Ac-SDKP Reverses Inflammation and Fibrosis in Rats With Heart Failure After Myocardial Infarction

Fang Yang, Xiao-Ping Yang, Yun-He Liu, Jiang Xu, Oscar Cingolani, Nour-Eddine Rhaleb, Oscar A. Carretero

Abstract—Inflammation may play an important role in the pathogenesis of cardiac fibrosis in heart failure (HF) after myocardial infarction (MI). N-acetyl-seryl-aspartyl-lysyl-proline (Ac-SDKP) is a naturally occurring antifibrotic peptide whose plasma concentration is increased 4- to 5-fold by angiotensin-converting enzyme inhibitors. We tested the hypothesis that in rats with HF after MI, Ac-SDKP acts as an anti-inflammatory cytokine, preventing and also reversing cardiac fibrosis in the noninfarcted area (reactive fibrosis), and thus affording functional improvement. We found that Ac-SDKP significantly decreased total collagen content in the prevention group from 23.7±0.9 to 15.0±0.7 μg/mg and in the reversal group from 22.6±2.2 to 14.4±1.6 (P<0.01). Intersitial collagen volume fraction and perivascular collagen were likewise significantly reduced. We also found that infiltrating macrophages were reduced from 264.7±8.1 to 170.2±9.2/mm², P<0.001 (prevention), and from 257.5±9.1 to 153.1±8.5 mm², P<0.001 (reversal), while transforming growth factor (TGF)-β-positive cells were decreased from 195.6±8.4 to 129.6±5.7/mm², P<0.01 (prevention), and from 195.6±8.4 to 130.7±10.8/mm², P<0.01 (reversal). Ac-SDKP did not alter either blood pressure or left ventricular hypertrophy (LVH); however, it depressed systolic cardiac function in the prevention study while having no significant effect in the reversal group. We concluded that Ac-SDKP has an anti-inflammatory effect in HF that may contribute to its antifibrotic effect; however, this decrease in fibrosis without changes in LVH was not accompanied by an improvement in cardiac function. (Hypertension. 2004;43:229-236.)

Key Words: rat myocardial infarction cardiac function collagen macrophages transforming growth factor-β

N-acetyl-seryl-aspartyl-lysyl-proline (Ac-SDKP) is a naturally occurring antifibrotic peptide whose plasma concentration is increased 4- to 5-fold by angiotensin-converting enzyme inhibitors. Ac-SDKP is released from its precursor thymosin-β, which is present in most cells.1 It inhibits pluripotent hematopoietic stem cell and hepatocyte proliferation by halting entry into the S phase of the cell cycle, maintaining cells in the G0/G1 phase and thereby helping control their proliferation.2-4 We have shown that in vitro Ac-SDKP inhibited cardiac fibroblast proliferation and collagen synthesis,5 while in vivo it prevented collagen deposition in the left ventricle (LV) and kidneys in rats with aldosterone-salt hypertension and renovascular hypertension.5,6 This decrease in collagen deposition was associated with a reduced number of proliferating cell nuclear antigen (PCNA)-positive cells, a marker of cell proliferation. These effects of Ac-SDKP occurred without changes in blood pressure or cardiomyocyte hypertrophy. Our studies suggest that one of the mechanisms by which Ac-SDKP prevents fibrosis is by inhibiting fibroblast proliferation and collagen synthesis. It is also known that inflammation plays a central role in the pathogenesis of interstitial and perivascular cardiac fibrosis in heart failure (HF) post-myocardial infarction (MI). Fibrosis is often co-localized with macrophages, which release cytokines such as transforming growth factor-β (TGF-β) that play a crucial role in myocardial fibrosis.7 There is evidence that Ac-SDKP inhibits TGF-β signal transduction through suppression of Smad2 phosphorylation.8,9 However, it is not known whether it also inhibits the expression of TGF-β.

In the present study, we tested the hypothesis that in HF post-MI, Ac-SDKP in the noninfarcted region of the myocardium acts as an anti-inflammatory cytokine, decreasing macrophage infiltration and TGF-β expression, and thereby reducing reactive cardiac fibrosis, resulting in improved cardiac function. We also tested the hypothesis that Ac-SDKP not only prevents the development of inflammation and fibrosis but also can reverse these processes when they are already established.

Methods

Eight-week-old male Lewis inbred rats weighing 255 to 275 g (Charles River Laboratories, Wilmington, Mass) were housed in an air-conditioned room with a 12-hour light/dark cycle, received standard laboratory chow (0.4% sodium), and drank tap water. Animals were given 5 to 7 days to adjust to their new environment before surgery and then were subjected to MI by ligating the left coronary artery and allowing the heart to develop a post-MI infarct. Animals were then divided into two groups: prevention group: Ac-SDKP (1 mg/kg) was administered intraperitoneally in 1 ml/kg once daily for 7 days after surgery, and the reversal group: Ac-SDKP, 1 mg/kg was administered intraperitoneally in 1 ml/kg once daily for 4 weeks after infarction. Animals were sacrificed by an overdose of pentothal anesthetics (100 mg/kg) and blood samples were obtained by cardiac puncture. Animals were killed at 2 weeks after surgery and 4 weeks after infarction, respectively. The heart was quickly isolated, cut into left ventricle (LV), right ventricle (RV), and septum, and weighed. Heart specimens were then fixed in 10% neutral buffered formalin for 1 week. LV and RV specimens were embedded in paraffin, and 4-μm-thick sections were cut and stained with Masson trichrome.

Received September 2, 2003; first decision September 12, 2003; revision accepted November 6, 2003. From the Hypertension and Vascular Research Division (X.-P.Y., Y.-H.L., J.X., O.C., N.-E.R., O.A.C.), Department of Internal Medicine, Henry Ford Hospital, Detroit, Mich, and the Department of Pathology (F.Y.), North China Coal Medicine College, Tangshan, Hebei, People’s Republic of China. Correspondence to Oscar A. Carretero, MD, Hypertension and Vascular Research Division, Henry Ford Hospital, 2799 West Grand Boulevard, Detroit, MI 48202-2689. E-mail ocarret1@hfhs.org © 2004 American Heart Association, Inc. Hypertension is available at http://www.hypertensionaha.org DOI: 10.1161/01.HYP.0000107777.91185.89
Effect of Ac-SDKP on Blood Pressure, Infarct Size, Left Ventricular Weight, Myocyte Size, and Cardiac Function

<table>
<thead>
<tr>
<th></th>
<th>SBP (mm Hg)</th>
<th>HR (bpm)</th>
<th>IS (% LV)</th>
<th>LW/BW (mg/10 g)</th>
<th>MCSA ((\mu m^2))</th>
<th>LVDd (mm)</th>
<th>EF (%)</th>
<th>E/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sham MI</td>
<td>115.2±2.5</td>
<td>346±8</td>
<td>17.0±0.2</td>
<td>205±4</td>
<td>5.9±0.1</td>
<td>59.6±3.1</td>
<td>1.64±0.06</td>
<td></td>
</tr>
<tr>
<td>MI–vehicle (2 mo)</td>
<td>110.5±3.2</td>
<td>334±11</td>
<td>20.5±0.4†</td>
<td>329±6†</td>
<td>8.5±0.2†</td>
<td>26.8±2.1†</td>
<td>2.35±0.22†</td>
<td></td>
</tr>
<tr>
<td>MI–vehicle (4 mo)</td>
<td>105.5±2.7</td>
<td>328±6†</td>
<td>19.7±0.5†</td>
<td>343±7†</td>
<td>8.0±0.1†</td>
<td>30.4±1.5†</td>
<td>2.24±0.13†</td>
<td></td>
</tr>
<tr>
<td>MI–Ac-SDKP (prevention)</td>
<td>104.1±4.4</td>
<td>314±28</td>
<td>20.2±0.3†</td>
<td>326±7†</td>
<td>8.9±0.4§</td>
<td>25.0±0.8‡</td>
<td>2.42±0.15‡</td>
<td></td>
</tr>
<tr>
<td>MI–Ac-SDKP (reversal)</td>
<td>113.9±3.1</td>
<td>331±7</td>
<td>19.6±0.3‡</td>
<td>312±11‡</td>
<td>7.9±0.2</td>
<td>31.8±1.3</td>
<td>2.25±0.16‡</td>
<td></td>
</tr>
</tbody>
</table>

SBP, indicates systolic blood pressure; HR, heart rate; IS, infarct size; LW/BW, left ventricular weight/body weight; MCSA, myocyte cross-sectional area; LVDd, left ventricular diastolic dimension; EF, ejection fraction; E/A, ratio of E and A waves. *P<0.01 vs sham; †P=0.001 vs sham; ‡P=0.004 vs MI-vehicle (4 months); ¶P=0.057 vs MI-vehicle (4 months); §P=ns vs MI-vehicle (4 months); ††P=ns vs MI-vehicle (2 months).

Data Analysis
Data are expressed as mean±SE. One-way ANOVA was used to test for differences among groups, such as sham versus MI-vehicle 2 months or MI-vehicle 4 months; MI-vehicle 4 months versus MI-Ac-SDKP prevention or MI-Ac-SDKP reversal; and MI-vehicle 2 months versus MI-Ac-SDKP reversal. Tukey’s method of post hoc testing was used for pairwise comparisons. Homogeneity of variance was checked for each comparison, with appropriate adjustments made when warranted.

Results
Of the 60 rats that underwent coronary ligation, 5 died after surgery, for a surgical mortality rate of 8%. In addition, 4 died within 2 months (2 in the HF-vehicle group and 2 in the Ac-SDKP prevention group) and 3 died within 3 months (1 in the HF-vehicle group and 2 in the Ac-SDKP reversal group). No deaths involved cardiac rupture, and no rats in the sham-ligated group died.

Blood Pressure and Heart Rate
Systolic blood pressure was not significantly different among groups (Table). Heart rate was also similar in all groups, suggesting that Ac-SDKP has no significant influence on blood pressure and heart rate either in normal rats or in rats with MI.

Cardiac Function and Infarct Size
Infarct size was similar among groups, indicating that early treatment with Ac-SDKP (prevention protocol) did not affect infarct size (Table). MI caused cardiac hypertrophy and chamber dilatation, as evidenced by increased LV weight, myocyte cross-sectional area (MCSA), and left ventricular diastolic dimension (LVDd). Ac-SDKP administered either early or late had no significant effect on these parameters. Ejection fraction (EF), an index of cardiac performance, was significantly decreased after MI; in the Ac-SDKP prevention group, EF tended to be lower compared with MI-vehicle (P=0.057) but it was not affected in the reversal group (Table). Ratio of E and A waves (E/A), an index of diastolic function, was significantly increased in both vehicle groups and was not affected by either early or late treatment with Ac-SDKP.

Macrophage Infiltration
A few macrophages were seen in the interstitial space of sham-MI rats (34.7±2.1 per mm²). The number of macrophages increased significantly at 2 months post-MI.
nucleus and located mainly in the interstitial space, suggesting that TGF-β is expressed mainly in macrophages in the rat heart post-MI.

**Collagen Content**

In the sham MI group, cardiac collagen content was 11.9±0.3 μg/mg LV dry weight, and it increased significantly and similarly at 2 and 4 months post-MI (22.6±2.0 and 23.7±0.9 μg/mg, respectively; \( P<0.001 \) versus sham MI). In the vehicle groups there were no significant differences in cardiac collagen content between 2 and 4 months post-MI. Ac-SDKP significantly attenuated the increase in collagen content in the prevention protocol to 15.0±0.7 μg/mg (\( P<0.001 \) versus MI-vehicle/4 months) and significantly decreased collagen content in the reversal protocol (14.4±1.5 μg/mg LV dry weight; \( P=0.006 \) versus MI-vehicle/2 months; \( P<0.001 \) versus MI-vehicle/4 months) (Figure 4).

**Interstitial Collagen Fraction**

Cardiac interstitial collagen fraction (ICF) in the sham MI group was 5.8±0.2% and increased significantly at 2 and 4 months post-MI (12.5±0.2% and 13.0±0.3%, respectively; \( P<0.001 \) versus sham MI). In the vehicle groups there were no significant differences in ICF between 2 and 4 months post-MI.

---

**Figure 1.** Effect of Ac-SDKP on macrophage infiltration (upper panel) and TGF-β expression (lower panel) in rat hearts with sham myocardial infarction (MI) or MI treated with vehicle or Ac-SDKP. *\( P<0.01 \) vs sham; † \( P<0.01 \) vs MI-vehicle (4 months); ‡ \( P<0.01 \) vs MI-vehicle (2 months).

---

**Figure 2.** Representative images showing macrophage infiltration (brown staining) in rat hearts with sham myocardial infarction (MI) or MI treated with vehicle or Ac-SDKP (immunohistochemical staining and hematoxylin counterstaining, ×400).
post-MI. Ac-SDKP attenuated the increase in ICF in the prevention protocol (10.2 ± 0.4%; \( P < 0.001 \) versus MI-vehicle/4 months) and decreased ICF in the reversal protocol (10.3 ± 0.6 mg/mg LV dry weight; \( P = 0.003 \) versus MI-vehicle/2 months; \( P < 0.001 \) versus MI-vehicle/4 months) (Figure 5, upper panel; Figure 6).

**Perivascular Collagen**

The ratio of perivascular collagen area to luminal area of the coronary arterioles (PVCA/LA) was 1.76 ± 0.1 in the sham MI group, and it increased significantly at 2 and 4 months post-MI (4.5 ± 0.5 and 4.8 ± 0.2, respectively; \( P < 0.001 \) versus sham MI). In the vehicle groups, there were no significant differences in PVCA/LA between 2 and 4 months post-MI. Ac-SDKP significantly attenuated the increase in perivascular collagen in the prevention protocol (2.5 ± 0.2; \( P < 0.001 \) versus MI-vehicle/4 months) and significantly decreased perivascular collagen in the reversal protocol (2.5 ± 0.2; \( P = 0.002 \) versus MI-vehicle/2 months; \( P < 0.001 \) versus MI-vehicle/4 months) (Figure 5, lower panel; Figure 7).

**Discussion**

Previously we have shown that Ac-SDKP prevents macrophage infiltration and cardiac fibrosis in rats with renovascular and mineralocorticoid-salt hypertension.\(^5\,\text{,}\,\text{14}\) In the present work, using a rat model of cardiac remodeling post-MI, we found that treatment with Ac-SDKP not only prevented but also reversed reactive cardiac fibrosis in the noninfarcted region of the myocardium (increase in total collagen, ICF, and perivascular collagen). In addition, Ac-SDKP partially prevented and also partially reversed the inflammatory pro-

---

**Figure 3.** Representative images showing TGF-\( \beta \)-positive cells (brown staining) in rat hearts with sham MI or MI treated with vehicle or Ac-SDKP (immunohistochemical staining and hematoxylin counterstaining, \( \times 400 \)).

**Figure 4.** Effect of Ac-SDKP on total collagen content in the left ventricle as measured by hydroxyproline assay. \( \ast P < 0.01 \) vs sham; \( \# \) and \( \delta P < 0.01 \) vs MI-vehicle (4 months); \( \dagger P < 0.01 \) vs MI-vehicle (2 months).

**Figure 5.** Effect of Ac-SDKP on left ventricular interstitial collagen fraction (ICF; upper panel) and perivascular fibrosis (lower panel), as indicated by the ratio of perivascular collagen area (PVCA) to luminal area (LA), in rats with sham MI or MI treated with vehicle or Ac-SDKP (4 months vs MI-vehicle/4 months; \( P = 0.003 \) vs MI-vehicle/2 months; \( P < 0.001 \) vs MI-vehicle/4 months) (Figure 5, upper panel; Figure 6).
cess in the heart (increase in macrophages and TGF-β-positive cells). Cardiac fibrosis and chronic inflammation were similar at 2 and 4 months after MI in the vehicle groups. We also found that Ac-SDKP did not change blood pressure. Thus, the effects of Ac-SDKP on inflammation and fibrosis do not appear to be secondary to hemodynamic changes. Also, as we found in the hypertensive models, Ac-SDKP did not decrease MCSA or left ventricular hypertrophy (LVH).5,14 LV remodeling after MI is a complex process that involves both the infarcted and noninfarcted areas and contributes significantly to LV dilatation, development of HF, and death. Reparative fibrosis occurs at the site of the MI and is essential to rebuilding the necrotic myocardium to preserve structural integrity of the heart and to avoid cardiac rupture;15 however, scar formation was not the focus of this study. In the present work, we focused on the noninfarcted myocardium, where reactive and reparative interstitial fibrosis occur. Collective evidence indicates that the interstitial collagen matrix in the noninfarcted area plays a major role in healing and remodeling after MI.16–18 In this area there is some controversy over whether cardiac stem cells and inflammatory cells (after infiltrating the tissue) are able to proliferate.17,19,20 It has been shown that infiltrating macrophages, fibroblasts, and myofibroblasts are abundant in the interstitium of the heart post-MI.20–22 Chemotactic factors (including monocyte chemoattractant protein-1 [MCP-1]) stimulate macrophage infiltration in the myocardium and other tissues.22–25 These infiltrating macrophages release cytokines such as TGF-β, which stimulates fibroblast proliferation and interstitial matrix accumulation and promotes cardiac fibrosis.21,26,27 It has been well documented that TGF-β1 is a key cytokine that promotes accumulation of collagen and other major components of the extracellular matrix (ECM) in many fibrotic disorders, including cardiac and pulmonary fibrosis, glomerulonephritis, and vascular restenosis.28,29 Also, high plasma TGF-β1 levels were found in hypertensive patients with LVH and microalbuminuria.28 The antifibrotic effect of Ac-SDKP may be at least partially due to its effect on TGF-β1, which in turn could decrease fibroblast proliferation and collagen synthesis. In the present study, we found that after MI, rat hearts had considerable collagen deposition associated with markedly increased TGF-β1. We also found that TGF-β1-positive cells and macrophages were co-localized mainly in the interstitial space, suggesting that TGF-β may be expressed mainly in infiltrating macrophages in this model. However, we are not sure the TGF-β1-positive cells are macrophages, because TGF-β1 is expressed not only in macrophages but also in...
Smad 7, and these events correlated positively with ongoing expression of Smad 2 and 4 and decreased expression of plasma membrane serine/threonine kinase receptor that phosphorlates Smad signaling proteins; these proteins are then translocated to the nucleus. In the heart during the chronic phase of MI, TGF-β1 activation was associated with increased expression of Smad 2 and 4 and decreased expression of Smad 7, and these events correlated positively with ongoing cardiac fibrosis.30,33 Recently, Pokharel et al.9 showed that in cardiac fibroblasts in culture, Ac-SDKP inhibits expression and nuclear translocation of Smad 2, which may be partially responsible for its antifibrotic action. Also, Kanasaki et al.9 showed that Ac-SDKP inhibits TGF-β1 signal transduction through suppression of R-Smad activation via nuclear export of Smad 7. In addition, our study demonstrates that Ac-SDKP decreases expression of TGF-β1, which has been proposed as the stimulus for differentiation of fibroblasts to myofibroblasts.32 Ac-SDKP acting via these mechanisms may inhibit differentiation of cardiac fibroblasts to myofibroblasts, which are largely responsible for collagen production during cardiac remodeling after MI.37,33–37 Previously, we have shown that Ac-SDKP inhibits fibroblast proliferation and collagen synthesis in vitro.6 This direct effect on proliferation and synthesis may also be partially responsible for its antifibrotic effect in vivo. In another study, we found that in renovascular and mineralocorticoid hypertension, enhanced cardiac expression of PCNA, a marker of cell proliferation (probably cardiac fibroblasts), was markedly reduced by Ac-SDKP. This reduction in PCNA was associated with reduced collagen deposition,5,14 supporting the hypothesis that the antifibrotic effect of Ac-SDKP could result from inhibition of both fibroblast proliferation and collagen synthesis.

It is generally believed that increased collagen in the heart will increase diastolic stiffness and impair relaxation, ultimately promoting LV dysfunction. Thus, we expected that preventing or reversing cardiac fibrosis would benefit cardiac function. However, we found that even though Ac-SDKP decreased cardiac fibrosis, it did not improve the EF and E/A ratio, indexes of systolic and diastolic function. On the contrary, in the prevention protocol EF decreased and LVIDd tended to increase compared with the MI-vehicle group (4 months). It could be that preventing collagen deposition soon after MI alters cardiac remodeling by causing cardiocyte slippage and increasing infarct expansion. These findings are in agreement with Baicu et al.,38 who found that in hypertrophied papillary muscles from cats, acute regression of fibrosis with plasmin through activation of matrix metalloproteinases can negatively affect systolic function. Contractility in isolated myocytes exposed to the same treatment was no different from nontreated myocytes, suggesting that collagen may play an important role in myocyte-to-myocyte interaction, optimizing ventricular systolic function; hence, targeting collagen early in the context of post-MI remodeling can be deleterious. In our reversal protocol, despite a decrease in cardiac fibrosis, Ac-SDKP did not modify cardiac function, suggesting that the extent of cardiac fibrosis may not be an important determinant of function, which may be mainly due to the quality of fibrosis, such as changes in collagen cross-linking.39 Other components of LV remodeling besides collagen are crucial to ventricular performance. It could be that in this rat model with a large infarct (>42% of the LV), a decrease in viable LV mass and an alteration in the geometry of the heart may be more important.

It has long been demonstrated that ACE inhibitors improve cardiac function, often associated with reduced collagen deposition.40–43 The antifibrotic effect of ACE inhibitors may be partially mediated by inhibiting degradation of Ac-SDKP, which is hydrolyzed almost exclusively by ACE.1,44 It has been shown that ACE inhibitors increase plasma Ac-SDKP 4- to 5-fold in vivo, while in vitro they inhibit hydrolysis of [3H]Ac-SDKP by 90% to 99%.1 Thus, increased Ac-SDKP may contribute significantly to the antifibrotic effect of ACE inhibitors. However, in this model of heart failure after MI, ACE inhibitors, unlike Ac-SDKP, improved cardiac function.12,40,45–49 The mechanism of action of ACE inhibitors in heart failure is complex. In addition to blocking the conversion of angiotensin I to II, they also inhibit kinin hydrolysis and stimulate the release of nitric oxide, effects not seen with Ac-SDKP.12,40,45–49

In summary, Ac-SDKP prevented and reversed interstitial collagen and perivascular collagen deposition in the rat heart post-MI, associated with reduced macrophage infiltration and TGF-β-positive cell expression. Our study suggests that the antifibrotic and anti-inflammatory effects of Ac-SDKP may be mediated in part by inhibition of macrophage infiltration and TGF-β expression. However, these effects per se do not necessarily translate into improved cardiac function.

**Perspective**

LV remodeling after MI is a complex process that involves both the infarcted and noninfarcted area. In the noninfarcted area, remodeling involves myocyte hypertrophy and an increase in ECM and myocyte cells. Remodeling of the ECM may participate in the development of cardiac dysfunction;16–18 however, myocyte growth is accompanied by coordinated increases in ECM that provide a scaffolding for the myocytes and vasculature, maintaining the appropriate geometric structure of the heart and proper alignment of myocytes and enabling optimal transduction of coordinated force generated by cardiac contraction.18,50 The collagen matrix in the heart has a three-dimensional configuration similar to a honeycomb; the perimysium envelops groups of myocytes, whereas the endomysium forms a fine fibrillar collagen weave that surrounds and supports the myocytes. Also, fine lateral struts connect adjacent myocytes. How Ac-SDKP alters this fine structure of the fibrillar collagen is not known. Here, we found that Ac-SDKP prevented and reversed total collagen deposition (the main component of the ECM) and decreased inflammation in the heart, but despite these changes neither diastolic nor systolic function improved. On the contrary, in the prevention group systolic cardiac function was slightly decreased and LVIDd was somewhat increased. The decrease in systolic function is in agreement with previous work by Baicu et al.,38 who found that regression of fibrosis negatively affected systolic function, suggesting that collagen may play an important role in myocyte-to-myocyte interaction, thereby optimizing ventricular systolic function.
Also, disruption of the ECM could interfere with cellular signaling processes mediated via ECM-integrins-cytoskeleton, thus affecting cardiac function. ACE inhibitors increase plasma Ac-SDKP 4- to 5-fold, and we have found recently that this concentration of Ac-SDKP has an antifibrotic effect (Rasoul et al, unpublished data, 2003). Yet unlike Ac-SDKP, ACE inhibitors improve myocyte and ECM remodeling and cardiac function in HF and are among the drugs of choice for treatment of this disease. One possibility is that Ac-SDKP participates in the antifibrotic effect of ACE inhibitors, but coordinated reduction of cardiac hypertrophy, fibrosis, and afterload needs to occur to improve cardiac function. Further work is needed to determine whether Ac-SDKP participates in the therapeutic benefit and in particular the antifibrotic effect of ACE inhibitors.

Acknowledgments

This work was supported by NIH grant HL28982.

References


Ac-SDKP Reverses Inflammation and Fibrosis in Rats With Heart Failure After Myocardial Infarction
Fang Yang, Xiao-Ping Yang, Yun-He Liu, Jiang Xu, Oscar Cingolani, Nour-Eddine Rhaleb and Oscar A. Carretero

Hypertension. 2004;43:229-236; originally published online December 22, 2003; doi: 10.1161/01.HYP.0000107777.91185.89

Hypertension is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2003 American Heart Association, Inc. 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/content/43/2/229

Data Supplement (unedited) at:
http://hyper.ahajournals.org/content/suppl/2004/01/27/43.2.229.DC1

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Hypertension can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Hypertension is online at:
http://hyper.ahajournals.org//subscriptions/