Localization and Production of Angiotensin II in the Isolated Perfused Rat Heart

Larissa M. de Lannoy, A.H. Jan Danser, Angélique M.B. Bouhuizen, Pramod R. Saxena and Maarten A.D.H. Schalekamp

Hypertension 1998;31:1111-1117

Hypertension is published by the American Heart Association. 7272 Greenville Avenue, Dallas, TX 75231

Copyright © 1998 American Heart Association. All rights reserved. Print ISSN: 0194-911X. Online ISSN: 1524-4563

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://hyper.ahajournals.org/cgi/content/full/31/5/1111
Localization and Production of Angiotensin II in the Isolated Perfused Rat Heart


Abstract—We used a modification of the isolated perfused rat heart, in which coronary effluent and interstitial transudate were separately collected, to investigate the localization and production of angiotensin II (Ang II) in the heart. During combined renin (0.7 to 1.5 pmol Ang I/mL per minute) and angiotensinogen (6 to 12 pmol/mL) perfusion (4 to 8 mL/min) for 60 minutes (n = 3), the steady-state levels of Ang II in interstitial transudate in two consecutive 10-minute periods were 4.3 ± 1.5 and 3.6 ± 1.5 fmol/mL compared with 1.1 ± 0.4 and 1.1 ± 0.6 fmol/mL in coronary effluent (mean ± half range). During perfusion with Ang II (n = 5), steady-state Ang II in interstitial transudate was 32 ± 19% of arterial Ang II compared with 65 ± 16% in coronary effluent (mean ± SD, P < .02). During perfusion with Ang I (n = 5), Ang II in interstitial transudate was 5.1 ± 0.6% of arterial Ang I compared with 2.2 ± 0.3% in coronary effluent (P < .05). The tissue concentration of Ang II in the combined renin/angiotensinogen perfusions (per gram) was as high as the concentration in interstitial transudate (per milliliter). Addition of losartan (10^-6 mol/L) to the renin/angiotensinogen perfusion (n = 3) had no significant effect on the tissue level of Ang II, whereas losartan in the perfusions with Ang I (n = 5) or Ang II (n = 5) decreased tissue Ang II to undetectably low levels. The results indicate that the heart is capable of producing Ang II and that this can lead to higher levels in tissue than in blood plasma. Cardiac Ang II does not appear to be restricted to the extracellular fluid. This is in part due to AT1-receptor–mediated cellular uptake of extracellular Ang II, but our results also raise the possibility of intracellular Ang II production. (Hypertension. 1998;31:1111-1117.)

Key Words: angiotensin II • heart • receptors, angiotensin

Angiotensin II is the primary mediator of the physiological actions of the RAS and has an important function in cardiovascular homeostasis. Ang II in the circulation is produced by the conversion of Ang I by ACE of the vascular endothelium. Ang I is generated in the circulation by the action of renin from the kidney on its substrate, angiotensinogen, produced by the liver. The various RAS components have all been identified in tissues,1-4 which suggests the existence of a locally acting RAS in the tissues, apart from the RAS in the circulation.

Local Ang II production in the heart is often invoked to explain the results of heart failure trials evaluating the effects of drugs that block angiotensin formation.5,6 Knowledge of cardiac Ang I and II production, however, is still fragmentary and little is known about its regulation and physiological significance.3

In a previous study we used a modified Langendorff rat heart preparation to investigate the production of Ang I in cardiac tissue.7 This isolated heart preparation enabled us to collect IST separately from the CE. During perfusion with renin and angiotensinogen, Ang I appeared in the transudate. This Ang I was produced in cardiac tissue and was not derived from Ang I in the perfusate. There was no indication that the heart was capable of producing Ang I independent of arterially delivered renin and angiotensinogen. Observations in nephrectomized pigs also indicated that the cardiac tissue levels of Ang I and II are determined by kidney-derived renin.4

Here we report on a study in which we used the same modified Langendorff rat heart preparation to investigate the production of Ang II. The presence of Ang II in tissue depends on arterial delivery of this peptide and on its local generation. Ang II may be formed from arterially delivered Ang I or from in situ synthesized Ang I. Extracellular Ang II is known to be taken up into cells by AT1-receptor endocytosis.5-11 The adrenals, the kidneys, and the heart accumulate Ang II from the circulation by an AT1-receptor–mediated process, probably endocytosis.12

The questions addressed by the present study are: In which tissue compartments is Ang II localized in the heart, where is it produced, and how are its levels in cardiac tissue influenced by AT1-receptor–mediated cellular uptake?

Methods

Chemicals and Reagents

[Ile5]-Ang-(1-10) decapeptide (Ang I) and [Ile5]-Ang-(1-8) octapeptide (Ang II) were obtained from Bachem. BSA was from Sigma,

Received August 19, 1997; first decision September 11, 1997; revision accepted December 15, 1997.
From the Departments of Internal Medicine I (L.M. de L., A.M.B.B., M.A.D.H.S.) and Pharmacology (L.M. de L., A.H.J.D., P.R.S.), Erasmus University Rotterdam, The Netherlands.
Correspondence to A.H. Jan Danser, PhD, Department of Pharmacology, Room EE 1418b, Erasmus University, Dr Molewaterplein 50, 3015 GE Rotterdam, Netherlands.
© 1998 American Heart Association, Inc.
Perfusion With Ang II to Study the Localization of Arterially Delivered Ang II

Langendorff hearts were perfused for 15 minutes with Ang II. Ang II diluted with Tyrode’s buffer to a concentration of 400 pmol/mL was infused into the perfusion system at a rate of 0.1 mL/min. Ang II caused a transient fall in coronary flow that stabilized in 2 to 3 minutes at 4 to 9 mL/min. After the Ang II infusion had been switched off, the heart was either quickly removed from the perfusion apparatus and transferred into liquid nitrogen or subjected to a 10-minute washout period. The tissue was frozen within 45 seconds after the Ang II infusion had been stopped. One-minute samples of CE and individual drops of IST were collected during the infusion and washout periods in order to study the uptake and washout kinetics of Ang II. A steady state was reached within 5 minutes. Samples of CE and IST that had been collected from 7 to 10 minutes and from 11 to 14 minutes were used to determine the steady-state levels of Ang II. The frozen hearts that were not subjected to a washout period were used to measure the steady-state tissue levels of Ang II.

In a separate series of experiments, the steady-state levels of Ang II in CE, IST, and cardiac tissue were measured during perfusions with Ang II in the presence of the AT₁-receptor antagonist losartan (10⁻⁶ mol/L) in the perfusion fluid. Coronary flow in these experiments was 4 to 11 mL/min.

Perfusion With Ang I to Study the Localization of Arterially Delivered Ang I and Locally Generated Ang II

Langendorff hearts were perfused for 15 minutes with Ang I. Ang I diluted with Tyrode’s buffer to a concentration of 400 pmol/mL was infused into the perfusion system at a rate of 0.1 mL/min. Coronary flow in these experiments was 5 to 10 mL/min. The uptake and washout kinetics of Ang I are known from our previous study. After the Ang I infusion had been switched off, the heart was removed from the perfusion apparatus and immediately transferred into liquid nitrogen. Samples of CE and IST collected from 7 to 10 minutes and from 11 to 14 minutes were used to determine the steady-state levels of Ang I. The frozen hearts were used to measure the steady-state tissue levels of Ang I and II.

In a separate series of experiments, the steady-state levels of Ang I and II in CE, IST, and cardiac tissue were measured during perfusions with Ang I in the presence of the AT₁-receptor antagonist losartan (10⁻⁶ mol/L) in the perfusion fluid. Coronary flow in these experiments was 4 to 9 mL/min.
were performed in the presence or absence of the AT₁-receptor antagonist losartan (10⁻⁶ mol/L) in the perfusion fluid. The renin and angiotensinogen solutions were kept at 4°C until they reached the aorta, in order to prevent angiotensin generation outside the heart. After the perfusion had been switched off, the hearts were frozen in liquid nitrogen.

Samples of CE and IST collected from 31 to 40 minutes and from 46 to 55 minutes were used to determine the steady-state levels of Ang I and II. Collections from 41 to 45 and from 56 to 60 minutes had been used for other measurements, reported in our previous study. The frozen hearts were used to measure the steady-state tissue levels of Ang I and II.

Measurements of Ang I and II

All angiotensin measurements were performed by a technician who did not know which experiments had been carried out with losartan and which without this drug. The Ang I and II concentrations in CE and IST samples, collected during Ang I and II perfusions, were measured directly with sensitive radioimmunoassays. Measurements were made in 50 μL of undiluted CE and in 50 μL IST diluted with 25 mL of 0.25 mol/L phosphate buffer, pH 7.4, containing 0.15 mol/L NaCl. The lowest measurable Ang I concentration was 15 fmol/mL in CE and 40 fmol/mL in IST. The lowest measurable Ang II concentration was 10 fmol/mL in CE and 25 fmol/mL in IST.

The Ang I and II concentration of CE and IST samples obtained during infusion with renin combined with angiotensinogen, as well as the cardiac tissue concentrations of Ang I and II both during Ang I and II perfusion and during combined renin and angiotensinogen perfusion, were measured by radioimmunoassay after SepPak extraction and reversed-phase HPLC separation. To measure tissue Ang I and II, the frozen hearts were minced and homogenized (1:10, wt/vol) in an iced solution of 0.1 mol/L HCl/80% ethanol. Homogenates were centrifuged at 20 000g for 25 minutes at 4°C. Ethanol in the supernatant was evaporated under constant air flow. The remainder of the supernatant was diluted in 20 mL 1% ortho-phosphoric acid and centrifuged again at 20 000g. The supernatant was diluted with 1% ortho-phosphoric acid 1:1 (vol/vol). The tissue homogenate supernatants and CE and IST samples were concentrated over SepPak columns (SepPak C18, Waters), and the concentrated extracts were subjected to HPLC followed by radioimmunoassay.

¹²⁵I-labeled Ang I had been added as an internal standard to the CE and IST samples before SepPak extraction and to tissue before its homogenization. Recovery was better than 70%, and the Ang I and II results were corrected for incomplete recovery. The lowest level of Ang I that could be measured with the Ang I radioimmunoassay after HPLC separation was 2.0 fmol/g in cardiac tissue, 0.05 fmol/mL in CE, and 2.5 fmol/mL in IST. The lowest level of Ang II that could be measured with the Ang II radioimmunoassay after HPLC separation was 1.0 fmol/g in cardiac tissue, 0.05 fmol/mL in CE, and 1.5 fmol/mL in IST.

Calculations

To determine in which tissue compartments Ang I and II are localized in the heart, the measured tissue levels of Ang I and II were compared with the levels predicted on the basis of the presence of these peptides in the cardiac extracellular fluid compartments. If the measured tissue levels are higher than predicted, angiotensin is not restricted to the extracellular fluid compartments. If the measured tissue levels are lower than predicted, angiotensin has disappeared from the extracellular fluid compartments during the period between the moment the heart has been removed from the perfusion equipment and the moment the tissue is transferred into liquid nitrogen. The predicted tissue level (fmol/g) was calculated as follows:

\[
\text{Predicted tissue Ang concentration} = \frac{[\text{Ang}_{\text{ISF}}] \times \text{ISF volume} + [\text{Ang}_{\text{CE}}] \times \text{IVF volume}}{\text{Blood flow rate}}
\]

in which [Ang_{\text{ISF}}] is the steady-state Ang I or II concentration in IST and [Ang_{\text{CE}}] is the steady-state Ang I or II concentration in CE. ISF volume is the cardiac interstitial fluid volume (0.23 mL/g), determined previously as the difference between the distribution volume of ⁵¹Cr-EDTA and ¹²⁵I-HSA, and IVF volume is the intravascular fluid volume (0.38 mL/g), determined previously as the distribution volume of ¹²⁵I-HSA. In this calculation, it is assumed that [Ang_{\text{CE}}] is representative for the angiotensin concentration in most of the intravascular fluid compartment (coronary venules and veins and right ventricle).

Statistical Analysis

The Ang I and II levels in CE, IST, and cardiac tissue during Ang I or II perfusion are expressed as a percentage of the arterial levels of Ang I (Ang I perfusion) or Ang II (Ang II perfusion). Ang I and II levels in CE, IST, and cardiac tissue during renin combined with angiotensinogen perfusion are given as absolute values. Differences between the experimental groups were evaluated for statistical significance by Student’s unpaired t test. Differences within groups were evaluated for statistical significance by Student’s paired t test. Bonferroni’s correction was applied to adjust for multiple comparisons. Differences were assigned to be significant for values of \(p < .05\).

Results

Localization of Arterially Delivered Ang II During Perfusion With Ang II

During perfusion with Ang II (n=10), the steady-state Ang II level in CE was 65% of the arterial level (Fig 1 and Fig 2).

![Figure 1](image1.png)

**Figure 1.** Ang II concentration in IST (●) and CE (○) during and after perfusion with Ang II (n=5). Data (mean±SEM) are presented as a percentage of the arterial Ang II concentration.

![Figure 2](image2.png)

**Figure 2.** Steady-state Ang II concentration in CE and IST during perfusion with Ang II for 15 minutes and the Ang II concentration in cardiac tissue shortly after the perfusion. Perfusions were carried out in the absence (n=5) or presence (n=5) of losartan (10⁻⁶ mol/L). The mean of the levels of the 7- to 10-minute and 11- to 14-minute perfusion periods was taken as the steady-state concentration. Data (mean±SD) are presented as a percentage of the arterial Ang II concentration. Ang II in IST was lower than in CE (\(p < .02\)) and higher than in cardiac tissue (\(p < .05\)) both with and without losartan. n.d. indicates not detectable.
Thus 35% of the arterially delivered Ang II was removed by the heart during a single passage of the perfusate. The intravascular fluid volume of the Langendorff heart was measured in our previous study of this model and was found to be 0.38 mL/g. Heart weight was 1.0 to 1.4 g, thus the intravascular fluid volume per heart was 0.38 to 0.53 mL. The perfusate flow was 4 to 9 mL/min; therefore the perfusate transit time of the isolated heart preparation was 0.04 to 0.13 minutes. It can be concluded, therefore, that 35% of the arterially delivered Ang II was removed in 0.04 to 0.13 minutes, which corresponds with a t1/2 of 0.06 to 0.21 minute. A steady-state level in IST was reached within 5 minutes. It was ≈35% of the arterial level (39% in the experiments in which also the Ang II washout was measured, Fig 1; 32% in the experiments in which also the tissue Ang II concentration was measured, Fig 2). The steady-state Ang II concentration in IST was significantly lower than in CE.

After discontinuation of the Ang II perfusion, Ang II disappeared from IST, in a monophasic way, with a t1/2 of 1.4 ± 0.3 minutes (mean ± SD, n = 5).

The cardiac tissue level of Ang II (per gram of tissue), shortly after the Ang II perfusion had been switched off, was ≈5% of the arterial level (per milliliter of perfusate) (Fig 2). This is lower than predicted on the basis of the presence of Ang II in the cardiac extravascular fluid compartments (see “Methods”). The predicted tissue concentration of Ang II would be 30% to 35% of the arterial concentration. This discrepancy suggests that extracellular Ang II was rapidly degraded in the short period (maximally 45 seconds) between the moment the Ang II infusion had been stopped and the moment the tissue was transferred into liquid nitrogen.

During perfusion with Ang II in the presence of the AT1-receptor antagonist losartan (n = 5), the steady-state Ang II levels in CE and IST were not significantly different from the levels during Ang II perfusion in the control situation (Fig 2). Ang II, which was above the detection limit in all cardiac tissue samples in the control Ang II perfusion experiments, could not be detected in the tissue samples in the Ang II/losartan perfusion experiments. This is likely to be due to blockade of the AT1-receptor–mediated cellular uptake of extracellular Ang II.

### Localization of Arterially Delivered Ang I and Locally Generated Ang II During Perfusion With Ang I

During perfusion with Ang I (n = 5), the steady-state Ang I level in CE was 48% of the arterial level (Fig 3). Thus 52% of arterially delivered Ang I was removed by the heart during a single passage of perfusate. Part of the Ang I removal was caused by conversion to Ang II (Fig 4).

The steady-state Ang II level in IST was higher than in CE, whereas the steady-state Ang I level in IST was lower than in CE. This, together with the finding that during perfusion with Ang II the Ang II level in IST was also lower than in CE (see above), indicates that part of the Ang II present in IST during Ang I perfusion was not derived from Ang II in the perfusate.

The cardiac tissue level of Ang I (per gram of tissue), shortly after the Ang I perfusion had been switched off, was ≈5% of the arterial level (per milliliter of perfusate) (Fig 3).

This is lower than predicted on the basis of the presence of Ang I in the cardiac extravascular fluid compartments (see “Methods”). The predicted tissue concentration of Ang I would be 22% of the arterial concentration. This discrepancy suggests that extracellular Ang I, like extracellular Ang II, was rapidly degraded in the short period between the moment the Ang I infusion had been stopped and the moment the tissue was transferred into liquid nitrogen.

During perfusion with Ang I in the presence of the AT1-receptor antagonist losartan (n = 5), the steady-state Ang I and II levels in CE and IST were not significantly different from those during Ang I perfusion in the control situation (Fig 3 and Fig 4). Ang II, which was above the detection limit in all cardiac tissue samples in the control Ang I perfusion experiments, could not be detected in the tissue samples in the Ang I/losartan perfusion experiments, which is probably due to blockade of the AT1-receptor–mediated cellular uptake of extracellular Ang II.

### Localization of Locally Generated Ang I and II During Combined Renin/Angiotensinogen Perfusion

Results of the combined renin/angiotensinogen perfusions are shown in Fig 5 and Fig 6. During combined renin/angiotensinogen perfusions, Ang I was rapidly degraded in the short period between the moment the Ang I infusion had been stopped and the moment the tissue was transferred into liquid nitrogen.

During perfusion with Ang I for 15 minutes and the Ang II concentration in cardiac tissue shortly after the perfusion, Perfusions were carried out in the absence (n = 5) or presence (n = 5) of losartan (10⁻⁶ mol/L). The mean of the levels of the 7- to 10-minute and 11- to 14-minute perfusion periods was taken as the steady-state concentration. Data (mean ± SD) are presented as a percentage of the arterial Ang I concentration. Ang I in IST was lower than in CE (P < .02) and higher than in cardiac tissue (P < .02) both with and without losartan.

![Figure 3. Steady-state Ang I concentration in CE and IST during perfusion with Ang I for 15 minutes and the Ang II concentration in cardiac tissue shortly after the perfusion.](Image)

![Figure 4. Steady-state Ang II concentration in CE and IST during perfusion with Ang I for 15 minutes and the Ang II concentration in cardiac tissue shortly after the perfusion. Perfusions were carried out in the absence (n = 5) or presence (n = 5) of losartan (10⁻⁶ mol/L). The mean of the levels of the 7- to 10-minute and 11- to 14-minute perfusion periods was taken as the steady-state concentration. Data (mean ± SD) are presented as a percentage of the arterial Ang I concentration. Ang II in IST was higher than in CE (P < .05) and cardiac tissue (P < .05) both with and without losartan. n.d. indicates not detectable.)
sinogen perfusion in the absence of losartan (n=3), the Ang I levels in IST in the 31- to 40-minute and 46- to 55-minute perfusion periods were 4.2 (1.5 to 8.2) and 3.2 (0.9 to 6.5) times higher than in CE, respectively (mean and range). The Ang II levels in IST in these perfusion periods were 4.8 (2.7 to 6.8) and 3.8 (2.2 to 5.7) times the levels in CE.

The cardiac tissue level of Ang I, 18.2 (11.4 to 22.8) fmol/g, shortly after the combined renin/angiotensinogen perfusion had been switched off, was close to the level predicted on the basis of the presence of Ang I in the cardiac extracellular fluid compartments (see “Methods”), \( \approx 20 \) fmol/g.

The cardiac tissue level of Ang II, 4.8 (2.8 to 6.4) fmol/g, was higher than the level predicted on the basis of the presence of Ang II in the cardiac extracellular fluid compartments, \( \approx 1.5 \) fmol/g. This suggests that the presence of the locally formed Ang II was not limited to the intravascular and interstitial fluid.

During combined renin/angiotensinogen perfusion in the presence of the AT1-receptor antagonist losartan (n=3), the Ang I and II levels measured in CE, IST, and cardiac tissue were similar to the levels measured in the control experiments without losartan. Thus blockade of the AT1-receptor–mediated uptake of extracellular Ang II in these experiments did not decrease tissue Ang II to an undetectably low level as it did in the Ang I and II perfusion experiments.

**Discussion**

In a previous series of experiments we studied the production of Ang I by the modified rat Langendorff heart, in which the ISF transudate could be collected separately from the CE.7 Our present study uses the same isolated heart model and focuses on the production of Ang II.

As expected, part of the Ang I present in the perfusate during the combined renin/angiotensinogen perfusions and formed by the reaction of arterially delivered renin with arterially delivered angiotensinogen was converted to Ang II and ejected by the CE. Ang I to II conversion by the coronary vascular bed has been reported by others.16,17 More interesting is our finding that during these combined renin/angiotensinogen perfusions, the concentration of Ang II in the IST was several times higher than in the CE, whereas during perfusions with Ang II, the Ang II concentration in the IST was lower than in the CE. These results indicate that a substantial part of Ang II in the ISF was not derived from the Ang II that was present in the perfusate.

At the time we finished this study, a report was published by Dell’Italia et al18 on measurements of Ang II in the ISF space of the dog heart by using microdialysis probes. The Ang II level in the ISF was higher than in blood plasma and did not change after systemic infusion of Ang I. These results indicate compartmentalization of Ang II in the heart between the interstitial and intravascular fluid compartments. Our results are in agreement with this conclusion and suggest that Ang II in the ISF is formed outside the intravascular fluid compartment.

In the combined renin/angiotensinogen perfusion experiments, the Ang II level we measured in cardiac tissue (expressed per gram of tissue) was higher than in CE (expressed per milliliter of fluid). It was in fact as high as in the IST. This is an indication that the locally produced Ang II is not restricted to the extracellular fluid and that a large part...
of this Ang II might be located in the cells, because the intravascular and interstitial fluid compartments comprise ≈38% and 23% of tissue weight, respectively. Cellular binding and uptake through AT1-type Ang II receptors is known to occur.10–12 I-125I-Ang II infused into the left cardiac ventricle of intact pigs is accumulated in cardiac tissue by an AT1-receptor–dependent process, and the kinetics of Ang II stimulation of renin release from the kidney after this drug.15 The losartan, an increase that is likely to be related to the locally formed Ang II during the combined renin/angiotensinogen perfusion, this intracellular Ang II will similarly be protected against this rapid degradation.

The results of the renin/angiotensinogen perfusion experiments indicate that in contrast with Ang II, most of the locally produced Ang I in the heart is restricted to the cardiac extracellular fluid compartments. Likely sites of cardiac Ang I production are the ISF and a site closer to the blood compartment, possibly vascular surface-bound renin (Fig 7). The question of where in the tissue the Ang II is formed is incompletely answered by the present study. Part of it is formed at the vascular endothelial and endocardial surfaces.16,21–23 Our observations in the present study on the effects of blockade of AT1-receptor–mediated uptake of Ang II, which did not show a change in the tissue level of locally produced Ang II as opposed to a decrease in the tissue level of arterially administered Ang II, raise the interesting possibility of intracellular Ang II formation (Fig 7). There is experimental evidence that neonatal rat cardiac myocytes are capable of binding and internalizing renin and prorenin through a mannose 6-phosphate receptor and that prorenin is activated in the cells.24 Internalized Ang II has a long half-life, and there is growing evidence that intracellular Ang II can serve important functions.25–27 AT1-receptor–mediated uptake of Ang II and the evidence that the formation and degradation of Ang I and II in cardiac tissue are highly compartmentalized has implications for the effects of drugs.
that interfere with Ang II receptor binding (AT₁-receptor antagonists) or reduce the production of Ang II (renin inhibitors, ACE inhibitors). These drugs may have different effects on the Ang II levels in different cardiac tissue compartments.

Acknowledgment
This study was supported by the Netherlands Heart Foundation, research grant 96.019.

References