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Graphical abstract

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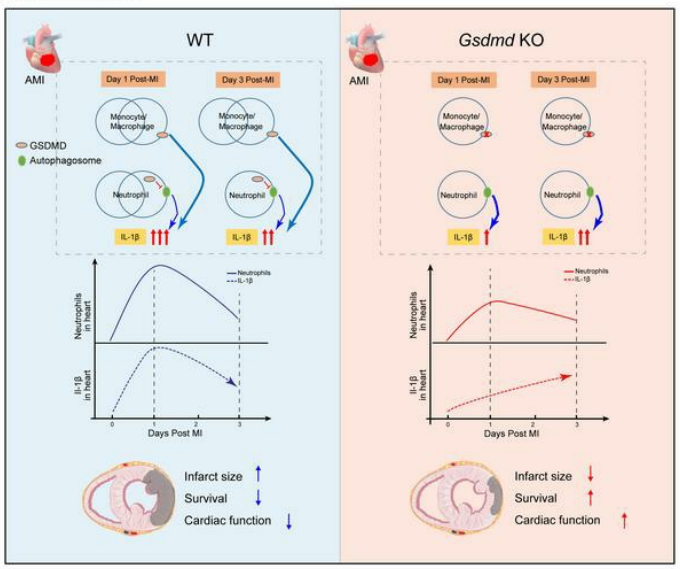

Title: Gasdermin D inhibition confers antineutrophil mediated cardioprotection in acute myocardial infarction

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Abstract

Acute myocardial infarction (AMI) induces blood leukocytosis, which correlates inversely with patient survival. The molecular mechanisms leading to leukocytosis in the infarcted heart, remain poorly understood. Using an AMI mouse model, we identified gasdermin D (GSDMD) in activated leukocytes early in AMI. We demonstrated that GSDMD is required for enhanced early mobilization of neutrophils to the infarcted heart. Loss of GSDMD resulted in attenuated IL-1β release from neutrophils and subsequent decreased neutrophils and monocytes in the infarcted heart. Knockout of GSDMD in mice significantly reduced infarct size, improved cardiac function, and increased survival post AMI. Through a series of bone marrow transplantation studies and leukocytes depletion experiments, we further clarified that excessive bone marrow derived and GSDMD-dependent early neutrophil production and mobilization (24 hours post AMI), contributed to the detrimental immunopathology after AMI. Pharmacological inhibition of GSDMD also conferred cardioprotection post AMI, through reduction of scar size and enhancement of heart function. Our study provides new mechanistic insights into molecular regulation of neutrophil generation and mobilization after AMI, and supports GSDMD as a new target for improved ventricular remodeling and reduced heart failure after AMI.

Introduction

Acute myocardial infarction (AMI) is a leading cause of death worldwide. Although reperfusion is successful in reducing infarct size and improving overall prognosis, AMI remains a major cause of heart failure and increased morbidity and mortality (1). In the past two decades, an increasing number of programmed cardiomyocyte cell death have been recognized in AMI and ischemia–reperfusion injury (1, 2). Sudden massive loss of cardiomyocytes post AMI exceeds the limited regenerative capacity of the myocardium (3). Cytokines released from necrotic cells can activate innate immune pathways, triggering an intense inflammatory response (4). Dysregulation of the inflammatory response may cause adverse remodeling (fibrosis and scar formation) in patients with AMI contributing to post infarction heart failure (5). Therapeutic attempts to suppress inflammation during AMI can lead to impaired cardiac repair and increased risk of cardiac rupture (6). More recent strategies aimed at selectively blocking key inflammatory factors rather than globally suppressing the response have shown some promising results (7).

Accumulating evidence has underscored a central role of inflammasome in AMI (8). The most widely characterized inflammasome sensor in the heart is the NACHT, LRR, and PYD domains-containing protein 3 (NLRP3), which is activated in response to cell debris during AMI (8). Activation of NLRP3 inflammasome triggers myocardial damage through promotion of inflammatory cell death via pyroptosis and through release of interleukin-1β (IL-1β) (8). In contrast, downregulation or inhibition of inflammasome components including Nlrp3 (9), ASC and Casp1 may reduce infarct size (8, 10). However, inhibition of IL-1β activity appears not to reduce infarct size (11). The pyroptotic substrate is the pore-forming protein gasdermin D (GSDMD) (12-14), which is widely expressed in different subsets of leukocytes (15). Cardiac neutrophil and monocyte/macrophage numbers expand rapidly in the days following AMI (16).

Recent findings suggests that GSDMD plays a distinct role in neutrophils during inflammasome activation, which differs from its role in macrophages (17, 18). The regulatory role of GSDMD in response to AMI is unknown.

We now demonstrate that GSDMD is activated early in AMI and plays a critical role in increased production and mobilization of neutrophils. Both genetic deletion and pharmacological inhibition of GSDMD attenuated myocardial injury, reduced infarct size and improved cardiac function and survival. We further demonstrated that GSDMD deficiency reduced acute cardiac cell death and IL-1β production independent of NLRP3 inflammasome activation. Consequently, reduced leukocyte numbers in the blood (and infarct) decreased inflammation and diminished post-AMI heart failure. Our work thus identifies GSDMD-dependent, bone marrow derived neutrophil generation and mobilization, as an important contributing factor to cardiac immunopathology after AMI, and provides mechanistic insights into modulation of inflammatory response during AMI, involving pyroptosis-dependent and pyroptosis -independent regulatory networks.

Results

GSDMD is activated in the early phase of AMI

We initially examined transcription levels of key factors involved in the acute inflammatory response to AMI by RNA sequencing of murine heart samples post AMI. Hierarchical clustering demonstrated samples from different experimental groups (sham, 1-day and 1-week post AMI groups) to be well separated from each other, while biological replicates from the same group clustered together well (**Supplemental Figure 1A**). We found 204 genes significantly up-regulated on Day1 AMI samples compared to the Sham samples and Day 7 AMI samples, while

64 genes were significantly downregulated (**Figure 1A**). Differentially expressed genes that had consistent expression patterns across Sham, AMI (Day 1) and AMI (Day 7) were further clustered together, and genes encoding the components of inflammasome showed a distinct increase, indicating the inflammasome may be activated post AMI (**Figure 1, B and C, and Supplemental Figure 1**). Furthermore, "Biological Process" enrichment analysis of DEGs also suggested upregulation of inflammatory responses, including "neutrophil chemotaxis", and "cellular response to Il-1" (**Supplemental Figure 1C**). Interestingly, *Nlrp3*, encoding a pattern recognition receptor, was rapidly upregulated within 24 hours post AMI followed by decline in expression at day 7 post AMI (**Figure 1C**). The expression of the downstream components of NLRP3 activation including *Casp1*, *Gsdmd*, *Il1b*, was upregulated in response to AMI, indicating myocardial NLRP3 inflammasome could be activated during AMI (**Figure 1C**). We further validated these findings by evaluating the protein level and activation level of *Gsdmd* in the heart. Baseline GSDMD exhibited low level of expression in heart but high level in other tissues like intestine, liver and spleen (**Figure 1D**), consistent with previous reports that GSDMD exhibited high level in immunocytes and fibroblasts and low level in cardiomyocytes, endothelial cells and smooth muscle cells (19, 20). Intriguingly, both expression and activation of GSDMD in heart were remarkably enhanced in response to myocardial ischemia/infarction in left anterior descending (LAD) ligation-operated wild type (WT) mice, as early as 24 hours post AMI (**Figure 1, E and F**). In addition, NLRP3, Caspase-1 cleavage and particularly Il-1β were induced early during myocardial ischemia/infarction (**Figure 1, E and F**). Taken together, these data suggest NLRP3 inflammasome and GSDMD-induced pyroptosis may be activated early post AMI and the likely source is from infiltrating leukocytes.

Loss of GSDMD attenuates myocardial injury post AMI

To determine the overall role of GSDMD in acute AMI, we initially utilized *Gsdmd*$^{-/-}$ (global knockout) mice and subjected the hearts to sham operations or AMI (as will be described later bone marrow transplantation and leukocyte depletion studies will provide tissue specific knockout studies). Unexpectantly, we observed significantly improved survival of the *Gsdmd*$^{-/-}$ mice post AMI compared with AMI-operated WT littermate controls (78.7% versus 50%, P = 0.0108) (**Figure 2A**). *Gsdmd* deficiency appeared to significantly improve left ventricular systolic function, which was severely impaired following AMI in WT littermate controls (**Figure 2, B and C**). Consistently, the ratio of heart weight to body weight ratio in *Gsdmd*$^{-/-}$ mice was significantly decreased compared to that of the littermate controls (**Figure 2D**). We further determined the effect of *Gsdmd* deficiency on cardiac structural remodeling post AMI. Masson's Trichrome staining analysis and quantification of the scar showed that the hearts from *Gsdmd*$^{-/-}$ mice had significant reduction in fibrotic scar size (**Figure 2, E and F**) and increase in thickness of left ventricular (LV) wall (**Figure 2F**). Apart from utilizing LAD ligation-operated mice, we also compared the myocardial infarction size in response to ischemia (30 minutes)/ reperfusion (24 hour) (I/R) in mice (**Figure 2G**). Remarkably, we observed that *Gsdmd*$^{-/-}$ mice compared to that of the littermate controls also exhibited a significant reduction in infarct size (**Figure 2, H and I**). These data suggested that *Gsdmd* deficiency reduces infarct size, preserves cardiac function, and improves survival post AMI. We set forth to determine the mechanisms for this unexpected protective effect.

GSDMD is essential for recruitment of neutrophils/monocytes to the infarcted heart

To explore the mechanisms underlying GSDMD deficiency conferred cardioprotection post AMI, and based upon recent suggestions that GSDMD may play a role in neutrophil production/mobilization, we investigated leukocyte infiltration and leukocytosis in AMI **(Supplemental Figure 2)**. After AMI, an increase particularly in neutrophils (and to a lesser extent monocyte) recruitment to the infarcted heart occurred within 12 hours, peaking at 24 hours (neutrophil) and 72 hours (monocyte) respectively during the 3-day observation period (**Figure 3, A and B**). The number of neutrophils (and monocytes) in the blood exhibited a similar pattern, with neutrophils peaking at 12 hours (**Figure 3, C and D**). This initial surge in blood neutrophils might result from mass exodus of neutrophils from the hematopoietic stem and progenitor cells in the bone marrow (**Figure 3, E and F**). Consistent with this notion, there was an initial significant decrease in the overall number of neutrophils (and monocytes) in the bone marrow followed by an increase in numbers (**Figure 3, E and F**), supporting the majority of the initial neutrophil mobilization as being from the bone marrow followed by new production of neutrophils, consistent with previous reports (16). Furthermore, in *Gsdmd*$^{-/-}$ mice, the observed increase in WT was significantly reduced in the heart, blood and bone marrow 24 hours post AMI (**Figure 3, G-J**), supporting an important role for GSDMD in neutrophil generation and mobilization in AMI. Intriguingly, there was no difference in number of neutrophils in the heart, blood and bone marrow between WT and *Gsdmd*$^{-/-}$ mice 72 hours post AMI (**Figure 4, A and B**). In contrast, *Gsdmd*$^{-/-}$ mice exhibited a marked reduction in number of monocytes both in heart and blood 72 hours post AMI compared to WT mice (**Figure 4, A and B**). These suggest that the inhibition of GSDMD could apply a brake on neutrophil mobilization at the initial stages of the inflammatory response to an AMI.

To validate these findings, we further sectioned the infarcted heart followed by immunofluorescence staining with MPO or CD68 antibody to specifically label and visualize the local neutrophils (MPO) and monocytes/macrophages ($CD68^+$). At 24 hours post AMI, in the WT mice a large number of MPO^+ neutrophils were recruited to the infarcted heart, while the number of neutrophils in the infarcted heart of *Gsdmd*$^{-/-}$ mice were markedly reduced (**Figure 4, C and D**). Notably, there was no difference in the number of the TUNEL-positive apoptotic cells in the infarcted heart between *Gsdmd*$^{-/-}$ mice and controls (**Figure 4, C and E**), suggesting that GSDMD deletion did not affect cardiac apoptosis after AMI, consistent with its key specific role in pyroptosis. By the end of the 72 hours post AMI, a large number of monocytes/macrophages were also recruited into both infarct zone and border zone of the heart in WT mice (**Figure 4, G-H**). Again, the *Gsdmd*$^{-/-}$ mice showed a significant decrease in the monocytes/macrophages infiltration particularly in the infarct border zone (**Figure 4, E and H**), suggesting the critical role of GSDMD in mediating function of monocytes/macrophages in the later acute phase of an AMI. Together, the data supports that GSDMD is involved in the recruitment of neutrophils (and monocytes) to the infarcted heart, contributing to the inflammatory response.

In addition, similar patterns of neutrophil and monocyte counts was observed in response to myocardial I/R (**Figure 5, A-F**). Notably, that *Gsdmd* deletion did not affect baseline leukocyte proportion (**Supplemental Figure 3**). Collectively, observation of significant reduction in the mobilized neutrophils in the heart 24 hours post AMI (**Figure 3, G-J**) and I/R (**Figure 5, G and H**) in *Gsdmd*$^{-/-}$ mice, suggests a distinct role of GSDMD in regulating neutrophils in response to AMI.

GSDMD deficiency reduces cell death and IL-1β

As noted above there was no difference in TUNEL positive apoptotic cell death between the WT and *Gsdmd*$^{-/-}$ mice. AMI-induced activation of NLRP3 inflammasome triggers further myocardial damage indirectly through the release of IL-1β and directly through promotion of inflammatory cell death via pyroptosis (8). Given GSDMD's role in releasing IL-1β from neutrophils independent of pore formation (18), we next sought to explore possible mechanisms for reduced recruitment of neutrophils to the infarcted heart caused by GSDMD deficiency. To determine secretion of IL-1β from leukocytes in the infarcted heart, CD11b^{+} leukocytes or Ly6G^{+} neutrophils were isolated from sham and ischemic mouse hearts (*Gsdmd*$^{-/-}$ mice and littermate controls), as described previously (21). The isolated CD11b^{+} or Ly6G^{+} neutrophils were cultured for 24 hours, followed by assays to measure the LDH, IL-1β, IL-18 and MCP-1 level (**Figure 6A and Supplemental Figure 4, A and B**). We observed significant reduction in both LDH and IL-1β level in isolated CD11b^{+} leukocytes from *Gsdmd*$^{-/-}$ mice compared to those from littermate controls after AMI-24h, with no significant difference 72h post-AMI (**Figure 6, B and C**). In contrast, there was no significant difference in both IL-1β and LDH level in isolated neutrophils from *Gsdmd*$^{-/-}$ mice and WT mice after AMI-24h, but a significant increase in IL-1β level in *Gsdmd*$^{-/-}$ mice 72h post-AMI (**Figure 6, D and E and Supplemental Figure 4, C and D**). Consistently, serum LDH level was markedly elevated 24 hours post AMI in WT mice while significantly reduced in *Gsdmd*$^{-/-}$ mice (**Supplemental Figure 4E)**. However, serum IL-1β showed an equal level between WT mice and *Gsdmd*$^{-/-}$ mice 72 hours post AMI (**Supplemental Figure 4F**). These suggest that it is neutrophil-released IL-1β dominates the serum IL-1β level 72 hours post AMI.

To explore how GSDMD modulate neutrophils death and IL-1β release independent of plasma membrane GSDMD pores and pyroptosis, we further analyzed the isolated heart and leukocytes

samples from *Gsdmd*$^{-/-}$ mice compared to those from littermate controls after AMI-24h and AMI-72h. Although there was no significant difference in NLRP3 activation and cleavage of Caspase-1 and IL-1β in heart 24 hours post AMI between WT mice and *Gsdmd*$^{-/-}$ mice (**Figure 6, F and G**), the cleaved LC3 (autophagy marker) in CD11b^{+} leukocytes or Ly6G^{+} neutrophils samples from the *Gsdmd*$^{-/-}$ mice 72 hours post AMI was significantly increased comparable with those in the WT mice (**Figure 6, H and I and Supplemental Figure 4, G-I)**. These indicated the autophagic flux in neutrophils may be enhanced by GSDMD deficiency, contributing to the release to IL-1β from neutrophils. Taken together, these data suggest that AMI-mediated activation of GSDMD resulting in the release of IL-1β, possibly leading to cardiac inflammation by recruitment of neutrophils to the infarcted heart.

GSDMD-dependent bone marrow-derived myeloid cell contributes to acute inflammatory response

Given that release of IL-1β induced by myocardial injury can be from leukocytes and non-leukocytes (e.g., fibroblast) (10), we hypothesized that AMI-induced neutrophil infiltration requires the GSDMD activation in cardiac neutrophils. To test this hypothesis, we transplanted bone marrows from WT or *Gsdmd*$^{-/-}$ mice into WT mice, or bone marrow from WT into *Gsdmd*$^{-/-}$ mice, and then subjected the transplanted animals to AMI (**Figure 7A and Supplemental Figure 5A**). This serves as a bone marrow specific knockout of *Gsdmd*. Consistent with our proposed sequelae of events, AMI-induced poor survival and adverse cardiac remodeling was improved by *Gsdmd*$^{-/-}$ bone marrow transplantation (**Figure 7, B-D**). There was no difference in cardiac function 1 week post MI among those that survived **(Supplemental Figure 5, B-F**). Given that

transplantation of wild-type bone marrow into *Gsdmd*$^{-/-}$ mice did not fully restore the WT phenotype (**Figure 7B**), a number of explanations are possible including gasdermin D in some not-radiosensitive cell may also contribute.

To further characterize the role of neutrophils in contributing to myocardial injury in vivo, we next depleted neutrophils or neutrophils/monocytes by intraperitoneal injection of anti-Ly6G and anti-Ly6G/Ly6C antibodies, respectively (**Figure 7E**). Injection of anti-Ly6G antibody effectively depleted the circulating neutrophils and did not affect the number of monocytes (**Figure 7F and Supplemental Figure 6**). Furthermore, anti-Ly6G/Ly6C injection leads to an effective clearance of circulating neutrophils and monocytes (**Figure 7F**). Both mice with neutrophils-depletion and neutrophil/monocyte-clearance exhibited a significantly reduced infarct size compared to control mice (**Figure 7, G and H**). Importantly, there was no significant difference in infarct size between anti-Ly6G injected mice and anti-Ly6G/Ly6C injected mice 72 hours post AMI **(Figure 7H)**, which emphasized the critical role of neutrophils in promoting myocardial injury. However, depletion of neutrophils with anti-Ly6G for 1 week mildly increased infarct size post AMI (**Figure 7, I and J**). This key result has important therapeutic implications, suggesting neutrophil depletion should be short term (first 3 days) as longer-term depletion (1 week) can be detrimental. These data suggest that bone marrow-derived neutrophils contribute to acute inflammatory response to AMI and their conferred cardioprotection depends on GSDMD activity.

Pharmacological inhibition of GSDMD reduces infarct size post AMI

The bone marrow transplant data suggests that GSDMD inhibition reduces infarct size and preserves cardiac function through leukocyte suppression. Given that pyroptotic cell death can be

pharmacologically inhibited by necrosulfonamide (NSA) (22), the role of NSA as a therapy in the initial inflammatory response was then tested in vivo in the above mouse model of permanent ligation of the LAD (**Figure 8A and Supplemental Figure 7A**). We optimized the dosage of NSA for in vivo stability, according to previous reports (22), and found that NSA administration with a dose of 20 mg/kg either 30 minutes before LAD ligation (**Figure 8**) or within 30 minutes (DMSO: 11.3 ± 1.9 min; NSA 11.2 ± 2.2 min) post LAD ligation (**Supplemental Figure 7**) did not demonstrate any adverse short term survival effect (toxicity or arrhythmia) one week post AMI (**Figure 8B and Supplemental Figure 7B**). However, there was significant improvement in systolic function (**Figure 8, C and D**, and **Supplemental Figure 7, C and D)**. Masson's Trichrome staining analysis of the scar showed that NSA treatment significantly reduced the fibrotic scar size (**Figure 8E and Supplemental Figure 7, E and F**) and increased LV wall thickness (**Figure 8F**). On the basis of our findings from the murine AMI models, GSDMD inhibition (within hours of AMI) may be a novel therapy to reduce scar formation and prevent heart failure post AMI. Inhibition of excess early (1-3 days) leukocyte mobilization and myocardial leukocyte infiltration may also be a potential strategy for therapy of AMI.

Human studies confirm the importance of AMI associated neutrophilia.

To highlight the impact of post AMI neutrophilia in human subjects we recruited 234 patients who had an AMI with only a single left anterior descending branch blockage (analogous to our mouse LAD ligation model) **(Supplemental Table1)** and correlated their neutrophil percentage to ejection fraction 5 days post PCI. There was a clear statistical negative correlation ($R=-0.41$, $p<0.0001$) (**Figure 8G**), with increased neutrophil percentage (greater than 60% being neutrophilia)

being associated with a reduced ejection fraction. In contrast, there was no significant correlation between monocytes (both admission and within 24 hours post PCI) and ejection fraction within 5 days post PCI. Taken together our mice AMI studies in combination with our preliminary human studies highlight the potential benefits of GSDMD inhibition in improving ventricular function and survival post AMI.

Discussion

Despite significant advances in percutaneous and surgical reperfusion, many patients who have an AMI ultimately develop heart failure with its associated poor prognosis. New mechanism-based therapies are urgently needed. An intense inflammatory response is triggered after myocardial ischemia and necrosis (23). Inflammation, although essential for wound healing, can mediate excessive scar formation and dysfunctional ventricular remodeling (24, 25). Clinically, neutrophilia (a key component of the inflammatory response to AMI) correlates with major adverse cardiovascular events in patients with AMI (16), implying neutrophil reduction may have more favorable outcomes. However, the mechanisms that determine neutrophil generation and recruitment to the infarcted heart remain unclear. Herein, we report that AMI-induced neutrophilia and early neutrophil infiltration into the heart are linked to increased expression and activation of inflammasome-effector GSDMD. Global knockout of *Gsdmd*, bone marrow-specific knockout of *Gsdmd* by BMT, and chemical inhibition of GSDMD reduced infarct size and improved cardiac function post AMI. In addition, GSDMD deficiency attenuated the myocardial injury in a murine ischemia reperfusion model. Loss of GSDMD resulted in decreased early generation and mobilization of neutrophils and monocytes to the infarcted heart. Furthermore, clearance of

neutrophils in vivo improved the heart function post AMI. Taken together, our findings support that inhibition of early neutrophil generation and mobilization is cardioprotective for AMI.

Cardiac neutrophils are the first responder in amplifying the acute inflammatory response after AMI. The initial wave of infiltrating neutrophils sets the tone for the ensuing inflammatory response by releasing key factors that activate the NLRP3 inflammasome, and promote the secretion of IL-1β (7). The released IL-1β interacts with interleukin 1 receptor type 1 on myeloid progenitor cells in the bone marrow and stimulates granulopoiesis in a cell-autonomous manner. Genetic deletion or pharmacological inhibition of the NLRP3 inflammasome–IL-1β signaling axis dampens granulopoiesis and improve cardiac function in mouse models of AMI (8). Although GSDMD promotes IL-1β release from hyperactive macrophages (26) and targeting IL-1β reduces leukocyte production after AMI (7, 11), how the release of IL-1β from distinct subsets of leukocytes and non-leukocytes is regulated in response to AMI is not fully understood. Our study demonstrated that GSDMD was predominantly expressed in leukocytes, but not in other types of cells in the heart tissue (data not shown). Importantly, through bone marrow transplantation, we demonstrated GSDMD-dependent neutrophil recruitment was required for myocardial injury in early phase. GSDMD deficiency reduced release of IL-1β from neutrophils and acute inflammatory response post AMI. For clinical translation, we further tested the inhibitor of pyroptotic cell death, NSA, which has recently been reported to inhibit GSDMD-mediated pore formation in cell membrane and subsequent pyroptosis (22), in a murine AMI model. We demonstrated that pharmacological inhibition of GSDMD also conferred cardioprotection post AMI, in reducing scar size and enhancing heart function. Although there is no difference in survival, significantly increased ejection fraction would be clinically associated with improved

signs and symptoms of heart failure, improved exercise tolerance, as well as reduced hospitalizations. With an increased cohort of treated mice, as well as longer term follow-up, we anticipate the significantly improved ejection fraction will translate to increased survival. These findings highlight the potential therapeutic application for targeting GSDMD early after AMI.

There has been a contradictory study that neutrophil depletion has no effect on infarct size at 24 hours post AMI and progressively worsens cardiac function from day 7 to day 14 (27). Since neutrophils are necessary in the repair process, optimized the dosage and time of anti-Ly6G injection is essential in addition to other supportive genetic, neutrophil depletion, and bone marrow transplant data. This suggests the timing of interventional strategies for targeting GSDMD as well as the degree of neutrophil inhibition are critical in preventing post-infarction heart failure. Previous in vitro studies demonstrated that in the absence of the pyroptosis-mediating substrate GSDMD, caspase-1 activates caspase-3 and induces apoptosis (28), indicating a possible bidirectional crosstalk between apoptosis and pyroptosis in monocytes and macrophages (29). However, in the present study, in vivo analysis with western blot and TUNEL staining revealed that loss of GSDMD did not significantly change the overall level of apoptosis in the infarcted heart (**Figure 4, C and F**). One recent in vitro study using ATG7-deficient cells demonstrated that neutrophils secrete IL-1β through N-terminal of GSDMD trafficking to neutrophil organelles, an autophagy-dependent mechanism (18), consistent with our findings that GSDMD regulating IL-1β release independently of plasma membrane pores and pyroptosis in neutrophil. In contrast, we have now demonstrated that GSDMD deficiency triggered autophagic flux in neutrophils using *ex vivo* assays (**Figure 6, H and I and Supplemental Figure 4)**. This will require further detailed exploration.

There are several limitations to this study, including choice of the infarct model. To establish the infarct model, we applied permanent ligation of a normal coronary artery, which differs substantially from the process of atherothrombosis in human subjects. To overcome these limitation, further clinical proof of concept studies that targeting GSDMD and neutrophil generation for management of AMI heart failure are needed.

In summary, we found that genetic knockout or pharmacological inhibition of GSDMD significantly improved heart function post AMI. Furthermore, bone marrow transplantation from *Gsdmd* knockout mice show the same improvement. We provide new mechanistic insights into molecular regulation of inflammatory response during an AMI. It is bone marrow derived and GSDMD-dependent neutrophils generation and mobilization that contribute to the detrimental immunopathology after AMI. We anticipate that our studies may be broadly applicable to cardioprotective therapy, specifically targeting GSDMD and neutrophil production for improved ventricular remodeling and reduced heart failure after AMI.

Methods

Human studies

Study design: The STEMI follow-up registry was a prospective, longitudinal, multicenter registry study of patients hospitalized with first-time STEMI in east China (ChiCTR-IDR-16007765). The study was performed following the principles of the Declaration of Helsinki. It was approved centrally by the Ethics Committee at Shanghai Chest Hospital, Shanghai Jiaotong University (in Dec. 2015; approved number 2015-111) and by the local health research ethics board at each participating hospital. Written informed consent was obtained from each patient to allow for

follow-up data. All data on patient demographics, signs and symptoms, medication, clinical characteristics, and discharge information were collected on a clinical-based registry.

Study population: A total of 8 sites were included in our registry, with three academic hospitals in each geographic city and five tier-2 district-centered hospitals. In short, our registry covered both tier 3 and tier 2 hospitals with long-term follow-up data. From June 2016 to June 2018, first-time STEMI patients aged ≧18 years old who survived at discharge were included. The only exclusion criterion was missing echo data within hospitalization. STEMI was defined as a chest pain lasting ≧ 30 minutes together with an ST-segment elevation in ≧ 2 contiguous leads on a standard 12-lead electrocardiogram (2 mm in precordial leads and 1mm in the limb leads).

Mice

Adult C57BL/6N mice were purchased from Shanghai SLAC Laboratory, C57BL/6N *Gsdmd*$^{-/-}$ mice were purchased from GemPharmatech. The knockout of *Gsdmd* gene was validated by genotyping and immunoblotting. All animal surgeries were performed at 10- to 14-week-old male mice. All animals were housed in a pathogen-free environment in the Tongji University animal facilities and all animal experiments were approved by the Tongji University Animal Research Committee (TJLAL-019-128).

To deplete neutrophils in mice, isotype IgG (Cell Signalling), anti-Ly6G antibody (BioLegend) or anti-Ly6G/Ly6C antibody (BioLegend) were injected intraperitoneally at a dose of 200 μg per mouse, as described previously(30, 31). The relevant mice were subjected to myocardial infarction surgery 24 hours later.

For NSA administration, 20 mg/ kg mouse weight of NSA (MedChemExpress) was injected intraperitoneally at 30 minutes before AMI surgery, a second injection was given at 8 hours after the surgery. Mice in the corresponding control groups were injected with the same amount of solvent without the chemical compounds.

Myocardial infarction

Mice were intubated and ventilated with 1-2% isoflurane. After left thoracotomy, the left coronary artery was ligated with a 6-0 polyester suture 1 mm below the left atrial appendage. Core temperature was monitored and maintained at 37 ℃, and the ECG was monitored to document ST-segment elevation during coronary occlusion. Surgeries were performed blinded to the genotypes. At corresponding time points, the mice were euthanized and the samples harvested.

Myocardial ischemia reperfusion and 2,3,5- triphenyltetrazolium chloride (TTC) staining

Mice were anesthetized by spontaneous inhalation of isoflurane and maintained under general anesthesia with 1% isoflurane. A left coronary artery occlusion was performed. 30 minutes later, the occlusion was reperfused for 24 hours prior to euthanization. The hearts were then harvested, dissected, and stained with Evans blue dye and triphenyltetrazolium chloride. The images were captured under a Leica microscope and the ischemic area at risk and the area of necrosis were quantified. Quantitation of the infarct area was normalized as a percentage of the nonperfused risk area during coronary occlusion.

Echocardiography

Echocardiography was performed before the AMI and at 7 days after AMI using a Vevo 2100 system (VisualSonics). Mice were kept under light anesthesia, and ultrasound gel was placed in the shaved chest and the probe was adjusted to a stable position. Midventricular M-mode echocardiogram was acquired at the level of the papillary muscles. Heart rate, intraventricular septum and posterior wall thickness, and end-diastolic and end-systolic internal dimensions of the left ventricle were obtained from the M-mode image.

Protein analysis by immunoblotting or ELISA

For heart tissues samples, hearts were harvested from mice, rinsed with cold PBS, and divided into left ventricle and right ventricle. The tissues were immediately frozen in liquid nitrogen and then transferred to -80 ℃ before homogenization. Total protein from tissues or cells was extracted in RIPA buffer (Cell Signaling) supplemented with protease and phosphatase inhibitor cocktail (Roche). Total protein concentration was determined by BCA assay (Pierce). Protein was denatured by mixing with LDS sample buffer (GenScript) and β-ME (Amresco) and heating. Equal amounts of protein were loaded to SurePAGE gels (GenScript) and subjected to gel electrophoresis, followed by blotting onto PVDF membranes (Millipore). Western blotting analysis was performed using antibodies against GSDMD (Abcam), NLRP3 (Cell Signaling), Caspase-1 (Adipogen), IL-1β (R&D Systems), HSP90 (Cell Signaling) and β-tubulin (Cell Signaling) followed by HRP-conjugated secondary antibodies (Invitrogen). The blot was visualized with SuperSignal West Femto substrate (Pierce) on a ChemiDoc Imaging System (Bio-Rad) and analyzed in ImageJ. To test secretion levels of IL-1β and MCP-1 from leukocytes in the infarcted heart, hearts were

harvested, rinsed in cold PBS and minced into small pieces, single cell suspensions were prepared and myeloid-originated cells were isolated using a CD11b antibody and a cell isolation kit in LS Column (Miltenyi Biotech) according to the manufacturer's instructions. The isolated myeloid-originated cells were then counted and cell numbers were adjusted to a same level, the cells were cultured for 24 hours, the supernatant was harvested, purified by centrifugation and further tested in ELISA assays. The cell supernatant was tested for IL-1β levels by Mouse IL-1 beta/IL-1F2 Quantikine ELISA Kit (R&D Systems) and lactate dehydrogenase (LDH) levels by CytoTox 96® Non-Radioactive Cytotoxicity Assay (Promega) according to the manufacturer's instructions. To test IL-1β or LDH levels in the serum, blood was drawn from the apex of heart, rested in a microcentrifuge tube for 30 minutes, and centrifuged at 1,500 g for 15 minutes, the supernatant serum was aliquoted and stored at -80 ℃ till the test.

Bone-marrow transplantation (BMT)

The recipient mice were given acidic water (pH 2.6) supplemented with neomycin and polymyxin B (both from BBI) 1 week prior to irradiation. The irradiation was given by a small animal X-ray irradiator (Rad Source) at a dose of 8 Gy. The donor bone marrow cells were isolated from the femurs of donor mice and injected into the recipient mice by tail vein injection within 4 hours after the irradiation (at a cell number of 5×10^6 per mouse). The recipient mice were housed for 4 more weeks prior to myocardial infarction surgery. Spleen tissues were harvested and immunoblotting was performed to confirm that the bone marrow cells had been replaced.

Immunofluorescence, TUNEL and Masson's trichrome staining

The hearts were harvested from euthanized mice, perfused from the apex with cold PBS to remove contaminating blood, embedded in OCT (Sakura) and then flash frozen. 5 µm frozen sections from mouse hearts were prepared for immunofluorescence staining. The sections were fixed with 4% paraformaldehyde for 30 minutes and washed in PBS, antigen retrieval was performed by boiling the sections in sodium citrate. The sections were then permeabilized in 1% Triton X-100 (Sigma Aldrich) for 10 minutes and blocked in 1% BSA for 30 minutes. Primary antibodies were diluted in 1% BSA and the sections were incubated with antibody dilutions at 4 ℃ overnight. The sections were then washed in PBS, incubated with secondary antibody dilutions and washed in PBS again. Subsequently, the sections were stained with DAPI (Invitrogen) and mounted with Prolong Gold Antifade Mountant (Invitrogen). The slides were scanned by a Nikon confocal microscope and quantification was performed in ImageJ. The immunofluorescence staining was performed using antibodies against CD68 (Abcam), MPO (R&D Systems) and alpha Actinin (Abcam). For TUNEL staining, 5 µm frozen sections were stained using a *In Situ* Cell Death Detection Kit (Roche) according to the manufacturer's instructions. For Masson's trichrome staining, 10 µm frozen sections from mouse hearts were prepared, the sections were stained with a Masson's Trichrome kit (Nanjing Jiancheng Bioengineering Institute) according to the manufacturer's instructions. The images were captured by a Leica microscope and the images of 7 sections were used for the quantification of fibrotic area and ventricular wall thickness.

Flow cytometry

Leukocytes from blood, bone marrow and heart were applied to flow cytometric analysis. Blood was drawn directly from the apex into centrifuge tubes containing 3.8% sodium citrate. The red

blood cells were lysed by RBC lysis buffer (BioLegend). The cells were centrifuged at 2,000 rpm for 3 minutes at 4 ℃ and the cell pellets were resuspended in antibody dilutions. To isolate leukocytes from bone marrow, femurs from mice were isolated, cleaned and the ends were cut open by a scissor. The bone marrow was flushed with cold PBS using a 23-gauge needle, filtered through a 100 μM strainer and centrifuged at 2,000 rpm for 3 minutes at 4 °C. The supernatant was discarded, the red blood cells were removed by RBC lysis buffer, and the cells were washed before resuspension in antibody dilutions. To analyze leukocytes in the heart, single cell suspensions were initially prepared. Hearts were harvested, rinsed with cold PBS, and minced into pieces. The tissues were incubated in a cocktail of collagenase I (450 U/ml), collagenase XI (125 U/ml), hyaluronidase type I-s (60 U/ml) and DNase (60 U/ml) (all from Sigma-Aldrich) at 37 ℃ for 1 hour with gentle agitation. After digestion, the single cell suspensions were then filtered through a 100 μM strainer into a 50 mL tube, rinsed with FACS buffer and centrifuged at 2,000 rpm for 3 minutes. The cell pellets were resuspended in antibody dilutions and incubated at room temperature for 30 minutes in dark. The following antibodies have been used: CD45-BV605, CD11b-AlexaFluor647, Ly6G-FITC, Ly6C-Perp-cy5.5 (all from BioLegend). Data was acquired on a LSRFortessa flow cytometer (BD Biosciences) and analyzed in FlowJo (Version 10.6.2). The the myeloid leukocytes were identified as $CD45^{+}CD11b^{+}$ and further classified as Ly6G positive neutrophils, Ly6C positive monocytes.

Myeloid-derived cells and Neutrophils Isolation and Culture

In order to explore the function of myeloid-derived cells and neutrophils, we isolated neutrophils in the heart by using the CD11b MicroBeads UltraPure or the neutrophil separation kit (Miltenyi Biotec) according to the manufacturer's instructions, as described previously (32). Myeloid-derived cells and neutrophils were isolated from the heart of mice with different time points post

myocardial infarction, followed by immunoblotting or ELISA. The viability of the neutrophils cultured for 24 and 72 hours was determined with an annexin V/PI staining kit (Thermo Fisher Scientific), followed by flow cytometry as described previously (33, 34).

RNA-seq data processing

Total RNAs derived from whole heart post AMI (Day 1), AMI (Day 7) and Sham were applied for whole transcriptome sequencing. Briefly, cDNA library was prepared using random hexamer primer and PCR amplification. PCR products were purified (AMPure XP system) and library quality was assessed on the Agilent Bioanalyzer 2100 system. After cluster generation via using TruSeq PE Cluster Kit v3-cBot-HS (Illumia), the library preparations were sequenced on an Illumina Hiseq platform and 150 bp paired-end reads were generated.

The quality of the reads was evaluated with FastQC. The reads were then trimmed with Cutadapt to remove low quality bases and remove adapters. Alignment of the resulting high-quality reads to the mouse reference Ensembl Version GRCm38.92 was performed via the splice-aware aligner STAR (v2.4.0j). Afterwards, using RSEM (RNA-Seq by Expectation Maximization), the abundance of each gene was quantified as TPM (Transcripts per million) value. All original data were deposited in the NCBI's Gene Expression Omnibus database (GEO GSE181872).

Principal component analysis

We calculated the standard deviation (SD) of each gene across samples and selected those with SD $\geq$ 0.5 to generate 1st and 2nd principal component with the unsupervised learning technique, Principal Component Analysis (PCA).

Analysis of differentially expressed genes (DEGs)

The DEGs, defined by fold change (FC) ≥ 2 and a false discovery rate (FDR) < 0.05, was called using the DESeq2, and were used to generate a hierarchical clustering with the "pheatmap" package in R. The intersections of DEGs created from different comparisons were calculated via the "VennDiagram" package. DEGs that had coherent expression patterns across Sham, AMI (Day 1) and AMI (Day 7) were further clustered together. The genes in different patterns were respectively mapped onto the Gene Ontology (GO), and the adjusted p value indicating whether a function was enriched by DEGs was calculated using the hypergeometric distribution.

Statistics

All data were presented as mean ± SD. Comparison of two groups were performed by an unpaired two-tailed Student's *t* test. When more than two groups were compared, statistical significance was determined using One-way analysis of variance followed by Tukey's multiple comparison test or Bonferroni's multiple comparison test. A difference of $P < 0.05$ was considered as significant and labeled with one star, a difference of $P < 0.01$ was labeled with two stars, a difference of $P < 0.001$ was labeled with three stars, a difference of $P < 0.0001$ was labeled with four stars. Statistical significances of Kaplan-Meier survival curves were determined by Mantel-Cox test. Relationships between variables were determined by the Pearson correlation coefficient. The statistical analysis was performed with Prism (GraphPad Software, version 8.3.0).

Study approval

For animal studies, all animal experiments were approved by the Tongji University Animal Research Committee (TJLAL-019-128). For human studies, it was approved centrally by the Ethics Committee at Shanghai Chest Hospital, Shanghai Jiaotong University (approved number 2015-111) and by the local health research ethics board at each participating hospital. Written informed consent was obtained from each patient to allow for follow-up data.

Author contributions:

Y. Xiang designed the study; K.J., Z.T., K.C., F.C, S.X, T.S and D.W. performed the animal experiments and the in vitro experiments; Y. Xiang, K.C., K.J, Y. Xu, J.Q, L.S and J.H analyzed the data. Y. Xiang wrote the manuscripts. K.J., Z.T., and K.C. are co–first authors based on their distinct contributions; the order of co–first authors was determined based on the overall scientific contribution.

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Conflict of interest: none declared.

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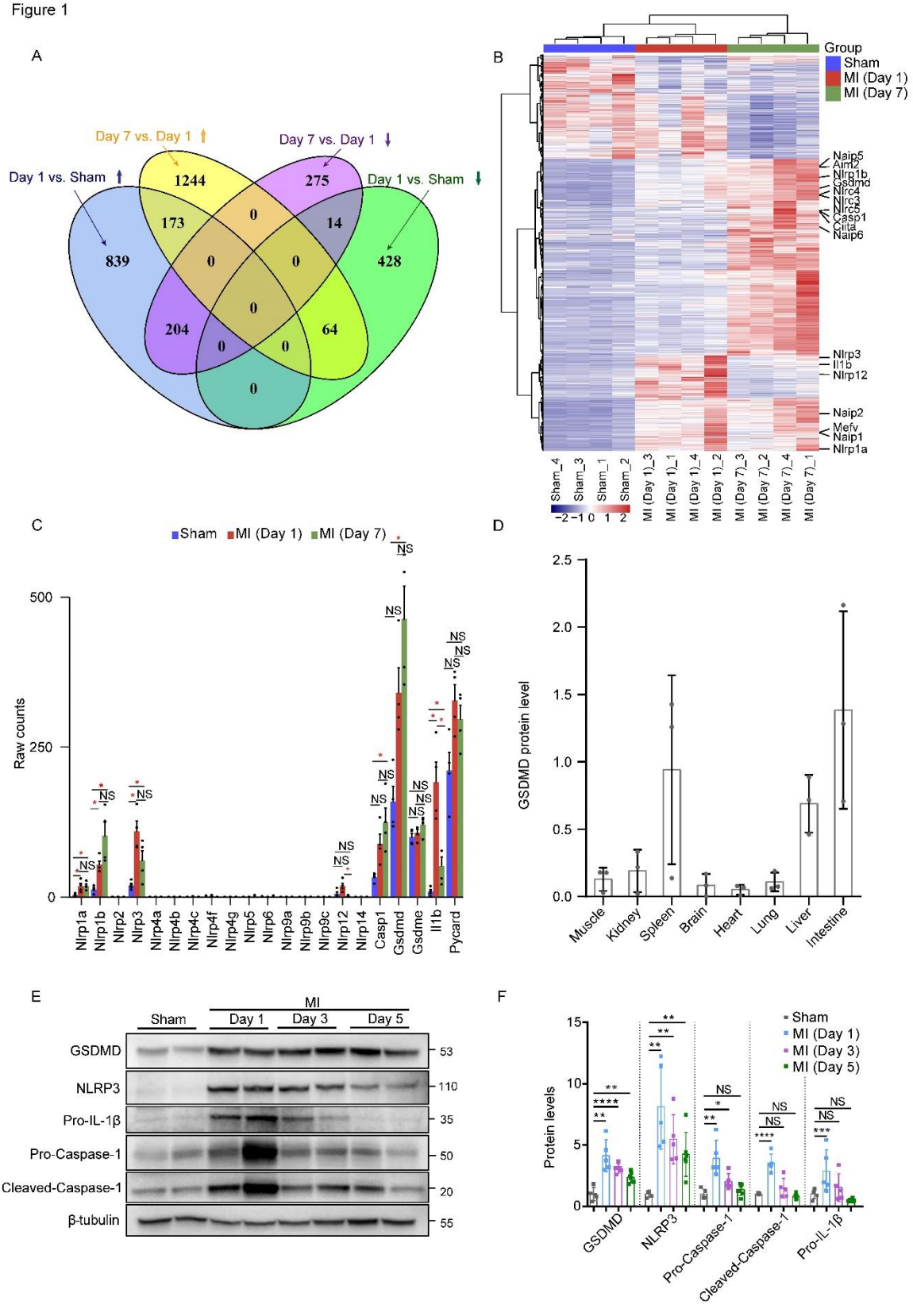
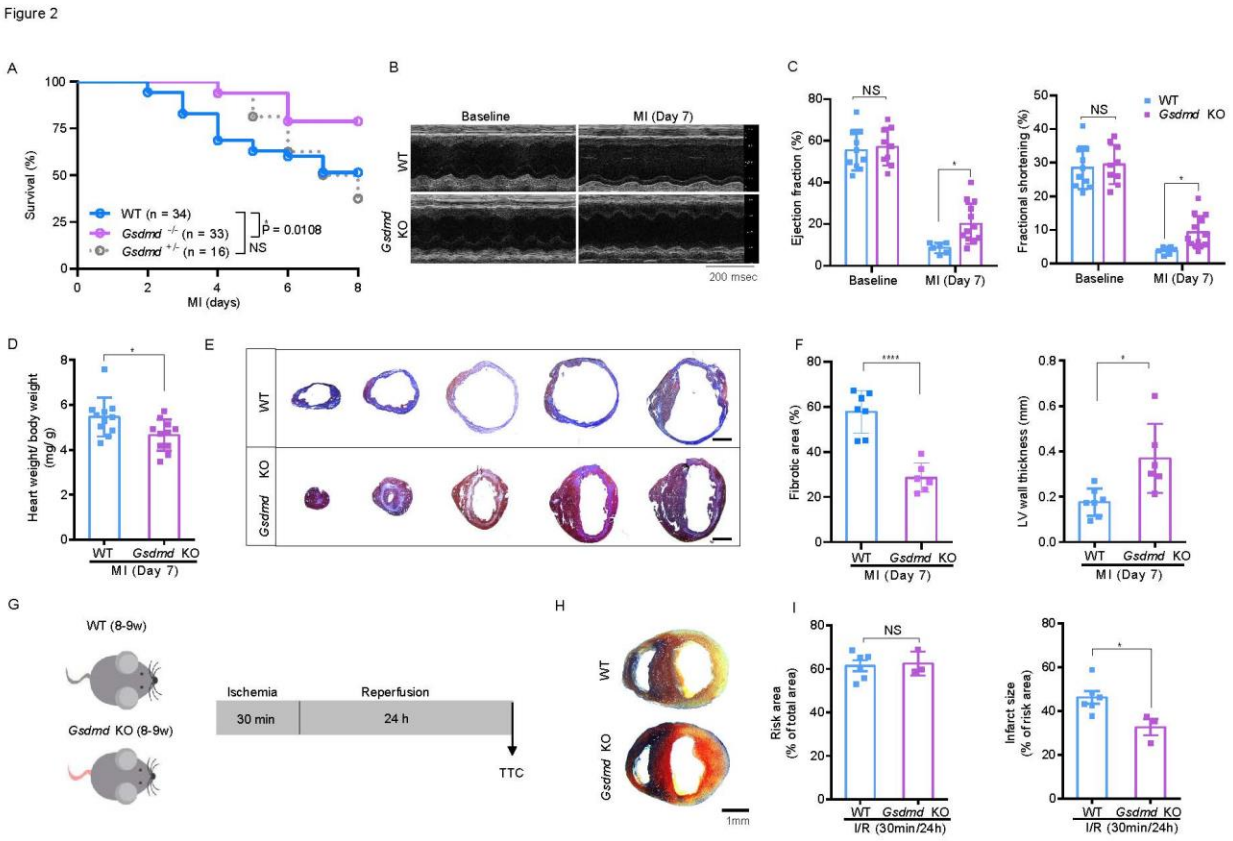
Figure 1


A
Day 7 vs. Day 1
Day 7 vs. Day 1
Day 1 vs. Sham
Day 1 vs. Sham
1244
275
173
14
839
428
204
64
0
B
Group
Sham
MI (Day 1)
MI (Day 7)
Naip5
Aim2
Nlrp1b
Gsdmd
Nlrc4
Nlrc3
Nlrc5
Casp1
Ciita
Naip6
Nlrp3
Il1b
Nlrp12
Naip2
Mefv
Naip1
Nlrp1a
Sham_4
Sham_3
Sham_1
Sham_2
MI (Day 1)_3
MI (Day 1)_1
MI (Day 1)_4
MI (Day 1)_2
MI (Day 7)_3
MI (Day 7)_2
MI (Day 7)_4
MI (Day 7)_1
−2 −1 0 1 2
C
Sham
MI (Day 1)
MI (Day 7)
Raw counts
500
250
0
NS
Nlrp1a
Nlrp1b
Nlrp2
Nlrp3
Nlrp4a
Nlrp4b
Nlrp4c
Nlrp4f
Nlrp4g
Nlrp5
Nlrp6
Nlrp9a
Nlrp9b
Nlrp9c
Nlrp12
Nlrp14
Casp1
Gsdmd
Gsdme
Il1b
Pycard
D
GSDMD protein level
2.5
2.0
1.5
1.0
0.5
0.0
Muscle
Kidney
Spleen
Brain
Heart
Lung
Liver
Intestine
E
Sham
MI
Day 1
Day 3
Day 5
GSDMD
NLRP3
Pro-IL-1β
Pro-Caspase-1
Cleaved-Caspase-1
β-tubulin
53
110
35
50
20
55
F
Sham
MI (Day 1)
MI (Day 3)
MI (Day 5)
Protein levels
15
10
5
0
NS
GSDMD
NLRP3
Pro-Caspase-1
Cleaved-Caspase-1
Pro-IL-1β

656

Figure 1. GSDMD is activated at the early phase of AMI.

(A) Venn plot revealed the intersection of differentially expressed genes created from the comparisons of MI (Day 1) vs. Sham and MI (Day 7) vs. MI (Day 1). **(B)** Each row in the heatmap represented a specific gene that had significantly different expression levels in comparisons between any two groups, the expression of which was normalized across the column, with high expression shown in red and low in blue. **(C)** Bar plot showed the trends of gene expression across Sham, MI (Day 1) and MI (Day 7). * indicated the statistical difference, with fold change (FC) $\geqslant$ 2 and false discovery rate (FDR) < 0.05. **(D)** Quantification of GSDMD protein levels by immunoblotting in different tissues of WT (C57BL/6N) mice (n = 3). **(E-F)** Representative immunoblotting **(E)** and quantification **(F)** of left ventricular tissues from mice subjected to MI for different time points (1 day, 3 days, 5 days) or a sham surgery (n = 5 per group), β-tubulin or HSP90 was used as a loading control. Shown are mean ± SD and were analyzed by One-way analysis of variance with Tukey's correction for multiple comparison **(F)**. NS, not significant; *, P<0.05; **, P<0.01; ***, P<0.001; ****, P<0.0001.



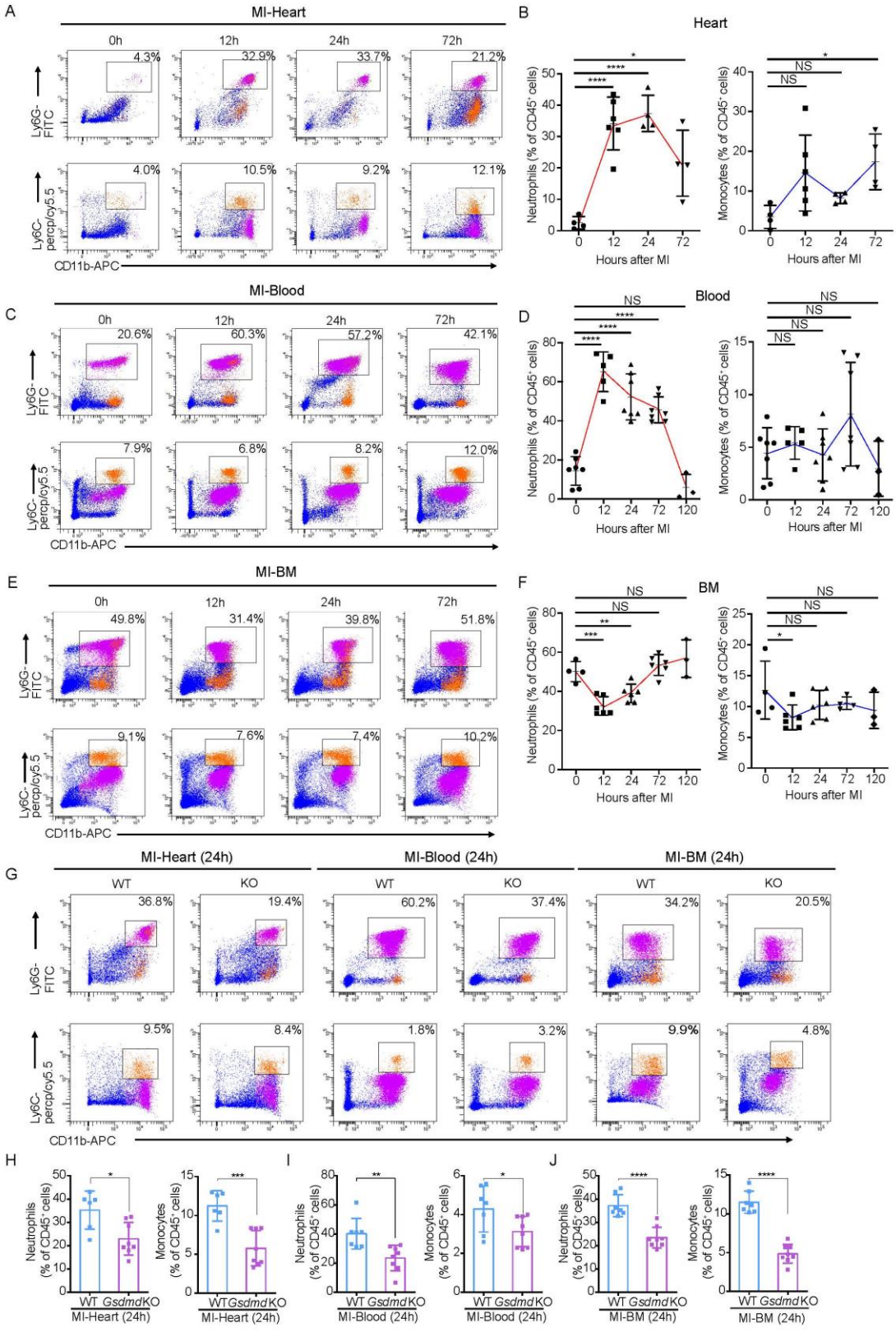
678

679 **Figure 2. Loss of GSDMD attenuates myocardial injury post AMI.**

680 **(A)** Kaplan-Meier survival curves comparing post-MI survival of WT (C57BL/6N) mice (n = 34)
681 to that of *Gsdmd*$^{-/-}$ mice (n = 33) or *Gsdmd*$^{+/-}$ mice (n = 16). Statistical significance was
682 determined by Mantel-Cox test. **(B-C)** Echocardiography images **(B)** and M-mode quantification
683 **(C)** of ejection fraction (left) and fractional shortening (right) for WT or *Gsdmd*$^{-/-}$ mice before or
684 1 week after MI (baseline: WT, n = 10; *Gsdmd*$^{-/-}$, n = 9; 1 week: WT, n = 6; *Gsdmd*$^{-/-}$, n = 12).
685 **(D)** A comparison of heart weight/ body weight ratio between WT mice and *Gsdmd*$^{-/-}$ mice 1 week
686 after MI (WT, n = 11; *Gsdmd*$^{-/-}$, n = 11). **(E-F)** Masson's Trichrome staining **(E)** and quantification
687 of fibrotic area and left ventricular (LV) wall thickness **(F)** of short-axis heart sections from WT
688 or *Gsdmd*$^{-/-}$ mice 1 week after MI (WT, n = 7; *Gsdmd*$^{-/-}$, n = 6). Scale bar = 1 mm. **(G)** Schematic

diagram showing the ischemia/ reperfusion (I/R) surgery strategy for WT and *Gsdmd*$^{-/-}$ mice. **(H-I)** Representative images of Evans blue dye and triphenyltetrazolium chloride (TTC) staining **(H)** and quantification of risk area (left) and infarct size (right) **(I)** for WT or *Gsdmd*$^{-/-}$mice after I/R surgery (WT, n = 6; KO, n = 3). Statistical tests for **C**: Data represent mean ± SD, NS, not significant; *; P<0.05, as analyzed by One-way analysis of variance followed by Bonferroni's multiple comparison test **(C)**. Statistical tests for **D, F** and **I**: Data are mean ± SD, NS, not significant; *, *P*<0.05; ****, *P*<0.0001, as analyzed by unpaired two-tailed Student's *t* test.

Figure 3


A
MI-Heart
0h
12h
24h
72h
4.3%
32.9%
33.7%
21.2%
4.0%
10.5%
9.2%
12.1%
Ly6G-FITC
Ly6C-percp/cy5.5
CD11b-APC
B
Heart
Neutrophils (% of CD45+ cells)
Monocytes (% of CD45+ cells)
Hours after MI
C
MI-Blood
20.6%
60.3%
57.2%
42.1%
7.9%
6.8%
8.2%
12.0%
D
Blood
E
MI-BM
49.8%
31.4%
39.8%
51.8%
9.1%
7.6%
7.4%
10.2%
F
BM
G
MI-Heart (24h)
MI-Blood (24h)
MI-BM (24h)
WT
KO
36.8%
19.4%
60.2%
37.4%
34.2%
20.5%
9.5%
8.4%
1.8%
3.2%
9.9%
4.8%
H
I
J
WT Gsdmd KO
MI-Heart (24h)
MI-Blood (24h)
MI-BM (24h)

709

Figure 3. GSDMD is essential for recruitment of neutrophils/monocytes to the AMI heart.

(A-F) Flow cytometric analysis and quantification of $Cd11b^{+}Ly6G^{+}$ neutrophils and $Cd11b^{+}Ly6C^{+}$ monocytes in heart **(A),** blood **(C)** or bone marrow (BM) **(E)** from WT or *Gsdmd*$^{-/-}$ mice at different time points (12 hours, 24 hours, 72 hours) after MI or a sham surgery (n = 4-7), along with their quantification **(B, D and F)**. **(G-J)** Flow cytometric analysis and quantification of $Cd11b^{+}Ly6G^{+}$ neutrophils and $Cd11b^{+}Ly6C^{+}$ monocytes in heart **(H)**, blood **(I)** or BM **(J)** from WT or *Gsdmd*$^{-/-}$ mice 24 hours after MI (n = 7-8). Data are mean ± SD as analyzed by One-way analysis of variance followed by Bonferroni's multiple comparison test **(B, D and F)** or unpaired two-tailed Student's *t* test **(H, I and J)**. NS, not significant; *, $P<0.05$; **, $P<0.01$; ***, $P<0.001$; ****, $P<0.0001$.

Figure 4

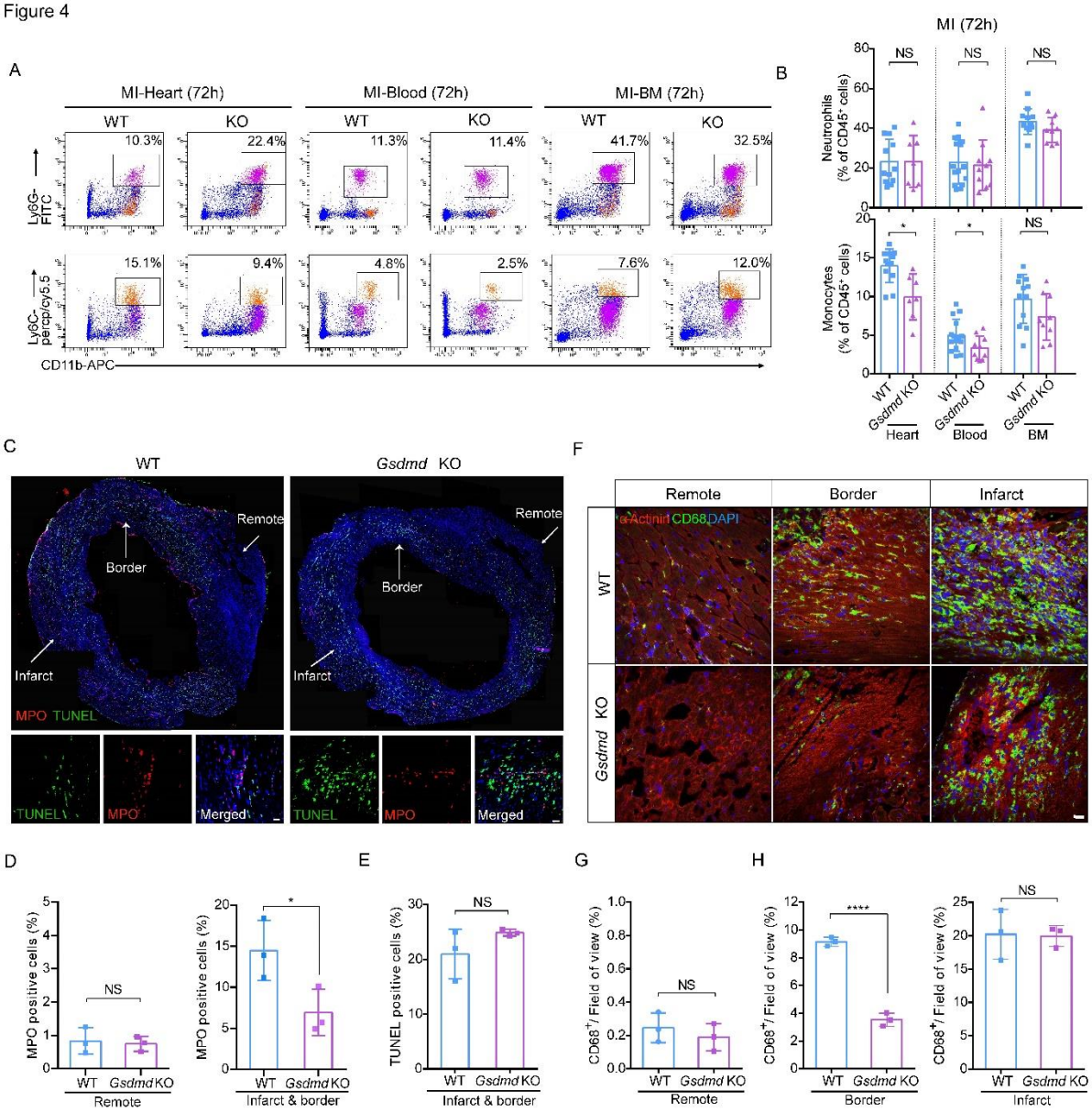
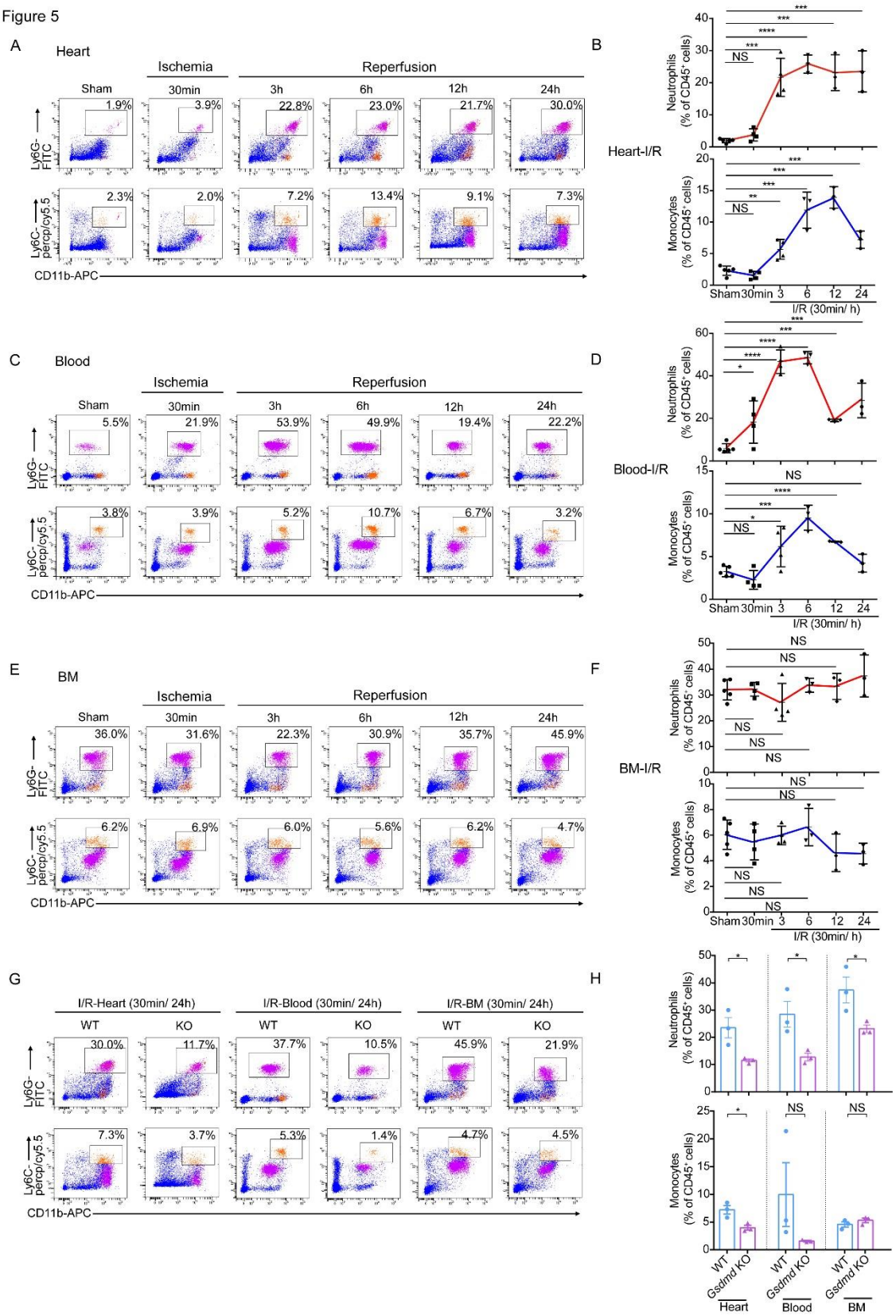


Figure 4. GSDMD is essential for recruitment of neutrophils/monocytes to the infarcted heart.

(A-B) Flow cytometric analysis and quantification of $Cd11b^{+}Ly6G^{+}$ neutrophils and $Cd11b^{+}Ly6C^{+}$ monocytes in heart (left), blood (middle) or BM (right) from WT or *Gsdmd*$^{-/-}$ mice 72 hours after MI (n = 7-15). **(C)** Immunofluorescence imaging and magnification for MPO (red),

TUNEL (green) and DAPI (blue) on heart sections from WT or *Gsdmd*$^{-/-}$ mice 24 hours after MI (scale bar, 20 μm). **(D-E)** Quantification of ratios of MPO or TUNEL positive cells of heart sections from WT or *Gsdmd*$^{-/-}$ mice. Each value was averaged from the values of 7 fields of view from the same mouse (n = 3 per group). **(F)** Immunofluorescence imaging on heart sections from WT or *Gsdmd*$^{-/-}$ mice 3 days after MI showing α-Actinin (red), CD68 (green) and DAPI (blue). Representative fields of remote zone, border zone and infarct zone are presented (scale bar, 20 μm). **(G-H)** Quantification of CD68 positive area proportion in the field of view in remote zone **(G)**, infarct zone and border zone **(H)** of heart sections from WT or *Gsdmd*$^{-/-}$ mice, each value was averaged from the values of 5 fields of view from the same mouse (n = 3 per group). Statistical tests for **B**: Data represent mean ± SD, NS, not significant; *, $P<0.05$; multiple two-tailed Student's *t* test. Statistical tests for **D, E G and H**: NS, not significant; *, $P<0.05$; ****, $P<0.0001$, unpaired two-tailed Student's *t* test.

Figure 5

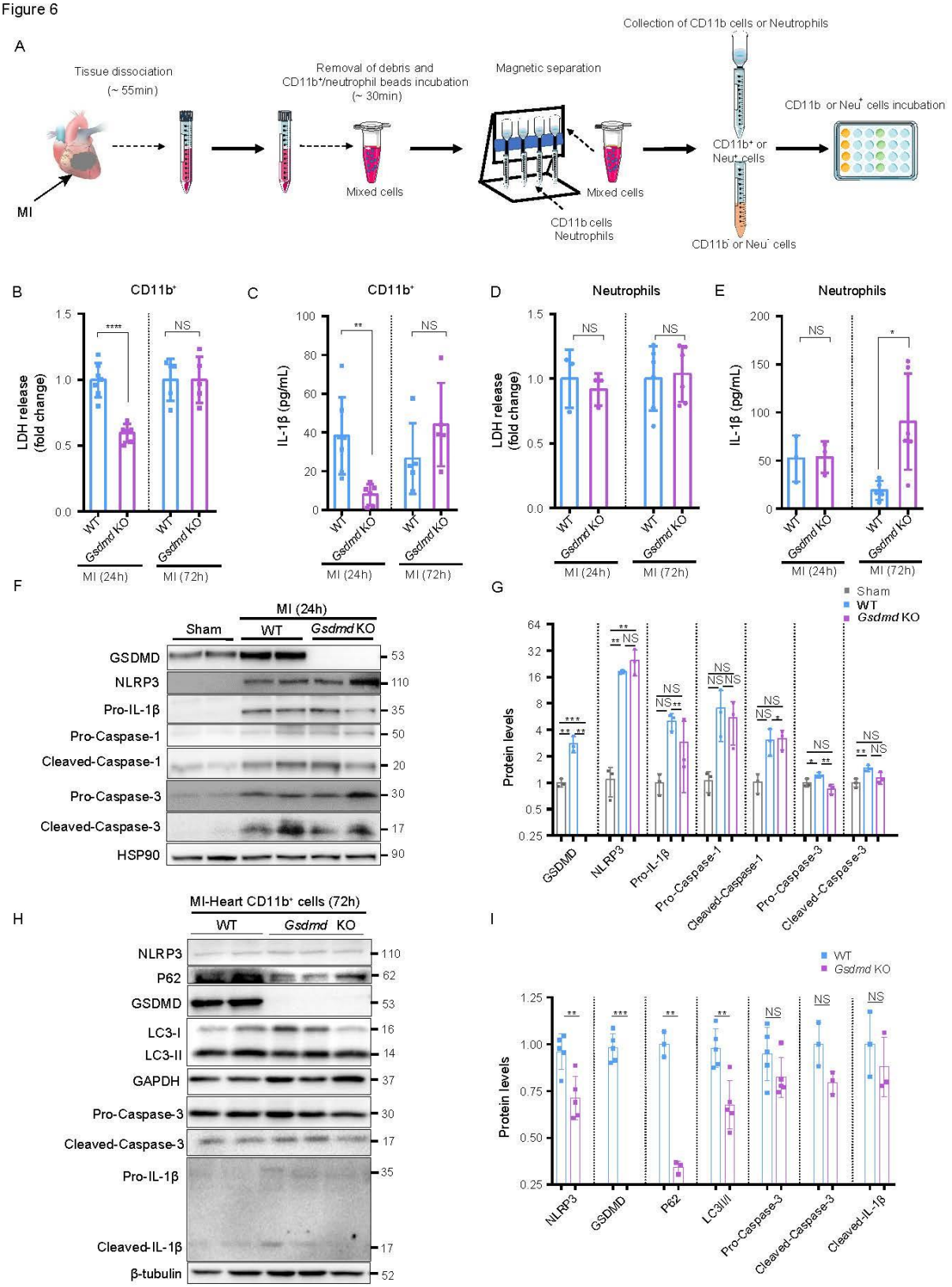

A
Heart
Ischemia
Reperfusion
Sham
30min
3h
6h
12h
24h
1.9%
3.9%
22.8%
23.0%
21.7%
30.0%
2.3%
2.0%
7.2%
13.4%
9.1%
7.3%
Ly6G-FITC
Ly6C-percp/cy5.5
CD11b-APC
B
Heart-I/R
Neutrophils (% of CD45+ cells)
Monocytes (% of CD45+ cells)
NS
Sham 30min 3 6 12 24
I/R (30min/ h)
C
Blood
5.5%
21.9%
53.9%
49.9%
19.4%
22.2%
3.8%
3.9%
5.2%
10.7%
6.7%
3.2%
D
Blood-I/R
E
BM
36.0%
31.6%
22.3%
30.9%
35.7%
45.9%
6.2%
6.9%
6.0%
5.6%
6.2%
4.7%
F
BM-I/R
G
I/R-Heart (30min/ 24h)
I/R-Blood (30min/ 24h)
I/R-BM (30min/ 24h)
WT
KO
30.0%
11.7%
37.7%
10.5%
45.9%
21.9%
7.3%
3.7%
5.3%
1.4%
4.7%
4.5%
H
WT
Gsdmd KO
Heart
Blood
BM

746

Figure 5. GSDMD is essential for recruitment of neutrophils/monocytes to the I/R heart.

(A-F) Flow cytometric analysis and quantification of $Cd11b^{+}Ly6G^{+}$ neutrophils and $Cd11b^{+}Ly6C^{+}$ monocytes in heart **(A-B)**, blood **(C-D)** or BM **(E-F)** from WT or *Gsdmd*$^{-/-}$ mice at different reperfusion time points (3 hours, 6 hours, 12 hours, 24 hours) after I/R or a sham surgery. Corresponding n values were indicated in the plots. The statistical significances of sham versus 3h, 6h, 12h or 24h were indicated (n = 3-5). **(G-H)** Flow cytometric analysis **(G)** and quantification **(H)** of $Cd11b^{+}Ly6G^{+}$ neutrophils and $Cd11b^{+}Ly6C^{+}$ monocytes in heart (left), blood (middle) or BM (right) from WT or *Gsdmd*$^{-/-}$ mice 24 hours after I/R (n =3). Data represent mean ± SD, One-way analysis of variance followed by Bonferroni's multiple comparison test **(B, D and F)** or multiple two-tailed Student's *t* test **(H)**. NS, not significant; *, $P<0.05$; **, $P<0.01$; ***, $P<0.001$; ****, $P<0.0001$.

Figure 6

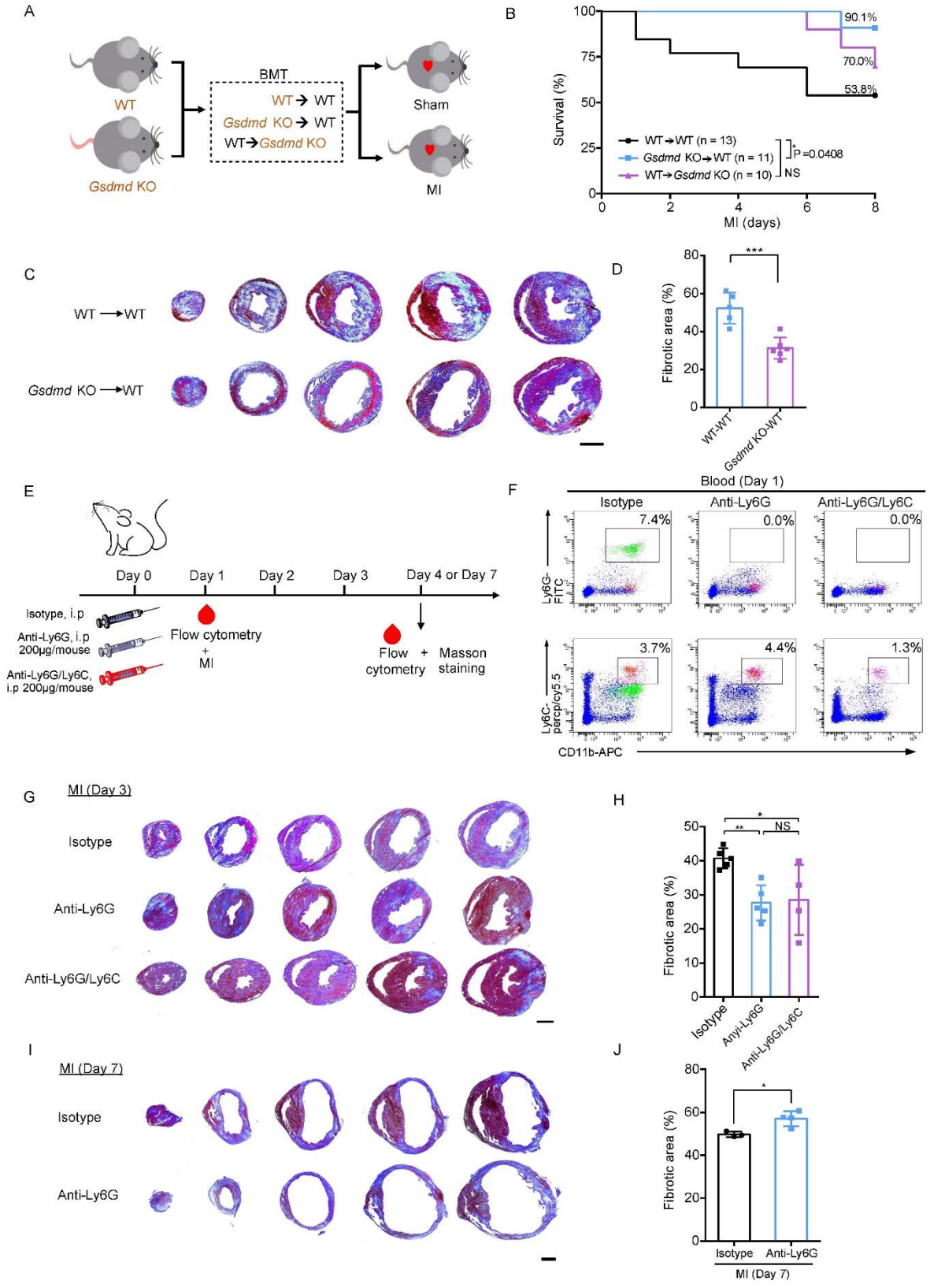

A
Tissue dissociation
(~ 55min)
Removal of debris and
CD11b+/neutrophil beads incubation
(~ 30min)
Magnetic separation
Collection of CD11b cells or Neutrophils
CD11b+ or Neu+ cells incubation
MI
Mixed cells
Mixed cells
CD11b cells
Neutrophils
CD11b+ or Neu+ cells
CD11b- or Neu- cells
B
CD11b+
LDH release (fold change)
C
CD11b+
IL-1β (pg/mL)
D
Neutrophils
LDH release (fold change)
E
Neutrophils
IL-1β (pg/mL)
WT
Gsdmd KO
MI (24h)
MI (72h)
NS
F
MI (24h)
Sham
WT
Gsdmd KO
GSDMD
NLRP3
Pro-IL-1β
Pro-Caspase-1
Cleaved-Caspase-1
Pro-Caspase-3
Cleaved-Caspase-3
HSP90
G
Sham
WT
Gsdmd KO
Protein levels
GSDMD
NLRP3
Pro-IL-1β
Pro-Caspase-1
Cleaved-Caspase-1
Pro-Caspase-3
Cleaved-Caspase-3
H
MI-Heart CD11b+ cells (72h)
WT
Gsdmd KO
NLRP3
P62
GSDMD
LC3-I
LC3-II
GAPDH
Pro-Caspase-3
Cleaved-Caspase-3
Pro-IL-1β
Cleaved-IL-1β
β-tubulin
I
WT
Gsdmd KO
Protein levels
NLRP3
GSDMD
P62
LC3II/I
Pro-Caspase-3
Cleaved-Caspase-3
Cleaved-IL-1β

767

Figure 6. GSDMD deficiency suppresses cell death and IL-1β secretion.

(A) Schematic diagram showing the strategy of preparing samples for IL-1β and lactate dehydrogenase (LDH) detection in $Cd11b^+$ myeloid-derived cells and neutrophils from the heart. **(B)** Secretion levels of LDH from leukocytes from the heart of WT or *Gsdmd*$^{-/-}$ mice 24 hours and 72 hours after MI. **(C)** Production of IL-1β from $Cd11b^+$ cells from the heart of WT or *Gsdmd*$^{-/-}$ mice 24 hours and 72 hours after MI assessed by ELISA. The corresponding n values were indicated in the plot. **(D)** Secretion levels of LDH from neutrophils isolated from the heart of WT or *Gsdmd*$^{-/-}$ mice 24 hours and 72 hours after MI. **(E)** Production of IL-1β from neutrophils isolated from the heart of WT or *Gsdmd*$^{-/-}$ mice at 24 hours and 72 hours after MI assessed by ELISA. The corresponding n values were indicated in the plot. **(F-G)** Representative immunoblotting images **(F)** and quantification **(G)** of protein levels in heart left ventricular tissues from WT or *Gsdmd*$^{-/-}$ mice 24 hours after MI or a sham surgery (n = 3 per group) **(H-I)** Representative immunoblotting images **(H)** and quantification **(I)** of protein levels of heart $Cd11b^+$ cells from WT or *Gsdmd*$^{-/-}$ mice 72 hours after MI or a sham surgery (n = 3-5). Statistical tests for **B-E and I**: Data are mean ± SD, NS, not significant; *, P<0.05; **, P<0.01;****, *P*<0.0001, as analyzed by unpaired two-tailed Student's *t* test**.** Statistical tests for **G**: Data represent mean ± SD, NS, not significant; *, *P*<0.05; **, *P*<0.01; ***, *P*<0.001, One-way analysis of variance with Tukey's correction for multiple comparison.

Figure 7


A
WT
Gsdmd KO
BMT
WT → WT
Gsdmd KO → WT
WT → Gsdmd KO
Sham
MI
B
Survival (%)
MI (days)
90.1%
70.0%
53.8%
WT→WT (n = 13)
Gsdmd KO→WT (n = 11)
WT→Gsdmd KO (n = 10)
P =0.0408
NS
C
WT → WT
Gsdmd KO → WT
D
Fibrotic area (%)
***
WT-WT
Gsdmd KO-WT
E
Day 0
Day 1
Day 2
Day 3
Day 4 or Day 7
Isotype, i.p
Anti-Ly6G, i.p 200μg/mouse
Anti-Ly6G/Ly6C, i.p 200μg/mouse
Flow cytometry + MI
Flow cytometry + Masson staining
F
Blood (Day 1)
Isotype
Anti-Ly6G
Anti-Ly6G/Ly6C
7.4%
0.0%
0.0%
3.7%
4.4%
1.3%
Ly6G-FITC
Ly6C-percp/cy5.5
CD11b-APC
G
MI (Day 3)
Isotype
Anti-Ly6G
Anti-Ly6G/Ly6C
H
Fibrotic area (%)
*
**
NS
Isotype
Anyi-Ly6G
Anti-Ly6G/Ly6C
I
MI (Day 7)
Isotype
Anti-Ly6G
J
Fibrotic area (%)
*
Isotype
Anti-Ly6G
MI (Day 7)

790

Figure 7. GSDMD-dependent bone marrow-derived myeloid cell contributes to acute inflammatory response.

(A) Schematic diagram showing the strategy of bone marrow transplantation (BMT) experiment. **(B)** Kaplan-Meier survival curves comparing post-MI survival of WT → WT mice (n = 13) to that of *Gsdmd* KO → WT mice (n = 11) or WT → *Gsdmd* KO mice (n = 10). Statistical significance was determined by Mantel-Cox test. **(C-D)** Masson's Trichrome staining **(C)** and quantification **(D)** of fibrotic area of short-axis heart sections from WT → WT (n = 5) or *Gsdmd* KO → WT (n = 6) mice 3 days after MI (scale bar, 1 mm). **(E)** Schematic diagram showing the strategy for neutrophil and monocyte depletion. **(F)** Flow cytometric gating of $Ly6G^+$ neutrophils and $Ly6C^+$ monocytes validating the successful elimination of neutrophils or monocytes in mice. **(G-H)** Masson's Trichrome staining **(G)** and quantification **(H)** of fibrotic area of short-axis heart sections from mice treated with isotype IgG (n = 5), anti-Ly6G antibody (n = 5) or anti-Ly6G/Ly6C antibody (n = 4) 3 days after MI (scale bar, 1 mm). **(I-J)** Masson's Trichrome staining **(I)** and quantification **(J)** of fibrotic area of short-axis heart sections from mice treated with isotype IgG (n = 3), anti-Ly6G antibody (n = 4) 1 week after MI (scale bar, 1 mm). Statistical tests: Data represent mean ± SD and were analyzed by unpaired two-tailed Student's *t* test **(D and J)** or One-way analysis of variance followed by Tukey's multiple comparison test **(H)**. NS, not significant; *, $P<0.05$; **, $P<0.01$; ***, $P<0.001$.

Figure 8

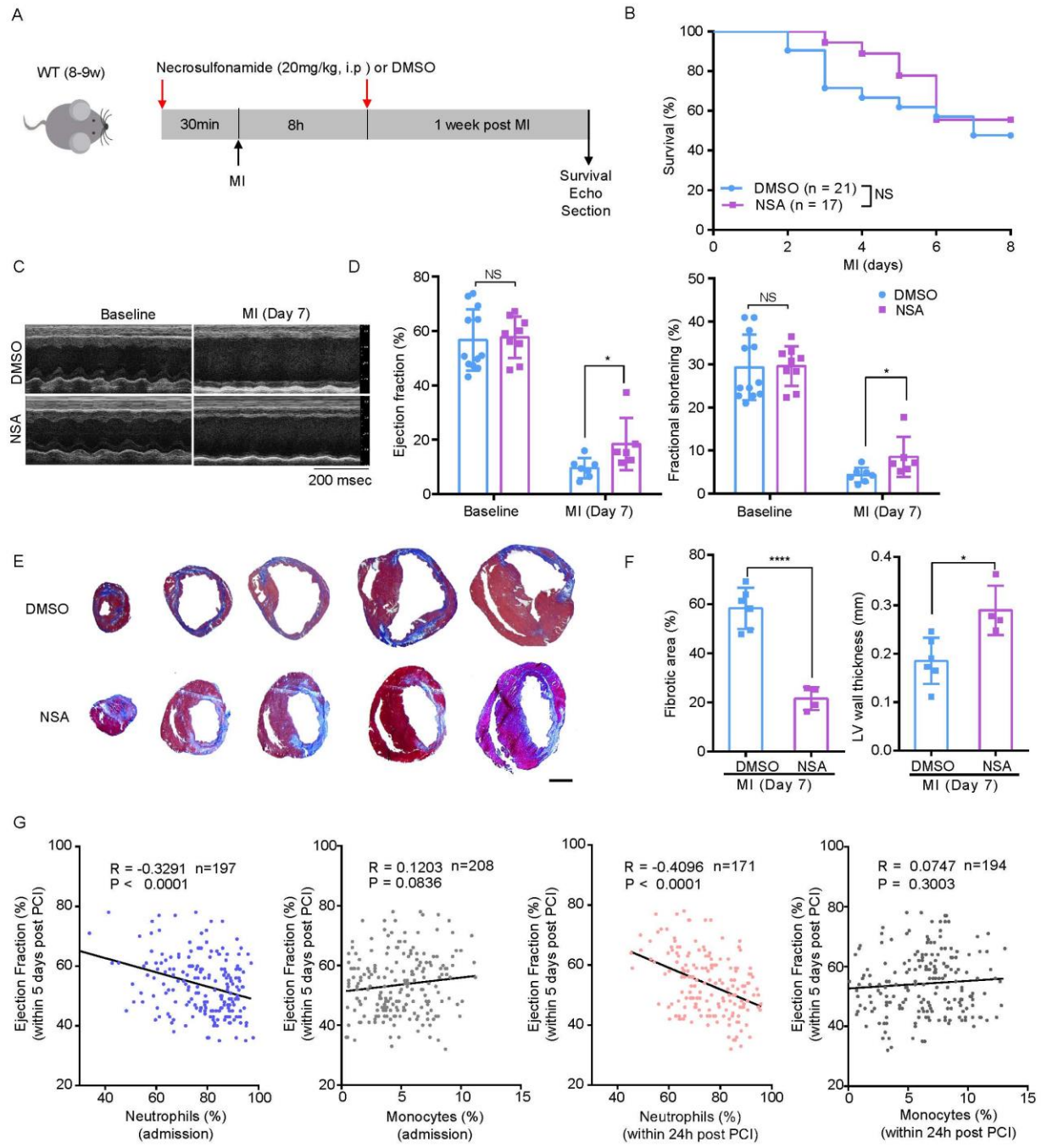


Figure 8. Pharmacological inhibition of GSDMD reduces infarct size post MI.

(A) Schematic diagram showing the strategy of NSA administration to the mice. **(B)** Kaplan-Meier survival curves comparing post-MI survival of control (DMSO administration) mice (n = 21) to

that of mice administrated with NSA (n = 17). Significance was determined by Mantel-Cox test. **(C-D)** Echocardiography images **(C)** and M-mode quantification **(D)** of ejection fraction (left) and fractional shortening (right) for control mice or mice with NSA administration before or 1 week after MI. (baseline: DMSO, n = 12; NSA, n= 9; 1 week: DMSO, n = 7; NSA, n = 6). **(E-F)** Masson's Trichrome staining **(E)** and quantification of fibrotic area and left ventricular (LV) wall thickness **(F)** of short-axis heart sections from control mice or mice with NSA administration 1 week after MI (DMSO, n = 6; NSA, n = 4) (scale bar, 1 mm). **(G)** Analysis of correlation between MI patients within 5 days post PCI ejection fraction (EF) and the percentage of neutrophils or monocytes in peripheral blood at the point of the admission or the patients within 24 h post PCI were performed with Pearson's correlation test. Statistical tests: Data represent mean ± SD and were analyzed by One-way analysis of variance with Tukey's correction for multiple comparison **(D)** or unpaired two-tailed Student's *t* test **(F)**. NS, not significant; *, $P<0.05$; ****, $P<0.0001$.