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Are there gender differences in left ventricular remodeling after myocardial infarction in rats?

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Abstract

Objective: An unclear issue is whether gender may influence at cardiac remodeling after myocardial infarction (MI). We evaluated left ventricle remodeling in female and male rats post-MI.

Methods: Rats were submitted to anterior descending coronary occlusion. Echocardiographic evaluations were performed on the first and sixth week post-occlusion to determine myocardial infarction size and left ventricle systolic function (FAC, fractional area change). Pulsed Doppler was applied to analyze left ventricle diastolic function using the following parameters: E wave, A wave, E/A ratio. Two-way ANOVA was applied for comparisons, complemented by the Bonferroni test. A P≤0.05 was considered significant.

Results: There were no significant differences between genders for morphometric parameters on first (MI [Female (FE): 44.0±5.0 vs. Male (MA): 42.0±3.0%, ]; diastolic [FE: 0.04±0.003 vs. MA: 0.03±0.005, mm/g] and systolic [FE: 0.03±0.0004 vs. MA: 0.028±0.005, mm/g] diameters of left ventricle) and sixth (MI [FE: 44.0±5.0 vs. MA: 42.0±3.0, %]; diastolic [FE: 0.043±0.01 vs. MA: 0.034±0.005, mm/g] and systolic [FE: 0.035±0.01 vs. MA: 0.027±0.005, mm/g] diameters of left ventricle) week. Similar findings were reported for left ventricle functional parameters on first (FAC [FE: 34.0±6.0 vs. MA: 32.0±4.0, %]; wave E [FE: 70.0±18.0 vs. MA: 73.0±14.0, cm/s]; wave A [FE: 20.0±12.0 vs. MA: 28.0±13.0, cm/s]; E/A [FE: 4.9±3.4 vs. MA: 3.3±1.8]) and sixth (FAC [FE: 29.0±7.0 vs. MA: 31.0±7.0, %]; wave E [FE: 85.0±18.0 vs. MA: 87.0±20.0, cm/s]; wave A [FE: 20.0±11.0 vs. MA: 28.0±17.0, cm/s]; E/A [FE: 6.2±4.0 vs. MA: 4.6±3.4]) week.

Conclusion: Gender does not influence left ventricle remodeling post-MI in rats.


Resumo

Objetivo: A influência do gênero no remodelamento cardíaco após o infarto do miocárdio é uma questão em intenso debate. Nós avaliamos o remodelamento ventricular esquerdo em ratos infartados de ambos os gêneros.

Métodos: O infarto do miocárdio foi induzido por oclusão da artéria coronária descendente anterior (fêmeas [FM]; machos [MC]). A ecocardiografia foi realizada na primeira e sexta semana pós-oclusão para determinar o tamanho do infarto do miocárdio e a função sistólica do ventricular esquerdo (mudança na área fracional [FAC]). A função diástolica derivou dos seguintes parâmetros: onda E; onda A; razão E/A. ANOVA duas vias com pós-teste de Bonferroni foi aplicado nas comparações (P≤0.05).

Resultados: Todas variáveis morfométricas foram similares (P>0.05) entre os gêneros com uma (infarto do miocárdio [FM: 44.0±5.0 vs. MC: 42.0±3.0, %]; diâmetro diastólico [FM: 0.04±0.003 vs. MC: 0.037±0.005, mm/g] e sistólico [FM: 0.03±0.0004 vs. MC: 0.028±0.005, mm/g] do LV) e seis (IM

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INTRODUCTION

Myocardial infarction (MI) is an important cause of heart failure and mortality among adults. A number of factors can determine a worsening in prognosis such as infarct expansion, hypertrophy of the non-infarcted myocardium, increased collagen deposition in the infarcted and non-infarcted areas, progressive dilatation, geometric changes in chamber shape, and eventual progression to chronic heart failure.

It is well known that premenopausal women are less likely to develop coronary heart disease than men. Previous studies have also shown that gender can be a key factor in cardiac remodeling post-MI. Thus, studies show gender as a risk factor of unfavorable prognostic[1,2]. Although valuable, these findings cannot be considered as absolute truth. Several issues such as age heterogeneity, drug therapy, associated risk factors, and hemodynamics (e.g., pre- and afterload; blood volume) may cause difficulties in ensuring that the data are differential cardiac remodeling between genders post-MI[2,3]. Moreover, some researchers have found higher survival rates in women[4,5] while others show higher mortality in women due to higher severity of MI[6].

Since possible gender differences in post-MI left ventricle (LV) remodeling are not clear, we conducted the current study using a rat MI model. The MI model by coronary occlusion represented a significant advance to provide accurate control of bias[7-13]. Moreover, coronary occlusion is the most commonly used experimental model to induce MI in rats and somewhat reproduces the findings in humans with cardiac decompensation[14]. We performed paired time evaluations in the LV with transthoracic echocardiography. This approach has been shown to be readily reproducible in longitudinal assessment of morphology and function of LV in rodents[15,16].

METHODS

Animal MI model

The study was approved by the Committee on Ethics from the Federal University of São Paulo and use the “Principles of Laboratory Animal Care formulated by the National Institutes of Health (National Institutes of Health publication number 96-23, revised, 1996; http://bioethics.od.nih.gov/animals.html”). The MI was induced in three-month-old female Wistar-EPM rats weighing between 180 to 220g. The animals were housed at regular temperature (22°-24°C) on a 12h dark/light cycle with food and water provided ad libitum. Rats were anesthetized with ketamine (50 mg/kg) plus xylazine (10 mg/kg) intraperitoneally; intubated, and ventilated with room air (rate: 90 breaths/minute; tidal volume: 2.5 ml on a Harvard rodent respirator [model 683, Harvard Apparatus Co., South Natik, MA, USA]). After thoracotomy, the MI was produced by ligation of the left descending coronary artery as previously described[17,18]. Sham surgery was performed with a similar process except the suture was tied loosely around the coronary artery. Afterward MI or Sham surgery, the rats returned to their plastic boxes and were kept under observation without any drug therapy. Survivor animals were assigned to the following groups: (1) Female sham (n=8); (2) Female MI (n=11); (3) Male sham (n=9); (4) Male MI (n=12).

Echocardiographic measurements

Echocardiography has been shown accurate in evaluating cardiac remodeling post-MI[16,19-20]. Echocardiographic analysis was applied on the first and sixth week post-MI. The rats were anesthetized as described above and measurements were performed using a 12-MHz transducer connected to an HP Sonos-5500 echocardiograph (Hewlett-Packard, California, USA)[11]. MI size was evaluated by transversal LV two-dimensional view on the basal, mid-transversal, and apical planes. In the diastolic phase, measurements of the endocardial perimeter (EP) and length of the infarcted segment (ISe) for each view were taken. MI size for each segment (ISe), expressed as the proportion of the LV perimeter for each view, was calculated by the following equation: Isi (%) = ISe/EP x 100. MI was defined as a segment with increased echogenicity and/or change in myocardial thickening or systolic movement.

Only rats with large infarctions (≥ 40% of LV) were included for evaluation since this is the group that shows the highest severity of the disease[8]. The diastolic (DA) and systolic (SA) transverse areas of the LV were measured by two-dimensional...
images on the basal, middle and apical parasternal transverse planes. The final value was the arithmetic mean of the measurements of the three views. Systolic function was analyzed by the fractional area change (FAC=DA - SA/DA, %) in the three transverse planes (basal, middle, and apical). Pulsed Doppler at the LV side of the mitral valve provided the flow velocity curve to analyze the diastolic function parameters (E and A waves and E/A ratio). Echocardiographic images for cardiac effects of MI are shown in Figure 1.

**Statistical analysis**

Data were analyzed with GraphPad Prism software 4.0 (San Diego, CA, USA) and values are expressed as mean ± S.D. The Shapiro-Wilk and Levene tests were applied to verify normal statistic distributions and error variances, respectively. To determine the effect of time and infarction on the echocardiographic parameters of respective genders, two-way analysis of variance (ANOVA) with repeated measures was performed. To evaluate the difference between genders at each respective time point, regular two-way ANOVA was performed. The Bonferroni post-hoc was carried out for all comparisons at each respective time point, regular two-way ANOVA was performed. The Bonferroni post-hoc was carried out for all analyses and level of significance was set at 5%.

**RESULTS**

To characterize the MI repercussions in both genders, echocardiography analyses were taken into account over six weeks after coronary occlusion. LV morphology and function were evaluated in the first and sixth week after ischemic insult. The sham group was evaluated at the same time.

LV morphology data are shown in Table 1. None of the evaluated parameters changed for female and male sham-operated rats during follow-up. MI size was similar between female and male rats, and we did not see expansion of MI in either gender during follow-up. Left atrium size was significantly higher in the infarcted rats regardless of gender; moreover, there was not difference in the left atrium size between female and male rats on any assessment time. There was LV dilatation with only a week post-MI; therefore, female and male rats showed a significant increase in diastolic and systolic LV diameter when comparing the first and sixth week. For all follow-ups, LV dilatation level was similar between genders. When LV diameters were indexed by body weight, LV dilatation post-MI was similar comparing first to sixth week for both genders.

The LV performance data are shown in Table 2.
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Fig. 1 - Illustrative example of two-dimensional mode traces of the left ventricle (LV) of the female and male rats. Images for mitral inflow velocity profile determined by pulsed wave Doppler are also shown. Sham rats are placed on the left, and infarcted rats are placed on the right.
The MI resulted in a significant reduction of LV systolic function within a week of coronary occlusion. The systolic dysfunction level was not significantly different compared to the sixth week post-MI. Our findings indicate that gender did not influence the deleterious MI effects on LV systolic function. Both genders showed significant increases in E wave in the sixth week post-MI, whereas the A wave remained unchanged. Thus, female and male rats had a restrictive LV filling pattern defined as an increased ratio of early (E) to late (A) filling velocities and rapid deceleration of the early filling wave with six weeks post-MI. There were no significant differences between genders for these parameters (Table 2).

DISCUSSION

We performed this study to evaluate if there are gender-related differences in the LV remodeling post-MI. Echocardiography serial analyses were performed including sham non-operated rats for paired comparisons. We have included in the study only animals with large infarcts, and this was based on the issue that large infarcts are representative of notable cardiac remodeling.

The current study showed that several indicators for poor prognosis were seen with only one week of coronary occlusion. Except for restrictive LV filling pattern (increased in the sixth week), the left atrium size, LV end-systolic and end-diastolic dimensions as well as depressed LV systolic function were increased. These findings are consistent with previous studies in rats on similar MI sizes and follow-up analysis.

As the main interest was the comparison between genders, we directly compared male and female rats with similar infarction sizes. The negative effects of MI on LV morphology and function were similar for both genders. Therefore, gender was not decisive for LV remodeling post-MI. In respect to LV dilatation and systolic dysfunction, we have shown similar results to other studies. On the other hand, our results do not corroborate results reported by Litwin et al. in regards to restrictive LV filling pattern. Although Litwin et al. showed a higher increase of E wave and E/A ratio in male rats, we have shown that there was a similar increase in these variables for both genders.

In terms of gender as a determinant of LV remodeling after MI, the reasons for the different patterns in male and female are not clear. Better remodeling of noninfarcted regions in female than in male animals can result in lower operating chamber stiffness; thus female rats may have attenuated the development of a restrictive LV filling pattern. Lines of evidence have attributed a key role for sex hormones. This is based, for example, in observations that testosterone is a potent inducer of LV hypertrophy while estradiol has an inhibitory action. There is evidence that estrogen reduces collagen content as well as wall stress in late MI. Moreover, studies showed that estrogen may favor remodeling by preventing apoptosis and increasing angiogenesis in female. It is also possible that sexual hormones may indirectly regulate myocardial adaptation by vascular or endocrine effects. For example, cardiac preload or afterload may be different between males and females with MI as a result of differences in blood volume regulation, venous or arterial tone.

The female rats used in this study were young adults with normal ovaries. This study was not designed to assess the role of sex hormones in post-MI LV remodeling, and we did not monitor the serum hormone changes. Although we can not exclude that there were minor effects of sex hormones on LV functional and echocardiographic parameters, our data do not support the view that the positive effects of the sexual hormones may spread for a beneficial LV remodeling in female rats with MI.

CONCLUSION

The current study had a preset end point of 6 weeks in which male and female rats showed similar morphological and functional abnormalities. Therefore, we cannot draw conclusions about gender differences in the LV remodeling post-MI. It should be noted that the rats were young adults with no atherosclerotic disorder. It is unlikely that humans would have MI at such a young age. However, this experimental model has been widely accepted in studying post-MI LV remodeling.

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Authors’ roles & responsibilities

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