Functional Cross-Talk Between Aldosterone and Angiotensin-(1-7) in Ventricular Myocytes

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Abstract—High serum levels of aldosterone have been linked to the development of cardiac disease. In contrast, angiotensin (Ang)-(1-7) was extensively shown to possess cardioprotective effects, including the attenuation of cardiac dysfunction induced by excessive mineralocorticoid activation in vivo, suggesting possible interactions between these 2 molecules. Here, we investigated whether there is cross-talk between aldosterone and Ang-(1-7) and its functional consequences for calcium (Ca2+) signaling in ventricular myocytes. Short-term effects of aldosterone on Ca2+ transient were assessed in Fluo-4/AM-loaded myocytes. Confocal images showed that Ang-(1-7) had no effect on Ca2+ transient parameters, whereas aldosterone increased the magnitude of the Ca2+ transient. Quite unexpectedly, addition of Ang-(1-7) to aldosterone-treated myocytes further enhanced the amplitude of the Ca2+ transient suggesting a synergistic effect of these molecules. Aldosterone action on Ca2+ transient amplitude was mediated by protein kinase A, and was related to an increase in Ca2+ current (Ica) density. Both changes were not altered by Ang-(1-7). When cardiomyocytes were exposed to aldosterone, increased Ca2+ spark rate was measured. Ang-(1-7) prevented this change. In addition, a NO synthase inhibitor restored the effect of aldosterone on Ca2+ spark rate in Ang-(1-7)-treated myocytes and attenuated the synergistic effect of these 2 molecules on Ca2+ transient. These results indicate that NO plays an important role in this cross-talk. Our results bring new perspectives in the understanding of how 2 prominent molecules with supposedly antagonist cardiac actions cross-talk to synergistically amplify Ca2+ signals in cardiomyocytes. (Hypertension. 2013;61:425-430.) ● Online Data Supplement

Key Words: calcium ■ myocytes ■ electrophysiology ■ angiotensin

Progression of chronic heart failure is mediated largely via persistent activation of different neuroendocrine systems. Both experimental and clinical studies have linked aldosterone excess to the development and progression of several different cardiovascular disease processes,1,2 and aldosterone levels are often elevated in patients with heart failure.2,3 In addition, the presence of both mineralocorticoid (MR) and glucocorticoid receptors (GR) has been reported in the heart, supporting a direct effect of aldosterone on cardiomyocyte function in normal condition and during pathological remodeling.

There is accumulating evidence that modulation of calcium (Ca2+) influx plays a central role in the action of aldosterone in cardiomyocytes. Consistently, aldosterone upregulates L-type Ca2+ current (Ica),7 enhances cardiomyocyte shortening,8 and increases ryanodine receptor (RyR) activity leading to abnormal Ca2+ release in ventricular myocytes.9

Previously, it has been shown in vivo that angiotensin (Ang)-(1-7) infusion protects the heart against deoxycorticosterone acetate–mediated cardiac dysfunction.10 Similar findings were observed in a transgenic rat with increased circulating levels of Ang-(1-7).11 Taken together, these data suggest an important interaction between Ang-(1-7) and aldosterone signaling in the heart that culminates with the activation of protective mechanisms. How these 2 signaling pathways interact and the impact of this interplay for Ca2+ handling in ventricular myocytes is still not known. To begin to investigate whether
cardioprotective effects of Ang-(1-7) against aldosterone excess represent a consequence of antagonistic outcomes or result from more complex interactions, we assessed short-term effects of aldosterone and Ang-(1-7) on freshly isolated ventricular myocytes, under conditions where both MR and GR were activated. Here, our goal was 2-fold: (1) to investigate whether there is a signaling cross-talk between aldosterone and Ang-(1-7) in ventricular myocytes and (2) to identify its functional consequences and underlying mechanisms.

For the detailed Methods Section, please see the online-only Data Supplement.

Results

In ventricular myocytes the global [Ca\(^{2+}\)] transient is central to cardiac function; it underlies contraction and contributes to the regulation of electric activity. To directly investigate the short-term effects of aldosterone on Ca\(^{2+}\) transient parameters, ventricular myocytes were loaded with the Ca\(^{2+}\)-sensitive fluorescent dye Fluo-4/AM and visualized by confocal microscopy. Here, we used a supraphysiological concentration of aldosterone (1 \(\mu\)mol/L) to fully activate both MR and GR in a redox-independent manner, as previously shown. Treatment of cardiomyocytes with aldosterone led to a significant increase in Ca\(^{2+}\) transient amplitude when compared with untreated cells, an effect that was partially abolished by preincubation with the MR antagonist spironolactone (10 \(\mu\)mol/L; Figure S1A in the online-only Data Supplement). Incubation of cardiomyocytes with mifepristone (10 \(\mu\)mol/L), a GR antagonist, also partially prevented aldosterone from inducing an increase in Ca\(^{2+}\) transient amplitude (Figure S1A). Finally, combining spironolactone and mifepristone completely prevented the increase in peak Ca\(^{2+}\) in aldosterone-treated myocytes (Figure S1B). Taken together, these data validated the use of supraphysiological concentrations of aldosterone for activating MR and GR, as previously shown by others.

We next investigated the effects of Ang-(1-7) on global Ca\(^{2+}\) levels under conditions of excessive aldosterone signaling. Top panels of Figure 1A display representative line-scanning images recorded from ventricular cells. Below the line scanning is a graphical representation of each selected cell. As we have previously shown, Ang-(1-7) (100 nmol/L) alone had no effect on Ca\(^{2+}\) transient amplitude (Figure 1B). Quite unexpectedly, addition of Ang-(1-7) to aldosterone-treated myocytes further enhanced the magnitude of the Ca\(^{2+}\) transient above the levels observed in cells exposed to aldosterone alone (Figure 1A and 1B). Thus, this finding suggests an important synergistic effect between aldosterone and Ang-(1-7) in ventricular myocytes, pointing to an important role of Ang-(1-7) in the modulation of intracellular Ca\(^{2+}\) under conditions of increased aldosterone signaling. To investigate the role of receptor Mas on Ang-(1-7) effects on Ca\(^{2+}\) transient in aldosterone-treated cardiomyocytes, we isolated cardiac cells from wild-type and Mas\(^{-/-}\) mice. Confirming our findings using rat ventricular myocytes, aldosterone significantly enhanced Ca\(^{2+}\) transient levels in myocytes from wild-type mice, an effect that was exacerbated in the presence of Ang-(1-7; Figure S2A and S2C). In contrast, Mas\(^{-/-}\) myocytes lack the synergistic effect of Ang-(1-7) on Ca\(^{2+}\) transient amplitude in aldosterone-treated cells (Figure S2B and S2D), suggesting an important role of receptor Mas on Ang-(1-7) actions in the presence of aldosterone.

To investigate the cellular basis of this phenomenon, we assessed \(I_{\text{Ca,L}}\) by electrophysiological techniques. As shown in Figure S3, Ang-(1-7) alone had no effect on \(I_{\text{Ca,L}}\) current density. In contrast, aldosterone treatment significantly enhanced \(I_{\text{Ca,L}}\) in cardiomyocytes when compared with untreated controls (at 0 mV: 8.1±0.4 pA/pF in 26 control versus 9.6±0.3 pA/pF in 30 aldosterone-treated cardiomyocytes; \(P<0.05\); Figure S4A and S4B), as previously shown by others. Importantly, this aldosterone-mediated effect was unchanged in the presence of Ang-(1-7). The importance of these data is 2-fold. First, increased \(I_{\text{Ca,L}}\) current density can explain the effects of aldosterone on Ca\(^{2+}\) transient. Second, synergistic effects of aldosterone and Ang-(1-7) were not observed at the \(I_{\text{Ca,L}}\) level, indicating that other factors would be possibly contributing to the observed effects of these 2 molecules on Ca\(^{2+}\) transient magnitude. Therefore, we next investigated the subcellular mechanisms underlying Ang-(1-7) enhancement of Ca\(^{2+}\) transient magnitude in conditions of aldosterone excess. Alterations in sarcoplasmic reticulum (SR) Ca\(^{2+}\) content contribute to enhance Ca\(^{2+}\) release in ventricular myocytes. To investigate this possible contribution, we recorded SR Ca\(^{2+}\) load in caffeine-dumped ventricular cells. Figure 2A shows that SR Ca\(^{2+}\) content was not significantly different between control and aldosterone-treated myocytes. However, it should be noted that there was a tendency for lower SR Ca\(^{2+}\) content in aldosterone-treated myocytes. Importantly, Ang-(1-7) induced a significant increase in SR Ca\(^{2+}\) content (by \(\approx34\%) in aldosterone-treated myocytes.

SR Ca\(^{2+}\) content reflects the balance between Ca\(^{2+}\) uptake via SR Ca\(^{2+}\) pump (SERCA) and Ca\(^{2+}\) efflux via RyR. Therefore, to assess RyR activity, Ca\(^{2+}\) sparks were examined in Fluo-4/AM loaded myocytes. Representative images of resting Ca\(^{2+}\) spark rate are shown in Figure 2B. Ang-(1-7) alone had no effect on

![Figure 1](image-url)
Ca\(^{2+}\) spark rate (Figure 2C), whereas aldosterone significantly increased Ca\(^{2+}\) spark rate (Figure 2D). We now show for the first time that addition of Ang-(1-7) markedly reduced Ca\(^{2+}\) spark rate in aldosterone-treated myocytes. SR Ca\(^{2+}\) load was mitigated by increased Ca\(^{2+}\) spark rate in aldosterone-treated myocytes, Ang-(1-7) contributes to increased SR Ca\(^{2+}\) content, consequently enhancing Ca\(^{2+}\) transient magnitude in these cells. Therefore, the increase in SR Ca\(^{2+}\) load observed when aldosterone-treated myocytes were exposed to Ang-(1-7) can account fully for the further enhancement of the Ca\(^{2+}\) transient magnitude found in this group when compared with aldosterone-treated cardiomyocytes.

Our next goal was then to investigate the molecular determinants of changes in Ca\(^{2+}\) signaling observed in response to aldosterone and Ang-(1-7). As previously shown by Christ et al., treatment of vascular smooth muscle cells with aldosterone increased cyclic adenosine 3',5'-monophosphate levels. To gain further insight into the signaling pathway by which aldosterone modulates global Ca\(^{2+}\) transient in cardiomyocytes, we investigated whether protein kinase A (PKA), a known cyclic adenosine 3',5'-monophosphate target, is a downstream mediator of aldosterone effects. We found that PKi, a PKA inhibitor, abolished the effect of aldosterone on peak Ca\(^{2+}\) transient amplitude (Figure 3A). Similar results were observed when aldosterone-treated cells were incubated with H89, another PKA inhibitor (data not shown).

Thus, we conclude that aldosterone alters global Ca\(^{2+}\) transient, through activation of PKA. Importantly, protein kinase inhibitor significantly reduced peak Ca\(^{2+}\) transient amplitude in cells treated with aldosterone and Ang-(1-7) (Figure 3B) indicating that PKA activation plays a major role in this cross-talk.

PKA targets phospholamban (PLN) a protein that regulates SERCA activity by increasing phosphorylation of Ser\(^{16}\). Dephosphorylated PLN inhibits SERCA, whereas phosphorylation of PLN reverses this inhibition, thus increasing the rate of Ca\(^{2+}\) uptake by the SR. Therefore, we next assessed PLN Ser\(^{16}\) phosphorylation levels by Western blot techniques. Figure 3C shows that aldosterone significantly increases PLN Ser\(^{16}\) phosphorylation. A similar effect was observed in cardiomyocytes exposed to aldosterone and Ang-(1-7). Thus these data suggest that SERCA activity is increased in cells treated with aldosterone, whether or not it is combined with Ang-(1-7). Interestingly, the increase in SERCA activity in aldosterone-treated myocytes leads to no change in SR Ca\(^{2+}\) content, indicating that the full effect of PKA activation on SR Ca\(^{2+}\) load was mitigated by increased Ca\(^{2+}\) spark rate in these cells. On the other hand, PKA activation and reduced Ca\(^{2+}\) spark activity explain the increased SR Ca\(^{2+}\) content found in aldosterone/Ang-(1-7) treated cardiomyocytes.
To establish the mechanisms involved in Ang-(1-7) effects on Ca\textsuperscript{2+} spark rate in cells treated with aldosterone was our next goal. NO is a well known modulator of Ca\textsuperscript{2+} handling proteins, including the RyR.\textsuperscript{17} Indeed, we have previously shown that Ang-(1-7) leads to NO production in cardiomyocytes.\textsuperscript{15} Therefore, we next assessed whether NO contributes to the observed effect of Ang-(1-7) on Ca\textsuperscript{2+} signaling under conditions of aldosterone excess. We assessed NO levels by using the fluorescent indicator diaminofluorescein-FM diacetate. Consistent with our previous findings,\textsuperscript{15,18} Ang-(1-7)-treated cardiomyocytes (100 nmol/L) showed an increase in NO generation (Figure 4A and 4B). We now show that Ang-(1-7) effects on NO were not affected by aldosterone, which alone had no effect on NO levels in cardiomyocytes. Figure 4B shows that the Ang-(1-7)-induced NO increase was completely abolished in cells preincubated with NO synthase (NOS) inhibitor L-NAME (10 µmol/L). Cardiomyocytes constitutively express both NOS1 and NOS3. We have previously shown that Ang-(1-7) increases NOS3 phosphorylation at the Ser\textsuperscript{1177} activation site in myocytes.\textsuperscript{15} To further investigate which NOS isoform is activated by Ang-(1-7) in aldosterone-treated myocytes, we assessed NOS3 and NOS1 phosphorylation levels at Ser\textsuperscript{1177} (activation site) and Ser\textsuperscript{852} (inhibitory site), respectively. As shown in Figure S5A, treatment with aldosterone alone did not affect NOS3 phosphorylation. In contrast, Ang-(1-7) stimulation of aldosterone-treated myocytes led to a significant increase in NOS3 Ser\textsuperscript{1177} phosphorylation levels confirming and extending our previous findings that NOS3 is activated by Ang-(1-7) even in the presence of aldosterone. A lack of aldosterone effects on NOS1 phosphorylation levels was also observed (Figure S5B). Furthermore, there was a significant decrease in NOS1 phosphorylation at the inhibitory site (Ser\textsuperscript{852}) in cardiomyocytes treated with a combination of aldosterone and Ang-(1-7). To confirm that NOS1 and NOS3 protein levels were unaltered during our experimental conditions, we measured total NOS protein levels. Figure S5C and S5D shows no significant changes in NOS1/NOS3 levels during our experiments. Importantly, Ang-(1-7) alone led to reduced NOS1 phosphorylation levels at Ser\textsuperscript{852} showing for the first time that this peptide modulates NOS 1 activity (Figure S6A and S6B). Reduced NOS1 phosphorylation at Ser\textsuperscript{852} increases enzyme activity, suggesting an increase in NO production under this condition. To investigate whether NO generation contributes to Ang-(1-7) effects on Ca\textsuperscript{2+} handling in aldosterone-treated myocytes, we measured Ca\textsuperscript{2+} transients in cells incubated with L-NAME. Although L-NAME alone had no effect on Ca\textsuperscript{2+} transient amplitude (Figure 5A), it significantly reduced the magnitude of Ca\textsuperscript{2+} transient in cells treated with aldosterone and Ang-(1-7) (Figure 5B). Thus, these data suggest that NO participates in the cross-talk between Ang-(1-7) and aldosterone contributing to the significant increase in Ca\textsuperscript{2+} transient amplitude observed under this condition. Because PKA is activated in cardiomyocytes treated with a combination of aldosterone and Ang-(1-7), it is expected that L-NAME would not completely abolish the increase in Ca\textsuperscript{2+} transient amplitude observed in this group. NO can interact with proteins involved in Ca\textsuperscript{2+} handling, including the RyR.\textsuperscript{17} Therefore, a possibility is that Ang-(1-7)-derived NO stabilizes the RyR reducing the channel open probability (P\textsubscript{o}) leading to an increase in SR Ca\textsuperscript{2+} load. If so, we would expect an increase in Ca\textsuperscript{2+} spark rate because of increased RyR activity in aldosterone/Ang-(1-7)-treated myocytes when NO synthesis is blocked. We next tested this hypothesis by recording Ca\textsuperscript{2+} sparks in the presence of L-NAME. Figure 5C shows that addition of L-NAME to aldosterone and Ang-(1-7) treated-cardiomyocytes significantly increased Ca\textsuperscript{2+} spark rate, whereas L-NAME alone did not influence Ca\textsuperscript{2+} spark rate. Taken together, these data support a direct role of Ang-(1-7)-derived NO as a modulator of Ca\textsuperscript{2+} handling in the presence of aldosterone and implicates NOS1 and NOS3 as sources of NO production.

Table S1 summarizes the important cellular changes found in Aldo/Ang-(1-7) treated myocytes.

Discussion

Our results bring new perspectives into the understanding of how 2 prominent molecules with supposedly antagonistic cardiac actions cross-talk to functionally amplify Ca\textsuperscript{2+} signals in cardiomyocytes. High serum levels of aldosterone have been identified as an independent predictor of all-cause mortality risk in patients with chronic heart failure of any cause and severity.\textsuperscript{19} In contrast, Ang-(1-7) was repeatedly shown to possess cardioprotective effects, preventing cardiac remodeling in vitro\textsuperscript{18,20} and in vivo\textsuperscript{18,21–24} and attenuating cardiac dysfunction and fibrosis induced by excessive MR activation.\textsuperscript{10,11} Notably, acute Ang-(1-7) treatment synergistically
Moreover, SR Ca²⁺ content is not altered in aldosterone-treated contractility associated with increased aldosterone levels. Therefore we conclude that the full effect of PKA activation on SR Ca²⁺ load was mitigated by increased Ca²⁺ spark rate in aldosterone-treated cells.

Interestingly, PKA remains activated in cells treated with a combination of aldosterone and Ang-(1-7), as seen by the significant reduction in Ca²⁺ transient amplitude observed in this group, when treated with protein kinase inhibitor. In addition to increased PKA activation, Ang-(1-7) also leads to NO enhanced aldosterone mediated effects on Ca²⁺ handling. This observation was initially unexpected because previous studies showed antagonistic effects exerted by these 2 molecules in the heart.⁰¹¹ We now show that Ang-(1-7) functionally cross-talks with aldosterone, via parallel and converging transduction pathways that include PKA activation and NO production, culminating with enhanced Ca²⁺ release in ventricular myocytes. These findings have important implications for our understanding of how 2 important signaling pathways interact in cardiac cells. One possibility is that this synergistic effect might result in amplification of Ang-(1-7) cardioprotection, preventing the progressive deterioration in myocardial contractility associated with increased aldosterone levels.

Short-term aldosterone incubation induces moderated PKA activation, which leads to increased Ca²⁺ transient, possibly through enhanced IₗCa. Consistent with our data, another study has shown that aldosterone increases cyclic adenosine 3′,5′-monophosphate levels in vascular smooth muscle cells.¹⁶ Moreover, SR Ca²⁺ content is not altered in aldosterone-treated cardiomyocytes despite increased PLN Ser¹⁵⁶ phosphorylation. Therefore we conclude that the full effect of PKA activation on SR Ca²⁺ load was mitigated by increased Ca²⁺ spark rate in aldosterone-treated cells.

Perspectives

Our finding of cross-talk between Ang-(1-7) and aldosterone signaling under conditions where both receptors are activated in cardiomyocytes uncovered a previously unrecognized signaling pathway that includes synergistic actions at the Ca²⁺ transient level, giving further insight into how these 2 signaling pathways interact in cardiac cells. As such, the NO-dependent action of Ang-(1-7) associated with its ability to keep aldosterone-induced PKA activation may confer to this peptide the capacity to maintain contractile function in conditions of generation in aldosterone-treated myocytes, with NO exerting a crucial role on Ang-(1-7) synergistic effects on Ca²⁺ transient. NO is known to regulate the L-type Ca²⁺ channel²² and the RyR,²⁶ working as both positive or negative inotropic agent. Because Ang-(1-7) alone increases NO levels without changing Ca²⁺ transient amplitude, it is conceivable that NO effects on Ca²⁺ transient under conditions of Ang-(1-7)/aldosterone cross-talk depend on other factors, such as the degree of PKA activation. Accordingly, Ziol et al¹⁷ have shown that NO effects on RyR activity and Ca²⁺ transients can be modulated by the state of PKA activation. PKA activation leads to the phosphorylation of several proteins involved in excitation-contraction coupling, including the RyR. In this context, PKA-phosphorylated RyR presented increased P₀, that is seen as an increase in resting Ca²⁺ spark frequency, which was reversed by addition of a NO donor.¹⁷ Our Ca²⁺ spark results support this assumption because cells treated with aldosterone/Ang-(1-7) showed a significant reduction in Ca²⁺ spark rate when compared with aldosterone-treated myocytes, an effect that was abolished by addition of L-NAME. Taken together, these findings suggest that RyR open probability is significantly reduced in aldosterone-treated myocytes when exposed to Ang-(1-7). Thus, our findings reveal a previously unidentified role for Ang-(1-7) as a modulator of diastolic Ca²⁺ sparks in the heart under conditions of elevated aldosterone levels. In fact, Gomez et al¹⁸ have shown that aldosterone directly affects RyR activity, by dissociating FKBP12.6, leading to abnormal Ca²⁺ sparks in ventricular myocytes. Aberrant Ca²⁺ release during diastole has been linked to the development of cardiac arrhythmia in heart failure models.²⁷ A potentially important implication of our findings is that Ang-(1-7), by reducing the Ca²⁺ spark rate in the presence of aldosterone, may protect the heart against life threatening arrhythmias. Further investigation will be necessary to understand whether Ang-(1-7) prevents aldosterone-induced arrhythmias.

NOS3 phosphorylation of Ser¹⁷⁷ was increased by Ang-(1-7) in aldosterone-treated myocytes. This supports our observation that Ang-(1-7) increases NOS3 phosphorylation in cardiomyocytes.¹⁸ We have now shown that NOS1 is activated by Ang-(1-7) in ventricular myocytes, and this effect is not altered by aldosterone. In addition, we have previously shown that transgenic rats with a chronic increase in circulating levels of Ang-(1-7) have increased NOS1 expression levels in cardiomyocytes,¹⁸ suggesting an important association between the Ang-(1-7) and NOS1 signaling pathways in cardiomyocytes. Therefore, it is possible that NOS1-derived NO plays a role in Ang-(1-7) effects on cardiomyocytes. However the specific contributions of each NOS isoform to Ang-(1-7) effects on Ca²⁺ handling still need to be determined.

Figure 5. NO mediates Angiotensin (Ang)-(1-7) effects on Ca²⁺ signaling in aldosterone-treated cardiomyocytes. A. Treatment of myocytes with L-NAME alone had no effect on Ca²⁺ transient amplitude. B, L-NAME significantly reduced the magnitude of the Ca²⁺ transient in cardiomyocytes treated with aldosterone and Ang-(1-7). C, L-NAME restored the effect of aldosterone (Aldo) on Ca²⁺ spark rate in aldosterone/Ang-(1-7) treated myocytes. n=number of cardiomyocytes. P<0.05 when compared with other experimental groups. #P<0.05 when compared with control. †P<0.05 when compared with control and Aldo/Ang-(1-7)-treated cardiomyocytes.
aldosterone excess. In addition, abnormal Ca\textsuperscript{2+} release during diastole has been linked to the development of cardiac arrhythmia in heart failure models. A potential implication of our findings is that Ang-(1-7) by reducing diastolic Ca\textsuperscript{2+} rate spark in the presence of aldosterone may protect the heart against life threatening arrhythmias. In light of Ang-(1-7) therapeutic potential it will also be extremely important to investigate whether these signaling pathways may account in vivo for Ang-(1-7) protective actions in models of hyperaldosteronism.

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**Disclosures**

None.

**References**


**Novelty and Significance**

**What Is New?**

- We demonstrate that Aldosterone is capable of cross-talk with Ang-(1-7) to amplify Ca\textsuperscript{2+} release in ventricular myocytes.

**What Is Relevant?**

- We provide a better understanding of Ang-(1-7) actions under conditions of increased aldosterone levels.
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FUNCTIONAL CROSS-TALK BETWEEN ALDOSTERONE AND ANGIOTENSIN-(1-7) IN VENTRICULAR MYOCYTES

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Short title: Cross-talk between aldosterone and Ang-(1-7)
Supplemental Material and methods

**Animals.** In this study we used 32 male Sprague-Dawley (SD) rats (250g). Experiments were also performed in 4 male C57Bl/6-wild type (C57Bl/6Mas\(^+/-\)) and 5 male C57Bl/6Mas-deficient (C57Bl/6Mas\(^{-/-}\)) mice. Mas\(^{-/-}\) mice were described previously.\(^1\) Animals were maintained at the Universidade Federal de Minas Gerais (UFMG), Brazil in accordance with NIH guidelines for the care and use of animals. Experiments were performed accordingly to approved animal protocols from the Institutional Animal Care and Use Committee at UFMG (protocol #68/2009).

**Cardiomyocyte isolation and Ca\(^{2+}\) recording.** Adult ventricular myocytes were freshly isolated and stored in Dulbecco’s modified Eagle's medium (DMEM, Sigma), as previously described.\(^2\) Intracellular Ca\(^{2+}\) (Ca\(^{2+}\)) imaging experiments were performed in Fluo-4 AM (10 µM; Invitrogen) loaded-cardiomyocytes for 30 min which were subsequently washed with a Tyrode solution that contained 1.8 mmol/L Ca\(^{2+}\) to remove the excess dye. Cells were electrically stimulated at 1 Hz to produce steady-state conditions. The confocal line-scan imaging was performed with a Zeiss LSM 510META confocal microscope. Digital image processing was performed by using custom-devised routines created with the IDL programming language (Research Systems, Boulder, CO). The Ca\(^{2+}\) level was reported as F/F\(_{0}\), where F\(_{0}\) is the resting Ca\(^{2+}\) fluorescence.

**Treatment of cardiomyocytes.** All experiments were carried out in ventricular myocytes incubated for 30-60 min with aldosterone (Sigma, 1 µmol/L), Ang-(1-7) (Millipore, 100 nmol/L) or a combination of aldosterone and Ang-(1-7). In some experiments, ventricular myocytes were pre-incubated for 20 min with other drugs as stated in the text, before the addition of aldosterone and/or Ang-(1-7). Drugs are as follows: Spironolactone (Sigma, 10 µmol/L), Mifepristone (Sigma, 10 µmol/L), N\(^{\circ}\)-nitro-L-arginine methyl ester (L-NAME, Sigma, 10 µmol/L) or Myristoylated Protein Kinase A Inhibitor Amide 14-22 (PKi, Calbiochem, 10µmol/L).

**Measurement of SR Ca\(^{2+}\) content and Ca\(^{2+}\) sparks.** The amplitude of the Ca\(^{2+}\) transient evoked by the application of a Ca\(^{2+}\)- and Na\(^{+}\)-free solution containing 10 mmol/L caffeine was used as an indicator of the sarcoplasmic reticulum (SR) Ca\(^{2+}\) load.\(^2\) Cells were subjected to a series of preconditioning pulses (1 Hz) before caffeine was applied. The Ca\(^{2+}\) level was reported as ΔF/F\(_{0}\), where F\(_{0}\) is the resting Ca\(^{2+}\) fluorescence. Ca\(^{2+}\) spark rate was recorded in resting ventricular myocytes loaded with Fluo-4 AM.

**Nitric oxide measurements.** Measurement of nitric oxide (NO) production in living cardiomyocytes was done using the membrane permeable fluorescent indicator 4-amino-5methylamino-2’,7’-difluorofluorescein (DAF-FM diacetate, Molecular Probes), as previously described.\(^3\) All cells were loaded with
fluorescent dye following the same protocol, and imaging was done preserving
the same parameters in both control and drug treated cardiomyocytes.

**Western-blot.** 40 to 50 µg of protein was separated by SDS-PAGE. Antibodies
used were anti-phospho nitric oxide synthase (NOS) 1 (Ser\(^{352}\) (1:800, Santa
Cruz), anti-phospho NOS3 (Ser\(^{1177}\)) (1:800, Cell Signaling), anti-PLN Ser\(^{16}\)
(1:800, Santa Cruz), anti-NOS1 (1:800, Millipore), anti-NOS3 (1:800, Cell
Signaling), and anti-GAPDH (1:5000, Santa Cruz). Immunodetection was carried
out using enhanced chemiluminescence (Immobilon Western Chemiluminescent
HRP Substrate, Millipore). Protein levels were expressed as ratios of optical
densities. GAPDH was used as a control for any variations in protein loading.
Image analyses were performed using ImageJ software (NIH).

**Whole-cell patch clamp recordings.** An EPC-9.2 (HEKA Electronics) was used
to patch clamp single myocytes (whole cell voltage- clamp configuration) and
currents were measured.\(^4\) All experiments were carried out at room temperature
(23-26°C). In all measurements, after obtained the break-in, from 3 to 5 minutes
were given in order to allow the internal solution equilibrium with cell cytoplasm.
In all experiments we used pipettes with 0.5-2 MΩ and signals were low pass
filtered at 2.9 kHz. Experiments where series resistance was larger than 7 MΩ
were discarded from the analysis. In all whole-cell voltage-clamp experiments
electronic series resistance compensation was performed (40 to 70%).

**L-Type Calcium Current (I\(_{Ca,L}\)).** To measure I\(_{Ca,L}\) pipettes were filled with
(mmol/L): 120 CsCl, 20 TEA-Cl, 5 NaCl, 10 Heps, 5 EGTA, pH set to 7.2 with
CsOH, using Tyrode’s as external solution. I\(_{Ca,L}\) was elicited by depolarization
steps from -40 to 50 mV for 300 ms from a holding potential of -80 mV, at a
frequency of 0.1 Hz and sampling frequency of 10 kHz. We used a pre-pulse of
50 ms duration from -80 to -40 mV to inactivate Na\(^+\) channels. Cardiac myocytes
were pre-incubated (30-60 min) with Aldosterone at 1 µmol/L and/or Angiotensin
(1-7) at 100 nmol/L.

**Ionic current analysis.** All ionic current were analyzed in terms of maximal
absolute value normalized by cell capacitance. Current density relationships
were fitted to the following equation:

\[
I_{I_{p}} = G_{max} \frac{(V_{m} - E_{Ca})}{1 + \exp(V_{m} - V_{0.5})/S} \]

where, \(G_{max}\), maximal conductance; \(V_{m}\), membrane potential; \(E_{Ca}\),
electrochemical equilibrium potential ; \(V_{0.5}\), potential where 50% of ion channels
are activated; \(S\), slope factor.

**Statistics.** All data are expressed as means ± SEM, and the number of cells or
experiments is shown as \(n\). Significant differences between groups were
determined with a Student’s \(t\)-test or ANOVA followed by the Bonferroni post hoc
test. Values of \(p < 0.05\) were considered to be statistically significant.
References


**Table S1**: Summary of significant cellular alterations observed in cardiomyocytes treated with aldosterone, Ang-(1-7) or aldosterone/Ang-(1-7) when compared to untreated control ventricular myocytes.

<table>
<thead>
<tr>
<th>Cellular alterations</th>
<th>Aldosterone</th>
<th>Aldosterone+Ang-(1-7)</th>
<th>Ang-(1-7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ca(^{2+}) transient amplitude</td>
<td>↑</td>
<td>↑↑</td>
<td>—</td>
</tr>
<tr>
<td>I(_{\text{Ca,L}}) magnitude</td>
<td>↑</td>
<td>↑</td>
<td>—</td>
</tr>
<tr>
<td>SR Ca(^{2+}) content</td>
<td>—</td>
<td>—†</td>
<td>*</td>
</tr>
<tr>
<td>PLN-Ser16 phosphorylation</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Ca(^{2+}) spark rate</td>
<td>↑</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Nitric oxide</td>
<td>—</td>
<td>↑</td>
<td>↑</td>
</tr>
</tbody>
</table>

↑ = increase, ↓ = reduction, — = not altered, * = not measured
† = not statistically different from control but significantly different from aldosterone-treated
Figure S1: Aldosterone increases the magnitude of the Ca\textsuperscript{2+} transient in cardiomyocytes. Supraphysiological concentration of aldosterone activates both MR and GR receptors. A-B. Bar graph shows the effect of aldosterone and its antagonism on peak Ca\textsuperscript{2+} transient amplitude. *p<0.05 when compared to the other groups. # p<0.05 when compared to control and aldosterone-treated myocytes.
**Figure S2:** Ang-(1-7) effects on Ca$^{2+}$ transient are lost in Mas$^{-/-}$ ventricular myocytes. Representative Ca$^{2+}$ transient line-scan profile from wild-type (A) and Mas$^{-/-}$ (B) cardiomyocytes. C-D. Bar graph showing that Ang-(1-7) effects on Ca$^{2+}$ transient in aldosterone-treated myocytes are mediated by receptor Mas. n= number of cells analysed. #p<0.05 when compared to the other groups. *p<0.05 when compared to untreated Mas$^{-/-}$ cells.
Figure S3: Ang-(1-7) does not alter $I_{Ca,L}$ in ventricular myocytes. Average I-V relationships for $I_{Ca,L}$ current density recorded from control, and Ang-(1-7) treated myocytes. $n=$number of cells analysed.
Figure S4: Aldosterone upregulates $I_{Ca,L}$ in ventricular myocytes. A. Sample $I_{Ca,L}$ currents recorded from depolarizations from -40 mV to 0 mV for 300 ms. Aldosterone (1 µmol/L) significantly increased the magnitude of $I_{Ca,L}$ in control cells, an effect that was not altered by Ang-(1-7) at 100 nmol/L. B. Average I-V relationships for $I_{Ca,L}$ current density recorded from control, aldosterone, and aldosterone/Ang-(1-7)-treated myocytes. *p<0.05 when compared to control. n=number of cells.
Figure S5: NOS phosphorylation levels are altered in aldosterone/Ang-(1-7)-treated myocytes. 

A-B Top, representative blots. Bottom, bar graph showing averaged-densitometry of NOS3 phosphorylation levels at Ser^{1177}, and NOS1 phosphorylation levels at Ser^{852}. *p<0.05 when compared with other experimental groups. 

C-D Top, representative blots. Bottom, bar graph showing averaged-densitometry of total NOS3 and NOS1 levels. n= number of cardiomyocyte samples from each group.
Figure S6: Ang-(1-7) activates NOS1 in cardiomyocytes. A. Representative blots. B. Bar graph showing averaged-densitometry of NOS1 phosphorylation levels at Ser$^{852}$ (inactivation site). *p<0.05 when compared with control. n= number of cardiomyocyte samples analysed from each group.