Endocannabinoids acting at CB\textsubscript{1} receptors mediate the cardiac contractile dysfunction in vivo in cirrhotic rats

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Recent studies have suggested that endocannabinoids and their receptors play an important role in the hypotension associated with various pathological states (32, 33, 34), including advanced liver cirrhosis (2, 19, 29). In cirrhotic rats, administration of the CB\textsubscript{1} antagonist rimonabant increased arterial blood pressure and total peripheral resistance (2, 29) and decreased mesenteric blood flow (2), whereas cardiac output remained unaffected (19, 29). The involvement of CB\textsubscript{1} receptors and their endogenous ligands was further indicated by the increased expression of CB\textsubscript{1} receptors in vascular endothelial cells from cirrhotic human livers (2) and the increased relaxation of mesenteric arteries from cirrhotic vs. control rats in response to the endocannabinoid anandamide [arachidonoyl ethanolamide (AEA)] (7). These in vivo and in vitro studies highlighted the vascular mechanisms contributing to the endocannabinoid-mediated hypotension in cirrhosis. However, in these earlier studies, the potential direct cardiac effects were not evaluated. Recent detailed in vivo hemodynamic analyses clearly indicate that AEA-induced hypotension is of predominantly cardiac origin due to a CB\textsubscript{1}-mediated decrease in cardiac contractility (4, 22), which has also been documented in human isolated cardiac preparations (5). In a recent in vitro study in rat isolated papillary muscle, CB\textsubscript{1} blockade was found to reverse the decreased β-adrenergic responsiveness observed in preparations from bile duct-ligated cirrhotic rats (10). This was the first indication that CB\textsubscript{1} receptors are involved in some aspects of abnormal myocardial contractility in liver cirrhosis (10), although in vivo evidence for this and direct proof for activation of the endocannabinoid system have been lacking. In the present study, we characterized the hemodynamic profile of rats with carbon tetrachloride (CCL\textsubscript{4})-induced advanced liver cirrhosis and analyzed the effects of the CB\textsubscript{1}-receptor antagonist AM251 on

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cardiac contractile function under both load-dependent and load-independent conditions. We also document the changes in tissue endocannabinoid levels associated with cirrhosis. The results indicate that cirrhosis activates the endocannabinoid system, both in the heart and liver, and extends earlier findings on the role of CB1 receptors in cardiac contractile dysfunction by demonstrating their contribution under in vivo conditions.

METHODS

Rat model of micronodular cirrhosis. All protocols were approved by the National Institute on Alcohol Abuse and Alcoholism Animal Care and Use Committee and were performed in accordance with the National Institutes of Health Guide for the Care and Use of Laboratory Animals. Male Sprague-Dawley rats (~200 g) received phenobarbital (35 mg/dl) through drinking water and were gavaged weekly with CCl4 in corn oil (1:1), or with corn oil only (controls), as described (2, 28). Body weight was monitored daily, and the dose of CCl4 was adjusted individually as described (2, 28). Systolic blood pressure was monitored daily using an automated tail-cuff procedure. As a result of the regular, repeated measurements, the animals had become well adapted to the procedure, resulting in reproducible, stable levels of arterial pressure. After 10–12 wk of treatment, CCl4-treated rats became hypotensive and, within 6–10 days, developed ascites. Cirrhosis was verified by postmortem microscopic examination of trichrome-stained sections of the liver.

Hemodynamic measurements. Cirrhotic and control animals were anesthetized with 2% isoflurane and tracheotomized to facilitate breathing. The animals were placed on controlled heating pads, and core temperature measured via a rectal probe was maintained at 37°C. The femoral artery and vein were cannulated for monitoring of MAP and injecting drugs, respectively. A microtip pressure-volume catheter (2F; SPR-838; Millar Instruments, Houston, TX) was inserted into the right carotid artery and advanced into the left ventricle (LV) under pressure control, as described (4, 25, 27). After stabilization for 20 min, the signals were continuously recorded at a sampling rate of 1,000/s using an ARIA pressure-volume conductance system (Millar Instruments) coupled to a Powerlab4SP analog-to-digital converter (AD Instruments, Mountain View, CA), and then stored and displayed on a computer. All pressure-volume loop data were analyzed using a cardiac pressure-volume analysis program (PVAN3.2; Millar Instruments), and the HR, maximal LV systolic pressure, LV end-diastolic pressure (LVEDP), MAP, maximum (dP/dtmax) and minimum slope of systolic pressure increment (dP/dtmin), cardiac index (calculated as the body weight-adjusted cardiac output), stroke work (SW), and relaxation time constant (τ) were computed. In six additional experiments, cardiac contractility parameters were determined under conditions of changing preload, elicited by transiently compressing the inferior vena cava, as described earlier (25, 27). These measures include the slope of the end-systolic (ESPVR) and end-diastolic pressure-volume relations (EDPVR) and the time-varying maximal cardiac elastance (Emax). They also include the preload-recruitable SW (PRSW) (13, 27), which represents the slope of the relation between SW and end-diastolic volume and is independent of chamber size and mass.

Western blot analyses. Frozen myocardial tissue from cirrhotic animals was homogenized in RIPA lysis buffer, containing protease inhibitor cocktail set III (EMD, San Diego, CA). One hundred micrograms of lysate protein were size-fractionated by 10% SDS-PAGE and transblotted to a nitrocellulose membrane. Western blotting, with rabbit CB1 polyclonal antibody (Cayman Chemicals, Ann Arbor, MI), rabbit fatty acid amide hydrolase (FAAH) antibody (Alpha Diagnostic, San Antonio, TX), or mouse anti-actin monoclonal antibody (Chemicon, Temecula, CA) was done as described previously (4). Immunoreactive bands were visualized with Supersignal West Pico chemiluminescent substrate kit (Pierce Biotechnology, Rockford, IL) and quantified by densitometry with background correction.

Measurement of tissue endocannabinoid content. For measuring tissue endocannabinoid levels, rats were euthanized, their livers and hearts removed, and the lipids extracted. Myocardial and hepatic...
levels of anandamide (AEA) and 2-arachidonoyl glycerol (2-AG) were quantified by liquid chromatography/in-line mass spectrometry, as previously described (35). Values are expressed as femtomoles or picomoles per milligram of wet tissue.

Drugs. AM251 was from Tocris (Baldwin, MO) and was emulsified in 10% DMSO, 10% Tween 80, and 80% saline.

Statistical analyses. Results are presented as means ± SE. One-way ANOVA followed by Newman-Keuls multiple-comparisons post hoc analysis or unpaired t-test for pairwise comparisons were used (GraphPad Prism, San Diego, CA). Significance was assumed if \( P < 0.05 \).

RESULTS

Tissue endocannabinoid levels of cirrhotic and control rats. Anandamide levels in both the liver and the heart are increased from cirrhotic animals (Fig. 1, left) compared with control rats. Interestingly, 2-AG levels were only elevated in the liver from cirrhotic animals (Fig. 1, right).

Hemodynamic profile of cirrhotic rats. Following 10–12 wk of CCl4 treatment, the rats became hypotensive, with systolic pressure of 90.2 ± 6.5 mmHg (n = 6) vs. 130.9 ± 16.9 mmHg in the controls (n = 6, \( P < 0.05 \)), as monitored in the unanesthetized animals using the tail-cuff technique. Following anesthesia, MAP of the cirrhotic animals was 57.8 ± 8.6 vs. 100.5 ± 5.6 mmHg in controls (\( P < 0.005 \)), with the respective systolic values (82.5 ± 10.8 vs. 123 ± 8.2 mmHg) not being significantly different from those measured by the tail-cuff technique before anesthesia (\( P > 0.3 \) for both). Basal HR of the cirrhotic group was elevated compared with the controls (Fig. 2). In agreement with published observations (19, 29), cardiac index was increased in the cirrhotic animals (Fig. 2). Analysis of the LV function demonstrated that the LV systolic pressure, SW, and \( \frac{dP}{dt}_{max} \) were decreased, indicating a systolic dysfunction and impaired contractility in the cirrhotic animals (Fig. 3). The load-independent indexes of systolic contractile function (Emax, ESPVR, and PRSW) were also decreased in the cirrhotic animals, indicating an impairment of the intrinsic inotropic state of the heart (Fig. 4, A and B). LV end-diastolic pressure and \( \tau \), indicators of diastolic function, were increased, and \( \frac{dP}{dt}_{min} \) was decreased. However, the EDPVR, an index of LV stiffness (13, 26), was not significantly altered in the cirrhotic animals (Fig. 4C).

Effect of CB1 blockade on cardiac function. Intravenous injection of AM251 had no effect on hemodynamic functions in normal rats. In contrast, in rats with advanced cirrhosis, intravenous injection of 3 mg/kg AM251 resulted in a gradual increase in MAP, reaching a plateau at ~30 min postinjection, which was maintained for over 1 h. The elevated basal HR and cardiac index were unaffected by AM251 (Fig. 2). In cirrhotic rats, AM251 treatment resulted in significant improvements of all measured parameters of LV systolic function (Fig. 3), including the load-independent indexes of contractility (Emax, ESPVR, and PRSW; Fig. 4B). The effect of AM251 was less clear for parameters of diastolic function. Although the increased end-diastolic pressure of cirrhotic rats was normalized following AM251 treatment, this may have resulted from a reduction in venous return due to blockade of endocannabinoid-mediated venodilation. On the other hand, diastolic chamber stiffness, as indicated by EDPVR, which was unaffected in cirrhosis, remained unchanged by AM251 treatment.

CB1-receptor and FAAH expression in the heart. The level of CB1-receptor expression in the myocardium, as detected by Western blotting, was similar in control and cirrhotic rats (Fig. 5). To test whether the elevated anandamide content of the cirrhotic heart (see Fig. 1) is due to its reduced in vivo degradation, we also quantified the myocardial expression of FAAH, the enzyme responsible for the metabolism of anandamide (6). FAAH protein levels were similar in control and cirrhotic hearts (Fig. 5).

DISCUSSION

The present findings document, for the first time, the cardiac contractile dysfunction in vivo in rats with CCl4-induced ad-
Advanced micronodular cirrhosis, as reflected by marked changes in both load-dependent and load-independent indexes of myocardial contractility. They provide evidence that increased activity of the endocannabinoid/CB1-receptor system is largely responsible for the impaired cardiac contractility in the intact animal. They further demonstrate that CB1 blockade can correct the contractile dysfunction in cirrhosis, which highlights the therapeutic potential of CB1 antagonists in this condition.

Cardiac index was increased in cirrhotic compared with normal rats and was unaffected by CB1 blockade (Fig. 2), which is in agreement with previous reports in rats with cirrhosis induced either by CCl4 treatment (28) or bile duct ligation (19). However, cardiac output is influenced by both preload and afterload, and the reduced cardiac contractile function in cirrhotic rats was likely offset by increased venous return and decreased peripheral resistance. Clearly, by relying on changes in cardiac output alone, one would have missed both the contractile dysfunction in cirrhosis, which highlights the therapeutic potential of CB1 antagonists in this condition.

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implicates anandamide as the endogenous agonist involved in the contractile dysfunction associated with liver cirrhosis. A possible mechanism for the increase in hepatic and cardiac endocannabinoid content may involve bacterial endotoxin (lipopolysaccharide), since advanced cirrhosis is known to be associated with endotoxemia (16), and lipopolysaccharide increases anandamide synthesis in macrophages (17), in isolated primary hepatocytes (4), and possibly other cell types/tissues. Endotoxin increases oxidative and nitrosative stress in various tissues (24, 15), which may also contribute to increased generation of endocannabinoids (3). Circulating macrophages, which are activated and have elevated anandamide content in cirrhosis (2), may also contribute to decreased cardiac contractility (30). The alternative possibility that the increase in the cardiac levels of anandamide is due to its decreased degradation is unlikely due to the unchanged expression of FAAH in the cirrhotic myocardium (Fig. 5).

The hyperdynamic circulation in cirrhosis has been related to either increased preload due to plasma volume expansion or decreased afterload resulting from arterial vasodilation. However, the use of load-independent measures of cardiac contractility in the present experiments has allowed us to unequivocally establish myocardial contractile dysfunction as the direct result of altered inotropic state.

Although the underlying cellular mechanisms have not yet been explored, CB₁-receptor activation is known to inhibit L-type calcium channels (11) and to reduce cAMP levels (12), both of which may contribute to a negative inotropic effect. A physiological role of such a cardiodepressor mechanism could be to counteract inappropriate increases in cardiac contractility.
such as in the early stages of hypertension. Indeed, CB₁ receptor blockade was reported to further increase blood pressure and cardiac contractility in rats with different forms of hypertension (4, 22).

It is noteworthy that, whereas AM251 did not affect hemodynamic variables in normal control rats, improvements in contractile indicators similar to those described here in cirrhotic rats were recently documented with AM281 and rimonabant in mice with doxorubicin-induced heart failure (21). In that study, doxorubicin also increased endocannabinoid production in the myocardium (21), presumably by oxidative/nitrosative stress-related mechanisms, which are pivotal in the cardiotoxicity of this chemotherapeutic agent (25). In addition, CB₁ antagonist exerted potent cytoprotective effects against doxorubicin-induced cell death, both in vitro and in vivo (21). Together, these observations suggest a novel pathogenic role of endocannabinoids in heart failure of various origins and also raise the potential value of CB₁ antagonists in the treatment of heart failure.

In addition to increased anandamide levels in the cirrhotic heart, we have also found upregulation of the endocannabinoid content of the cirrhotic liver, with both 2-AG and anandamide being markedly increased over levels measured in controls. It has been recently demonstrated that CB₁-receptor knockout mice are resistant to liver fibrosis induced by different stimuli, and the progress in hepatic fibrosis in control mice can be delayed by chronic treatment with a CB₁-receptor antagonist (31). Unlike the unchanged expression of CB₁ receptors in the cirrhotic myocardium found in the present experiments, fibrogenic stimuli were reported to increase the expression of CB₁ receptors in hepatic stellate cells (31). Thus the hepatic fibrogenic action of endocannabinoids may be increased in cirrhosis as the result of both increased end-organ sensitivity and increased concentrations of the endogenous ligands. Regardless of the underlying mechanism, however, the present findings suggest a unique therapeutic potential for CB₁-receptor antagonists in cirrhosis, as they may not only slow the progress of the fibrotic process, but could also improve cardiac contractile performance and correct the associated hemodynamic abnormalities, including the systemic and mesenteric vasodilation. This, in turn, may reduce the risk for preterminal or life-threatening complications, such as the development of ascites or the rupture of varicose veins (1), helping patients to survive until a transplant becomes available.

GRANTS
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REFERENCES
ENDOCANNABINOID SYSTEM AND CIRRHOTIC CARDIOMYOPATHY


