralateral nonischemic hind limbs or remote organs (liver, spleen, kidney, and heart) at any time point (data not shown).

Effects of pitavastatin-NP on exercise-induced ischemia induced by electrical stimulation. To assess the functional efficacy of pitavastatin-NP on collateral arterial development, the effects of pitavastatin-NP on exercise-induced ischemia by electrical stimulation were examined. In the control PBS group, venous oxygen saturation in ischemic muscle decreased, and thus the difference in arteriovenous oxygen saturation increased after 15 and 30 minutes of electrical stimulation (Fig 6, *A*), suggesting the occurrence of exercise-induced ischemia. Treatment with pitavastatin-NP, but not with FITC-NP or pitavastatin only, abrogated the increase in arteriovenous oxygen difference in the ischemic limb (Fig 6, *B*). There were no significant differences in systemic blood hemoglobin levels among the four groups (data not shown).

Effects of vatalanib-NP on angiogenesis and arteriogenesis induced by pitavastatin-NP. We recently reported in a murine model that therapeutic neovascularization induced by pitavastatin-NP was mediated by increased eNOS activity and multiple endogenous angiogenic growth factors, such as VEGF.[10,25] Consequently, we examined VEGF expression in the four groups 28 days after treatment by immunohistochemistry and found increased VEGF positivity in CD31$^+$ endothelial cells of the capillaries and arterioles in the pitavastatin-NP group compared with other groups (Appendix Fig III, online only). Interestingly, positive VEGF staining was also detected in myocytes in the pitavastatin-NP group.

Vatalanib was selected because this molecule inhibits receptor tyrosine kinases of VEGR receptor types 1-3. Treatment with vatalanib-NP elicited no effects on angiographically visible collateral arterial development induced by hind limb ischemia in animals treated with PBS; however, it abrogated the arteriogenic response induced by pitavastatin-NP (Fig 7, *A* and *B*). In addition, treatment with vatalanib-NP abrogated histopathologic, angiogenic (capillary density), and arteriogenic (arteriolar density) responses induced by pitavastatin-NP (Fig 7, *C*). Vatalanib-NP elicited significant effects on histopathologic arteriogenic (arteriolar density) responses under baseline conditions (Fig 7, *C*).

Effects of pitavastatin-NP on angiogenesis and arteriogenesis in flt-1 TK$^{-/-}$ mice transfected with and without the *sFlt-1* gene. To examine the role of VEGF receptors (flk-1 and flt-1), the effects of pitavastatin-NP on ischemia-induced neovascularization were examined in wild-type and flt-1 TK$^{-/-}$ mice (Appendix Fig IV, online only). Compared with wild-type mice, the therapeutic effects of pitavastatin-NP decreased but were still observed in flt-1 TK$^{-/-}$ mice. To further examine the role of flk-1, *sFlt-1* gene transfer was performed into flt-1 TK$^{-/-}$ mice. The *sFlt-1* gene transfer blunted the therapeutic effects of pitavastatin-NP.

DISCUSSION

The present study demonstrates that NP-mediated endothelial cell-selective delivery of pitavastatin increased the development of collateral arteries (arteriogenesis) and improved exercise-induced ischemia in a rabbit model of chronic hind limb ischemia, indicating that this novel cell-selective delivery system is feasible for therapeutic arteriogenesis. We selected this rabbit model for translation to clinical settings in humans because it represents a preclinical model of arteriogenesis after femoral artery occlusion,[26] as observed in patients with severe peripheral artery disease.

Stimulation of the growth of collateral arteries (arteriogenesis) is evolving as a new therapeutic option for patients with atherosclerotic occlusive vascular disease, even though induction of additional angiogenesis or vasculogenesis is beneficial.[11,13] We assumed that the vascular endothelium would be an appropriate cellular target for the development

Table. Serum biochemical profiles

Variable[a]	*PBS*	*FITC-NP*	*Pitavastatin only*	*Pitavastatin-NP*
CPK (U/L)				
Day 7	345 ± 30	766 ± 270	445 ± 98	385 ± 44
Day 14	279 ± 8	486 ± 38	459 ± 118	296 ± 18
Day 21	242 ± 16	535 ± 58	396 ± 72	252 ± 12
Day 28	275 ± 60	229 ± 15	275 ± 33	259 ± 31
AST (IU/L)				
Day 7	10 ± 1	19 ± 3	16 ± 2	10 ± 1
Day 14	7 ± 0.3	19 ± 3	19 ± 6	8 ± 3
Day 21	15 ± 1	20 ± 2	22 ± 7	19 ± 4
Day 28	31 ± 11	29 ± 6	18 ± 2	20 ± 2
ALT (IU/L)				
Day 7	36 ± 9	36 ± 10	38 ± 5	29 ± 11
Day 14	26 ± 1	34 ± 6	37 ± 7	33 ± 9
Day 21	38 ± 7	33 ± 5	37 ± 8	43 ± 11
Day 28	42 ± 8	41 ± 10	35 ± 11	53 ± 19
BUN (mg/dl)				
Day 7	24 ± 0.2	17.3 ± 0.2	18 ± 1.5	24 ± 2
Day 14	23 ± 1	19.6 ± 2	24 ± 2	25 ± 1
Day 21	19 ± 1	18 ± 4	20 ± 2	19 ± 0.4
Day 28	26 ± 1	17 ± 0.3	17 ± 0.4	29 ± 2
Creatinine (mg/dL)				
Day 7	0.66 ± 0.01	0.82 ± 0.07	0.89 ± 0.01	0.80 ± 0.11
Day 14	0.70 ± 0.04	0.81 ± 0.09	0.87 ± 0.08	0.73 ± 0.05
Day 21	0.95 ± 0.02	0.80 ± 0.06	0.95 ± 0.01	1.03 ± 0.02
Day 28	0.85 ± 0.08	0.91 ± 0.06	0.86 ± 0.03	0.92 ± 0.03
Total cholesterol (mg/dL)				
Day 7	31 ± 10	31 ± 1	19 ± 5	46 ± 5
Day 14	26 ± 8	24 ± 3	19 ± 1	31 ± 4
Day 21	29 ± 10	18 ± 1	18 ± 3	32 ± 6
Day 28	18 ± 3	18 ± 2	21 ± 1	17 ± 2

ALT, Alanine aminotransferase; *AST,* aspartate transaminase; *BUN,* blood urea nitrogen; *CPK,* creatinine phosphokinase.
[a]Data are mean ± standard error of the mean (n = 3 each).

of collateral arteries after arterial occlusion because the endothelium plays a central role in the mechanism of arteriogenesis by expressing multiple growth factors and by recruiting monocytes and smooth muscle cells. We found that FITC signals were localized mainly to the vascular endothelium for up to 4 weeks after the injection of FITC-NP into ischemic skeletal muscles of rabbits in vivo, indicating that this NP-mediated delivery system may be useful as an innovative strategy for a therapy targeting endothelial cells. We recently reported that after cellular delivery of NP by endocytosis into endothelial cells, the PLGA NP escapes from the endosomal compartment to the cytoplasmic compartment and is retained in the cytoplasm, where release of the encapsulated drug occurs slowly in conjunction with the hydrolysis of PLGA.[10,27-29]

Daily administration of statins at high doses has been reported to augment arteriogenesis in normocholesterolemic rabbits.[6] These pleiotropic effects of statins are mediated through reduced levels of cholesterol biosynthesis pathway intermediates that serve as lipid attachments for post-translational modification (isoprenylation) of proteins, including Rho and Rac. Pitavastatin was selected as the NP compound because (1) pitavastatin elicited the most potent effects on the angiogenic activity of HECs in vitro compared with other statins, and (2) NP-mediated intracellular delivery of pitavastatin showed greater angiogenic activity of HECs compared with pitavastatin alone (Figs 1 and 2).

We also found in an in vivo rabbit model that (1) a single intramuscular injection of pitavastatin-NP increased the angiographic score in a dose-dependent manner, (2) pitavastatin (0.5 mg/kg) -NP significantly increased arteriogenesis and tissue oxygen pressure (tissue perfusion), and (3) the treatment of pitavastatin-NP increased immunoreactive VEGF expression selectively in vascular endothelial cells in the ischemic limb. Therefore, it is likely that that after NP-mediated endothelial delivery, pitavastatin is slowly released from the NP into the cytoplasm, resulting in significant therapeutic effects. Sata et al[8] reported that systemic daily administration of pitavastatin (1 mg/kg/day × 49 days = 49 mg/kg) has significant therapeutic effects in mice with hind limb ischemia. In our previous study, we reported the efficacy of pitavastatin (0.4 mg/kg)-NP in a murine model.[10] Therefore, at an approximately 100-fold lower dose, our NP-mediated delivery system is as effective as the cumulative systemic dose.

In clinical trials that examined the effects of a single vascular growth factor on peripheral and coronary artery disease, clinical end points such as increased exercise tolerance were negative or disappointing, although increased vascularity was noted.[14,15] It has been reported that limb hemodynamics, such as ankle-brachial index or muscle

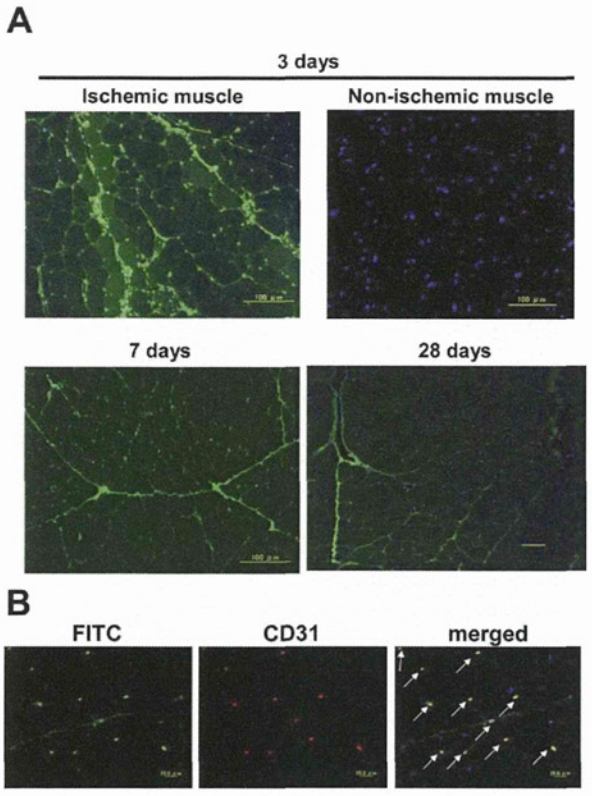

Fig 5. Cellular distribution of nanoparticles is shown in ischemic muscles. **A,** Fluorescent photomicrographs show cross sections of control nonischemic muscle and ischemic muscles at 3, 7, and 28 days after fluorescein isothiocyanate *(FITC)* nanoparticle *(NP)* injection. Nuclei were counterstained with 4′,6-diamidino-2-phenylindole *(blue)*. Fluorescence microscopic settings (exposure, filter, excitation light intensity, etc.) were the same for all images. Scale bar = 100 μm. **B,** Photomicrographs of cross sections of ischemic muscle 28 days after FITC-NP injection stained immunohistochemically with the endothelial marker CD31 *(red)*. Most FITC signals colocalized with the vascular endothelium *(arrows)*. Scale bars = 20 μm.

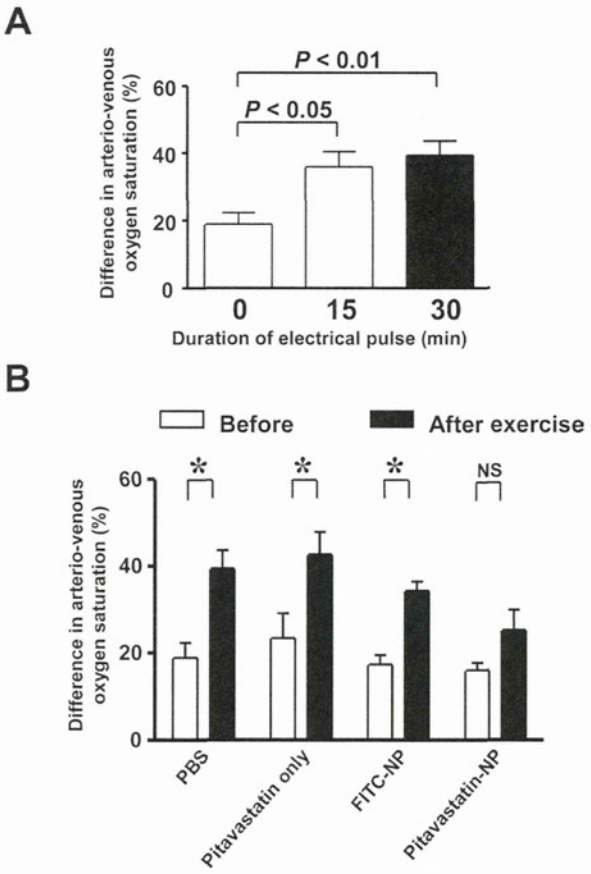

Fig 6. Effects are shown of pitavastatin nanoparticles *(NP)* on exercise-induced ischemia induced by electrical stimulation. **A,** Oxygen saturation in the femoral artery and vein in ischemic muscle is shown before and 15 and 30 minutes after muscular exercise by electrical stimulation in the phosphate-buffered saline (*PBS*) group (n = 6 each). **B,** The difference in arterial and venous oxygen saturation after 30 minutes of electrical pulse is shown in the four groups (n = 6 each). *FITC,* Fluorescein isothiocyanate.

blood flow at rest, are not correlated with functional capacity (claudication time or walking distance) in patients with peripheral arterial disease.[30] Therefore, assessment of the functional capacity of neovessels is needed in preclinical studies in animals. In other words, the improved functional capacity of collateral arteries must be a clinically important therapeutic goal in preclinical studies; however, few previous preclinical studies have addressed this point.

In the present study, we demonstrate that the arteriovenous oxygen difference in the ischemic hind limb increased in response to exercise in the PBS group, suggesting the development of exercised-induced ischemia. Treatment with pitavastatin-NP, but not with FITC-NP or pitavastatin only, prevented the development of exercise-induced ischemia. These data suggest that therapeutic arteriogenesis induced by pitavastatin-NP is associated with improved functional capacity.

We previously reported that the beneficial therapeutic effects induced by pitavastatin-NP are mediated by increased eNOS activity and multiple endogenous angiogenic growth factors in a murine model.[10] Recent reports by others have shown that mice lacking VEGF receptor 1 or placenta growth factor (a specific agonist of VEGR receptor 1), but not those lacking VEGF receptor 2, display impaired development of ischemia-induced angiogenesis and arteriogenesis.[31-33] However, roles of endogenous angiogenic growth factors in the mechanism of therapeutic effects of pitavastatin-NP have not been addressed.

In the present study, vatalanib-NP abrogated arteriogenic and angiogenic responses to pitavastatin-NP in rabbits. Furthermore, experiments with flt-1 $TK^{-/-}$ mice transfected with or without the *sFlt-1* gene showed partial contribution of both flt-1 and flk-1 to therapeutic angiogenic effects of pitavastatin-NP. These findings suggest that pitavastatin-NP produces an integrative system to form

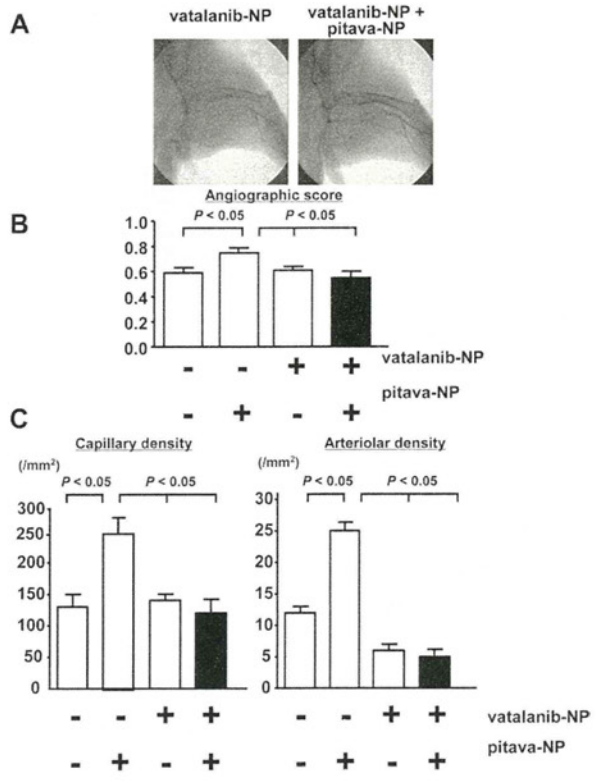

Fig 7. Effects of vatalanib nanoparticles *(NP)* are shown on angiogenesis and arteriogenesis induced by pitavastatin-NP. **A,** Representative angiograms show vatalanib-NP only and vatalanib-NP plus pitavastatin-NP groups 28 days after treatment. **B,** Summary of the angiographic scores obtained for the four groups (n = 3 each). **C,** Effects of vatalanib-NP are shown on histopathologic angiographic (capillary density) and arteriogenic (SMC-positive arteriolar density) responses induced by pitavastatin-NP.

functionally mature collaterals by controlled expression of endogenous VEGF and its receptor signals.

There are several limitations to the present study. First, only a single intramuscular injection of pitavastatin-NP was examined. In clinical settings, repetitive administration of an optimal dose may produce greater therapeutic effects. Second, we did not examine the contribution of bone marrow-derived progenitor cells because appropriate antibodies for detecting endothelial or smooth muscle progenitor cells are not available in rabbits. Further studies are needed to examine whether therapeutic effects afforded by pitavastatin-NP are associated with an increase in circulating endothelial progenitor cells.

CONCLUSIONS

This nanotechnology platform for vascular endothelial cell-selective delivery of pitavastatin is a promising strategy for the treatment of patients with severe organ ischemia and represents a significant advance in therapeutic arteriogenesis over current approaches. The nanotechnology platform may be further developed as a more effective and safer approach for therapeutic neovascularization.

AUTHOR CONTRIBUTIONS

Conception and design: SO, KE
Analysis and interpretation: SO, RN, KN, KE
Data collection: SO, RN, KN, KE
Writing the article: SO, KN, TM, KE
Critical revision of the article: SO, RN, KN, KE
Final approval of the article: SO, RN, KN, TM, MK, KS, RT, KE
Statistical analysis: SO, KN, KE
Obtained funding: KE
Overall responsibility: SO, KE

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REVIEW

Oxidative Stress and Central Cardiovascular Regulation

– Pathogenesis of Hypertension and Therapeutic Aspects –

Yoshitaka Hirooka, MD; Yoji Sagara, MD; Takuya Kishi, MD; Kenji Sunagawa, MD

Oxidative stress is a key factor in the pathogenesis of hypertension and target organ damage, beginning in the earliest stages. Extensive evidence indicates that the pivotal role of oxidative stress in the pathogenesis of hypertension is due to its effects on the vasculature in relation to the development of atherosclerotic processes. It remains unclear, however, whether oxidative stress in the brain, particularly the autonomic nuclei (including the vasomotor center), has an important role in the occurrence and maintenance of hypertension via activation of the sympathetic nervous system. The aim of the present review is to describe the contribution of oxidative stress in the brain to the neural mechanisms that underlie hypertension, and discuss evidence that brain oxidative stress is a potential therapeutic target. (*Circ J* 2010; **74:** 827–835)

Key Words: Blood pressure; Brain; Heart rate; Hypertension; Sympathetic nervous system

Accumulating evidence indicates that the sympathetic nervous system plays an important role in the pathogenesis of hypertension.[1–3] Activation of the sympathetic nervous system is involved in the stages, clinical forms, 24-h blood pressure patterns, end-organ damage, and metabolic abnormalities of hypertension.[1–3] Although peripheral factors are also involved, the central nervous system (CNS) mechanisms are considered crucial.[3–7] The results of recent studies strongly suggest that central sympathetic outflow is increased in hypertension.[3–7] Increased oxidative stress is also involved in the pathogenesis of hypertension.[8] Although there have been many studies regarding target organ damage in hypertension, relatively few studies have addressed the role of oxidative stress in sympathetic nervous system activation.[9–11] Based on the role of angiotensin II (Ang II) in the generation of reactive oxygen species (ROS), the relationship between brain angiotensin and central sympathetic outflow has been examined.[12,13] Our group was the first to report that increased ROS generation in the brainstem contributes to the neural mechanisms of hypertension in hypertensive rats,[14] and we and other investigators have reported additional evidence to support this concept and the potential therapeutic aspects.[9–11] This review focuses on the role of oxidative stress within the brain in the neural pathogenesis of hypertension.

Increased Oxidative Stress in the Brain in Hypertension

Among the target organs of hypertensive vascular diseases, the brain is most affected by aging and oxidative stress.[15,16] Cell membranes in the brain contain a high concentration of polyunsaturated fatty acids. These fatty acids are targeted by ROS, which elicit chain reactions of lipid peroxidation. Oxidative stress is determined by measuring levels of thiobarbituric acid-reactive substances (TBARS), end products of lipid peroxidation. The levels of TBARS reflect those of malondialedehyde, although the assay is not specific for malondialedehyde.[15,17] There are some important points, however, for assessing the levels of TBARS.[17] The medium used for tissue preparation needs to contain a chelating agent and an antioxidant, and conditions for the assay must be kept constant. Therefore, we used another method for assessing the ROS production, which is electron spin resonance (ESR) spectroscopy. The amount of ROS was quantified by monitoring the time-dependent decay of the amplitude of the ESR spectra produced by the nitroxide radical 4-hydroxy-2,2,6,6-tetramethyl-piperidine-*N*-oxyl (hydroxyl-TEMPO) as a spin probe.[9,14] The signal decay of ESR spectroscopy reflects oxidative stress more directly. Also, it has an advantage for in vivo study.[18] We evaluated oxidative stress in the brains of stroke-prone spontaneously hypertensive rats (SHRSP) compared with normotensive Wistar–Kyoto (WKY) rats.[9,14] The rostral ventrolateral medulla (RVLM) is the major vasomotor center that determines basal sympathetic nervous system activity and it is essential for the maintenance of basal vasomotor tone.[3–7] Spontaneously hypertensive rats (SHR) or SHRSP exhibit increased sympathetic nervous system activity during the development of hypertension and are commonly used in experimental studies as models of human essential hypertension.[3–7] We previously investigated whether ROS are increased in the RVLM of SHRSP.[14] First, we found that ROS levels measured by TBARS and ESR spectroscopy were increased in the RVLM of SHRSP compared with WKY

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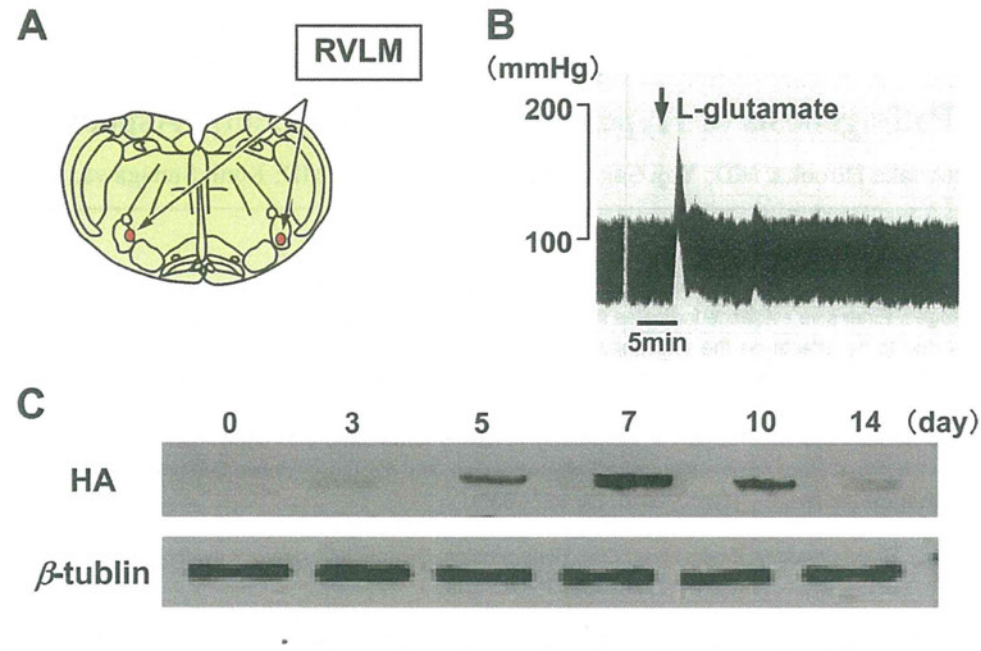

Figure 1. In vivo gene transfer of dominant-negative Rac1 into the rostral ventrolateral medulla (RVLM). (**A**) Schematic diagram showing the transfection sites. Gene transfer of adenovirus encoding dominant negative Rac1 (AdDNRac1) bilaterally into the RVLM (1.4×10^9 pfu/ml; 500nl/site). (**B**) Transfection sites were confirmed by prior microinjection of L-glutamate. (**C**) Time course of AdDNRac1 expression levels in the RVLM on western blot. HA, hemagglutinin.

rats. In addition, superoxide dismutase (SOD) expression and activity, which are ROS scavenging factors, were decreased in the RVLM of SHRSP compared with WKY rats. Functionally, microinjection of the membrane-permeable radical scavenger tempol into the RVLM decreased blood pressure, heart rate, and sympathetic nervous system activity in SHRSP but not in WKY rats. More importantly, overexpression of Mn-SOD, an antioxidant enzyme, in the RVLM of SHRSP decreased blood pressure and sympathetic nervous system activity. These findings strongly indicate that oxidative stress in the RVLM is increased in SHRSP and contributes to the neural mechanisms of hypertension. As described here, brain ROS is one of the results of generalized target organ damage, appearing earlier in the brain due to its susceptibility. The brain ROS would increase blood pressure via activation of the sympathetic nervous system and this would ultimately result in a vicious cycle. It would be possible, however, that brain ROS is involved in the early stage of hypertension in SHR or SHRSP, because we found that oxidative stress in the brain assessed on in vivo ESR was enhanced in young (6-week-old) SHR or SHRSP compared with age-matched WKY rats (unpublished data). The levels of TBARS were not different, probably because the levels of TBARS reflect lipid peroxidation caused by ROS. Other investigators also found that an increase in superoxide anions in the RVLM is associated with hypertension in SHR,[19] and reduced expression and activity in Cu/Zn-SOD and Mn-SOD within the RVLM contribute to oxidative stress and neurogenic hypertension in SHR.[20] An increase in oxidative stress within the RVLM also plays an important role in maintaining high arterial blood pressure and sympathetic activation in 2-kidney 1-clip (2K-1C) hypertensive rats, which is a renovascular hypertension model.[21] In that study, Oliveira-Sales et al demonstrated that the mRNA expression of NAD(P)H oxidase subunits ($p47^{phox}$ and $gp91^{phox}$) in the RVLM was greater in 2K-1C than in the control group. Interestingly, there were no differences in Cu/Zn-SOD expression between the two groups. TBARS levels in the RVLM were significantly greater in the 2K-1C than in the control group, suggesting enhanced oxidative stress. Functionally, microinjection of vitamin C into the RVLM decreased blood pressure and renal sympathetic nerve activity in 2K-1C but not in controls. Importantly, in a subsequent study, these authors suggested that the paraventricular nucleus of the hypothalamus is also involved.[22] Notably, although 2K-1C is a model of renovascular hypertension, suggesting that circulating Ang II is increased, angiotensin type I (AT1) receptor gene expression levels within the RVLM and paraventricular nucleus were upregulated in this model, indicating that ROS was produced via the activation of nicotinamide-adenine dinucleotide phosphate [NAD(P)H] oxidase.

Sources of ROS Production in the Brain

As a source of ROS production in the CNS, NAD(P)H oxidase is a major player. NAD(P)H oxidase is composed of two membrane-bound subunits, $gp91^{phox}$ and $p22^{phox}$; several cytoplasmic subunits, $p47^{phox}$, $p40^{phox}$, and $p67^{phox}$; and the small G-protein Rac1.[23–26] Stimulation of AT1 receptors activates NAD(P)H oxidase by which the cytoplasmic subunits of Rac1NAD(P)H oxidase such as Rac1 bind to the membrane subunits, thereby activating the enzyme leading to superoxide generation. Rac1 requires lipid modification to migrate from the cytosol to the plasma membrane, which is a necessary step for activating ROS-generating NAD(P)H oxidase. NAD(P)H oxidase activity is greater in the brainstem of SHRSP than in that of WKY.[27,28] We transfected adenovirus

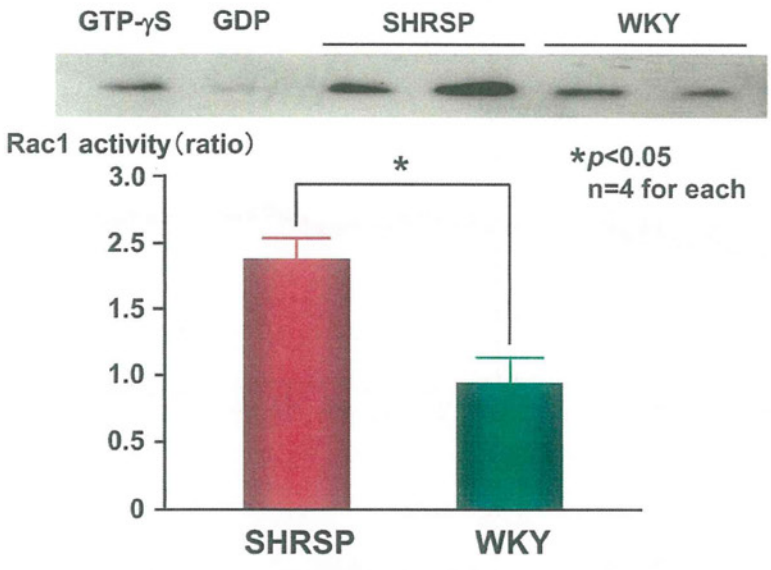

Figure 2. Rac1 activity is elevated in the rostral ventrolateral medulla of stroke-prone spontaneously hypertensive rats (SHRSP) compared to Wistar–Kyoto (WKY) rats. GDP, guanosine 5'-diphosphate; GTP-γS, guanosine 5'-*O*-(3-thiotriphospahte).

encoding dominant-negative Rac1 into the RVLM of SHRSP and WKY rats (Figure 1).[27] Rac1 activity in the RVLM tissue was increased in SHRSP compared to WKY rats (Figure 2).[27] Importantly, we demonstrated that inhibition of Rac1-derived ROS in the RVLM decreased blood pressure, heart rate, and urinary norepinephrine excretion in SHRSP (Figure 3).[27] A similar response occurs after inhibition of Rac1-derived ROS in the nucleus tractus solitarius (NTS).[28]

In addition to the cytosolic production of ROS, mitochondria are the primary source of ROS production in many cells. Ang II increases mitochondrial ROS production in the RVLM, leading to sympathoexcitation.[29] Furthermore, NAD(P)H oxidase-derived ROS might trigger Ca^{2+} accumulation, which leads to mitochondrial ROS production.[29] This suggestion is based on the finding that gene transfer of dominant negative Rac1 attenuated the Ang II-induced increase in reduced Mito-Tracker red fluorescence.[29] In contrast, impairment of mitochondrial electron transport chain complexes in the RVLM might be involved in the neural abnormality underlying hypertension in SHR.[30] This issue was recently discussed by Zimmerman and Zucker.[31] Although we did not detect impairment of brain mitochondrial respiratory complexes in SHRSP, we propose that mitochondria-derived ROS mediate sympathoexcitation via NAD(P)H oxidase activation.[29]

Another possibility for ROS generation is uncoupling nitric oxide synthase (NOS). In the absence of L-arginine or with tetrahydrobiopterin, NO production from inducible NOS (iNOS) causes uncoupling from the oxidation of NADPH, resulting in superoxide generation.[9] iNOS overexpression in the RVLM causes hypertension and sympathoexcitation that is mediated by an increase in oxidative stress.[32] This might be relevant to our observation that iNOS expression levels in the RVLM are greater in SHRSP than in WKY rats.[33] In addition, microinjection of iNOS antagonists into the RVLM reduces blood pressure only in SHR, but not in WKY rats.[33]

ROS-Mediated Activation of Transcriptional Factors

It has been suggested that an Ang II-mediated influx of Ca^{2+} in neurons depends on increased superoxide generation by a Rac1-dependent NAD(P)H oxidase.[34] Ang II also regulates neuronal activity via inhibition of the delayed rectifier potassium current.[35] Ang II-mediated upregulation of L-type Ca^{2+} currents in neurons isolated from the NTS is inhibited by scavenging ROS, indicating a role for NAD(P)H oxidase-derived superoxide in the activation of Ca^{2+} channels in the NTS.[24]

NAD(P)H oxidase-derived superoxide mediates an Ang II-induced pressor effect via the activation of p38 mitogen-activated protein kinase (MAPK) in the RVLM.[36] Recently, we suggested that AT1 receptor-activated caspase-3 acting through the Ras/p38 MAPK/extracellular signal-related protein kinase pathway in the RVLM is involved in sympathoexcitation in SHRSP.[37] These pathways may be downstream effectors of ROS in the RVLM, which in turn plays a crucial role in the pathogenesis of hypertension. Interestingly, the pro-apoptotic proteins Bax and Bad were enhanced and the anti-apoptotic protein Bcl-2 was decreased in the RVLM of SHRSP, and inhibition of caspase-3 normalized these changes in pro- and anti-apoptotic protein levels.[37] These alterations in the RVLM of SHRSP were stimulated by Ang II via activation of the AT1 receptors, which are upregulated in this strain and other hypertensive models.[38] It would be reasonable to consider that different mechanisms may be responsible for sympathoexcitation in different brain sites (influx of Ca^{2+} for RVLM, apoptosis for NTS), and activation of the apoptotic pathway is involved in sympathoexcitation in the RVLM.[37] The exact physiologic implication of these observations requires further evaluation.

Effects of Angiotensin Receptor Blockers on Brain Oxidative Stress

The existence of an independent renin–angiotensin system in the brain is well established. Activation of the brain renin–angiotensin system substantially contributes to the development and maintenance of hypertension through activation of the sympathetic nervous system, vasopressin release, and drinking behavior.[39,40] There is considerable evidence that

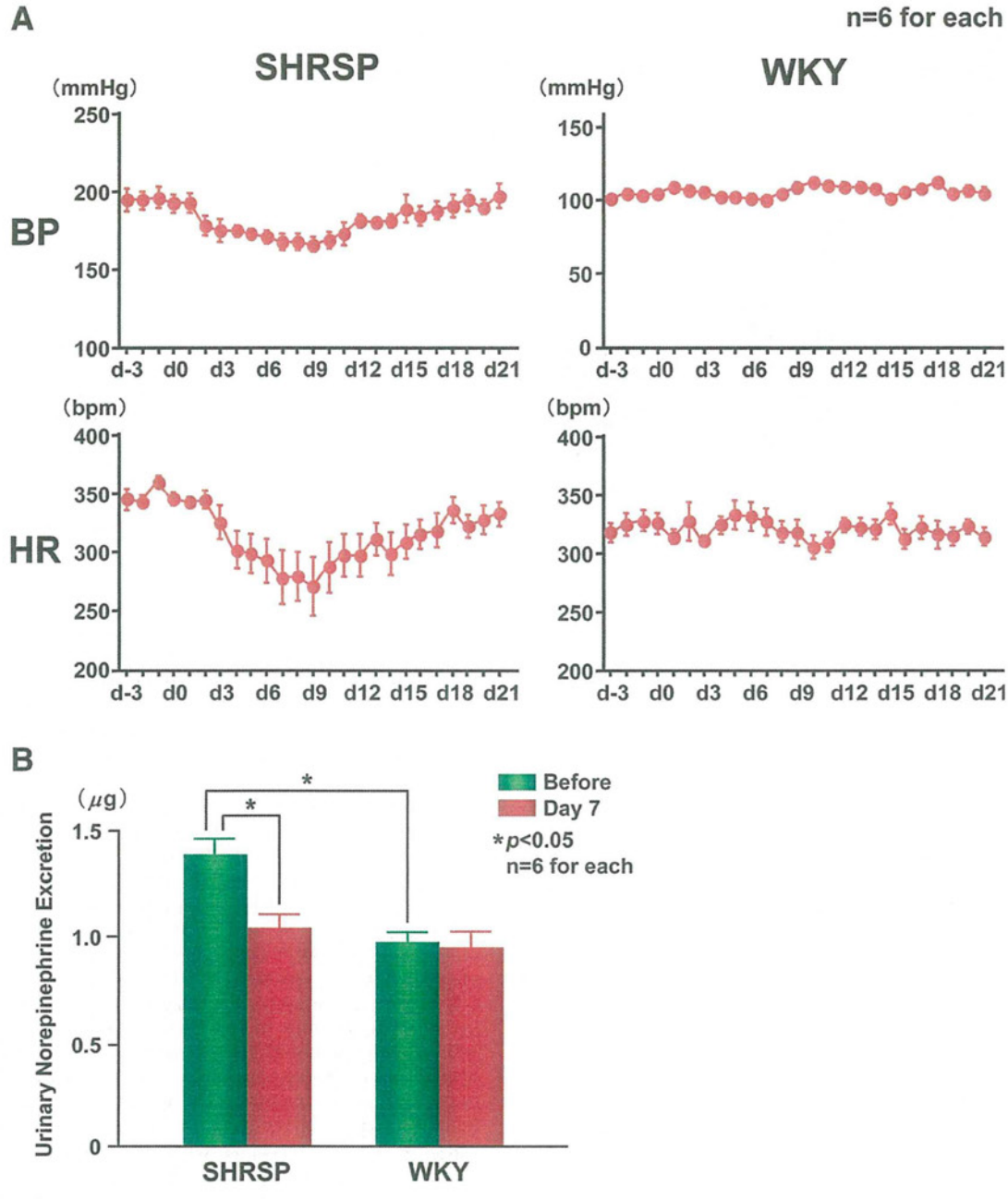

Figure 3. Inhibition of Rac1-dependent superoxide production in the rostral ventrolateral medulla (RVLM) decreases blood pressure, heart rate, and urinary norepinephrine excretion in stroke-prone spontaneously hypertensive rats (SHRSP). (**A**) Time course of mean blood pressure (BP) and heart rate (HR) before and after gene transfer of dominant negative Rac1 (DNRac1). (**B**) Twenty-four-hour urinary norepinephrine excretion before and after gene transfer of DNRac1 into the RVLM. d, day; WKY, Wistar–Kyoto rats.

peripherally administered angiotensin receptor blockers (ARBs) penetrate the blood–brain barrier, although there are some differences among ARBs.[41,42] AT1 receptors are abundant in the circumventricular organs, such as the subfornical organ and the organum vasculosum lamina terminalis, and the area postrema, which lack a blood–brain barrier.[39–42] Therefore, peripherally administered ARBs can also bind to those areas, thereby inhibiting the central actions of Ang II. Oral treatment with the ARB telmisartan appears to inhibit the central responses to Ang II in awake rats.[43] Although other ARBs also inhibit the central actions of Ang II within the brain beyond the blood–brain barrier,[41,42,44] these effects might differ depending on the pharmacokinetics and properties of each drug (ie, lipophilicity etc).[43] We evaluated the

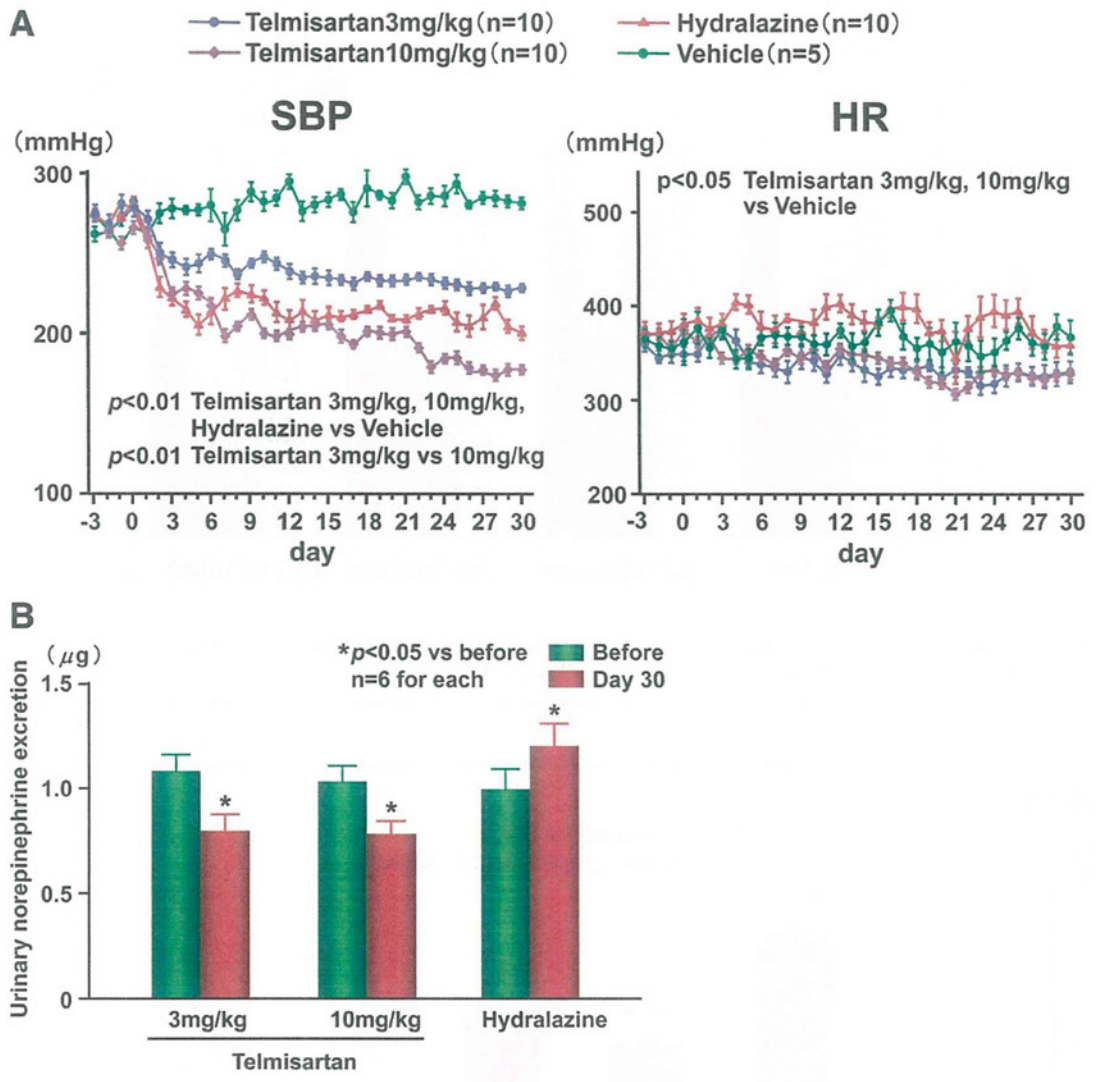

Figure 4. (**A**) Time course of changes in systolic blood pressure (SBP) and heart rate (HR) in SHRSP treated with telmisartan. (**B**) Telmisartan decreases 24-h urinary norepinephrine excretion at day 30, and hydralazine increases 24-h urinary norepinephrine excretion.

effect of treatment with telmisartan at either a high dose ($10 mg \cdot kg^{-1} \cdot day^{-1}$) or a low dose ($3 mg \cdot kg^{-1} \cdot day^{-1}$), or hydralazine for 30 days on hypertension.[45] Systolic blood pressure (SBP) and heart rate were measured using the tail-cuff method. Urinary norepinephrine excretion was measured as a marker of the sympathetic nervous system activity. We evaluated ROS in the brain (cortex, cerebellum, hypothalamus, and brainstem) of SHRSP on ESR spectroscopy and TBARS. Oral treatment with telmisartan reduced SBP dose-dependently and hydralazine reduced SBP to a similar level to the high dose of telmisartan (**Figure 4**). Telmisartan reduced, while hydralazine increased, urinary norepinephrine excretion (**Figure 4**). TBARS levels were significantly increased in each area of the brain of SHRSP compared with WKY rats (**Figure 5**). Oral treatment with telmisartan reduced the TBARS levels, but hydralazine did not (**Figure 5**). These findings suggest that (1) anti-hypertensive treatment with telmisartan reduces ROS in the brain of SHRSP; (2) telmisartan decreases blood pressure, at least in part, via a reduction of the sympathetic nervous system activity in SHRSP; and (3) these effects induced by telmisartan might be associated with protection of the brain of SHRSP from oxidative stress. We also measured the concentration of hydroxyl radicals using a modified procedure based on the hydroxylation of sodium salicylate by hydroxyl radicals,[46] leading to the production of 2,3-dihydroxybenzoic acid (2,3-DHBA).[29,47] Inhibition of Rac1 in the RVLM and oral treatment with telmisartan significantly decreased the production of hydroxyl radicals in the RVLM (**Figure 6**).[47]

Recently, we used in vivo ESR to assess oxidative stress in the brain, and found that oral treatment with another ARB, olmesartan, reduces oxidative stress in the brain of SHRSP without inducing reflex activation of the sympathetic nervous system.[48] In that study we evaluated the in vivo ESR signal

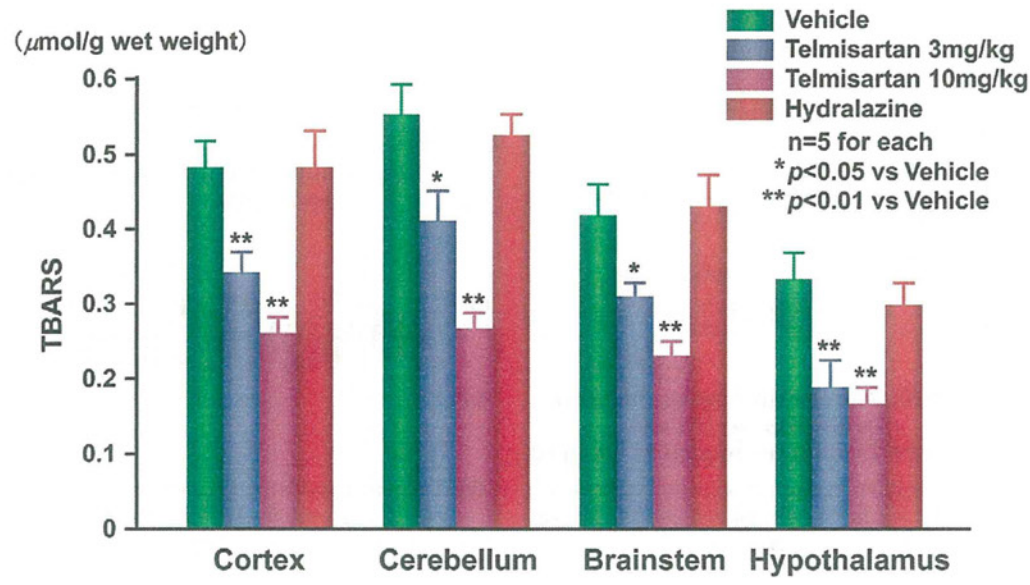

Figure 5. Antioxidant effects of telmisartan in different brain areas. Thiobarbituric acid-reactive substances (TBARS) levels after treatment with telmisartan (3 or 10mg/kg), hydralazine, or vehicle in SHRSP.

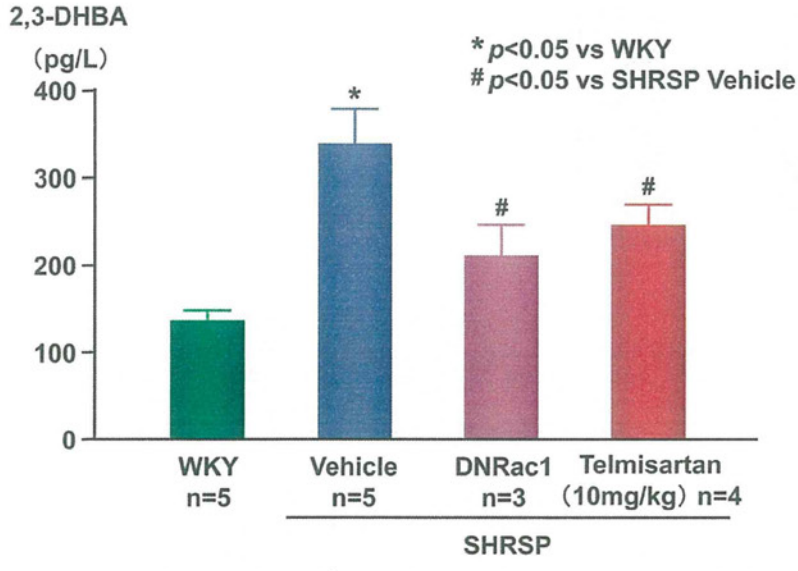

Figure 6. Reactive oxygen species production in the rostral ventrolateral medulla assessed by measuring 2,3-dihydroxybenzoic acid (2,3-DHBA) is decreased after gene transfer of dominant negative Rac1 (DNRac1) or treatment with telmisartan in stroke-prone spontaneously hypersensitive rats (SHRSP). WKY, Wistar–Kyoto rats.

decay rates of the brain using methoxycarbonyl-PROXYL, a nitroxyl radical species, as a blood–brain barrier-permeable spin probe.[49] Oral treatment with olmesartan attenuated the exaggerated pressor response to an excitatory amino acid, L-glutamate, in the RVLM of SHR compared to WKY rats.[50] Further, the pressor response to microinjection of Ang II into the RVLM was diminished in SHR treated with olmesartan.[50] Thus, the importance of oxidative stress in the brain and hypertension is supported by our studies as well as those of others.[11]

Several questions, however, remain to be answered. A recent study suggested that systemic administration of candesartan reduces brain Ang II levels because it attenuates the mRNA expression of both angiotensinogen and angiotensin-converting enzyme in Ang II-infused rats.[51] Whether systemic treatment with ARBs indirectly regulates brain Ang II remains to be determined.[52]

Effects of Other Cardiovascular Drugs on Brain Oxidative Stress

Considering that ARBs act to inhibit NAD(P)H oxidase activ-

ity, it is reasonable that ARBs have an antioxidant effect, although there are some unresolved questions, as mentioned previously. Calcium channel blockers, azelnidipine and amlodipine, but not nicardipine, which also have antioxidant properties, have a sympatho-inhibitory effect on the brain.[53,54] In particular, treatment with azelnidipine reduces oxidative stress in the RVLM associated with a decrease in the activity of NAD(P)H oxidase, Cu/Zn-SOD, and Mn-SOD.[53] These effects might be related to an improvement in NO production,[55] because we also demonstrated that overexpression of endothelial NOS in the NTS or RVLM decreases blood pressure and heart rate via the inhibition of sympathetic nervous system activity.[56–59] Surprisingly, we also found that atorvastatin inhibits the sympathetic nervous system as a result of upregulating NO activity and reducing oxidative stress.[60–63] Further studies are needed to determine if this mechanism is also applicable in humans.

Salt-Sensitive Hypertension and Brain Oxidative Stress

Activation of the sympathetic nervous system, in particular, an increase in central sympathetic outflow, plays an important role in the pathogenesis of salt-sensitive hypertension as well as that of kidney diseases.[64,65] Recent studies suggest that oxidative stress in the brain contributes to blood pressure elevation in salt-sensitive hypertension.[66,67] We demonstrated that high salt intake exacerbates blood pressure elevation and sympathetic nervous system activity during the development of hypertension in SHR, and these responses are mediated by increased ROS generation, probably because of an upregulation of AT1 receptors and NAD(P)H oxidase in the RVLM.[66] The findings of a recent study from Kyushu University Graduate School of Medical Sciences indicate that mice with pressure overload acquired brain salt-sensitivity.[68] This means that high salt intake increases the transport from the blood to the cerebrospinal fluid and the response of the sympathetic nerve activity to salt administered into the brain. These results suggest that pressure overload affects salt sensitivity, thereby enhancing central sympathetic outflow and cardiac function.[68] Left ventricular hypertrophy is an independent risk of cardiovascular event and high salt intake is an important environmental factor of hypertension, both of which increased ROS, and sympathoexcitation may be involved in the pathogenesis of the development of hypertension. A recent clinical trial suggested that left ventricular hypertrophy is related to cardiovascular events in Japanese high-risk hypertensive patients.[69]

Summary and Future Perspectives

Currently in Japan, many patients with hypertension also have metabolic syndrome. Importantly, the prevalence of metabolic syndrome increases linearly with an increase in heart rate among Japanese men and women,[70] suggesting that activation of the sympathetic nervous system is involved in the pathogenesis of hypertension.[71] The prevalence of obstructive sleep apnea has increased as a result of the increase in the number of obese patients with hypertension. Obese patients with sleep apnea have enhanced central sympathetic outflow, which worsens hypertension and leads to cardiovascular events.[72] Further, there is considerable evidence that psychological stress is a major risk factor for cardiovascular diseases and events associated with hypertension.[73] Another therapeutic target for the treatment of hypertension is heart failure with a preserved ejection fraction.[74] As suggested here, salt-sensitivity might also be enhanced in these patients, thereby further enhancing central sympathetic outflow.[68] Oxidative stress in the brain as well as other organs might underlie these mechanisms. Future studies of the effects of oxidative stress in the brain are warranted and will provide useful information for the treatment of hypertension.

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Cross-Sectional Characterization of all Classes of Antihypertensives in Terms of Central Blood Pressure in Japanese Hypertensive Patients

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BACKGROUND

Central blood pressure (CBP) has been reported to be superior to brachial blood pressure (BP) as a cardiovascular risk predictor in hypertensive patients; however, the effects of antihypertensives on CBP have not been fully examined. This cross-sectional hypothesis-generating study aimed to tentatively characterize all classes of antihypertensives in relation to CBP.

METHODS

Calibrated tonometric radial artery pressure waveforms were recorded using an automated device in 1,727 treated hypertensive patients and 848 nonhypertensive (non-HT) participants. Radial artery late systolic BP (SBP) has been reported to reflect central SBP. The difference between late and peak SBPs (ΔSBP2) was assessed with linear regression model-based adjustments. Separate regression models for ΔSBP2 were constructed for both participant groups as well as specified sub-populations.

RESULTS

ΔSBP2 was 3.3 mm Hg lower in patients treated with any single-vasodilating (VD) antihypertensive agent without significant interclass difference than with non-VD agents, and was 2.0 mm Hg lower than estimated in nonhypertensive subjects. Combinations of two vasodilators were 6.6 and 2.9 mm Hg lower in ΔSBP2 than nonvasodilator combinations and nonhypertensive subjects, respectively ($P < 0.001$ for all comparisons). Nonvasodilators and their combination showed high ΔSBP2, 1.1 and 3.7 mm Hg higher than in nonhypertensive subjects ($P < 0.001$ for both). Additional adjustment of the pulse rate reduced high ΔSBP2 with β-blockers (βBLs).

CONCLUSIONS

This cross-sectional observation suggests that vasodilatory antihypertensives lower CBP independently of peripheral BP levels without evident class-specific differences, whereas nonvasodilators may raise CBP.

Keywords: angiotensin receptor blockers; angiotensin-converting enzyme inhibitors; antihypertensive agents; blood pressure; calcium channel blockers; central blood pressure; diuretics; hypertension; late systolic blood pressure; nonvasodilating antihypertensive agents; pulse waveform; radial artery tonometry; vasodilating antihypertensive agents; α-blockers; β-blockers

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From the physical viewpoint, central blood pressure (CBP) more directly imposes mechanical stress on the left ventricle, large arteries and the vital organ vasculature than brachial blood pressure (BP). This impact of CBP was suggested by large-scale intervention trials and population-based studies, such as the Conduit Artery Function Evaluation (CAFE) study of the Anglo-Scandinavian Cardiac Outcomes Trial (ASCOT)[1] and Strong Heart Study (SHS).[2] In the CAFE study, only calcium channel blocker (CCB) and β-blocker (βBL)-based treatments were compared in estimated CBP. Prior to the study, several small-scale investigations assessing therapeutic alterations in CBP or aortic wave reflection had been reported.[3–11] Various theoretical explanations of the benefit of vasodilators to lower CBP have also been published;[12–14] however, only limited classes of antihypertensive drugs, such as angiotensin-converting enzyme inhibitors (ACEI) and βBL, including nitrates, have been investigated comparatively or noncomparatively. Hence, the effects of various antihypertensives on CBP are not fully understood. Randomized intervention trials are necessary to assess the effects of each antihypertensive

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