Chronic Treatment With Losartan Results in Sufficient Serum Levels of the Metabolite EXP3179 for PPARγ Activation

Kai Kappert, Oleg Tsuprykov, Jan Kaufmann, Jan Fritzsche, Ingo Ott, Matthias Goebel, Ilse Nirmala Bähr, Paul-Laszlo Häßle, Ronald Gust, Eckart Fleck, Thomas Unger, Philipp Stawowy, Ulrich Kintscher

Abstract—The losartan metabolite EXP3174 exhibits angiotensin II receptor 1 (AT1R)-blocking properties, whereas the metabolite EXP3179 potently induces the activity of the insulin-sensitizing peroxisome proliferator-activated receptor γ (PPARγ) as a partial agonist in vitro. We investigated whether chronic treatment with losartan leads to sufficient serum levels of EXP3179 to activate PPARγ in monocytes derived from losartan-treated patients. Hypertensive patients (n = 15) treated with losartan (100 mg/daily for at least the past 2 months) and untreated control patients (n = 7) were included. Monocytes were extracted by negative isolation using a Dynal Monocyte Kit, followed by analysis of PPARγ target gene expression (CD36, ABC transporter G1 [ABCG1]) by quantitative real-time RT-PCR. Serum was prepared before, 2, 4, and 6 hours after losartan (100 mg) ingestion for HPLC-based determination of losartan, EXP3174, and EXP3179. Chronic treatment with losartan resulted in basal levels of losartan, EXP3174, and EXP3179 of 348.3 ± 101.8 ng/mL, 115.3 ± 56.1 ng/mL, and 176.2 ± 143.4 ng/mL, respectively. Levels of both EXP3174 and EXP3179 were time-dependently increased in serum with a maximum 2 hours after drug intake (1706.0 ± 760.1 ng/mL, 808.9 ± 618.2 ng/mL, respectively). In consonance with detectable PPARγ-activating EXP3179 serum levels, monocytic PPARγ target gene expression was significantly upregulated in patients treated with losartan by 3.75-fold for CD36 and ABCG1 (P = 0.043, P = 0.0045 versus control patients, respectively). This is the first clinical description of monocytic PPARγ-target gene regulation by chronic treatment with losartan, which likely is mediated by its metabolite EXP3179. Our data show that sufficient serum levels of EXP3179 are present under losartan treatment. PPARγ activation by AT1R-blockers may translate into synergistic beneficial actions in monocytes. (Hypertension. 2009;54:738-743.)

Key Words: peroxisome proliferator-activated receptor gamma ■ angiotensin receptor blocker ■ losartan ■ CD36 ■ ABCG1 ■ monocytes ■ hypertension

Most angiotensin II–induced actions have been attributed to be mediated through the angiotensin II receptor 1 (AT1R). This led to the use of AT1R-blockers (ARBs) as antihypertensive drugs, which exhibit a variety of pleiotropic protective vascular effects. Along with this, the Losartan Intervention For End point reduction in Hypertension (LIFE) study demonstrated a significantly greater benefit for cardiovascular morbidity and mortality and a 25% lower rate of new-onset diabetes in patients treated with losartan compared to β-blocker treatment. Interestingly, blood pressure reduction in LIFE was identical in both groups, strongly indicating that the antidiabetic action of the ARB was independent of blood pressure lowering. This is further supported by data from the VALUE (Valsartan Antihypertensive Long-term Use Evaluation) trial in which valsartan was compared to amlodipine. Despite a more prominent blood pressure–lowering effect in the amlodipine group, valsartan lowered the risk of new-onset diabetes by 23%. Thus, these data suggest cardiovascular protective and antidiabetic properties of losartan which are, at least in part, independent from its blood pressure lowering actions. The molecular mechanisms for the beneficial effects of losartan beyond AT1R blockade are still incompletely understood.

Losartan is metabolized via cytochrome-P450 degradation into EXP3174, serving as the AT1R-blocking metabolite, and into EXP3179 with no AT1R-blocking properties. The latter exhibits molecule homology to indomethacin, a cyclooxygenase inhibitor with antiinflammatory and antiaggregatory
properties.³ Consistently, this metabolite was capable of blocking cyclooxygenase-2 and ICAM-1 mRNA upregulation, and cyclooxygenase-dependent thromboxane A2 and prostaglandine F2α generation in vitro. Moreover, EXP3179 stimulated the phosphorylation of the endothelial nitric oxide synthase through a PI3-kinase/Akt-pathway downstream of the VEGF-receptor 2 in cultured endothelial cells.⁴

We and others demonstrated that a subset of ARBs, including losartan, induces the activity of a nuclear hormone receptor named peroxisome proliferator-activated receptor γ (PPARγ) by partial agonism.⁵,⁶ Importantly, this activation was shown to be independent of AT1R expression, and therefore not related to the AT1R-blocking properties.⁶ PPARγ functions as a transcriptional regulator in adipose tissue where it regulates multiple genes involved in lipid and glucose metabolism.⁷ PPARγ is abundantly expressed in adipose tissue, but also in vascular and nonvascular cells in the vessel wall (monocytes/macrophages, endothelial cells, vascular smooth muscle cells).⁸ PPARγ activated by synthetic agonists like glitazones improves whole-body insulin sensitivity resulting in decreased levels of fasting plasma glucose, insulin, and triglycerides.⁹ In addition, ligand-activated PPARγ mediates direct antiatherosclerotic actions resulting in marked reduction of cardiovascular morbidity and mortality.¹⁰–¹² We could demonstrate that EXP3179, but not the losartan metabolite EXP3174, markedly stimulated PPARγ activity and target gene expression of adipose protein 2 in vitro.¹³ Whether EXP3179-induced PPARγ-activity plays a significant role in the observed beneficial actions of losartan in patients is currently unknown. Therefore, we analyzed (1) levels of losartan and losartan metabolites in hypertensive patients chronically treated with losartan, and (2) PPARγ activation in isolated monocytes.

Materials and Methods

The extended material and methods used are described in the online Data Supplement (please see http://hyper.ahajournals.org).

Patients’ Characteristics

Hypertensive patients who had been treated with losartan 100 mg/daily for at least 2 months (n=15) and hypertensive volunteers without losartan-treatment (n=7) were recruited in the Department of Internal Medicine/Cardiology at the Deutsche Herzzentrum Berlin, Germany. Patients’ characteristics are summarized in Table 1. No patient was taking indomethacin or any other antiphlogistic drug (NSAIDS), except for antiplatelet acetylsalicylic acid, or other ARBs or glitazones for the past 2 months. The study was approved by the ethics committee of the Charité-Universitätsmedizin Berlin, Germany. All patients provided written informed consent. The study was registered as ClinicalTrials.gov-ID NCT00561327.

Results

Losartan and Losartan Metabolites Serum Levels

Levels of losartan and metabolites were clearly detectable in serum from losartan-treated patients at t=0 hour, demonstrating that chronic administration of losartan leads to steady-state levels that can be discriminated to levels of untreated control patients, which were negative in our experimental set-up, providing evidence for yielding valid serum levels (no biological noise; Table 2).

<table>
<thead>
<tr>
<th>Time</th>
<th>Losartan</th>
<th>EXP3174</th>
</tr>
</thead>
<tbody>
<tr>
<td>t=0</td>
<td>348.3±101.8</td>
<td>115.3±56.1</td>
</tr>
<tr>
<td>t=2</td>
<td>0.82±0.24</td>
<td>0.26±0.13</td>
</tr>
<tr>
<td>t=4</td>
<td>Not determined</td>
<td>3.91±1.74</td>
</tr>
<tr>
<td>t=6</td>
<td>Not determined</td>
<td>1.96±0.86</td>
</tr>
</tbody>
</table>

Table 1. Characteristics of the Study Population

<table>
<thead>
<tr>
<th>Patients’ Characteristics</th>
<th>Control, n=7 (%)</th>
<th>Losartan, n=15 (%)</th>
<th>P for Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex, male/female</td>
<td>7/0</td>
<td>11/4</td>
<td>n.s.</td>
</tr>
<tr>
<td>Age, y</td>
<td>59±9</td>
<td>68±6</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>28.3±2.0</td>
<td>31.4±3.1</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Mean systolic blood pressure, mm Hg</td>
<td>145.0±17.3</td>
<td>147.8±14.3</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mean diastolic blood pressure, mm Hg</td>
<td>78.9±10.9</td>
<td>79.4±8.5</td>
<td>n.s.</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>7 (100%)</td>
<td>15 (100%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2 (29%)</td>
<td>7 (47%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>5 (71%)</td>
<td>12 (80%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Comedication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antplatelets</td>
<td>5 (71%)</td>
<td>13 (87%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Statins</td>
<td>5 (71%)</td>
<td>12 (80%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>ACE-inhibitors</td>
<td>4 (57%)</td>
<td>2 (13%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>4 (57%)</td>
<td>12 (80%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Calcium channel blockers</td>
<td>3 (43%)</td>
<td>9 (60%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Serum parameters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine, mg/dL</td>
<td>1.14±0.24</td>
<td>1.06±0.17</td>
<td>n.s.</td>
</tr>
<tr>
<td>Sodium, mmol/L</td>
<td>140.2±3.7</td>
<td>140.5±2.5</td>
<td>n.s.</td>
</tr>
<tr>
<td>Potassium, mmol/L</td>
<td>3.78±0.55</td>
<td>3.81±0.35</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

Consistent with previous reports, mean losartan baseline serum levels were 348.3 ng/mL corresponding to 0.82 μmol/L (Table 2). The AT1R-blocking metabolite EXP3174 was characterized by low baseline levels, reached a maximum after 2 hours with 1706.0 ng/mL (=3.91 μmol/L), and showed a second peak after 6 hours (1222.7 ng/mL=2.80 μmol/L; Table 2). The PPARγ-activating EXP3179 could be clearly detected in serum samples from losartan-treated patients. Serum levels peaked after 2 hours with 808.9 ng/mL, which represents 1.92 μmol/L followed by a decrease over time (Table 2).

PPARγ Target Gene Expression in Monocytes

As a model for in vivo target gene expression, monocytes were isolated from hypertensive losartan-treated patients and

Table 2. HPLC-Based Analyses of Losartan and Losartan Metabolites

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</tr>
</tbody>
</table>
hypertensive control patients. Monocytes from losartan-treated and control patients were prepared by negative isolation from blood that was withdrawn at t=0 hour (before losartan intake in the treated group) and at t=6 hours (6 hours after oral losartan ingestion). RNA was extracted from isolated monocytes, reverse transcribed to cDNA, and used as a template for quantitative RT-PCR analyses on PPARγ target gene expression (Figure 1). PPARγ activators have previously been described to enhance the expression of the scavenger receptor CD36 and the cholesterol efflux transporter ABCG1, implicated in the elimination of the excess of free cholesterol. Transcript levels were normalized to transcript expression of the house-keeping gene human 18S, and levels in control-patients were arbitrarily set to 1. PPARγ target gene expression was significantly increased in patients chronically treated with losartan. CD36 was upregulated by 3.75±0.95-fold (P=0.043 versus control patients; Figure 1). ABCG1 levels were increased to 252.02±46.86-fold (P=0.0045 versus control patients) compared to expression of untreated control patients (Figure 1), in consonance with the concept of sufficient levels of losartan and losartan-metabolites to induce PPARγ target gene expression in vivo under chronic treatment with losartan. Interestingly, gene transcript expression from monocytes isolated 6 hours after losartan ingestion (data not shown) did not differ significantly from values detected at t=0 hour, underlining the assumption of chronic losartan and losartan metabolite levels particularly impacting on target gene expression.

**Functional Impact of PPARγ Agonism on Monocyte Migration**

Exploring the actual biological effects of PPARγ agonism by losartan and its metabolites, we analyzed cellular responses of THP-1 human monocytes. Monocytes were characterized with regard to monocyte chemoattractant protein-1 (MCP-1)–directed chemotaxis in a transwell migration system in the absence or presence of ARBs known to activate PPARγ (telmisartan, irbesartan), or valsartan, an ARB without PPARγ agonistic properties. In addition, chemotaxis was analyzed in the presence of losartan, and the losartan metabolites EXP3174 and EXP3179, as well as pioglitazone as a PPARγ full agonist. As shown in Figure 2, MCP-1–directed migration was significantly and concentration-dependently impaired by EXP3179, telmisartan, irbesartan, and pioglitazone. In contrast, losartan, EXP3174, and valsartan failed to alter migration. Importantly, monocytes being subjected to EXP3179 at levels that were actually achieved in hypertensive patients (approximately 2 µmol/L) were characterized by significantly reduced migration. These data support that the

![Figure 1. PPARγ target gene expression in control and losartan-treated patients. Quantitative real-time PCR of the PPARγ target genes (A) CD36 and (B) ABCG1 in isolated monocytes from hypertensive control patients and patients chronically treated with losartan. Levels of control patients were arbitrarily set to 1. Shown are analyses of transcript levels at t=0 hour, which equates to 24 hours after last oral ingestion of 100 mg losartan. Data are expressed as mean relative expression±SEM of CD36/18S, and ABCG1/18S mRNA ratios. *P<0.05, **P<0.01 vs Control.](image1)

![Figure 2. Migration of human monocytes. Human monocyctic THP-1 cells were pre-treated for 24 hours with vehicle (control) or compounds at concentrations indicated. Cells were then subjected to chemotaxis assays using 0.2% gelatin-coated transwell chambers. Cells were placed in the upper chamber and were allowed to migrate for 2.5 hours toward a monocyte-chemoattractant protein-1 (MCP-1, 10 ng/mL) gradient, either in the presence of vehicle (control) or compounds as indicated. Each experiment was performed with n=3 wells per condition. Data are expressed as fold migration of control cells without MCP-1 chemotaxis-induction. Shown is the mean±SEM from 3 independent experiments. #P<0.001 vs Control; *P<0.05 vs MCP-1; **P<0.01 vs MCP-1; ***P<0.001 vs MCP-1.](image2)
plasma levels of the PPARγ agonist EXP3179 are capable of reducing monocyctic cellular responses.

**EXP3179 Induces PPARγ Target Gene Expression in Monocytes Ex Vivo**

PPARγ target genes were significantly upregulated in hypertensive patients chronically treated with losartan. Thus, we next analyzed whether the PPARγ agonistic losartan metabolite EXP3179 induces gene expression at concentrations achieved in vivo in primary human monocytes ex vivo. Monocytes were isolated from drug naïve healthy volunteers and treated with various ARBs (losartan, telmisartan, irbesartan), the losartan metabolites EXP3174 and EXP3179, and pioglitazone as a full PPARγ agonist for 24 hours. In accordance with previous reports, EXP3179 treatment resulted in induction of CD36 (Figure 3A). Importantly, both losartan and the losartan metabolite EXP3174 failed to significantly induce CD36 in human monocytes. Moreover, the observed effect attributable to EXP3179 treatment was achieved after incubation at concentrations that were indeed detectable in hypertensive patients chronically treated with losartan. Confirming previous data, telmisartan and irbesartan treatment resulted also in PPARγ target gene expression, underlining the dual molecular targets of these ARBs. Furthermore, repetitive incubation of monocyctic THP-1 cells with the losartan metabolite EXP3179 (2 μmol/L for 2 hours every 24 hours) produced a larger induction of PPARγ target gene expression than one single dose (Figure 3B), thus substantiating the assumption of repeated peaks being capable of inducing higher and long-standing effects on PPARγ responsive genes.

**Discussion**

Here we provide evidence for significant monocyctic PPARγ-target gene regulation by chronic treatment with losartan, which likely is mediated by its metabolite EXP3179. Our data show that serum levels of EXP3179, which have recently been acknowledged to induce PPARγ target gene expression in vitro, are present under chronic losartan treatment of patients. These observations are consistent with the idea of losartan metabolites exhibiting advantageous effects in hypertensive patients beyond blood pressure reduction. This is also supported by impaired migration of EXP3179 treated monocytes. In conclusion, the observed PPARγ activation by the ARB losartan may translate into synergistic beneficial actions (AT1-receptor blockade + PPARγ activation) in monocytes.

**Pleiotropic Actions of Losartan**

The blockade of the renin–angiotensin system (RAS) by both ACE-inhibitors and ARBs provides a well-established pharmacological strategy for treatment of patients with heart failure, chronic renal failure, atherosclerotic disease, and hypertension. In particular, ARBs provide effective inhibition of the RAS interfering with angiotensin II at the receptor level. Early findings indicated that the action of the ARB losartan could not solely be explained by the antagonistic effects of losartan and the metabolite EXP3174 at the AT1-receptor. Additional studies suggest blood pressure–independent pleiotropic effects of losartan and other ARBs on certain end points such as new-onset of diabetes. Along this line, the LIFE and VALUE trial have demonstrated antidiabetic actions of ARBs which cannot be directly attributed to blood pressure differences. Indeed, the losartan metabolite EXP3179 exhibits a variety of beneficial pleiotropic effects in vitro that may also account for antiinflammatory, antiaggregatory, and antidiabetic actions of losartan observed in clinical trials. The underlying molecular mechanism of
these actions is unknown. PPARγ activation by EXP3179 demonstrated in the present study may provide a potential molecular explanation for these clinical findings.

**Pharmacokinetics of EXP3174 and EXP3179**

The kinetics of the serum concentration of EXP3174 and EXP3179 has to be interpreted with caution and requires future additional studies. EXP3179 is supposed to be a short-lived intermediate of losartan, which may explain its fast serum appearance and its marked tail-off after 2 hours. Serum concentration of EXP3174 peaks at 2 hours with an additional second peak after 6 hours showing a divergence of the EXP3174 – EXP3179 curves. The most probable explanation for this phenomenon might be that EXP3179 undergoes substantial enterohepatic circulation, which then results in a second peak of the serum concentration time curve. Previous reports on the pharmacokinetics of losartan and EXP3179 demonstrated a peak plasma concentration of EXP3179 between 3 to 6 hours. However, in most cases pharmacokinetic data are based on results from early clinical development phases tested in untreated healthy volunteers with short-term treatment. In the present study, hypertensive patients chronically treated with losartan and concomitant medication were investigated. Thus, drug interactions on different levels of drug metabolism (eg, enteral transport, hepatic metabolism, etc) or potential saturation of metabolizing enzymes under chronic conditions may have affected our results.

**EXP3179: A PPARγ-Activator in Hypertensive Patients**

It has been previously demonstrated that a single oral dose of losartan (100 mg) reached maximal serum levels of EXP3179 between 0.1 and 1 μmol/L. Our group showed PPARγ-mediated adipocyte differentiation at concentrations between 1 and 10 μmol/L. The high lipophilicity of EXP3179 with possible accumulation of this metabolite in target cells (eg, monocytes), and the characteristics of repetitive elevated levels under chronic losartan treatment, may produce sufficient EXP3179 intracellular concentrations in vivo to activate PPARγ. This is substantiated by our findings that repetitive incubation of monocytic cells with EXP3179 resulted in larger induction of PPARγ target gene expression than 1 single dose (Figure 3B). Rapid hepatic metabolization of EXP3179, however, might not be negligible. In agreement with the data from Kramer and colleagues, we could now demonstrate maximal EXP3179 serum levels of 1.92μmol/L under chronic losartan (100 mg daily) treatment (Table 2). This serum concentration is in a range which is compatible with previous PPARγ inducing concentrations in in vitro settings. In line with this, we could demonstrate increased PPARγ target gene expression in monocytes treated with EXP3179 ex vivo at concentrations detectable in hypertensive patients treated with losartan (Figure 3).

CD36 and ABCG1, 2 previously recognized PPARγ target genes, were significantly increased in patients chronically treated with losartan (Figure 1). Both genes have been implicated in cholesterol uptake and removal in monocytes/macrophages, suggesting a significant role in foam cell formation and, thus, atherosclerotic disease. In this context, PPARγ-mediated cholesterol efflux via ABCA1 and ABCG1 appears to be more prominent than cholesterol influx resulting in a net antiatherosclerotic action of PPARγ activation. In the present study we detected serum levels of EXP3179 in the range of PPARγ-activating concentrations. Thus, it is likely that the differences in monocyctic CD36 and ABCG1 expression levels between losartan-treated and -untreated patients result from the presence/absence of the PPARγ-activating EXP3179 metabolite. These data are consistent with previous reports demonstrating that telmisartan, another PPARγ-activating ARB, induces ABCG1 expression in human THP-1 macrophages. Notably, downregulation of PPARγ by siRNA abolished the telmisartan-induced expression, underlining the importance of PPARγ for the induction of ABCG1 by this distinct group of ARBs. However, the role of AT1R blockade by losartan for monocyctic gene expression and cholesterol efflux has to be taken into consideration. Angiotensin II has been consistently shown to reduce cholesterol efflux from monocytes/macrophages. Takata and colleagues demonstrated that angiotensin II–induced cholesterol efflux is mediated via downregulation of the ABCA1 transporter in macrophages, whereas ABCG1 expression was not affected. Moreover, treatment with the ARB valsartan resulted in an induction of ABCA1 gene expression but had no effect on ABCG1. These studies suggest that the induction of ABCG1 observed in our study may mainly result from losartan-metabolite (EXP3179)–mediated PPARγ activation, because AT1-blockade has not been described to regulate this gene. The bimodal mechanism of action of losartan and other PPARγ-activating ARBs may provide synergistic benefits with regard to cholesterol efflux comprising AT1R-dependent ABCA1 regulation and PPARγ-dependent ABCG1 regulation. Furthermore, proliferation and accumulation of monocytes account for inflammation in both obesity/insulin-resistance and atherosclerosis. In line with previous reports we demonstrate impaired monocyte migration attributable to PPARγ activation (Figure 2). In particular, EXP3179 at concentrations detectable in vivo in losartan-treated hypertensive patients significantly inhibited MCP-1–directed transwell migration. These results may provide an additional mechanism of the cardiovascular protective actions of losartan observed in clinical end point trials.

Taken together, chronic losartan treatment in hypertensive patients leads to serum levels of losartan and losartan metabolites, which seem sufficient for induction of PPARγ target gene induction. Whereas earlier findings demonstrated significant reduction of atherosclerotic disease by losartan, our data suggest PPARγ activation as a potential mechanism by which beneficial clinical impact is induced under chronic treatment with the ARB losartan.

**Clinical Perspective**

AT1 receptor blockade and PPARγ activation have been shown to exert beneficial actions on cardiovascular morbidity and mortality. Combination of the 2 pharmacological principals in 1 compound may result in synergistic actions in patients with cardiovascular risk. In this regard, the present study provides a potential cardiovascular protective mecha-
nism for losartan. In addition, these data demonstrate the possibility to activate monocytyc PPARγ in patients treated with an AT1 receptor blocker serving as a clinical model for the future development of bimodal drugs.

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Disclosures

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References


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Online data supplement

Chronic treatment with losartan results in sufficient serum levels of the metabolite EXP3179 for PPARγ activation

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²: Department of Medicine/ Cardiology, Deutsches Herzzentrum Berlin, Augustenburger Platz 1, 13353 Berlin, Germany
³: Institute of Pharmaceutical Chemistry/ Technische Universität Braunschweig, Beethovenstr. 55, 38106 Braunschweig, Germany
⁴: Institute of Pharmacy, Free University Berlin, Königin-Luise-Str. 2+4, 14195 Berlin, Germany
materials and methods

sample preparation/ storage
A total volume of 60mL venous blood was withdrawn for baseline drug serum concentrations and monocyte isolation from all patients (in the losartan group immediately before oral administration). Blood samples were drawn from the antecubital vein. 5-10mL serum was extracted at 4°C at 3000g, and immediately stored at –20°C. From the remaining sample monocytes were isolated, shock-frozen in liquid nitrogen, and then stored at –80°C until further use.

In losartan patients, 2, 4, and 6 hours after drug ingestion an additional sample for analysis of drug serum concentrations was taken, and at 6h also for a second monocyte isolation.

Monocyte isolation
Monocyte isolation technique, referred to as the Ficoll Hypaque method, employed a liquid density gradient medium of Ficoll 400® and sodium metrizoate or sodium diatrizoate solution. Vacutainer Cell Preparation Tubes (Becton Dickinson, Heidelberg, Germany) were filled with peripheral whole blood and centrifuged to isolate the mononuclear cells above the medium. To separate monocytes from other mononuclear cells we used the Dynal monocyte negative isolation kit (Invitrogen GmbH, Karlsruhe, Germany). Non-monocytes (e.g. T-, B-cells, NK cells) were depleted by magnetic Dynabeads®, which are able to bind to them after preincubation with an antibody mix against non-monocytes. Finally, bead- and antibody-free pelleted monocytes were shock-frozen in liquid nitrogen and stored at –80°C until further processing. For gene expression analyses of primary monocytes after incubation with vehicle, losartan metabolites, ARBs or pioglitazone ex vivo, monocytes were isolated from non-hypertensive individuals using the same cell isolation procedure, followed by cell culturing.

RNA isolation and quantitative reverse transcriptase real-time polymerase chain reaction
Isolation of RNA from frozen monocyte pellets was performed by using the RNAeasy Mini or Micro kit from Qiagen (Hilden, Germany). Quality of RNA was routinely analyzed using an Agilent 2100 Bioanalyzer (Agilent Technologies, Boeblingen, Germany). RNA was transcribed to complementary DNA using random primers (Promega, Madison, WI, USA), SuperScript II Reverse Transcripase (Invitrogen GmbH, Karlsruhe, Germany), Thermocycler (Biometra, Göttingen, Germany), and was subjected to quantitative real-time polymerase chain reaction (qRT-PCR) using the Power SYBRGreen PCR Master Mix Reagent Kit (Applied Biosystems, Foster City, CA, USA). Primer sequences were for human 18S ribosomal RNA 5′-CCGCAGCTAGGAATAATGGAATA-3’ (forward), and 5′-TCTAGCGCGCAATACGAAT-3’ (reverse); for human CD36 5′-GAGAACTGTATGCGCAG-3’ (forward), and 5′-TTCAACTGGAGGCAAAGG-3’ (reverse); for human ABCG1 5′-CCATGAATGCCAGCAGTAC-3’ (forward), and 5′-GGGCTTCCGTGAGGTTATT-3’ (reverse). The reaction was performed in duplicate to quadruplicate with Mx3000P® QPCR System (Stratagene, La Jolla, CA, USA). Data from the reaction were collected and analyzed by the complementary Mx3000P analysis software. Expression of analyzed genes was normalized to the average expression of the housekeeping gene human 18S ribosomal RNA.

Monocyte gene expression ex vivo
After monocyte isolation from non-hypertensive drug naïve healthy individuals, cells were cultured in RPMI 1640 (Gibco) without serum or antibiotics in the absence or presence of vehicle, losartan metabolites, ARBs or pioglitazone for 24h at concentrations indicated in the figure legend. Thereafter, cells were washed in PBS, RNA was isolated, cDNA was prepared and subjected to quantitative real-time RT-PCR procedures. Experiments were performed four times. In addition, THP-1 cells were subjected to EXP3179 stimulation for 2h every 24h, and lysed after 24, 48, and 72h, respectively, followed by quantitative RT-PCR procedures as described above (n=3).
Monocyte chemotaxis
The human monocytic THP-1 cell line was purchased from DSMZ (Deutsche Sammlung von Mikroorganismen und Zellkulturen, Germany). Cells were cultivated in RPMI 1640 (10% FCS, 2mmol/L of L-glutamine, 100U/mL of penicillin, and 100μg/mL of streptomycin) at 95% relative humidity and 5% CO2 at 37°C, and cells were stimulated with vehicle, losartan metabolites, ARBs, or pioglitazone for 24h at concentrations indicated in the figure legend. Chemotaxis experiments towards an MCP-1 gradient (10ng/mL, Chemicon) were performed using transwell chambers (Becton Dickinson) with a gelatin-coated (0.2%) polycarbonate membrane with 8μm pores. The number of THP-1 monocytes per high power field (HPF, magnification 320×) that had migrated after 2.5h in the presence or absence of vehicle, losartan metabolites, ARBs, or pioglitazone to the lower surface of the filters was determined microscopically. Three randomly chosen HPFs were counted per filter. Experiments were performed three times.

High-performed liquid chromatography
For valid high-performance liquid chromatography (HPLC)-based measurements of losartan and losartan metabolites (EXP 3174/ EXP 3179), methodological establishment of internal controls was performed. Therefore, losartan and losartan metabolites were prepared as described earlier 1. Sera obtained from treated or untreated patients were purified and separated into two aliquots. To one aliquot losartan, EXP 3174 and EXP 3179 were added. Both aliquots were measured by HPLC and the amount of losartan, EXP 3174 and 3179 in the original patient samples was calculated by linear extrapolation (matrix matched calibration). No signals for losartan, EXP 3174 and EXP 3179 were observed in samples obtained from untreated patients. In more detail, to one aliquot (3.5mL) of serum two aliquots of ice-cold ethanol (96%) were added, the mixture was shaken, stored at -20°C for 20min and centrifuged (4000rcf, 10min). The supernatant was isolated, evaporated to dryness by use of a rotovapor (operated at a maximum of 40°C) and freeze drying (Christ Loc-1m Alpha1-4). The residue was resuspended in 1.0mL of methanol/H2O (6/2), centrifuged (10000rcf, 2min) and filtered (Whatman Mini-Uniprep™, 0.45µmol/L pore size, PP membrane). To 500µL thereof 5µL of losartan (0.5mg/mL), 10µL of EXP3174 (1.0mg/mL) and 5µL EXP3179 (1.0mg/mL) were added for the purpose of analysis by matrix matched calibration. Each 100µL of the methanolic solutions (unmodified and containing the standards, respectively) were analyzed by HPLC (Kontron apparatus, isocratic operating mode, mobile phase: phosphate buffer (pH = 3.5)/MeOH: 40/60 or 55/45, stationary phase: Machery-Nagel Nucleosil C18, 25cm, 4mm ID, 5µmol/L, flow rate: 0.6mL/min, detection: 210nm).

Statistics
Results of gene expression analyses and compound serum levels are reported as mean ± standard error (SD) or mean ± standard error of the mean (SEM), as indicated in the tables and figure legends. Differences were analyzed by ANOVA followed by least significance difference post-hoc test, or t-test, as appropriate. Differences between patients’ characteristics were analyzed by Fisher´s exact test or t-test. A p-value <0.05 was regarded as significant.

References