Cardiac nucleotides in hypoxia: possible role in regulation of coronary blood flow

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BERNE, ROBERT M. Cardiac nucleotides in hypoxia: possible role in regulation of coronary blood flow. Am. J. Physiol. 204(2): 317-322. 1963.—Experiments were performed on isolated cat hearts perfused with Tyrode's solution and intact hearts of open-chest dogs. Cardiac hypoxia resulted in a decrease in coronary vascular resistance and a release of significant amounts of inosine and hypoxanthine from the myocardium. From 3 to 27 times more inosine and hypoxanthine were released from the heart during myocardial hypoxia than were required to double the coronary blood flow when infused as adenosine into the left coronary artery. Based on the assumption that with hypoxia the nucleotide derivatives leave the myocardial cell as adenosine, an hypothesis is proposed for the metabolic regulation of coronary blood flow.

At a constant level of energy expenditure by the myocardium, coronary blood flow is relatively stable in the face of alterations in perfusion pressure (1, 2). The nature of the mechanism responsible for this phenomenon, known as autoregulation, remains obscure. The cardiac nerves are apparently not involved, since autoregulation is readily observed in the denervated heart. However, the occurrence of reactive hyperemia in the heart and the striking parallelism between coronary blood flow and the metabolic activity of the myocardium have directed attention to products of metabolism as possible mediators. To date, none of the known metabolites or vasoactive constituents of cardiac muscle have been shown to be released from the myocardium in concentrations sufficient to account for the coronary vasodilation observed with hypoxia or augmented cardiac metabolism (3). Furthermore, reoxygenated coronary sinus blood collected from hearts subjected to hypoxia or ischemia failed to produce changes in vascular resistance when infused into test coronary vessels (4). This observation could mean that if a vasoactive substance is released from the myocardium during hypoxia it is rapidly inactivated and/or greatly diluted by the blood.

Adenosine may conceivably be the vasoactive substance since: 1) it is a potent coronary vasodilator (5); 2) it is rapidly inactivated by adenosine deaminase in blood and tissues (6, 7); 3) it can rapidly penetrate the myocardial cell membrane (7); and 4) there is a large potential source of adenosine in the form of adenine nucleotide in the myocardium. Analysis of nucleotide derivatives in perfusates and coronary sinus blood was undertaken to test the hypothesis that the release of adenosine from the myocardium is responsible for the coronary vasodilation observed in cardiac hypoxia.

METHODS

Cat heart experiments. Cats were struck a sharp blow on the head and the hearts of the unconscious animals were quickly excised, rinsed with warm Tyrode's solution, and perfused with oxygenated Tyrode's solution in the manner originally described by Langendorf (8). The perfusion fluid was equilibrated with a gas mixture of 5% O2 and 5% CO2 and introduced into the aorta at a pressure of 40 cm of water. After all residual blood was flushed out of the heart, a control period was begun in which 200 ml of oxygenated Tyrode's solution was recycled through the heart for 15 min and then collected in iced flasks. In the recovery period the heart was perfused with oxygenated Tyrode's solution and the perfusate collected. The perfusates were then treated with perchloric acid for protein precipitation and the nucleotide derivatives adsorbed on charcoal, eluted, separated on Dowex-1-chloride columns and assayed enzymatically as previously described (7).

Two hundred milliliters of this anoxic perfusion fluid was recycled through the heart for 15 min and collected in iced flasks. In the recovery period the heart was perfused with oxygenated Tyrode's solution and the perfusate collected. The perfusates were then treated with perchloric acid for protein precipitation and the nucleotide derivatives adsorbed on charcoal, eluted, separated on Dowex-1-chloride columns and assayed enzymatically as previously described (7).

Dog heart experiments. Dogs were anesthetized with intravenously administered sodium pentobarbital (30 mg/kg), placed on artificial respiration, and thoracotomized in the fourth left intercostal space. After the ad-
ministration of heparin, the left coronary artery was cannulated with an Eckstein cannula and the coronary sinus cannulated with a modified Murawicz cannula. The left coronary artery was perfused with blood from the left carotid artery and the coronary sinus outflow was directed to the left jugular vein. Coronary blood flow was measured with a rotameter and mean left coronary perfusion pressure with a mercury manometer. During control periods the animal was respirated with room air, whereas during the experimental periods partial asphyxia was produced by greatly reducing the respiratory minute volume. Approximately 30 ml of coronary arterial and coronary sinus blood were simultaneously obtained from the tubing of the respective cannulas. In experimental periods, when asphyxia was well established, coronary blood flow was reduced to control levels by an adjustment of a screw clamp on the coronary artery inflow tubing before blood samples were drawn. The blood was immediately chilled and the red cells sedimented in a refrigerated centrifuge. Fifteen to twenty milligrams of acid-washed, activated wood charcoal (Darco) was added to each plasma sample (ca. 12 ml) and the suspension shaken in a cold room for 60 min.

After centrifugation, the plasma was discarded and the sedimented charcoal was transferred with 15 ml of water to a column 1 cm in diameter containing 150 mg of washed Celite packed over a small glass-wool plug. Fifty percent ethanol at pH 10 was put through the column until the eluate read zero against the eluting solution in the Beckman model DU spectrophotometer. All UV-absorbing material was eluted with water in a chromatography jar saturated with water vapor. All UV-absorbing material was eluted from the small strips in 1-3 ml water in about 20 hr. Volumes were adjusted to 2.1 ml by evaporation at 40 C, or by the addition of water. Aliquots of this solution were then analyzed for their inosine and hypoxanthine content by the enzymatic methods of Kalckar (9) using microcuvettes in the Beckman model DU spectrophotometer. All determinations were made in duplicate.

### RESULTS

**Cat heart experiments.** Adenine nucleotides and adenosine were not present in the perfusates of hearts perfused with oxygenated or deoxygenated Tyrode's solution. It is quite possible that adenosine was released from the perfused heart but was degraded to inosine and/or hypoxanthine before the addition of perchloric acid to the perfusate. Previous studies (7) have shown that adenosine deaminase and nucleoside phosphorylase, which convert adenosine to inosine and hypoxanthine, are leached out of hearts perfused with oxygenated Tyrode's solution.

**Replacement of oxygenated Tyrode's solution with Tyrode's solution equilibrated with nitrogen resulted in the appearance of hypoxanthine and inosine in the perfusate.** Reinstitution of oxygenated perfusion fluid produced a decrease in the amounts of these compounds released from the heart. Although the absolute values for the hypoxanthine and inosine content of the perfusates are large they represent only about 0.3-0.4% of the total adenine nucleotide content of the myocardium. Coronary vasodilation and a reduction in heart rate were associated with the anoxia-induced appearance of inosine and hypoxanthine. The bradycardia is indicative of the severe degree of anoxia produced in these experiments.

**Dog heart experiments.** The isolated Tyrode-perfused nonworking cat heart was employed in the initial studies because it is a simple preparation free of possible contaminating nucleotide derivatives from erythrocytes and one which can be subjected to complete anoxia. Gross changes observed with such a preparation may be indicative of normal phenomena but, because of the unphysiological nature of the preparation, extrapolation to normal heart muscle could be misleading. Therefore, the next series of experiments was carried out on the intact working heart in the open-chest dog in order to determine whether similar observations could be made under more physiological conditions. Before undertaking animal experiments, it was considered desirable to demonstrate to what extent and with what degree of accuracy nucleotide derivatives could be recovered from dog plasma.

Separation of the nucleotide derivatives was accomplished by paper chromatography, since the use of columns resulted in poor recoveries when small amounts

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**TABLE I. Effect of hypoxia on coronary flow, heart rate, and release of myocardial inosine and hypoxanthine in isolated perfused cat hearts.**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Coronary Flow, ml/min</th>
<th>Heart Rate, beats/min</th>
<th>Hypoxanthine, μg/ml</th>
<th>Inosine, μg/ml</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>17</td>
<td>74</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>20</td>
<td>97</td>
<td>0.166</td>
<td>0.233</td>
</tr>
<tr>
<td>Recovery</td>
<td>9</td>
<td>50</td>
<td>0.098</td>
<td>0.210</td>
</tr>
<tr>
<td>Control</td>
<td>14</td>
<td>128</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>21</td>
<td>88</td>
<td>0.084</td>
<td>0.250</td>
</tr>
<tr>
<td>Recovery</td>
<td>14</td>
<td>102</td>
<td>0.021</td>
<td>0.062</td>
</tr>
<tr>
<td>Control</td>
<td>15</td>
<td>120</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>32</td>
<td>77</td>
<td>0.028</td>
<td>0.161</td>
</tr>
<tr>
<td>Recovery</td>
<td>17</td>
<td>108</td>
<td>0.028</td>
<td>0.088</td>
</tr>
</tbody>
</table>

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In earlier studies plasma proteins were precipitated with perchloric acid and the resultant supernatant treated with charcoal. This procedure was discontinued because of the losses of nucleotide derivatives, presumably due to adsorption on the protein precipitate.
NUCLEOTIDE DEGRADATION IN MYOCARDIAL HYPOXIA

made detection of these nucleotide derivatives impossible.

When analysis of coronary sinus blood in all but one of
these experiments presented in Table 2, coronary blood
flow was adjusted to approximately control levels during
the periods of asphyxia period by means of a screw clamp on
the arterial inflow tubing. As can be seen from the reduction
in perfusion pressure required to maintain a relatively
constant coronary blood flow, vascular resistance was
significantly reduced by the partial asphyxia. On release
of the constriction and restoration of perfusion pressure
of the constriction and restoration of perfusion pressure.

In the first few experiments no attempt was made to
restrict coronary blood flow during the periods of partial
asphyxia. Consequently, a large flow increase occurred
as a result of the hypoxemia and the increase in aortic
pressure which usually accompanied the partial asphyxia.

Since analysis of coronary sinus blood in all but one of
these experiments revealed insignificant quantities of
inosine or hypoxanthine, it was thought possible that
dilution by the large volume of blood perfusing the heart
made detection of these nucleotide derivatives impossible.

The data from the one experiment in which significant
quantities of hypoxanthine were present in coronary
sinus blood (with asphyxia), despite a twofold increase in
coronary blood flow, are shown in Table 2 (exp. 5). A
second period of asphyxia, more severe than the first,
was associated with an increase in the concentration of
hypoxanthine in the coronary sinus blood and the
appearance of significant amounts of inosine. In the remain-
ing experiments presented in Table 2, coronary blood
flow was adjusted to approximately control levels during
the asphyxia period by means of a screw clamp on the
arterial inflow tubing. As can be seen from the reduction
in perfusion pressure required to maintain a relatively
constant coronary blood flow, vascular resistance was
significantly reduced by the partial asphyxia. On release
of the constriction and restoration of perfusion pressure
of the constriction and restoration of perfusion pressure.

During each of the hypoxic periods of the last four ex-
periments in Table 2, the coronary sinus plasma fraction
contained 4.4–19.2 µmole hypoxanthine and 0.5–15.8
µmole inosine/ml plasma, whereas simultaneously
drawn arterial blood samples contained 0.3–0.4 µmole
hypoxanthine/ml plasma and no inosine. In control and
recovery arterial and venous plasma samples inosine was
absent and the maximum concentration of hypoxanthine
found was 0.7 µmole/ml.

An approximation of the amounts of nucleotide deriv-
atives released per minute from the heart during the
periods of asphyxia is presented in Table 2. These esti-
mates are products of the coronary blood flow in milli-
liters per gram wet weight of heart and the sum of the
arteficially introduced species. Since the values ranged from 2.7 to 21.3 µmole/min g

Glutamic oxalacetic transaminase determinations were
carried out on control and experimental arterial and

### Table 2. Release of inosine and hypoxanthine from dog hearts during partial asphyxia

<table>
<thead>
<tr>
<th>Exp. No.</th>
<th>Procedure</th>
<th>Perfusion Pressure, mm Hg</th>
<th>Coronary Blood Flow, ml/min</th>
<th>Hypoxanthine, µmole/ml Plasma</th>
<th>Inosine, µmole/ml Plasma</th>
<th>Inosine + Hypoxanthine, µmole/min g Heart</th>
<th>Transaminase, GOT U/ml plasma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Arterial</td>
<td>Venous</td>
<td>Arterial</td>
<td>Venous</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Control</td>
<td>142</td>
<td>53</td>
<td>0.2</td>
<td>0.1</td>
<td>0</td>
<td>0</td>
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<tr>
<td>6</td>
<td>Asphyxia</td>
<td>136</td>
<td>107</td>
<td>0.5</td>
<td>0.6</td>
<td>0</td>
<td>0</td>
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<tr>
<td>7</td>
<td>Control</td>
<td>125</td>
<td>68</td>
<td>0.4</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>Asphyxia</td>
<td>75</td>
<td>72</td>
<td>0.2</td>
<td>0.7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>Control</td>
<td>84</td>
<td>122</td>
<td>0.3</td>
<td>0.3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>Asphyxia</td>
<td>67</td>
<td>116</td>
<td>0.3</td>
<td>0.3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>Control</td>
<td>80</td>
<td>102</td>
<td>0.3</td>
<td>0.3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>Asphyxia</td>
<td>70</td>
<td>158</td>
<td>0.3</td>
<td>0.3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>Control</td>
<td>83</td>
<td>64</td>
<td>0.0</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>Asphyxia</td>
<td>59</td>
<td>56</td>
<td>0.4</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Numbers in parentheses refer to wet weight of perfused myocardium. GOT U = Amount of glutamic-oxalacetic transaminase which produces a decrease in optical density at 340 mp of 0.001/ml min plasma per cm light path at 25°C. * Ventricular fibrillation occurred during blood sampling.
TABLE 3. Effect of intracoronary infusion of adenosine on coronary blood flow

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Perfusion Pressure, mm Hg</th>
<th>Coronary Blood Flow, ml/min</th>
<th>Inosine, * mmoles/ml Plasma</th>
<th>Inosine, * mmoles/min/g Heart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Arterial</td>
<td>Venous</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td>84</td>
<td>59</td>
<td>0</td>
</tr>
<tr>
<td>Adenosine†</td>
<td></td>
<td>76</td>
<td>124</td>
<td>2.9</td>
</tr>
<tr>
<td>Adenosine with constriction of tubing</td>
<td>55</td>
<td>47</td>
<td>105</td>
<td>0</td>
</tr>
<tr>
<td>Adenosine with release of constriction</td>
<td>82</td>
<td>3</td>
<td>64</td>
<td>0</td>
</tr>
<tr>
<td>Recovery</td>
<td></td>
<td>03</td>
<td>64</td>
<td>0</td>
</tr>
</tbody>
</table>

Numbers in parentheses refer to wet weight of perfused myocardium. * Includes adenosine since no attempt was made to separate the two nucleosides. No hypoxanthine was found. † Adenosine dissolved in 0.9% NaCl infused at 0.25 mmoles/min into left coronary artery.

Failure to detect any inosine or hypoxanthine in coronary sinus blood during intracoronary artery infusion of adenosine is consonant with a previous observation that adenosine readily enters myocardial cells where it is phosphorylated to adenosine triphosphate (ATP) (7).

DISCUSSION

With hypoxia, inosine and hypoxanthine appeared in the perfusate of the isolated cat heart and in the coronary sinus blood of the intact, working dog heart. Neither of these adenine nucleotide derivatives was present in significant amounts in arterial blood of the hypoxic dog or in arterial or cardiac venous blood of the normally ventilated animal. These observations indicate that the inosine and hypoxanthine originated in the myocardium and that the partial asphyxia in the dog did not produce a release of such compounds from other body tissues in quantities sufficient to be detected in the arterial blood. Because of its simplicity the Langendorff preparation was ideally suited for preliminary studies. However, the release of inosine and hypoxanthine from the anoxic cat heart may not be physiologically significant, since the heart is perfused with salt solution and is somewhat hypoxic even during control periods, as suggested by the leakage of enzymes into the perfusion fluid (7). In contrast, the hypoxic dog heart is capable of performing work and shows no impairment of the integrity of the cell membranes, as evidenced by the absence of transaminase or adenosine deaminase in coronary sinus blood. However, the presence of erythrocytes in the dog heart experiments poses several problems. The erythrocytes are rich in ATP and thus are a potential source of contaminating adenine nucleotide derivatives. Therefore, it is necessary to exercise considerable care in the collection and handling of the blood samples to avoid red cell lysis. A second problem is the uptake and metabolism of nucleosides by the red cells. Inosine and adenosine readily enter red cells where the ribose moiety is metabolized and the purine can be utilized in the synthesis of nucleotides. The experiments on the intracoronary infusion of adenosine (Table 3) indicate that approximately one half of the nucleoside disappeared between the point of infusion and the point of sampling (transit time between these points being about 15 sec). Presumably the lost nucleoside was in the erythrocytes. A third problem related to the use of blood as a perfusion medium is the presence of adenosine deaminase and nucleoside phosphorylase in erythrocytes. These enzymes rapidly degrade adenosine and thereby make accurate calculation of the effective concentration of adenosine at its site of action virtually impossible.

The amount of the nucleotide derivatives released per minute from the hypoxic dog heart constitutes a small fraction (approx. $10^{-3}$ to $10^{-4}$) of the available adenine nucleotide, in contrast to complete anoxia in which the total adenine nucleotide content of the intact heart is reduced to about 60% of normal in a period of 45 min (10). However, if the hypoxic period were to persist for more
NUCLEOTIDE DEGRADATION IN MYOCARDIAL HYPOXIA

![Diagram of arterial blood flow and myocardial metabolism](image)

Necessary to produce a marked reduction in coronary re-

fraction of the amount recovered in the present study is

leased from the myocardium as adenosine, only a small

quired to double the coronary blood flow when infused as

would be lost from the heart, particularly with a severe

from the heart during myocardial hypoxia than are re-

tions of adenosine in arterial blood are effective in elicit-

that very small and probably undetectable concentra-

one-half of the adenosine disappeared between the point

of infusion and the point of sampling of arterial blood,

making it unavailable as a vasodilating agent. Second, a

large portion of the recoverable nucleoside had probably

been inactivated by deamination during this brief ex-

posure to the blood, since Conway and Cooke (6) have

shown that adenosine is deaminated in shed blood in a

number of seconds. It is quite reasonable to expect that

the concentration of adenosine that reached the effective

site, the coronary arterioles, was still further reduced by

virus of continuing deamination and utilization by the

red cells as the blood containing adenosine coursed

through the cannula and coronary arteries. Consider-

ation of these points, in the light of the barely detectable

ccentration of adenosine found in coronary arterial

blood during infusions of adenosine at a rate which

elicted a twofold increment in coronary blood flow

(Table 3), emphasizes the vasodilator potency of this

ucleoside. Furthermore, when the infused adenosine

(Table 3) and the nucleotide derivatives released from

the heart during moderate to severe asphyxia (Table 2)

are compared on the basis of equal amounts of myo-

cardium perfused per unit time, one finds that from 3 to

7 times more inosine and hypoxanthine are released

from the heart during myocardial hypoxia than are re-

quired to double the coronary blood flow when infused as

adenosine into the left coronary artery. These calcula-

tions indicate that if the nucleotide derivatives are re-

leased from the myocardium as adenosine, only a small

fraction of the amount recovered in the present study is

ecessary to produce a marked reduction in coronary re-

sistance. Therefore it is possible that less drastic and more

physiological stimuli than those employed in these ex-

periments could bring about the release of vasoactive

amounts of adenosine from the myocardium which could

ot be detected in coronary sinus blood by the methods

presently available.

In none of the cat or dog experiments were adenosine

or the adenine nucleotides detected in the heart effluents.

There is no good evidence that the phosphorylated

adenosine compounds can traverse the intact cell mem-

brane, although adenosine has been shown to enter myo-

cardial cells with relative ease (7). Adenosine and the

adenine nucleotides are potent vasodilators, whereas

inosine and hypoxanthine are virtually ineffective in

altering vascular resistance. To be of physiological signifi-
cance in the regulation of coronary blood flow it must be

demonstrated that the inosine and hypoxanthine leave

the myocardial cell in a form that has vasodilator ac-

activity. At present it has not been possible to show that

any of the recoverable nucleotide derivatives cross the

myocardial cell membrane as adenosine. In the cat heart

experiments adenosine deaminase and nucleotide phos-

phoryase are leached out of the perfused heart and any

adenosine released into the perfusate would be converted

to inosine and hypoxanthine before in vitro inactivation of

these enzymes could be accomplished (7). In the dog-

heart experiments the time required to collect the coro-

nary sinus blood and to separate cells and plasma is suffi-
cient for complete destruction of any adenosine which

might have been present.

Studies by Angkapindu, Stafford, and Thorp (11) on

aqueous extracts of guinea pig heart suggest that de-

phosphorylation of adenyllic acid (AMP) precedes deamination. If this is true in the intact heart it is con-

ceivable that the inosine found in the heart effluents is in

some measure derived directly from adenosine by deami-
nation and not by the dephosphorylation of inosinic acid.

Based on the assumption that a significant amount of the

adenosine formed from AMP is deaminated outside of

the myocardial cell in a form that has vasodilator ac-

tivity. At present it has not been possible to show that

any of the recoverable nucleotide derivatives cross the

myocardial cell membrane as adenosine. In the cat heart

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phoryase are leached out of the perfused heart and any

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Based on the assumption that a significant amount of the

adenosine formed from AMP is deaminated outside of

the myocardial cell in a form that has vasodilator ac-


adenosine, and permits the intrinsic vascular tone to reduce coronary blood flow to control levels.

REFERENCES


The author wishes to express his gratitude for the excellent technical assistance of Miss M. Hadady.