Ca\(^{2+}\)- and mitochondrial-dependent cardiomyocyte necrosis as a primary mediator of heart failure

Hiroyuki Nakayama,\(^1\) Xiongwen Chen,\(^2\) Christopher P. Baines,\(^1\) Raisa Klevitsky,\(^1\) Xiaoying Zhang,\(^3\) Hongyu Zhang,\(^2\) Naser Jaleeli,\(^2\) Balvin H.L. Chua,\(^4\) Timothy E. Hewett,\(^1\) Jeffrey Robbins,\(^1\) Steven R. Houser,\(^2\) and Jeffery D. Molkentin\(^1\)

\(^1\)Department of Pediatrics, Cincinnati Children’s Hospital Medical Center, University of Cincinnati, Cincinnati, Ohio, USA. \(^2\)Department of Physiology, Temple University School of Medicine, Philadelphia, Pennsylvania, USA. \(^3\)Fox Chase Cancer Center, Philadelphia, Pennsylvania, USA. \(^4\)James H. Quillen School of Medicine, East Tennessee State University, and James H. Quillen Veterans Affairs Medical Center, Johnson City, Tennessee, USA.

Loss of cardiomyocytes in heart failure is thought to occur largely through an apoptotic process. Here we show that heart failure can also be precipitated through myocyte necrosis associated with Ca\(^{2+}\) overload. Inducible transgenic mice with enhanced sarcolemmal L-type Ca\(^{2+}\) channel (LTCC) activity showed progressive myocyte necrosis that led to pump dysfunction and premature death, effects that were dramatically enhanced by acute stimulation of \(\beta\)-adrenergic receptors. Enhanced Ca\(^{2+}\) influx–induced cellular necrosis and cardiomyopathy was prevented with either LTCC blockers or \(\beta\)-adrenergic receptor antagonists, demonstrating a proximal relationship among \(\beta\)-adrenergic receptor function, Ca\(^{2+}\) handling, and heart failure progression through necrotic cell loss. Mechanistically, loss of cyclophilin D, a regulator of the mitochondrial permeability transition pore that underpins necrosis, blocked Ca\(^{2+}\) influx–induced necrosis of myocytes, heart failure, and isoproterenol-induced premature death. In contrast, overexpression of the antiapoptotic factor Bcl-2 was ineffective in mitigating heart failure and death associated with excess Ca\(^{2+}\) influx and acute \(\beta\)-adrenergic receptor stimulation. This paradigm of mitochondrial- and necrosis-dependent heart failure was also observed in other mouse models of disease, which supports the concept that heart failure is a pleiotropic disorder that involves not only apoptosis, but also necrotic loss of myocytes in association with dysregulated Ca\(^{2+}\) handling and \(\beta\)-adrenergic receptor signaling.

Introduction

Cardiovascular disease remains the primary cause of mortality in the Western world, with heart failure representing the fastest-growing subclass over the past decade (1–3). There are approximately 5 million Americans currently diagnosed with heart failure, which is characterized by a 5-year survival rate of approximately 50% and which has a total economic impact as high as $100 billion per year (4–6). Typically, heart failure is the culmination of long-standing diseases such as hypertension, ischemia from atherosclerosis, viral myocarditis, valvular insufficiency, or mutations in genes encoding sarcomeric proteins (6, 7). Poor ventricular pump function in heart failure activates reflex pathways that lead to increased catecholamine release within the heart and endocrine tissues in an attempt to maintain adequate perfusion. The persistent activation of these reflex responses appears to hasten the demise of the myocardi um, in part through an increase in myocyte death associated with excess catecholamines (7–12). Beneficial cardiac remodeling at the cellular and whole-organ level is promoted by \(\beta\)-adrenergic receptor antagonists, which results in an increase in left ventricular ejection fraction and a significant prolongation in lifespan through mechanisms that are largely unknown (13–15).

Heart failure is also characterized by ventricular dilation, elevated systolic wall stress, dysregulation in Ca\(^{2+}\) homeostasis within the myocyte, and activation of the sympathetic nervous system (13–16). To induce ventricular contraction, Ca\(^{2+}\) enters cardiomyocytes through the L-type Ca\(^{2+}\) channel (LTCC) during the early portion of the action potential, causing the release of a much larger amount of Ca\(^{2+}\) from the sarcoplasmic reticulum (SR) storage compartment by activating the ryanodine receptor (17) and thereby causing contraction. Myocyte relaxation is initiated by resequestration of Ca\(^{2+}\) into the SR via SR Ca\(^{2+}\) ATPase (SERCA2) and by Ca\(^{2+}\) efflux via the sarcolemmal Na\(^+/\)Ca\(^{2+}\) exchanger (NCX). The magnitude and timing of the Ca\(^{2+}\) transient determines the strength of contraction and is dynamically regulated by catecholamines binding to \(\beta\)-adrenergic receptors, resulting in the activation of adenyl cyclase, the generation of cAMP, and the subsequent activation of PKA (17). Once activated, PKA directly phosphorylates nodal Ca\(^{2+}\) regulatory proteins such as the LTCC (increased Ca\(^{2+}\) influx), the ryanodine receptor (increased SR Ca\(^{2+}\) release), and phospholamban (PLN; increased SERCA2 activity) as a means of enhancing total intracellular Ca\(^{2+}\) release (17, 18). In the dilated, failing heart, myocytes must generate greater than normal amounts of force to eject blood against a pathologically elevated increase in afterload (systolic wall stress). This requires persistent activation of sympathetic regulatory pathways to augment myocyte Ca\(^{2+}\) handling in a PKA-dependent manner. When myocytes are isolated from these failing hearts and taken out of this “sympathetic” context, they show a compensatory prolongation and slowed decay of the Ca\(^{2+}\) transient and an inability to effectively remove Ca\(^{2+}\) in diastole.

Nonstandard abbreviations used: Ca\(^{2+}\), cyclosporine A; Dox, doxycycline; DTG, double transgenic; Iso, isoproterenol; LTCC, L-type Ca\(^{2+}\) channel; α-MHC, α-myosin heavy chain; MPT, mitochondrial permeability transition; NCX, Na\(^+/\)Ca\(^{2+}\) exchanger; PLN, phospholamban; SERCA2, SR Ca\(^{2+}\) ATPase; SR, sarcoplasmic reticulum; TAC, transverse aortic constriction; ITA, tet-transactivator protein.

Conflict of interest: The authors have declared that no conflict of interest exists.

Citation for this article: J. Clin. Invest. 117:2431–2444 (2007). doi:10.1172/JCI31060.
(16, 19). Persistent Ca$^{2+}$ and adrenergic stress in the failing heart is thought to enhance cell death, although this hypothesis has yet to be definitively evaluated in vivo (20).

Alterations in catecholamines and Ca$^{2+}$ handling could promote cardiomyocyte death in heart failure through an apoptotic pathway, a necrotic pathway, or both. Apoptotic cell death is mediated by both an extrinsic pathway, consisting of death receptor signaling constituents, and an intrinsic pathway, consisting of pro-death Bcl-2 family members functioning at the level of the mitochondria and endoplasmic reticulum (21, 22). Countless studies have shown the association and/or causation between the apoptotic loss of myocytes and the progression of heart failure in humans and in animal models (12). While considerably less studied, necrosis may also be a critical mechanism underlying myocyte loss in heart failure or with aging (10, 21). Necrotic cell death is largely initiated at the level of the mitochondria following Ca$^{2+}$ overload, hypoxia, and oxidative damage (22). The mitochondrial permeability transition (MPT) pore, a protein complex that spans the outer and inner mitochondrial membranes, is considered to be the mediator of this event. The MPT has been hypothesized to minimally consist of the voltage-dependent anion channel in the outer membrane, the adenine nucleotide translocase in the inner membrane, and cyclophilin-D in the matrix (23–25). Mitochondrial Ca$^{2+}$ overload following ischemic injury, and possibly in disease states that lead to heart failure, can promote MPT and the induction of necrosis, although the contribution of this process to heart failure has not been evaluated (26–28). This concept is also supported by the observation of focal necrosis in Syrian cardiomyopathic hamsters deficient in β-sarcoglycan (Scgd) through a mechanism that may involve calcium overload (29).

Here we show that enhancement of cardiomyocyte Ca$^{2+}$ influx within the hearts of adult mice through sustained LTCC activation induced cell death through a mitochondrial-dependent necrotic process. This Ca$^{2+}$ overload–dependent necrosis was enhanced or abated by activation or inhibition, respectively, of β-adrenergic receptors. Inhibition of cellular apoptosis by Bcl-2 overexpression in the heart did not diminish Ca$^{2+}$ overload–induced myocyte death or heart failure or affect premature lethality in mice. In contrast, deletion of Ppif, which encodes cyclophilin D, blocked Ca$^{2+}$ overload–induced cell death, heart failure, and premature lethality. These results demonstrate that myocyte necrosis can be a significant contributor to heart failure through a β-adrenergic receptor–modulated pathway involving Ca$^{2+}$ overload and MPT.

**Results**

Generation of mice with inducible LTCC activity. The LTCC is the primary source of Ca$^{2+}$ influx that causes SR Ca$^{2+}$ loading and release in cardiac myocytes. In heart failure the overall activity of the LTCC is likely increased, contributing to a greater profile of Ca$^{2+}$ handling dysfunction (30, 31). Here we generated an inducible transgenic mouse to examine the effects of persistent increases in LTCC activity in the initiation and progression of heart failure. The β2a subunit of the LTCC was selected for overexpression because it enhances channel open probability and increases trafficking of the pore-forming α1c subunit to the sarcolemma, thereby causing greater Ca$^{2+}$ influx (18, 32, 33). A modified α- myosin heavy chain (α-MHC) promoter was used as the responder (34); when crossed with transgenic mice containing the α-MHC promoter–driven tet-transactivator protein (tTA), this produced cardiac-specific expression in the heart that was regulated by doxycycline (Dox) administration and/or withdrawal (Figure 1A). Multiple lines of β2a-containing mice were initially generated, and we selected lines with low (3.1-fold), medium (4.5-fold), and high (7.4-fold) β2a expression in the heart that was regulated by doxycycline (Dox) administration. TG, β2a transgene alone (without the driver tTA transgene). Control samples were from tTA single-transgenic mice.

**Characterization of Ca$^{2+}$ handling and contractility.** Myocytes isolated from young adult high- and low-expressing DTG mice without...
Dox administration had significantly larger L-type Ca\(^{2+}\) currents, Ca\(^{2+}\) transients, and myocyte fractional shortening compared with wild-type controls (Figure 2, A–C, and data not shown). Hearts isolated from young adult low-expressing DTG mice had greater contractility in systole in a working heart preparation, while relaxation was not altered (Figure 2D). The increase in total Ca\(^{2+}\) influx observed in DTG mice was associated with a significant increase in NCX activity, the primary mechanism for Ca\(^{2+}\) efflux in cardiac myocytes, in isolated myocytes (Figure 2E). There were no changes in SERCA2 or PLN mRNA levels (Figure 2F). Adult myocytes isolated from low-expressing DTG mice showed no significant increase in diastolic calcium at 0.5 Hz stimulation, although at higher stimulation frequencies, DTG myocytes showed higher diastolic calcium levels compared with wild-type control myocytes (data not shown). These experiments showed that inducible overexpression of the \(\beta2a\) subunit of the LTCC increased Ca\(^{2+}\) influx and myocyte and cardiac contractility in young mice. However, low- and high-expressing DTG mice showed activation of hypertrophic/stress response genes in the heart, such as atrial natriuretic factor and \(\alpha\)-actin, suggesting that pathology might ensue as the mice aged further (Figure 2F).

**Overexpression of \(\beta2a\) induces cardiomyopathy.** The analysis of Ca\(^{2+}\) current and contractile properties presented above was performed in low-expressing DTG mice at a relatively young age (12–14 weeks), when they had normal or enhanced ventricular function; fibrosis, ventricular dysfunction, and premature lethality became apparent in these mice by 6–12 months of age (Figure 3A). By comparison, high- and medium-expressing DTG mice already showed signs of cardiomyopathy by 12–14 weeks of age.

Hearts from low- and high-expressing DTG mice without Dox administration were hypertrophic by 4 months of age, with significant increases in heart weight normalized to body weight (Figure 3B). Cardiac function, as assessed by echocardiography, was abnormal in high-expressing DTG mice by 4 months of age (Figure 3C) and became dysfunctional in low-expressing DTG mice by 12 months of age (data not shown). Histological assessment of cardiac pathology demonstrated areas of myocyte disorganization and focal and interstitial fibrosis in both low- and high-expressing DTG mice, although these abnormalities were always more pronounced in high-expressing DTG mice (Figure 3, D and E). Approximately 1 of 3 hearts from high-expressing DTG mice at 4 months of age showed areas of myocyte dropout that reacted with the Ca\(^{2+}\)-specific von Kossa deposition stain, suggestive of Ca\(^{2+}\) overload in these myocytes (Figure 3D, far right panel). Cardiac histological sections left at room temperature (from animals that had expired 8 hours prior) did not react with von Kossa staining, suggesting specificity for Ca\(^{2+}\) deposits associated with an active overload process (data not shown). These histological abnormalities were not associated with increased levels of TUNEL staining, suggesting that myocytes were not undergoing apoptosis as a result of increased Ca\(^{2+}\) influx (Figure 3F). As an important control, wild-type mice subjected to pressure overload by transverse aortic constriction (TAC) showed a nearly 3-fold increase in TUNEL (Figure 3F) (see Discussion).

**Verapamil prevents disease in DTG mice.** We examined whether overexpression of the \(\beta2a\) subunit of the LTCC induces disease specifically through increased Ca\(^{2+}\) influx by treating high-expressing DTG mice without Dox administration with the LTCC inhibitor verapamil. Mice were given verapamil at weaning (3 weeks of age) and maintained on drug for 14 weeks before analysis. Verapamil-treated high-expressing DTG mice had no hypertrophy and reduced atrial pathology, and cardiac function as assessed by fractional shortening was not diminished (Figure 4, A–C). Verapamil treatment also reduced histopathology and the relative extent of fibrosis and completely prevented histological Ca\(^{2+}\) deposits (Figure 4, D and E). These results indicate that the mechanism for \(\beta2a\)
overexpression–induced cardiomyopathy involves increased Ca\textsuperscript{2+} influx through the LTCC.

**Synergy of β-adrenergic receptor activity with the LTCC induces Ca\textsuperscript{2+} overload and necrosis.** Because β-adrenergic receptor activity augments LTCC and SR activity, it should further increase Ca\textsuperscript{2+} influx and SR Ca\textsuperscript{2+} loading in β2a DTG mice. Infusion of isoproterenol (Iso; 60 mg/kg/d) induced death in all high-expressing DTG mice within 12 days and in 4 of 9 low-expressing DTG mice (Figure 5A). No tTA single-transgenic control mouse showed any lethality at this dosage of Iso, nor did the mice have increased histopathology beyond wild-type mice treated with Iso. The low-expressing DTG mice that survived Iso infusion had significant reductions in ventricular performance, with large areas of myocyte loss and fibrosis (Figure 5, B, C, and E). Remarkably, large areas of myocyte dropout were observed in the ventricular walls and septum of Iso-infused DTG mice (Figure 5C). von Kossa staining showed areas of significant Ca\textsuperscript{2+} deposition in myocytes throughout the ventricular walls and septum that corresponded with regions of focal myocyte necrosis (Figure 5, D and F). However, the number of TUNEL-positive myocytes in these same histological sections was not significantly greater than in control hearts without Iso, suggesting that the widespread and focal loss of myocytes during and after Iso infusion was primarily caused by myocyte necrosis (data not shown). Collectively, these results suggest that β-adrenergic receptor–augmented LTCC activity in β2a mice caused acute Ca\textsuperscript{2+} overload, myocyte necrosis, and premature death.

The pathology associated with β2a overexpression in low- and high-expressing DTG mice was prevented when the inducible transgene was extinguished with Dox administration. For example, high-expressing DTG mice showed no overt pathology, hypertrophy, or reduction in ventricular performance when administered Dox (Figure 6, A–C). Moreover, low-expressing DTG mice challenged with Iso infusion showed almost no lethality when given Dox continuously 2 weeks prior to minipump insertion, which completely extinguished β2a overexpression (Figure 6D). These mice also did not develop cardiac dysfunction (Figure 6E), and histological assessment showed no significant increase in fibrosis or von Kossa–positive myocytes (Figure 6, F and G).

**Assessment of cellular necrosis.** The focal areas of myocyte loss, fibrosis, and von Kossa–positive myocytes in β2a DTG mice sug-
gested a cellular phenotype of necrosis, but not apoptosis. Indeed, in addition to no increase in TUNEL (Figure 3), DTG mice also failed to show significant increases in caspase 3 cleavage in the heart at baseline or after acute ISO infusion (data not shown). However, assessment of necrosis using the myosin antibody injection technique showed detectable levels of basal necrosis in the hearts of low-expressing DTG mice without stimulation (5 cells per 10,000), yet no reactivity was observed in control mice (Figure 7, A and B) (21). Acute infusion of ISO caused a massive increase in necrotic myosin-positive cells in DTG mice, compared with a small effect in control mice (Figure 7, A and B). The baseline increase in necrosis in DTG mice was also associated with a small, albeit significant, increase in myeloperoxidase activity in the heart that was associated with increased granulocyte content that typically occurs with necrosis (Figure 7C).

We previously observed an increase in cell death in cultured adult feline ventricular myocytes overexpressing the same β2a subunit of the LTCC (35). Loss of β2a-dependent cells (adenoviral gene transfer) showed indexes of both apoptotic and necrotic cell death, although the relatively unphysiologic context associated with culturing precludes a rigorous assignment of the exclusivity between apoptotic and necrotic mechanisms (35). Here we extended these observations to show that very low levels of β-adrenergic receptor stimulation (ISO, 10⁻¹⁰ M) synergized with β2a overexpression to induce myocyte death (Figure 7, D and E). This dose of ISO had no effect on control-infected myocytes without β2a overexpression (Figure 7, D and E). Moreover, this synergistic increase in cell death was partially blocked (about 50% recovery; P < 0.05) with cyclosporine A (CsA), which can antagonize MPT associated with calcium overload (data not shown). These results are consistent with our in vivo observations suggesting that myocyte calcium overload in conjunction with β-adrenergic receptor stimulation can lead to rapid cell death.

Blockade of β-adrenergic receptors prevents disease in DTG mice. The interplay between β-adrenergic receptors and LTCC activity as a primary determinant of Ca²⁺ overload–induced cell death and cardio-
myopathy was further investigated using a β-adrenergic receptor antagonist. High-expressing DTG mice without Dox administration were given metoprolol at weaning for a 3-month period before being analyzed. Remarkably, metoprolol prevented overt ventricular and atrial hypertrophy, prevented increased heart weight normalized to body weight, and prevented the cardiac dysfunction that was normally observed in high-expressing DTG mice (Figure 9A–C). Histological analysis also showed a remarkable improvement in fibrosis and areas of myocyte dropout with metoprolol treatment (Figure 8, D and E). These results suggest that inhibition of β-adrenergic receptors reduced disease associated with increased β2a expression by antagonizing the overall Ca²⁺ overload phenomenon itself, likely at multiple levels (see Discussion).

**Bcl-2 overexpression does not prevent β2a-dependent Ca²⁺ overload and cardiomyopathy.** Overexpression of the antiapoptotic protein Bcl-2 in the heart was previously shown to dramatically attenuate ischemia-reperfusion injury and some forms of cardiomyopathy by directly reducing cardiomyocyte apoptosis (36–38). Thus, the Bcl-2 transgene can serve as an indicator of apoptotic-dependent cardiomyopathy. The Bcl-2 transgene was crossed into the high-expressing DTG background to assess the contribution of apoptosis to the development of β2a-dependent cardiomyopathy. However, no prevention of disease was observed in β2a mice with the Bcl-2 transgene at any age. For example, ventricular and atrial enlargement, reduction in fractional shortening, and histopathology and fibrosis were all identical between high-expressing DTG mice and DTG mice that also contained the Bcl-2 transgene (Figure 9, A–E). Moreover, high-expressing DTG mice with the Bcl-2 transgene showed complete lethality with 14 days of Iso infusion (Figure 9F), similar to DTG mice without the Bcl-2 transgene (Figure 5A). Importantly, overexpression of the β2a subunit did not affect Bcl-2 expression levels driven from this transgene (Figure 9G). Thus, attenuation of apoptotic cell loss with the Bcl-2 transgene did not prevent or reduce disease associated with increased LTCC activity, suggesting that Ca²⁺ overload induces cell loss and cardiomyopathy somewhat independent of apoptosis, at least in the high-expressing β2a line.

**Loss of cyclophilin D prevents disease in DTG mice.** We have previously shown that loss of Ppif, which encodes cyclophilin D, renders cells less sensitive to Ca²⁺ overload–induced necrosis (26). Indeed, Ppif−/− mice have 40% less overall cell loss in the heart following ischemia-reperfusion injury (26). Here we crossed β2a DTG mice into the Ppif−/− background to investigate the centrality of necrosis in the ensuing myocyte loss and cardiomyopathy associated with Ca²⁺ overload. Remarkably, loss of Ppif prevented disease associated with the β2a DTG phenotype. For example, DTG mice lacking Ppif showed no ventricular or atrial enlargement, no reductions in fractional shortening, and much fewer histological abnormalities such as fibrosis and myocyte dropout (Figure 10, A–E). We were also unable to identify von Kossa–positive myocytes in DTG mice lacking Ppif, while DTG controls in the same background showed Ca²⁺ deposits (data not shown). Furthermore, 14 days of

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**Figure 5**
Iso infusion dramatically enhances β2a-dependent disease and death. (A) Kaplan-Meier curves of control tTA single-transgenic as well as low- and high-expressing DTG mice infused with Iso at 60 mg/kg/d for 14 days. *P < 0.05 versus control with PBS, ANOVA. (B) Histological assessment of cardiac ventricular pathology by Masson’s trichrome in control tTA single-transgenic and low-expressing DTG mice with Iso or PBS infusion for 14 days. *P < 0.05 versus PBS-infused control, ANOVA. (C) Histological assessment of cardiomyopathy by Masson’s trichrome in control tTA single-transgenic and low-expressing DTG mice with Iso or PBS infusion for 14 days. Original magnification, ×200 (C); ×40 (D). (E) Quantitation of fibrotic area (blue) from trichrome-stained cardiac histological sections. Numbers indicate the number of mice analyzed in each group (10 photographs quantified per mouse heart). *P < 0.05 versus PBS-infused control, ANOVA. (F) Quantitation of areas of myocytes with Ca²⁺ deposits in control tTA single-transgenic and low-expressing DTG mice with Iso or PBS infusion for 14 days. *P < 0.05 versus PBS-infused DTG, Student’s t test.
Iso infusion produced no lethality in DTG mice in the absence of \( \text{Ppif}^{-/-} \), while DTG mice from the same cross containing \( \text{Ppif}^{-/-} \) showed identical lethality to other groups of DTG mice discussed above (Figure 10F). As an important control, \( \text{Ppif}^{+/+} \) mice with the \( \beta_2a \) DTG configuration showed the same augmentation in L-type Ca\(^{2+} \) current as did \( \beta_2a \) DTG mice with 2 good copies of \( \text{Ppif} \) (Figure 10G). These results indicate that inhibition of MPT prevents Ca\(^{2+} \) overload–induced disease associated with increased LTCC activity and \( \beta \)-adrenergic receptor signaling (see Discussion).

Assessment of necrotic cell loss in other mouse models of disease. Because overexpression of \( \beta_2a \) as a means of inducing heart failure is somewhat arbitrary (although it reveals the underlying pathophysiology of the pathway), we investigated other mouse models of heart failure for signs of mitochondrial-dependent necrosis. Interestingly, the cardiomyopathic hamster lacking \( \text{Scgd} \) showed disease that was associated with enhanced LTCC density and focal necrosis in the heart (29). Serendipitously, we have already crossed \( \text{Ppif}^{-/-} \) mice with \( \text{Scgd}^{-/-} \) mice, resulting in a near-complete rescue of focal fibrosis and ventricular performance, which are both normally compromised in this mouse model of muscular dystrophy (D.P. Millay and J.D. Molkentin, unpublished observations). This suggests that muscular dystrophy, which is known to promote an unstable membrane and more Ca\(^{2+} \) influx, may also result from a progressive loss of myocytes through a necrotic process.

Experimentally, we also examined antecedents of necrotic cell loss by performing von Kossa staining in hearts from either FVB mice or C57BL/6 mice subjected to long-term pressure overload by TAC. Interestingly, FVB mice are known to be resistant to TAC-induced dysfunction and showed no von Kossa–positive myocytes. However, C57BL/6 mice after only 4 weeks of TAC showed reduced ventricular performance and areas of focal von Kossa–positive myocytes (Figure 11A). In contrast, heart failure associated with disruption of the gene encoding muscle lim protein (\( \text{Mlk} \)) showed no Ca\(^{2+} \) accumulation in the heart, suggesting...
The observations made here suggest a unique signaling mechanism underlying heart failure that is induced by persistent increases in Ca^{2+} influx through the LTCC, activation of β-adrenergic receptors, and cellular necrosis. To our knowledge, it has not been directly demonstrated before that Ca^{2+} influx–induced myocyte necrosis might be a significant contributor to heart failure, although a number of lines of indirect evidence support this overall hypothesis. Changes in the amount of Ca^{2+} within adult ventricular myocytes needed to alter contractility are primarily accomplished by increasing LTCC-mediated Ca^{2+} fluxes across the sarcolemma. Physiologically, transient increases in cardiac function during exercise occur via catecholamine-regulated increases in Ca^{2+} influx through the LTCC, which increases SR Ca^{2+} loading, the magnitude of the Ca^{2+} transient, and cardiac contractility (39). In the new steady state this increased Ca^{2+} influx and SR Ca^{2+} loading is balanced by increased Ca^{2+} efflux via the NCX or by the plasma membrane Ca^{2+} ATPase pump (39). However, if Ca^{2+} influx is persistently activated or if Ca^{2+} removal systems are persistently compromised, as can occur in heart failure (40), dysfunctional Ca^{2+} handling can induce Ca^{2+} overload. Indeed, loss of the gene encoding NCX1, which removes the protein primarily responsible for Ca^{2+} efflux in cardiac myocytes, results in cardiomyopathy, premature lethality in adulthood, and increased diastolic Ca^{2+} in embryonic heart tubes (41, 42). Abnormal diastolic Ca^{2+} handling can increase diastolic tension by activation of contractile proteins, thus negatively affecting ventricular filling and myocardial energetics, but our present study suggests it may also predispose myocytes to mitochondrial dysfunction and premature death.

We largely expected that β2a overexpression would induce cardiomyopathy since a mouse model with α1c overexpression (pore forming subunit of the LTCC) in the heart was reported to develop disease later in life (43), and based on our earlier observations in β2a adenoviral-infected feline myocytes in culture (35). Indeed, destabilization of the sarcolemmal membrane in mdx mice, a model of muscular dystrophy, is associated with increased Ca^{2+} influx and cardiac dysfunction (44), and the hamster model of muscular dystrophy associated with Sgfd deficiency showed focal necrosis in the...
cytosolic $\text{Ca}^{2+}$ levels averaged across systole and diastole that are not appreciably different from wild type (39). However, human heart failure is characterized by increased LTCC activity (30, 31) and fractional shortening assessment (C) for control TTA single-transgenic and high-expressing DTG mice with or without metoprolol. Numbers indicate the number of sections analyzed in each group. *P < 0.05 versus untreated control, ANOVA. (D) Histological assessment of cardiac ventricular pathology by Masson’s trichrome staining in the indicated mice. Original magnification, ×200. (E) Quantitation of fibrotic area (blue) from trichrome-stained cardiac histological sections. Numbers indicate the number of sections analyzed in each group. *P < 0.05 versus untreated control; **P < 0.05 versus DTG without metoprolol, ANOVA.

Figure 8

Blocking $\beta$-adrenergic receptor prevents disease in high-expressing DTG mice. (A) Gross morphological view of hearts from high-expressing DTG β2a mice (4 months of age) with or without metoprolol treatment. (B and C) Heart weight normalized to body weight (B) and fractional shortening assessment (C) for control TTA single-transgenic and high-expressing DTG mice with or without metoprolol. Numbers indicate the number of mice analyzed in each group. *P < 0.05 versus untreated control, ANOVA. (D) Histological assessment of cardiac ventricular pathology by Masson’s trichrome staining in the indicated mice. Original magnification, ×200. (E) Quantitation of fibrotic area (blue) from trichrome-stained cardiac histological sections. Numbers indicate the number of sections analyzed in each group. *P < 0.05 versus untreated control; **P < 0.05 versus DTG without metoprolol, ANOVA.

expression of $\beta$-adrenergic receptors. For example, when cardiac pump function is reduced following an injury, such as after a myocardial infarction, sympathetic reflex responses maintain cardiac pump function and cardiac output by increasing contractility (increased $\text{Ca}^{2+}$) in the surviving myocytes. While initially compensatory, prolonged increases in catecholamines, or supplementation with inotropes that function $\beta$-adrenergic receptors, enhance the progression of heart failure and can lead to cell loss (7–11). Indeed, pharmacologic blockade of $\beta$-adrenergic receptors in heart failure provides a significant benefit to patient survival, demonstrating the largely deleterious role associated with constitutively high $\beta$-adrenergic receptor signaling in the heart (13–15). It is well established that acute signaling through both $\beta$- and $\beta$-adrenergic receptors result in PKA-mediated phosphorylation of nodal $\text{Ca}^{2+}$ handling proteins, leading to augmentation in the $\text{Ca}^{2+}$ transient and contractility. It is less certain that $\beta$-adrenergic receptors promote heart failure progression through a $\text{Ca}^{2+}$-dependent mechanism, given their prominent desensitization over time. However, a reasonable case can be made that a primary disease mechanism in heart failure is constitutively increased catecholamine levels and $\beta$-adrenergic receptor signaling. For example, overexpression of the $\beta$-adrenergic receptor in the hearts of transgenic mice, or high levels of $\beta$-adrenergic receptor expression, eventually induced heart failure with abundant fibrosis (54–58). That $\text{Ca}^{2+}$ serves as a pri-


mary effector of β-adrenergic receptor–induced heart failure was demonstrated by a rescue of disease associated with β1-adrenergic receptor overexpression through simultaneous deletion of the Pln gene (59). This result suggests that simple removal of diastolic Ca\(^{2+}\) caused by enhanced β-adrenergic receptor signaling was sufficient to abate heart failure. This result also suggests that while β-adrenergic receptors may be desensitized in heart failure, they contain sufficient functional capacity to promote Ca\(^{2+}\) overload and enhance heart failure progression (19). Our results also support a critical role for β-adrenergic receptors in further augmenting a pathologic profile of Ca\(^{2+}\) overload, which likely occurs at the level of the SR (ryanodine receptor) and sarcolemma (LTCC). Indeed, β-adrenergic receptor blockade prevented heart failure in our high-expressing DTG mice.

Heart failure is a complex and progressive syndrome that often culminates in death by arrhythmias or hemodynamic instability. One significant mechanism underlying its progressive nature is a stochastic loss of cardiac myocytes that eventually renders the heart with too few cells to properly function (11, 12). This cumulative loss of myocytes in heart failure has been generally attributed to an apoptotic process (12), suggesting the use of pharmacologic agents that antagonize apoptotic effector proteins such as caspases, pro-death Bcl-2 family members, or nucleases (60). Indeed, alterations in Ca\(^{2+}\), either global or within select microenvironments, can activate Ca\(^{2+}\)/calmodulin-dependent kinase in the heart and lead to further alterations in Ca\(^{2+}\) handling that can induce myocyte apoptosis and heart failure (61–64). However, essentially no mechanistic data exist implicating a necrotic process of cell loss as a significant contributor to heart failure, although correlative data have been shown. Necrosis occurs in most tissues following ischemic injury or Ca\(^{2+}\) overload in combination with depletion of high-energy phosphates such as ATP, resulting in mitochondrial swelling and rupture (22–24). Necrosis associated with mitochondrial swelling and rupture is not thought to be a strictly passive process, but instead can be regulated at the level of the MPT pore through the activity of cyclophilin D (23–25). Disruption of Ppif significantly desensitized cells and tissues to necrotic cell death following hypoxia, Ca\(^{2+}\) overload, and ROS stimulation in the heart and brain (26–28). Indeed, doxorubicin-induced cardiomyopathy, which involves high levels of ROS as the disease-inducing mechanism, was prevented in Ppif\(^{-/-}\) hearts. Moreover, enhanced Ca\(^{2+}\) influx associated with muscular dystrophy in Scgd\(^{-/-}\) mice was also partially blocked by deletion of Ppif (D.P. Millay and J.D. Molkentin, unpublished observations). There is also evidence that ROS may be even more potent than calcium overload in causing MPT as an underlying determinant of necrotic cell loss in adult myocytes (65).
Regardless of the stimulus, the cumulative loss of cells by necrosis has been correlated with heart failure and aging in a number of previous studies (10, 21). Ppif−/− mice may serve as a critical tool for parsing the mechanistic associations between cellular necrosis and heart failure propensity in additional mouse models of disease. Such data might suggest the most appropriate treatments for certain types of heart disease through antinecrotic, antiapoptotic, or a combination of both therapeutic agents for slowing or halting the progression of cellular attrition in heart failure. Inhibition of cyclophilin D can be the loss of cells by necrosis in select forms of heart failure. Inhibition of cyclophilin D can be the loss of cells by necrosis in select forms of heart failure. Inhibition of cyclophilin D can be the loss of cells by necrosis in select forms of heart failure.

Methods

Generation of transgenic mice and animal procedures. A cDNA encoding the rat LTCC β2a subunit (35) was cloned into the modified murine α-MHC promoter expression vector to permit Dox-regulated expression in combination with a cardiac-specific tTA-expressing transgene (34). Bel-2 transgenic mice were described previously (36). Ppif-targeted mice were also described previously (26), as were Mlp−/− mice (67). TAC was performed as previously described by us (45). Doxorubicin was given by i.p injection at 15 mg/kg, and mice were followed for 2 weeks. To quantify necrotic myocytes, 100 μg of mAb against cardiac myosin (Biogenesis) was injected i.v followed by analysis 24 hours afterward by immunohistochemistry on frozen 7-μm sections with Alexa Fluor–conjugated anti-mouse antibody (Invitrogen). Experiments involving animals were approved by the Institutional Animal Care and Use Committee of Cincinnati Children’s Hospital.

Western blot and RT-PCR analyses. Ventricle samples from mouse hearts were frozen in liquid nitrogen and stored at −70°C. For Western blot analysis, heart samples were homogenized in extraction buffer [100 mM (NH₄)₂SO₄, 20 mM Tris-HCl, pH 7.5; 10% glycerol; 1% Triton X; 1 mM DTT; 1 mM EDTA; 1 mM EGTA; 10 μM calpain inhibitor II (Roche); and 1 μg/ml pepstatin] and a protease inhibitor cocktail (Complete EDTA-free; Roche) and centrifuged at 3,000 g for 5 minutes at 4°C, and the resultant supernatants were saved. Proteins were also analyzed by Western blotting from heart tissue prepared in a sucrose-based buffer (250 mM sucrose; 10 mM Tris-HCl, pH 7.5; 1 mM DTT; 1 mM EDTA; 1 mM EGTA; and protease inhibitors; Roche). These heart samples were homogenized with a motor-driven teflon homogenizer in sucrose extraction buffer, homogenates were centrifuged at 3,000 g for 5 minutes at 4°C, and the resultant supernatants were saved and stored at −70°C until use. Western blotting conditions were described previously (68). Antibodies included β2a subunit (gift from K. Campbell, University of Iowa Carver College of Medicine, Iowa City, Iowa).
Kossa staining was performed to detect Ca
tic Instruments Inc.). For each heart section, 10 photographs were taken
at x200 magnification to represent the entire heart section. Images were
analyzed with Metamorph 6.1 software (Universal Imaging Corp.), and
the average percent blue area was calculated across at least 3 independent
hearts by an investigator blinded to group.

Echocardiography, working heart preparation, and minipump implantation. Mice
from all genotypes or treatment groups were anesthetized with isoflurane, and
echocardiography was performed using a Hewlett Packard 5500 instru-
ment with a 15-MHz microprobe as previously described (45). Echocardi-
ographic measurements were taken on M-mode in triplicate for each mouse.
The isolated work-performing heart preparation from mice was described in
detail previously (71). Alzet mini-osmotic pumps (no. 2002; Alza Corp.)
containing either Iso (60 mg/kg/d) or PBS were surgically inserted dorsally
and subcutaneously in mice under isoflurane anesthesia. All surviving mice
were analyzed by echocardiography and sacrificed 2 weeks later.

Drug treatment. To shut down β2a protein expression in DTG mice, Dox
(Sigma-Aldrich) was administered at 1 g/l in the drinking water for 2–3
weeks. The Ca2+ channel antagonist verapamil (Sigma-Aldrich) was given at
0.1 mg/ml (roughly 10 mg/kg/d) in the drinking water as previously reported
(72). The β-adrenergic receptor antagonist metoprolol (Sigma-Aldrich) was
also given in the drinking water at 2 g/ml as previously reported (73).

Ca2+ current measurements and cell shortening. Ventricular myocytes were iso-
lated as described previously (74). Myocytes were maintained at room tempera-
ture in 5% CO2 and 95% O2 and used within 8 hours of isolation. Myocytes
were placed in a chamber mounted on an inverted Nikon microscope and
perfused with normal physiological solution (Tyrode) containing 1 mM Ca2+.
Contractions were measured with video edge detector (35). Adenoviral infec-
tion with β2a or GFP adenoviruses was described previously (35). Intracellular
Ca2+ was measured with either Fluo-4 or Indo-1 as described previously (35,
2007). Whole-cell Ca2+ ([Ca2+]o, 2 mM) current was recorded as described previ-
ously (35). NCX current was measured as described by Wei et al. (76).

Statistics. All results are presented as means ± SEM. Statistical analysis
was performed using InStat 3.0 software (GraphPad Software) for all unpaired
Student’s t tests. Prism 3.0 software was used for ANOVA (GraphPad Soft-
ware). All tests were performed as described in the figure legends. A P value
of less than 0.05 was considered significant.

Acknowledgments
This work was supported by the National Institutes of Health (to J.D. Molkentin). H. Nakayama was supported by a Post-Doctoral Fellowship from the Ohio Valley Affiliate branch of the American Heart Association (0425386B). J.D. Molkentin is an Established Investigator of the American Heart Association. This work was also supported by an international collaborative research grant in cardiovascular disease from the Leducq Fondation.

Received for publication November 26, 2006, and accepted in revised form May 14, 2007.

Address correspondence to: Jeffery D. Molkentin, Cincinnati Children’s Hospital Medical Center, Molecular Cardiovascular Biology, 3333 Burnet Ave. MLC 7020, Cincinnati, Ohio 45229, USA. Phone: (513) 636-3557; Fax (513) 636-5958; E-mail: jf.molkentin@cchmc.org. Or to: Steven R. Houser, Department of Physiology, Temple University School of Medicine, 3400 N. Broad St., Phila-
delphia, Pennsylvania 19140, USA. Phone: (215) 707-3278; Fax: (215) 707-0170; E-mail: srhouser@temple.edu.

Hiroyuki Nakayama and Xiongwen Chen contributed equally
to this work.


The Journal of Clinical Investigation


