EXPERIMENTAL STUDY

Effects of apelin-13 on myocardial ischemia reperfusion injury in streptozotocine induced diabetic rats

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ABSTRACT
AIM: We want to investigate the protective effects of apelin-13 on myocardial ischemia reperfusion (I/R) injury. MATERIAL AND METHODS: 30 Wistar Albino rats were divided into 5 groups (n:6), namely control group (C), diabetes group (D), diabetes+apelin-13 group (DA), diabetes I/R group (DIR) and diabetes I/R+apelin-13 group (DIR-A). Rats were subjected to 30-min ischemia and 90-min reperfusion. Biochemical and histopathological parameters were measured. RESULTS: Caspase-3 enzyme activity was significantly higher in the DIR group than in the C, DA, and DIR-A groups. The intensity of caspase 3 enzyme activity was significantly higher in the I/R group than in all other groups. Inflammation and vascular dilation were found significantly higher in the DIR group than in all other groups. Congestion was significantly higher in the DIR group than in the C and D groups. TOS enzyme activity was significantly higher in the DIR group than in the C and DIR-A groups. TAS enzyme activity was significantly lower in the DIR group than in the C and DIR-A groups. CONCLUSION: We believe that the protective effects of apelin-13 in ischemia-reperfusion injury and its use indications can be demonstrated in detail as long as the findings we have reached in our study are supported by other studies (Tab. 2, Fig. 10, Ref. 43). Text in PDF www.elis.sk. KEYWORDS: diabetes mellitus, apelin-13, TOS, TAS, caspase-3, ischemia reperfusion.

Introduction

In the past 20 or 30 years the prevalence of diabetes mellitus (DM) has rapidly increased throughout the world, and experts estimate that it is going to increase by 200 % in the next several decades (1).

A 50 % increase in early mortality following coronary artery bypass grafting has been described in diabetic patients (2). Margolis et al showed that the rate of unrecognized myocardial infarction was 39 % in diabetic patients while in non-diabetic patients it was 22 % (3). Cardiac surgery with cardiopulmonary bypass inevitably causes a systemic inflammatory response and ischemia-reperfusion (I/R) injury affecting multiple organs (1). Several drugs have been used to prevent I/R injury, including Vitamin C, levosimendan, and dexmedetomidine (1, 4, 5).

Apelin is a recently discovered peptide encoded by APLN gene in humans and it is an endogenous ligand of the human G-protein-coupled apelin receptor (APJ); 6). The APLN gene encodes a 77-amino acid prepropeptide divided by shorter mature peptides such as apelin-13, apelin-17 and apelin-36 (7). The most studied apelins are apelin-13 and apelin-36 (8). There is increasing evidence suggesting that apelin regulates multiple physiological functions, including fluid homeostasis, food intake, cell proliferation, blood pressure regulation, angiogenesis, and glucose utilization (8, 9). Therefore, it may be associated with diabetes, obesity, hypertension and / or cardiovascular diseases (9, 10). In spite of its increased clinical use the effects of apelin-13 on myocardial injury induced by left coronary artery (LAD) I/R have not yet been investigated.

This study was carried out to investigate the possible protective role of apelin-13, which is the most active form of apelin and has the highest biological activity against oxidative damage caused by myocardial I/R in diabetic rats.

Materials and methods

Animals and experimental protocol

This study was conducted in the GUDAM Laboratory of Gazi University with the consent of Experimental Animals Ethics Committee of Gazi University. All of the procedures were performed according to the accepted standards of the Guide for the Care and Use of Laboratory Animals.

Thirty female Wistar Albino rats (180– 220 g) were used. The rats were kept at 20–21 °C in cycles of 12 hours of daylight and 12

Indexed and abstracted in Science Citation Index Expanded and in Journal Citation Reports/Science Edition
hours of darkness and had free access to food until two hours before
the anesthetic procedure. The animals were randomly separated into
five groups, each containing six rats. Control group (C), diabetes
group (D), diabetes+apelin-13 (DA), diabetes+ischemia-reperfu-
sion (DIR), and diabetes+ischemia-reperfusion+apelin-13 (DIR-A).

Diabetes was induced by a single injection of streptozotocin
(Sigma Chemical, St. Louis, MO, USA), at a dose of 55 mg/kg
(i.p.) body weight. Seventy-two hours after the injection, the blood
glucose levels were measured. Rats were classified as diabetic if
their fasting blood glucose (FBG) levels exceeded 250 mg/dl, and
only animals with FBGs of > 250 mg/dl were included in the
diabetic groups (diabetes, diabetes+apelin-13, diabetes+ischemia-
reperfusion and diabetes+apelin-13-ischemia-reperfusion). The
rats were kept alive for four weeks after streptozotocin injection
in order not to increase the temperature, a homogeniza-
tion process was completed. The homogenate was transferred
to an eppendorf tube. Eppendorf tubes were coated with parafilm
and then centrifuged (Hettich Micro 200R®) for 10 minutes at
3000 rpm. After centrifugation, the supernatant was taken into
another eppendorf tube and TAS and TOS levels were measured.

Total antioxidant status (TAS)

TAS was measured by a TAS test kit (RelAssay Diagnostic®,
Turkey). For TAS measurement, as described in kit’s procedure,
500 μL of reagent 1 (measurement buffer) and 30 μL of sample
were mixed and absorbance was measured at 660 nm by a spec-
traphotometer (NanoDrop® ND-1000) (A1). A volume of 75 μL of
reagent 2 (colored 2,2-azino-bis-3-ethylbenothiazoline-6-sulfonic
acid; ABTS) was added to the mixture in the Eppendorf tube. The
tube was coated with paraffin and incubated for 5 minutes in a hot
water bath at 37 °C (Lightning Laborteknik®). After incubation,
absorbance measurement was performed at 660 nm (A2). For stan-
dard measurement, the Trolox Eq solution at a concentration of
1 mmol / L was used instead of the sample. The first and second
measurements were made for three times and their averages were
measured. The absorbance change (ΔAbs) was calculated by sub-
tracting the first absorbance value (A1) from the second absorbance
value (A2). TAS levels were calculated using the formula given
in the kit and expressed as mmol Trolox Eq / L.

\[ \text{TAS} = \frac{[(\Delta \text{Abs}_{\text{H}_2\text{O}}) - (\Delta \text{Abs}_{\text{Sample}})]}{(\Delta \text{Abs}_{\text{H}_2\text{O}})} \times \text{Standard} \]

Total oxidative status (TOS)

TOS was measured by a TOS test kit (RelAssay Diagnostic®,
Turkey). For TOS measurement, as described in kit’s procedure,
500 μL of reagent 1 (measurement buffer) and 75 μL of sample
were mixed and absorbance was measured at 530 nm by a spe-
trophotometer (NanoDrop® ND-1000; A1). A volume of 25 μL of
reagent 2 (Pro-chromogenic solution) was added to the mixture.
The tube was coated with paraffin and incubated for 5 minutes in a
hot water bath at 37 °C (Lightning Laborteknik®). After incuba-
tion, absorbance measurement was performed at 530 nm (A2).
A standard solution containing 10 μmol / L hydrogen peroxide
(H2O2) equivalent / liter given in the kit was used for standard
measurement. The first and second measurements were made for
three times and their averages were measured. The absorbance
change (ΔAbs) was calculated by subtracting the first absorbance
value (A1) from the second absorbance value (A2). TOS levels
were calculated using the formula given in the kit and expressed
as mmol H2O2 Eq / L.

\[ \text{TOS} = \frac{(\Delta \text{Abs}_{\text{sample}}) / (\Delta \text{Abs}_{\text{standard}})}{10} \times \text{Standard} \]

Histological and immunohistochemical evaluation

At the end of each experiment, one of the myocardial tissue in
each rat was fixed in 10% buffered formalin for 48 h, dehydrated in
a graded ethanol series, cleaned in xylene, and embedded in paraf-
fin wax, and sections of 5-μm thickness were cut using a sliding
microtome (Leica Microsystems, Germany). Tissue sections were
stained with hematoxylin-eosin (H&E).
All the sections were performed by the same pathologist who was blinded to the study. The scoring system was used for histopathological evaluation of the myocardial tissues. Interstitial edema, congestion, vascular dilatation, inflammation, fibrosis and steatosis were scored from 0 to +2 for each parameter and the total of these parameter scores was used for determining the final tissue damage. The scores of each parameter represented the severity of the pathological finding as follows: 0: no pathologic lesions, 1: low finding, 2: high pathological finding in myocardial tissue section.

### Immunohistochemical evaluation

For immunohistochemical studies, complete surface sections of 3–4 μL of poly-L-lysine-coated slides were prepared from formalin-fixed paraffin-embedded blocks of biopsy specimens in all of the events. The sections were left overnight at 45 degrees. Standard antigen retrieval methods, namely deparaffinization, blocking, primer antibody (Caspase-3: Citrate 30 min), post-primer, and polymer, DAP were used in Bond-maximal immunohistochemistry (Leica) device for Caspase-3 (p11, C-6, 1/400, Group C (n=6) Group D (n=6) Group DA (n=6) Group DIR (n=6) Group DIR-A (n=6) P**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Group C</th>
<th>Group D</th>
<th>Group DA</th>
<th>Group DIR</th>
<th>Group DIR-A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caspase-3 (1: less than 50%, 2: more than 50%)</td>
<td>1.00±0.00*</td>
<td>1.20±0.20</td>
<td>1.00±0.00*</td>
<td>1.60±0.25</td>
<td>1.00±0.00*</td>
</tr>
<tr>
<td>Caspase-3 (1: poor staining, 2: strong staining)</td>
<td>1.00±0.00*</td>
<td>1.40±0.25*</td>
<td>1.20±0.20*</td>
<td>2.00±0.00</td>
<td>1.20±0.20*</td>
</tr>
<tr>
<td>Edema</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
</tr>
<tr>
<td>Inflammation</td>
<td>0.00±0.00*</td>
<td>0.20±0.20*</td>
<td>0.00±0.00*</td>
<td>0.80±0.20</td>
<td>0.00±0.00*</td>
</tr>
<tr>
<td>Fibrosis</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
</tr>
<tr>
<td>Vascular dilatation</td>
<td>0.00±0.00*</td>
<td>0.60±0.40*</td>
<td>0.00±0.00*</td>
<td>1.80±0.20</td>
<td>0.40±0.40*</td>
</tr>
<tr>
<td>Congestion</td>
<td>1.00±0.00*</td>
<td>1.40±0.25*</td>
<td>1.60±0.25</td>
<td>2.00±0.00</td>
<td>1.60±0.20</td>
</tr>
<tr>
<td>Steatosis</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
<td>0.00±0.00</td>
</tr>
</tbody>
</table>

P**: significance level with Kruskal–Wallis test p<0.05, *p<0.05: compared with Group DIR

**Fig. 1. Control Group. Conjugate vein structures are observed in the heart muscle. Edema, inflammation, fibrosis, vascular dilatation and fatigue are not observed in heart-muscle cells (H&E x100).**

**Fig. 2. Diabetes group. Severe inflammation of the interstitial area is observed in the heart muscle (H&E x100).**

**Fig. 3. Diabetes+apelin-13 group. Vessels containing mild congestion are observed in the heart muscle (H&E x40).**

**Fig. 4. Diabetes+ischemia-reperfusion group. Scoring 2 congestion and dilatation vein structures are observed in the heart muscle (H&E x100).**
mouse monoclonal antibody) antibodies immunohistochemically. Hematoxylin II and blue reagent were applied in the background dye for 6 and 4 min, respectively.

Immunohistochemical staining preparations were washed in water and alcohol and after being clarified with xylene they were covered with balsam. The intensity and severity of immunohistological staining in vascular endothelium were evaluated with Caspase-3. The intensity was scored as follows: 0: no staining, 1: less than 50 %, 2: more than 50 %. The severity was scored as follows: 0: no staining, 1: poor staining, 2: strong staining.

**Statistical analysis**

All the data were processed by variance analysis in the Statistical Package for the Social Sciences (SPSS, Chicago, IL, USA) 20.0 program for Windows statistical software. Kruskal–Wallis test was used to assess the results. Bonferroni-adjusted Mann–Whitney U test was used after significant Kruskal–Wallis to determine which group differs from the other. The data were expressed as mean ± standard error (Mean±SE). Value of p < 0.05 was considered statistically significant.

**Results**

Caspase-3 enzyme activity was significantly higher in the DIR group than in the C, DA, and DIR-A groups (p = 0.007, all). The intensity of caspase-3 enzyme activity was significantly higher in the DIR group than in all other groups (p < 0.0001, p = 0.020, p = 0.003, p = 0.003, respectively) (Tab. 1, Figs 1–5).

Inflammation and vascular dilatation were found significantly higher in the DIR group than in the other groups. Congestion was significantly higher in the DIR group than in the C and D groups (p = 0.001, p = 0.037, respectively) (Tab. 1, Figs 6–10).

TOS enzyme activity was significantly higher in the DIR group than in the C, DA, and DIR-A groups (p = 0.001, p = 0.013, p = 0.003, respectively). TAS enzyme activity was significantly lower in the DIR group than in the C and DIR-A groups (p = 0.009, p = 0.036, respectively) (Tab. 2).

**Discussion**

Myocardial ischemia and the following reperfusion is often a fatal consequence of increased oxygen requirement and/or diminished oxygen supply to the myocardium. Thirty minutes after

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**Tab. 2. Oxidative Status Parameters (mean ± SE).**

<table>
<thead>
<tr>
<th></th>
<th>Group C (n=6)</th>
<th>Group D (n=6)</th>
<th>Group DA (n=6)</th>
<th>Group DIR (n=6)</th>
<th>Group DIR-A (n=6)</th>
<th>p***</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOS (mmol H₂O₂ Eq/l)</td>
<td>6.95±1.59*</td>
<td>12.30±3.68</td>
<td>9.94±5.22*</td>
<td>16.57±3.04</td>
<td>8.45±4.64*</td>
<td>0.019</td>
</tr>
<tr>
<td>TAS (mmol Trolox Eq/l)</td>
<td>1.14±0.78*</td>
<td>0.63±0.09</td>
<td>0.63±0.12</td>
<td>0.36±0.09</td>
<td>0.93±0.46*</td>
<td>0.032</td>
</tr>
</tbody>
</table>

p**: significance level with Kruskal–Wallis test p< 0.05, *p=0.05: compared with Group DIR
coronary ligation, the signs of cellular injury start, and if duration of coronary occlusion lengthens out, the signs of irreversible myocardial injury occur, caused by contraction band necrosis and myocytolysis. After a period of ischemia (60 min) and reperfusion (60 min), edematous and nuclear changes such as chromatin clumping and swelling, apoptosis induced by increased Bcl-2, and Fas ligand are observed. Also, glycogen depletion, mitochondrial swelling, and dilatation of sarcoplasmic reticulum are observed 60 min after occlusion (12).

Yang et al (13) reported in their study that apelin could activate multiple protective mechanisms to prevent injury to the heart, brain, liver and kidney. Apelin/APJ system may be a promising therapeutic target for ischemic and other related diseases. Studies carried out report that apelin decreases the oxidative stress in the cardiomyocytes and veins of smooth muscle cells (14, 15).

Studies in mice and rats show that apelin has an analgesic role in acute pain models. (16–18). Xu et al (16) presents evidence that apelin-13 plays a significant role in the modulation of pain response at the supraspinal level in mice.

Another study has also similar results, indicating that intracerebroventricular and intrathecal (but not intraperitoneal) injection of apelin-13 induced an antinoceptive effect in the acetic acid-induced visceral pain in a mouse model. The APJ receptor and μ-opioid receptor were involved in the antinoception of i.c.v. apelin-13 and apelin-13 (0.3 μg) significantly potentiated the analgesic potencies of morphine (17).

Turtay et al (18) aimed herein to compare the possible analgesic effects of apelin-13 and morphine, and to reveal the mechanistic pathways underlying the analgesic effects of apelin-13 co-administered with serotonin and nitric oxide, in a rat model indexed by analgesic response times during hot-plate and tail-flick tests. Their results demonstrate that apelin-13 exerts an analgesic effect; co-administration of apelin-13 and ondansetron inhibits antinociception, an effect apparently mediated by five hydroxytryptamine-three (5-HT3) receptors. These results should facilitate the analysis of the role of apelin-13 in acute pain and may open novel pharmacological interventions.

Unpaired electrons, free radicals, are highly reactive and readily take part in chemical reactions with virtually all cell components (lipids, proteins, complex carbohydrates and nucleic acids) in the body. These reactions occur through a chain of oxidative reactions to cause tissue injury. For most biological structures (like lipids, proteins, and nucleic acids), free radical damage is closely associated with oxidative damage, causing direct cellular injury by inducing lipid and protein peroxidation and damaging nucleic acids (19). I/R results in the generation of toxic reactive oxygen species (ROS) in the organs. Ischemia reduces the activity of cellular defense enzymes against ROS, and reperfusion or the introduction of oxygen further disturbs the delicate balance of oxidants/antioxidants (20) while intracellular calcium overload, adenosine triphosphate depletion, myocardial apoptosis, and endothelial dysfunction are all observed as a result of this (21, 22). Also, oxidative products such as ROS, reactive nitrogen species, hydrochloric acid, MDA, and lipid peroxides constitute TOS (23).
Serum concentrations of different oxidative components can be measured in the laboratory separately, but the measurement of these molecules is labor-intensive, requires much time, and complicated techniques, and is costly. TAS and TOS reflect the redox balance between oxidation and antioxidation. TAS measurement is an indicator of the activity of all antioxidants while TOS is an indicator of ROS (24, 25).

Oxidative stress is an oxidant-antioxidant imbalance status, due to oxidants which exceed the antioxidant capacity. OSI is the ratio of TOS to TAS and is an indicator of OS degree (24, 25). It may offer a more accurate comment for the evaluation of the change in oxidant-antioxidant balance. Mentese et al studies found a significant increase in OSI values at Rp 30 min. This finding suggested the development of oxidative imbalance or increase in the degree of OS in ONCABG patients (26).

In this study, TAS, as a marker of total antioxidant protection against the attack of free radicals in the organism and TOS, as a marker of total value of OS were used. Studies have shown that TAS measurement provides more valuable information than individual measurements of antioxidants (27, 28).

When we compared myocardial tissue in terms of TOS enzyme activity in our study, there was a significant difference between the groups. TOS enzyme activity was significantly higher in DIR group when compared with that of C, D and DIR-A groups. Oxidative stress, which is the primary actor of I/R injury, was found to be lower in the apelin-13-treated groups in the TOS measurement.

When comparing myocardial tissue in terms of TAS enzyme activity in our study, there was a significant difference between the groups. TAS enzyme activity was found to be significantly higher in DIR group than in C, D and DIR-A groups, which is parallel to the fact that antioxidant systems are impaired by I/R damage, while the low activity of TAS enzyme in the groups given apelin-13 indicates that the antioxidant systems are protected, in other words active. Kim et al (29) found that administration of 2.5 mg vitamin C during 5 days increased the TAS levels, and after the administration of 2.5 mg vitamin C for 5 days, TAS was found to be decreased. They thought that this decrease in TAS was related to a decrease in antioxidant stress. To the best of our knowledge, in this study, for the first time, it has been reported that I/R of the diabetic rat heart results in significant negative changes that can be observed in myocardial tissue and that the apelin signaling mediated important events in cardiovascular homeostasis. At the same time, apelin-13 has been shown to have a positive effect on myocardial contractility by promoting a potent positive inotropic effect and when administered at the beginning of heart ischemia it can provide varying degrees of protection against negative effects of variations in myocardial injury.

Recent studies suggested that apelin signaling mediated important events in cardiovascular homeostasis and has been shown to have a positive effect on myocardial contractility by promoting a potent positive inotropic effect (30, 31). Apelin is a vasodilatorator both in in-vivo (32) and ex-vivo models employing human arteries and veins (33). Accordingly, intravenous apelin administration in rodents reduces mean arterial pressure (34), systemic venous tone (35), and cardiac preload and afterload (30).

Rastaldo et al have found that apelin-13 could limit infarct size and improve cardiac post-ischemic mechanical recovery only if given after ischemia (36). Furthermore, Tao et al (37) reported that apelin-13 protects the heart against I/R injury through inhibition of endoplasmic reticulum-dependent apoptotic pathways.

Some reports have shown that ischemic pre- and post-conditioning could decrease cell apoptosis and myocardial injury, which could activate the PI3K/Akt and ERK1/2 signal, phosphorylate eNOS, p70S6K, GSK-3β, GLUT4 and anti-apoptosis proteins such as Bcl-2, Bad, Bax, Caspase, as a result of which the delivery of Cyt-C is inhibited and cell apoptosis is blocked (38–43).

Apelin signaling may have an important role in the physiopathology of diseases such as hypertension, heart failure, cardiovascular disease, type-2 diabetes, and obesity, although their effects and functions are still unclear. The physiological effects of apelin on diabetes are not fully known.

We can conclude that both types of apelin effectively decrease heart tissue injury following LAD clamping-induced I/R injury in the diabetic rat. Additionally, apelin-13 administered before induction of ischemia was observed to have protective effects on these alterations in myocardial I/R injury. Other aspects of these findings, including clinical significance and practical applications, merit further experimental and clinical investigation.

References


