Invited Review: point-counterpoint

Nitric oxide’s role in the heart: control of beating or breathing?

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Paulus, Walter J., and Jean G. F. Bronzwaer. Nitric oxide’s role in the heart: control of beating or breathing? Am J Physiol Heart Circ Physiol 287: H8–H13, 2004; 10.1152/ajpheart.01147.2003.—Beneficial actions of nitric oxide (NO) in failing myocardium have frequently been overshadowed by poorly documented negative inotropic effects mainly derived from in vitro cardiac preparations. NO’s beneficial actions include control of myocardial energetics and improvement of left ventricular (LV) diastolic distensibility. In isolated cardiomyocytes, administration of NO increases their diastolic cell length consistent with a rightward shift of the passive length-tension relation. This shift is explained by cGMP-induced phosphorylation of troponin I, which prevents calcium-independent diastolic cross-bridge cycling and concomitant diastolic stiffening of the myocardium. Similar improvements in diastolic stiffness have been observed in isolated guinea pig hearts, in pacing-induced heart failure dogs, and in patients with dilated cardiomyopathy or aortic stenosis and have been shown to result in higher LV preload reserve and stroke work. NO also controls myocardial energetics through its effects on mitochondrial respiration, oxygen consumption, and substrate utilization. The effects of NO on diastolic LV performance appear to be synergistic with its effects on myocardial energetics through prevention of myocardial energy wastage induced by LV contraction against late-systolic reflected arterial pressure waves and through prevention of diastolic LV stiffening, which is essential for the maintenance of adequate subendocardial coronary perfusion. A drop in these concerted actions of NO on diastolic LV distensibility and on myocardial energetics could well be instrumental for the relentless deterioration of failing myocardium.

myocardium; diastole; mitochondria; energetics

Nitric oxide (NO) is universally accepted as an important regulator of vascular tone, capillary permeability, and platelet adhesion. NO’s myocardial actions are unfortunately less well understood despite the growing clinical awareness that progressive dysfunction of the failing heart could well result from an imbalance between myocardial NO and oxidative stress induced by excess neurohormonal and inflammatory mediators (32). The appreciation of a beneficial role of NO in failing myocardium was a recent turnaround (8, 11, 15, 33) and resulted mainly from an appraisal of NO’s favorable effects on cardiac energetics (52) and on left ventricular (LV) diastolic distensibility (35) clearly outweighing the negative inotropy of NO reported in the very initial studies looking at its contractile effects. These studies had observed a reduction of extent and velocity of shortening of isolated cardiomyocytes after administration of exogenous NO (3) and an increase in extent and velocity of shortening of adrenergically stimulated cardiomyocytes after inhibition of endogenous NO production (1). At that time, these experiments were thought to provide an explanation for simultaneously published clinical observations that reported inducible NO synthase (NOS2) activity in patients with nonischemic dilated cardiomyopathy (10). These initial experimental studies and the potential link to myocardial dysfunction of nonischemic dilated cardiomyopathy were, however, rapidly rebutted by several investigators reporting positive inotropic effects of low doses of exogenous NO or of cGMP (23, 29) and by clinical studies reporting myocardial NOS2 expression in ischemic cardiomyopathy, in valvular heart disease, and even in the athlete’s heart (5, 16). These clinical studies also found higher NOS2 expression in heart failure patients with lower functional class, larger stroke work, and preserved LV diastolic distensibility. Nevertheless, the idea of NO being deleterious because of a negative inotropic effect gained widespread acceptance and subsequently hindered a correct appreciation of NO’s favorable effects on failing myocardium.

NO-INDUCED MYOCARDIAL CONTRACTILE DEPRESSION: TIME FOR ACQUITTAL!

Detailed analysis of the time course of isometric contraction of isolated cat papillary muscle strips revealed endogenous NO, released from the endothelium, to affect cardiac muscle contraction in a unique way (29, 48): NO induced an earlier onset of isometric tension decay, which reduced peak isometric tension without an effect on the rate of rise of tension (Fig. 1A). This effect was attributed to a NO-induced reduction in myofilamentary calcium sensitivity because of phosphorylation of troponin I by cGMP-dependent protein kinase as evident from simultaneous recordings in isolated cardiomyocytes of cell lengthening and of the calcium transient (45). In these cardiomyocytes, diastolic cell length was not clamped, and, after the administration of NO or of cGMP, diastolic cell length con-
Fig. 1. A: effects of nitric oxide (NO) on isolated papillary muscle isometric contraction (I.C.). NO has no effect on the rate of rise of isometric tension but causes earlier isometric tension decay with a concomitant small reduction in peak isometric tension. These effects are counteracted by an increase in muscle preload (NO + stretch). B: effects of an intracoronary infusion of sodium nitroprusside (SNP) on left ventricular (LV) pressure (LVP) in the normal human heart. There is no effect on the rate of rise of LVP but an earlier onset of isovolumic LVP decay with concomitant reduction in peak and end-systolic LV pressures. C: effects of an intracoronary infusion of substance P (SP) on the LVP-LV volume (LVV) relation in the normal human heart. Intracoronary SP caused a small right and downward displacement of the end-systolic pressure-volume point and a right and downward displacement of the diastolic pressure-volume relation consistent with an increase in LV distensibility. [Adapted from Ref. 32.]

sitionally increased (20, 45). This finding implied a rightward shift of the passive length-tension relation of the cardiomyocyte. This shift was also explained by NO-induced phosphorylation of troponin I, which prevented calcium-independent diastolic cross-bridge cycling and concomitant diastolic stiffening of the myocardium. Both the relaxation-hardening and distensibility-increasing effects of NO were confirmed in the human heart. During intracoronary infusions of low doses of NO donors (35) or of substance P (36), which releases NO from the coronary endothelium, there was an earlier onset of isovolumic LV pressure decay (Fig. 1B), lower LV peak systolic, end-systolic, and end-diastolic pressures, and rightward displacement of the diastolic LV pressure-volume relation (Fig. 1C). In patients with a hypertrophied LV of aortic stenosis, the NO-induced rightward displacement of the diastolic LV pressure-volume relation was larger than in controls (27). In patients with dilated cardiomyopathy, the rightward displacement of the diastolic LV pressure-volume relation was accompanied by a significant increase in LV stroke volume because of improved recruitment of the LV preload reserve (18). The lower LV end-systolic pressure at unaltered LV end-systolic volume observed during intracoronary infusions of NO donors or of substance P implied a downward shift of the LV end-systolic pressure-volume relation and was therefore consistent with a negative inotropic effect of NO. The unaltered LV dP/dt max at larger LV end-diastolic volume was also theoretically consistent with a lower myocardial inotropic state. The simultaneous fall in LV end-diastolic pressure and the rise in LV stroke volume or stroke work, however, argue against significant cardiac contractile depression as a result of these NO-induced effects. Finally, direct positive inotropic effects of NO were recently demonstrated in normal control patients (7), in whom an intracoronary infusion of N(E)-monomethyl-L-arginine (L-NMMA) induced a modest (14%) drop in LV dP/dt max. In the same study, intracoronary L-NMMA failed to alter LV dP/dt max in dilated cardiomyopathy patients despite myocardial expression of NOS2 in simultaneously procured endomyocardial biopsies.

After β-adrenoreceptor stimulation of isolated cardiac muscle strips, the NO-induced relaxation-hardening effect was larger probably because of simultaneous phosphorylation of troponin I by cAMP-dependent and cGMP-dependent protein kinases (29). In dilated cardiomyopathy patients, similar cooperative effects of NO and of β-adrenoreceptor stimulation were reported: during concomitant intravenous infusion of dobutamine, intracoronary infusion of substance P caused a larger drop in LV end-systolic pressure (≥30 mmHg) and a small (6%) reduction in LV dP/dt max (34). Both effects were again accompanied by a fall in LV end-diastolic pressure implying absence of hemodynamic deterioration. Similar findings have been observed during concomitant intravenous infusion of dobutamine and intracoronary infusion of the NO synthase inhibitor L-NMMA (14, 47) or of the angiotensin-converting enzyme (ACE) inhibitor enalaprilat (51). Intracoronary L-NMMA infusion raised LV dP/dt max and increased the slope of the LV end-systolic pressure-volume relation without a change in LV end-diastolic pressure, again implying no substantial change in overall hemodynamic status. Intracoronary enalaprilat in the presence of angiotensin II receptor blockade caused bradykinin-induced coronary endothelial release of NO, and this also resulted in a small reduction of LV dP/dt max accompanied by a fall in LV end-diastolic pressure and no change in LV stroke volume. Hence, from these observations in dilated cardiomyopathy patients, it can be concluded that in terms of overall LV performance, improvement in diastolic LV function also overrode the NO-induced attenuation of the LV contractile response to β-adrenoreceptor stimulation.

In transgenic mice with cardioselective overexpression of endothelial NOS (NOS3) (6) and a 60-fold increase in myocardial NOS3 activity (L-[3H]citrulline production), there was only a small reduction in peak LV developed pressure without hemodynamic consequence mainly because of myofilamentary
desensitization. A similar small reduction in peak LV developed pressure without signs of cardiac dysfunction was also observed in transgenic mice with cardioselective overexpression of NOS2 and a 20-fold increase in myocardial l-[^3]H]citrluline production (17). In these mice, the addition of l-arginine to the perfusion augmented the drop in LV developed pressure to 20% of the basal value again without hemodynamic consequence. In experimental volume overload, basal isometric twitch characteristics were more depressed in papillary muscles retrieved from decompensated than from compensated rats despite similar myocardial NOS2 activity (12).

**MAINTENANCE OF PRELOAD RESERVE: AN IMPORTANT TASK FOR NO IN THE STRESSED HEART!**

In isolated ejecting guinea pig hearts, a perfusate containing l-NMMA raised LV end-diastolic pressure and reduced preload recruitable LV stroke work because of an acute left and upward shift of the diastolic LV pressure-volume relation (40). In this preparation, use of the LV preload reserve also induced a rise in the NO concentration of the coronary effluent. This preload-triggered enhancement of myocardial NO production confirmed earlier observations using porphyric sensors inserted in the wall of the beating rabbit heart (38). In rats receiving 8 wk of treatment with a NOS inhibitor, the diastolic LV pressure-volume relation shifted upward with reduced LV unstressed volume and no increase in LV mass despite the elevated blood pressure (26). In chronically instrumented dogs, oral administration of a NOS inhibitor resulted in a left and upward shift of the diastolic LV pressure-volume relation and a drop in LV stroke work despite a simultaneous small upward displacement of the LV end-systolic pressure-volume relation (39). NO-related modulation of diastolic LV distensibility was also observed in the pacing-induced heart failure dog model (41), in which a fall in myocardial NO production occurred after 4 wk of pacing. This fall was accompanied by a drop in LV stroke volume and a steep rise in LV end-diastolic pressure, probably because of reduced diastolic LV distensibility.

A NO-induced diastolic LV distensibility increasing effect was observed not only in experimental models but also in the normal human heart (35), in the cardiac allograft (36), in the hypertrophied LV of aortic stenosis (27), and in the failing LV of dilated cardiomyopathy (18). In dilated cardiomyopathy patients with elevated LV filling pressures (18), enhanced myocardial NOS3 activity during intracoronary substance P infusion increased LV stroke volume and LV stroke work. This acute increase in LV stroke work resulted from a simultaneous NO-induced increase in diastolic LV distensibility and LV preload reserve (5).

In patients with dilated cardiomyopathy, limited LV preload reserve (19) corresponds with a restrictive LV filling pattern on the Doppler echocardiogram (37). This phenotype of dilated cardiomyopathy is characterized by a worse symptomatic course and a worse prognosis. Low intensity of LV endomyocardial NOS2 and NOS3 gene expression was recently demonstrated to coincide with this hemodynamic phenotype (5). In contrast, dilated cardiomyopathy patients with maintained LV preload reserve, normal Doppler echocardiographic LV filling dynamics, and low LV diastolic stiffness had a high intensity of LV endomyocardial NOS2 and NOS3 gene expression, comparable to the intensity observed in the athlete’s heart (5). Low LV diastolic stiffness and high LV preload reserve are also typical features of the athlete’s heart and could also be NO mediated because of the well-documented upregulation of NOS3 activity and expression by intense physical exercise (2, 43). Further evidence for a beneficial effect of high endomyocardial NO activity on prognosis of dilated cardiomyopathy was recently provided by studies looking at NOS3 gene polymorphism in humans. In these studies, dilated cardiomyopathy patients of a genotype with high NOS3 activity had a more benign course of their disease than patients of a genotype with low NOS3 activity (28). These findings also resemble the superior long-term outcome of LV remodeling after myocardial infarction in wild-type mice compared with NOS3 knockout mice (42). Finally, the improved prognosis of dilated cardiomyopathy patients treated with ACE inhibitors or β-blockers is paralleled by an upregulation of their endomyocardial NOS3 activity (18).

A beneficial effect of high endomyocardial NO activity on diastolic LV distensibility of the cardiomyopathic heart could result not only from NO-induced phosphorylation of troponin I and a concomitant reduction of diastolic cross-bridge cycling but also from prevention of endomyocardial fibrosis. Chronic inhibition of NO synthesis has indeed been demonstrated to induce progressive myocardial fibrosis through a signaling cascade involving endothelin, angiotensin II, aldosterone, and transforming growth factor-β. A recent study looked at the interaction between endomyocardial NOS gene expression and fibrosis in patients with dilated cardiomyopathy (4). This study found no correlation between endomyocardial NOS mRNA and collagen volume fraction and observed additive but opposite effects of intensity of NOS gene expression and of fibrosis on diastolic LV stiffness (Fig. 2). The lack of correlation between NOS expression and collagen does not exclude involvement of NOS in the development of myocardial fibrosis in dilated cardiomyopathy but suggests excessive deposition of collagen in cardiomyopathic hearts to result more from upregulation of stimulatory pathways such as endothelin, angiotensin II, or aldosterone than from downregulation of inhibitory pathways such as NO or natriuretic peptides.

**NO’S CONTROL OF DIASTOLE AND ENERGETICS: TWO OF A KIND?**

The altered energetics of failing myocardium are characterized by 1) reduced creatine kinase activity and phosphocreatine...
levels, 2) loss of control of myocardial mitochondrial respiration leading to excessive oxygen consumption, and 3) a switch in preferential myocardial substrate utilization from free fatty acids to glucose. Apart from creatine kinase activity (13), NO appears to correct all these derangements of myocardial energetics (50). NO can bind to heme moieties of proteins involved in mitochondrial respiration. Reduced inhibition of these enzymes explains the higher myocardial oxygen consumption in conscious dogs during NOS inhibition (46) and in terminal stages of experimental (52) and clinical heart failure (25), which are characterized by low cardiac NO production (18, 41). In failing human myocardium, this excessive myocardial oxygen consumption reacted favorably to ACE inhibitors, amlodipine, or a neutral endopeptidase inhibitor (25), all of which are known to raise myocardial NO content through inhibition of kinin degradation. In pacing-induced heart failure, at the time of transition to decompensation, a drop in myocardial NO production is observed, which coincides with a switch in myocardial substrate utilization from free fatty acids to glucose (41). A similar switch was also observed in transgenic mice with absent NOS gene expression (49). The altered energetics of failing myocardium are paralleled by a shift of myofilamentary gene expression toward isoforms with higher calcium sensitivity and lower ATPase activity. This shift in gene expression enhances contractile efficiency of failing myocardium even in the presence of a deranged oxygen consumption (21). In the human cardiomyopathic heart, administration of L-NMMA does not affect its efficiency (47) despite the augmented LV contractile response to β-adrenergic stimulation.

NO’s effects on LV contractile performance appear to be synergistic with its effects on energetics through prevention of inappropriate contractile augmentation in the setting of reperfusion, through prevention of myocardial energy wastage induced by LV contraction against late-systolic reflected arterial pressure waves and through prevention of diastolic LV stiffening, which preserves adequate subendocardial coronary perfusion. In NOS3 knockout mice subjected to 30 min of global ischemia, followed by reperfusion, a paradoxical increase in NO production was observed, which coincides with a switch in myocardial substrate utilization from free fatty acids to glucose (41). A similar switch was also observed in transgenic mice with absent NOS gene expression (49). The altered energetics of failing myocardium are paralleled by a shift of myofilamentary gene expression toward isoforms with higher calcium sensitivity and lower ATPase activity. This shift in gene expression enhances contractile efficiency of failing myocardium even in the presence of a deranged oxygen consumption (21). In the human cardiomyopathic heart, administration of L-NMMA does not affect its efficiency (47) despite the augmented LV contractile response to β-adrenergic stimulation.

In conclusion, in heart failure patients, beneficial effects of NO on diastolic LV function always overrule a small NO-induced attenuation of LV developed pressure in terms of overall hemodynamic status, either at baseline or after β-adrenergic stimulation. The absence of hemodynamic deterioration in transgenic mice overexpressing either myocardial NOS2 or NOS3 confirms these clinical observations. In failing myocardium, NO’s correction of diastolic LV dysfunction...
reinforces NO’s energy sparing effects and the concerted action of NO on both diastolic LV dysfunction and deranged energetics could well be instrumental for preventing relentless deterioration of failing myocardium.

REFERENCES
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