Effects of Adiponectin on Calcium Handling Proteins in Heart Failure with Preserved Ejection Fraction

Tanaka et al: Adiponectin and HFpEF

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Abstract

Background—Despite the increasing prevalence of heart failure (HF) with preserved ejection fraction (HFpEF) in humans, there remains no therapeutic options for HFpEF. Adiponectin (APN), an adipocyte-derived cytokine exerts cardioprotective actions and its deficiency is implicated in the development of hypertension and HF with reduced ejection fraction. Similarly APN deficiency in HFpEF exacerbates left ventricular hypertrophy (LVH), diastolic dysfunction and HF. However, the therapeutic effects of APN in HFpEF remain unknown. We sought to test the hypothesis that chronic APN overexpression protects against the progression of HF in a murine model of HFpEF.

Methods and Results—APN transgenic (APNTG) and wild-type (WT) mice underwent uninephrectomy, a continuous saline or d-aldosterone infusion and given 1.0% sodium chloride drinking water for 4-weeks. Aldosterone-infused WT mice developed HFpEF with hypertension, LVH and diastolic dysfunction. Aldosterone infusion increased myocardial oxidative stress and decreased sarcoplasmic reticulum Ca$^{2+}$-ATPase (SERCA2a) protein expression in HFpEF. Although total phospholamban (PLN) protein expression was unchanged, there was decreased expression of PKA-dependent PLN phosphorylation at Ser16 and CaMKII-dependent PLN phosphorylation at Thr17. APN overexpression in aldosterone-infused mice ameliorated LVH, diastolic dysfunction, lung congestion and myocardial oxidative stress without affecting blood pressure (BP) and LVEF. This improvement in diastolic function parameters in aldosterone-infused APNTG mice was accompanied by preserved protein expression of PKA-dependent phosphorylation of PLN at Ser16. APN replacement prevented the progression of aldosterone-induced HFpEF, independent of BP, by improving diastolic dysfunction and modulating cardiac hypertrophy.

Conclusions—These findings suggest that APN may have therapeutic effects in patients with HFpEF.

Key Words: adiponectin, heart failure with preserved ejection fraction, left ventricular hypertrophy, diastolic dysfunction, oxidative stress, calcium handling proteins
Heart failure with preserved ejection fraction (HFpEF), also known as “diastolic heart failure”, is a clinical syndrome characterized by signs and symptoms of heart failure (HF) with preservation of left ventricular (LV) ejection fraction (LVEF). HFpEF accounts for up to 50% of all patients presenting with HF, yet there remains no therapies for HFpEF. In addition to associated comorbidities, there are likely many divergent pathophysiological mechanisms similar to HF with reduced EF (HFrEF). HFpEF is highly prevalent in obese individuals and hypertension remains the major cause of HFpEF. Emerging evidence also indicates that factors secreted by adipocytes play a role in hypertension-related diseases.

Adiponectin (APN), an adipocyte-derived cytokine, is abundant in human plasma with low APN levels seen in diseases such as hypertension, coronary artery disease, obesity and insulin resistance. As such in experimental models, APN deficiency exacerbates the development of obesity-related hypertension, adverse cardiac remodeling in ischemia-reperfusion injury and myocardial infarction. Recently, we showed that lack of APN in a murine model of diastolic HF, increased the propensity to develop diastolic HF and diastolic dysfunction. Although, hypoadiponectinemia in aldosterone-induced HFpEF exacerbates hypertension, LVH, diastolic dysfunction, and HF, the pathophysiological role and therapeutic effects of APN repletion in HFpEF are unknown. We thus sought to test the hypothesis that chronic APN overexpression protects against the progression of HFpEF and sought to investigate the proposed mechanism.
Methods

An expanded Materials and Methods section is available in the Online Data Supplement. The Institutional Animal Care and Use Committee at Boston University School of Medicine approved all study procedures related to the handling and surgery of the mice. APN transgenic (APNTG) and wild-type (WT) mice in a C57BL/6J background were generated as previously described19.

Experimental Model

Twelve-week old APNTG mice and WT littermates were anesthetized with pentobarbital sodium (50 mg/kg, intraperitoneally). They underwent uninephrectomy and intraperitoneal implantation of osmotic mini-pumps (Durect Corp., Cupertino, CA) that delivered a continuous infusion of either saline or 0.15 μg/hr aldosterone (Sigma-Aldrich Co., St. Louis, MO) for 4 weeks. See online supplement for mice groups.

Physiological Measurements

Heart rate and blood pressure (BP) were measured weekly using a noninvasive tail-cuff BP analyzer, BP-2000 Blood Pressure Analysis System (Visitech Systems, Inc., Apex, NC)18, 20.

Echocardiography

Transthoracic echocardiography was performed at the end of 4 weeks using the Vevo 770 High-Resolution In Vivo Micro-Imaging System and a Real-Time Micro Visualization...
707B Scanhead (VisualSonic Inc., Toronto, Ontario, Canada)\textsuperscript{18, 20}. For details of LV structure, function and Doppler measurements see online supplement.

Mice were sacrificed 4 weeks after saline or aldosterone infusion and biomarker, organ weight, tissue analysis and cardiomyocyte sizes were determined. Myocardial oxidative stress by 3-nitrotyrosine staining and immunoblotting of calcium handling proteins and signaling pathway were also measured. qRT-PCR for atrial natriuretic peptide (ANP) mRNA expression was also determined. See online supplement for all details.

**Statistical Analysis**

Data are expressed as mean± standard error of the mean (SEM). For comparisons of multiple groups, Kruskal–Wallis 1-way ANOVA was performed with a post hoc Dunn test for multiple comparisons. Paired data were evaluated by Mann–Whitney test. P<0.05 values were considered significant. All statistical analyses were performed using GraphPad Prism (GraphPad Software, Inc., La Jolla, CA).

**Results**

**General characteristics**

There were no deaths in the mice during the 4-week period. Characteristics of WT and APNTG mice 4-weeks after saline or aldosterone infusion are summarized in Table 1. Body weights (BW) were comparable between WT and APNTG mice regardless of saline or aldosterone infusion.
Hemodynamic parameters

Heart rates (HR) were comparable between WT and APNTG mice regardless of saline or aldosterone infusion (Table 1). Systolic BP (SBP) was measured weekly (Supplemental Figure 1) and was significantly increased by 4-weeks of aldosterone infusion in WT-aldosterone (127±3 vs. 105±2 mmHg; P<0.01) and APNTG-aldosterone mice (125±4 vs. 100±2 mmHg; P<0.01) compared with their respective saline-infused controls. There was no difference in SBP between the aldosterone-infused WT and APNTG mice.

Serum aldosterone levels

Serum aldosterone levels in WT-aldosterone (6,542.6±324.2 vs. 626.0±66.4 pg/mL; P<0.01) and APNTG-aldosterone mice (5,317.4±551.7 vs. 810.7±85.9 pg/mL; P<0.01) were significantly elevated compared with respective saline-infused mice. There was no difference in serum aldosterone levels between WT and APNTG mice regardless of saline or aldosterone infusion (Table 1).

Serum adiponectin levels

Serum APN levels in APNTG-saline mice (27.0±1.0 μg/mL) were ~1.9 times higher than in WT-saline mice (14.5±1.3 μg/mL; P<0.01). Serum APN levels in APNTG-aldosterone mice (29.2±0.3 μg/mL) were significantly elevated vs. APNTG-saline mice (27.0±1.0 μg/mL; P<0.05). There was no difference in APN levels between WT-saline and WT-aldosterone mice (Table 1).
**LV structure and systolic function**

Echocardiographic parameters for LV structure and systolic function are summarized in Table 2. Aldosterone infusion significantly increased total wall thickness (TWT) and LV mass in WT-aldosterone (1.04±0.02 mm and 140.4±6.5 mg) and APNTG-aldosterone mice (0.93±0.02 mm and 110.9±12.7 mg). Consistent with these findings, the heart weight (HW) to BW ratio (HW/BW) was also significantly increased in the WT-aldosterone (5.69±0.15) and APNTG-aldosterone mice (5.14±0.07; Table 1). There were no significant differences in cardiac hypertrophy between WT-saline and APNTG-saline mice (Table 1 and 2). However, cardiac hypertrophy in APNTG-aldosterone mice was significantly less vs. WT-aldosterone mice (P<0.01 for TWT; P<0.05 for LV mass and P<0.05 for HW/BW). There was no difference in LV chamber size and LVEF between the WT and APNTG mice regardless of saline or aldosterone infusion (Table 2).

**Diastolic function**

Echocardiographic parameters (mitral and tissue Doppler) for LV diastolic function in the mice are summarized in Table 2; Figure 1A-B. *Mitral Doppler:* Aldosterone infusion significantly increased peak E velocity in the WT-aldosterone vs. WT-saline mice and in APNTG-aldosterone vs. APNTG-saline mice (Table 2; Figure 1B). The peak E velocity in APNTG-aldosterone mice was however, significantly lower than in WT-aldosterone mice (P<0.01). Aldosterone infusion significantly increased peak A velocity in APNTG-aldosterone vs. APNTG-saline mice, but not in WT-aldosterone vs. WT-saline mice (P=NS). The resultant ratio of peak E velocity to peak A velocity (E/A) was significantly higher in WT-aldosterone (2.17±0.17) vs. WT-saline mice (1.45±0.04; P<0.01). This
increase in E/A ratio in WT-aldosterone mice, indicating impaired LV compliance, was
attenuated in APNTG-aldosterone mice (1.50±0.09; P<0.01). Deceleration time (DT) was
significantly shortened in WT-aldosterone vs. WT-saline mice (P<0.01). The shortened
do of DT in WT-aldosterone mice, indicates abnormal LV relaxation and was attenuated in
APNTG-aldosterone mice (P<0.01). There was no difference in isovolumic relaxation
time (IVRT) between WT and APNTG mice regardless of saline or aldosterone infusion.

Tissue Doppler: (Table 2) Aldosterone infusion significantly decreased peak e’ velocity
in WT-aldosterone vs. WT-saline mice (P<0.01) and APNTG-aldosterone mice vs.
APNTG-saline mice (P<0.01). However, the peak e’ velocity in APNTG-aldosterone
mice was significantly higher than in WT-aldosterone mice (P<0.01). The resultant ratio
of peak E velocity to peak e’ velocity (E/e’) was significantly higher in WT-aldosterone
mice compared with WT-saline mice (P<0.01). The increase in E/e’ in WT-aldosterone
mice, indicates elevated diastolic filling pressure and was significantly attenuated in
APNTG-aldosterone mice (P<0.01).

APNTG-aldosterone mice showed a reduction in the ratio of peak E velocity to
peak A velocity compared with WT-aldosterone mice. However relative to the saline-
infused mice this ratio of peak E velocity to peak A velocity was elevated. The reduction
in E/A ratio in APNTG-aldosterone mice is due to a decrease in peak E velocity
demonstrating an improvement in early transmitral flow (E wave) in the restrictive filling
pattern. Despite a reduction in E/A ratio in APNTG mice the E/e’ remained elevated
suggesting elevated filling pressures or restrictive filling.
Lung congestion

Aldosterone infusion significantly increased wet/dry lung weight, an indicator of pulmonary congestion, in WT-aldosterone vs. WT-saline mice (P<0.01) and APNTG-aldosterone vs. APNTG-saline mice (P<0.05; Table 1). There was no difference in wet/dry lung weight, between saline-infused WT and APNTG mice. However, the wet/dry lung weight in APNTG-aldosterone mice was significantly lower compared with WT-aldosterone mice indicating less pulmonary congestion (P < 0.05).

LV cardiomyocyte hypertrophy

Aldosterone infusion significantly increased LV cardiomyocyte C/S area in the WT-aldosterone and APNTG-aldosterone mice compared with respective saline-infused mice (P<0.01 for both; Figure 2A-B). Consistent with these findings, ANP mRNA expression, a molecular marker of cardiomyocyte hypertrophy, was increased in the LV of WT-aldosterone vs. WT-saline mice (P<0.01) and APNTG-aldosterone vs. APNTG-saline mice (P<0.05; Figure 2C). There was no difference in the LV cardiomyocyte C/S area and ANP mRNA expression in saline-infused WT and APNTG mice. However, both LV cardiomyocyte C/S area and ANP mRNA expression in APNTG-aldosterone mice were significantly decreased vs. WT-aldosterone mice (P<0.01 and P<0.05, respectively; Figure 2).

Myocardial fibrosis

Aldosterone infusion significantly increased the area of myocardial fibrosis in WT-aldosterone vs. WT-saline mice (P<0.01) and APNTG-aldosterone vs. APNTG-saline
mice (P<0.05; Figure 3). Myocardial fibrosis in APNTG-aldosterone mice was significantly less than the WT-aldosterone mice (P<0.05).

**Myocardial oxidative stress**

Myocardial oxidative stress, assessed by 3-nitrotyrosine staining, was markedly increased in WT-aldosterone mice vs. WT-saline mice. The increase in nitrotyrosine staining in WT-aldosterone mice was attenuated in APNTG-aldosterone mice (Figure 4A-B). There was a 54% reduction in nitrotyrosine staining in APNTG-aldosterone mice (P<0.05 vs. WT-aldosterone mice).

**Calcium handling proteins: SERCA2a and PLN**

Four weeks of aldosterone infusion significantly decreased SERCA2a protein expression in WT-aldosterone vs. WT-saline mice (0.71-fold; P<0.01) and APNTG-aldosterone vs. APNTG-saline mice (0.66-fold; P<0.05). The decrease in SERCA2a protein expression was comparable between WT-aldosterone and APNTG-aldosterone mice (Figure 5A). There was no difference in PLN protein expression between WT and APNTG mice regardless of saline or aldosterone infusion (Figure 5B). Four weeks of aldosterone infusion significantly decreased phosphorylation of PLN at Ser16 in WT-aldosterone vs. WT-saline mice (0.55-fold; P<0.01; Figure 5C). However, this decrease in PLN phosphorylation at Ser16 in WT-aldosterone mouse was significantly attenuated in APNTG-aldosterone mouse (P<0.05; Figure 5C). Four weeks of aldosterone infusion significantly decreased phosphorylation of PLN at Thr17 in WT-aldosterone vs. WT-saline mice (0.73-fold; P<0.01) and APNTG-aldosterone vs. APNTG-saline mice (0.68-
fold; P<0.01; Figure 5D). PLN phosphorylation of at Thr17 was similar between WT-aldosterone and APNTG-aldosterone mice (Figure 5D).

**PKA expression**

Four weeks of aldosterone infusion significantly decreased PKA C-α protein expression in WT-aldosterone vs. WT-saline mice (0.78-fold; P<0.01). This decrease of PKA C-α protein expression in WT-aldosterone mice was however significantly attenuated in APNTG-aldosterone mice (P<0.05; Figure 6).

**CaMKII expression**

There was no difference in CaMKII protein expression between WT and APNTG mice regardless of saline or aldosterone infusion (Figure 7A). Four weeks of aldosterone infusion significantly decreased phosphorylation of CaMKII in WT-aldosterone vs. WT-saline mice (0.65-fold; P<0.01) and APNTG-aldosterone vs. APNTG-saline mice (0.66-fold; P<0.05; Figure 7B). There was no difference in phosphorylation of CaMKII between WT-aldosterone and APNTG-aldosterone mice.

**APN supplementation** (Figure 8A-B)

To examine whether Ad-APN supplementation ameliorated aldosterone-induced diastolic dysfunction in vivo, both WT-saline and WT-aldosterone mice were treated with either adenovirus-APN (Ad-APN) or adenovirus-β-galactosidase (Ad-βgal). Ad-APN or Ad-βgal were injected into the jugular vein of mice 14 days after surgery. This dose of Ad-APN raises APN levels in the physiological range and contains the 3 isoforms$^{14,21}$ that
are present in mice with the hexamer form being dominant. Neither Ad-APN nor Ad-βgal had an effect on SBP in WT-saline and WT-aldosterone mice (data not shown).

Ad-APN attenuated the aldosterone-induced changes in diastolic dysfunction: E/A ratio WT-aldosterone treated with Ad-APN (2.4) vs. WT-aldosterone mice treated with Ad-βgal (1.75; P<0.01). Similarly, E/e’ decreased 34% vs. WT-aldosterone mice treated with Ad-βgal (P<0.01).

**Discussion**

In this study, aldosterone-infused WT mice developed hypertension, LVH, diastolic dysfunction, and increased lung congestion while maintaining a preserved LVEF, thus resulting in HFpEF. Aldosterone infusion also increased myocardial oxidative stress, decreased SERCA2a protein expression, decreased PKA-dependent PLN phosphorylation at Ser16, and decreased CaMKII-dependent phosphorylation of PLN at Thr17. Chronic hyperadiponectinemia ameliorated LVH, diastolic dysfunction, and lung congestion without effects on BP or LVEF in HFpEF mice. Chronic APN overexpression also decreased myocardial nitrotyrosine staining, a measure of oxidative stress. The improvement of diastolic dysfunction parameters was associated with preserved PKA-dependent PLN phosphorylation at Ser16. In addition, APN supplementation with Ad-APN improved measures of diastolic dysfunction in HFpEF mice infused with aldosterone.

We previously showed that APN deficiency in aldosterone-induced HFpEF mice exacerbated hypertension and LVH\textsuperscript{18}. Although it has been reported that hypoadiponecinemia is a risk factor for hypertension\textsuperscript{11}, the therapeutic effect of APN on
hypertension is largely unknown. Ohashi, et al. reported that adenovirus-mediated overexpression of APN ameliorated obesity-related hypertension in mice\textsuperscript{13}. However, in our study, transgenic mice with chronic APN overexpression and Ad-APN supplementation of WT mice did not affect BP. This difference may be due to pathophysiological differences of targeted experimental models and less likely due to the difference of APN levels in each experimental model. APN levels in our APNTG mice were about 2-fold higher than those in WT mice\textsuperscript{19}, and although we did not measure APN levels in the APN supplementation experiments, it was likely similar to adenovirus-mediated APN levels in Ohashi’s study where APN levels were about 6-fold higher than those at baseline. Further studies are needed to determine the therapeutic effect of APN in hypertension, but the importance of our study is that chronic APN overexpression ameliorates the progression of LVH, independent of alterations in BP. Aldosterone-induced LVH, which is composed of LV cardiomyocyte hypertrophy and myocardial fibrosis\textsuperscript{20, 22} is accompanied by oxidative stress via mineralocorticoid receptor activation\textsuperscript{23-25}. Thus, suppression of oxidative stress might be an important therapeutic target in HFpEF\textsuperscript{26, 27}. Several studies have recently shown that APN exerts its cardioprotective effect by inhibiting oxidative stress\textsuperscript{28-30}. Consistent with these findings, we showed that APN overexpression diminished aldosterone-induced myocardial 3-nitrotyrosine production, a marker of oxidative stress. APN likely mitigates aldosterone-induced adverse cardiac remodeling partly by suppressing oxidative stress\textsuperscript{29, 30}. In a high fat experimental model, APN prevented platelet aggregation by attenuating oxidative and nitrosative stress\textsuperscript{31} and modulated ROS metabolite levels and increased antioxidant levels in an ischemia/reperfusion porcine model\textsuperscript{32}. Mitochondrial targeted antioxidant peptide,
SS-31 may prove to be a therapeutic option in HFpEF patients as it targets mitochondrial ROS, and modulates LVH, fibrosis, and LV diastolic dysfunction in an experimental model.33

Both cardiomyocyte hypertrophy and myocardial fibrosis contribute to impaired active relaxation and increased passive stiffness of the LV, and subsequently leads to diastolic dysfunction and clinical HF34, 35. In our study, hyperadiponectinemia decreased cardiac hypertrophy and improved some measures of diastolic dysfunction, independent of BP. Thus, chronic hyperadiponectinemia may improve diastolic dysfunction and HF by ameliorating LVH18. In human studies, it has been reported that low plasma APN is associated with diastolic dysfunction.36

Diastolic intracellular calcium handling is a major determinant of LV relaxation.35, 37 Dephosphorylated PLN is an inhibitor of SERCA2a, but PKA-catalyzed (or CaMKII), phosphorylation of PLN results in the dissociation of PLN from SERCA2a, thus activating this Ca²⁺ pump and augmenting SERCA2a activity. In our study, chronic aldosterone infusion decreased SERCA2a protein expression and PLN phosphorylation at both Ser16 and Thr17, but did not alter PLN protein expression. In addition, PKA C-α, an active catalytic subunit of PKA, and protein expression and phosphorylation of CaMKII, an indicator of CaMKII activity, were both decreased by chronic aldosterone infusion. Accumulating evidence indicates that β-adrenergic receptor stimulation regulates PKA and CaMKII activity.38-40 Additionally, it has also been reported that Ser16 phosphorylation is mainly affected by PKA activity whereas Thr17 phosphorylation is affected by CaMKII activity.38, 39, 41 Although β-adrenergic signaling affected by chronic aldosterone infusion remains to be clarified in this study, decreased PKA and CaMKII
activity suggest that β-adrenergic signaling is downregulated by chronic aldosterone infusion. Collectively, our data indicates that chronic aldosterone infusion decreased PKA-dependent phosphorylation of PLN at Ser16 and CaMKII-dependent phosphorylation of PLN at Thr17, presumably followed by β-adrenergic signaling down-regulation, and subsequently suppressed SERCA2a protein expression. We did not measure intracellular Ca$^{2+}$ concentrations. However, evidence indicates that diastolic intracellular calcium handling is mainly regulated by SERCA2a and its modulator PLN$^{35, 37, 41}$. Thus, changes in SERCA2a protein expression and/or phosphorylation of PLN in our study, may be associated with abnormal intracellular diastolic calcium handling and subsequent diastolic dysfunction, as demonstrated by impaired LV compliance (increased E/A), abnormal LV relaxation (shortened DT), and elevated diastolic filling pressure (increased E/e’). Nonetheless, in our study hyperadiponectinemia and chronic APN overexpression ameliorated these measures of diastolic dysfunction in HFP EF indicating that the improvement in these measures might be due to alterations in calcium handling protein signaling.

At cellular and molecular levels, APN induces Ca$^{2+}$ influx via AdipoR1 and subsequently activates CaMKK, AMPK and SIRT1 in skeletal muscle$^{42}$. However in the myocardium, SERCA2a protein expression in chronic aldosterone infusion was not affected by chronic APN overexpression. Likewise, CaMKII activity and CaMKII-dependent phosphorylation of PLN at Thr17 were both decreased and to comparable levels. Yet chronic APN overexpression ameliorated the decrease of PLN phosphorylation at Ser16, followed by preserved PKA activity. SERCA2a function is determined not only by SERCA2a protein expression$^{43}$, but also by the phosphorylation
status of PLN\textsuperscript{44}. In our study, chronic APN overexpression did not affect the SERCA2a protein expression, but improved diastolic dysfunction. These findings may be partly explained by improvement of SERCA2a function through phosphorylation of PLN. In addition, several studies have shown that APN is associated with cyclic adenosine monophosphate (cAMP)-dependent PKA signaling\textsuperscript{45, 46}. Thus, our finding suggests that chronic APN overexpression preserves phosphorylation of PLN at Ser16 through PKA activation, and improves SERCA2a dysfunction.

Finally, the potential beneficial effects of APN may extend to the downregulation of inflammatory cytokines or the upregulation of anti-inflammatory cytokines which may impact cardiac hypertrophy, the extracellular matrix, diastolic dysfunction and HFpEF. Pro-inflammatory cytokines, such as TNF-\(\alpha\) which is pro-hypertrophic\textsuperscript{47}, are increased in diastolic dysfunction and HFpEF\textsuperscript{18} (Supplemental Figure 2). We recently showed that IFN-\(\gamma\), a pro-inflammatory cytokine attenuated cardiac hypertrophy and is a regulator of cardiac hypertrophy in HFpEF thus disputing the notion that inflammatory cytokines mediate only adverse effects\textsuperscript{48}.

In conclusion, chronic APN overexpression and supplementation prevented the progression of aldosterone-induced HFpEF, independent of blood pressure. The beneficial effect of APN was associated with reduced myocardial oxidative stress and modulation of intracellular calcium handling regulatory proteins. Our findings indicate that APN and its signaling pathway may be a therapeutic target for patients with HFpEF.
Sources of Funding

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Disclosures

None.
References


Table 1. Characteristics of WT/APNTG Mice 4 Weeks after Saline/Aldosterone Infusion

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**General**

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<td>127±3††</td>
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<td>Heart weight / Body Weight (mg/g)</td>
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<td>Wet-Lung Weight / Dry-Lung Weight</td>
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<td>4.48±0.05††</td>
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<td>1.0±0.1</td>
<td>0.9±0.2</td>
<td>6.7±0.7††</td>
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**Blood Chemical Analysis**

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<td>Serum aldosterone levels (pg/mL)</td>
<td>626.0±66.4</td>
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<td>Serum adiponectin levels (µg/mL)</td>
<td>14.5±1.3</td>
<td>27.0±1.0††</td>
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<td>29.2±0.3††,*</td>
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Data are expressed as mean ± SEM.

Abbreviations: WT; wild-type, APNTG; adiponectin transgenic, aldo; aldosterone

††*P < 0.01 vs. WT-saline, ‡‡*P < 0.05 vs. APNTG-saline, ‡‡‡*P < 0.01 vs. APNTG-saline, *P < 0.05 vs. WT-aldo, **P < 0.01 vs. WT-aldo.

WT-saline, ‡‡*P < 0.05 vs. APNTG-saline, ‡‡‡*P < 0.01 vs. APNTG-saline, *P < 0.05 vs. WT-aldo, **P < 0.01 vs. WT-aldo.
Table 2.  Echocardiographic Parameters of WT/APNTG Mice 4 Weeks after Saline/Aldosterone Infusion

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<td>TWT (mm)</td>
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<td>0.73±0.01</td>
<td>1.04±0.02 ††</td>
<td>0.93±0.02 ††: **</td>
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<td>LVEDD (mm)</td>
<td>3.42±0.06</td>
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<td>LVESD (mm)</td>
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<td>654.83±13.79</td>
<td>677.60±14.50</td>
<td>1008.73±27.19 ††</td>
<td>873.75±20.96 ††: **</td>
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<td>Peak A (mm/s)</td>
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<td>449.61±15.34</td>
<td>490.50±40.89</td>
<td>591.24±34.94†</td>
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<td>E/A</td>
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<td>1.51±0.04</td>
<td>2.17±0.17 ††</td>
<td>1.50±0.09 **</td>
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<tr>
<td>DT (ms)</td>
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<td>21.88±0.63</td>
<td>15.56±1.00 ††</td>
<td>20.42±0.77 **</td>
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<tr>
<td>IVRT (ms)</td>
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<td>20.63±1.88</td>
<td>19.72±0.77</td>
<td>20.00±1.12</td>
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<td>e (mm/s)</td>
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<td>17.81±0.33 ††</td>
<td>20.55±0.69 †‡, **</td>
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<tr>
<td>E/e</td>
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<td>24.14±1.02</td>
<td>56.84±1.96 ††</td>
<td>42.67±1.28 †‡, **</td>
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Data are expressed as mean± SEM.

Abbreviations: WT; wild-type, APNTG; adiponectin transgenic, aldo; aldosterone, LV; left ventricular, LVEDD; LV end-diastolic diameter, LVESD; LV end-systolic diameter, TWT; total wall thickness, LVEF; LV ejection fraction, E; early, A; late, DT; early filling deceleration time, IVRT; isovolumic relaxation time, e; peak early diastolic myocardial velocity.

††P < 0.01 vs. WT-saline, ‡P < 0.05 vs. APNTG-saline, ‡‡P < 0.01 vs. APNTG-saline, *P < 0.05 vs. WT-ald, **P < 0.01 vs. WT-ald.
Figure Legends

Figure 1. Representative pulse wave and tissue Doppler images in WT and APNTG mice 4 weeks after saline or aldosterone infusion. A) WT-saline; B) WT-saline, APNTG-saline, WT-aldosterone, and APNTG-aldosterone. IVRT indicates isovolumetric relaxation time, E; peak early transmitral flow velocity, A; peak late transmitral flow velocity, DT; early filling deceleration time, e'; peak early diastolic myocardial velocity.

Figure 2. LV cardiomyocyte hypertrophy in WT and APNTG mice 4 weeks after saline or aldosterone infusion. A) Representative H&E staining. Scale bar is 10μm; B) LV cardiomyocyte C/S area; C) ANP mRNA expression (n=4-9 per group). ††P<0.01 vs. WT-saline, ‡P<0.05 vs. APNTG-saline, ‡‡P<0.01 vs. APNTG-saline, *P<0.05 vs. WT-aldosterone, **P<0.01 vs. WT-aldosterone.

Figure 3. Myocardial fibrosis in WT and APNTG mice 4 weeks after saline or aldosterone infusion. A) Representative Masson trichrome staining. Original magnification x400; B) Myocardial fibrosis area (n=4-9/group); ††P<0.01 vs. WT-saline, ‡P<0.05 vs. APNTG-saline, *P<0.05 vs. WT-aldosterone.

Figure 4. Myocardial oxidative stress in WT and APNTG mice 4 weeks after saline or aldosterone infusion. A) Representative 3-nitrotyrosine staining. Original magnification x400. B) Semiquantitative analysis of nitrotyrosine staining of C/S of murine
myocardium. Nitrotyrosine staining was scored using an arbitrary grade from 1 to 4. 

\( n=4-9/\text{group} \). \( \dagger P<0.01 \) vs. WT-saline, \( *P<0.05 \) vs. WT-aldosterone.

Figure 5. Expression of calcium handling regulatory proteins in WT and APNTG mice 4 weeks after saline or aldosterone infusion. A) \((\text{Upper})\) Representative blots of SERCA2a and GAPDH. \((\text{Lower})\) Quantitative analysis of SERCA2a protein expression; B) \((\text{Upper})\) Representative blots of PLN and GAPDH. \((\text{Lower})\) Quantitative analysis of PLN protein expression; C) \((\text{Upper})\) Representative blots of PLN phosphorylation at Ser16 and GAPDH. \((\text{Lower})\) Quantitative analysis of PLN phosphorylation at Ser16; D) \((\text{Upper})\) Representative blots of PLN phosphorylation at Thr17 and GAPDH. \((\text{Lower})\) Quantitative analysis of PLN phosphorylation at Thr17. \( \ddagger P<0.01 \) vs. WT-saline, \( \ddagger P<0.05 \) vs. APNTG-saline, \( \ddagger \ddagger P<0.01 \) vs. APNTG-saline, \( *P<0.05 \) vs. WT-aldosterone; \( (n=3-8/\text{group}) \).

Figure 6. PKA C-\( \alpha \) protein expression in WT and APNTG mice 4 weeks after saline or aldosterone infusion. \((\text{Upper})\) Representative blots of PKA C-\( \alpha \) and GAPDH. \((\text{Lower})\) Quantitative analysis of PKA C-\( \alpha \) expression \((n=3-8/\text{group})\); \( \ddagger P<0.01 \) vs. WT-saline, \( *P<0.05 \) vs. WT-aldosterone.

Figure 7. CaMKII protein expression and phosphorylation of CaMKII in WT and APNTG mice 4 weeks after saline or aldosterone infusion. A) \((\text{Upper})\) Representative blots of CaMKII and GAPDH. \((\text{Lower})\) Quantitative analysis of CaMKII protein expression; B) \((\text{Upper})\) Representative blots of phosphorylation of CaMKII and GAPDH.
Quantitative analysis of phosphorylation of CaMKII (n=3-8/group); ††P<0.01 vs. WT-saline, ‡P<0.05 vs. APNTG-saline.

Figure 8. Ad-APN supplementation modulates diastolic dysfunction in aldosterone-infused WT. A) Ad-APN attenuated the E/A ratio by 37% in WT-aldosterone mice treated with Ad-APN vs. WT-aldosterone mice treated with Ad-βgal (***P<0.01). B) Ad-APN decreased E/e’ by 34% in WT-aldosterone mice vs. WT-aldosterone mice treated with Ad-βgal (†††P<0.01).
Figure 1B
Figure 2

Scale bar, 10µm
Figure 3

A

WT-saline

WT-aldo

APNTG-saline

APNTG-aldo

B

Myocardial fibrosis area (%)

WT-saline

APNTG-saline

WT-aldo

APNTG-aldo

Original magnification x400
Figure 4

Original magnification x400
Figure 5A

<table>
<thead>
<tr>
<th>Sample Type</th>
<th>SERCA2a Protein Expression (Fold Change vs. WT-saline)</th>
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</thead>
<tbody>
<tr>
<td>WT-saline</td>
<td>1.0</td>
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<tr>
<td>APNTG-saline</td>
<td>1.0</td>
</tr>
<tr>
<td>WT-aldosterone</td>
<td>0.5</td>
</tr>
<tr>
<td>APNTG-aldosterone</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Legend:**
- ††: Significant difference compared to WT-saline
- †: Significant difference compared to APNTG-saline

**Image:**
- Blots for SERCA2a and GAPDH expression in different sample types.

**Journal:** Circulation: Heart Failure

**Authors:**
- [List of authors]

**DOI:**
- [DOI link]
Figure 5B

WT-saline  APNTG-saline  WT-aldo  APNTG-aldo

PLN

GAPDH

Circulation
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PLN protein expression
(fold change vs. WT-saline)

WT-saline  APNTG-saline  WT-aldo  APNTG-aldo
Figure 5C

WT-saline  APNTG-saline  WT-aldo  APNTG-aldo

P-PLN at Ser16

GAPDH

Phosphorylation of PLN at Ser16 (Fold change vs. WT-saline)

WT-saline  APNTG-saline  WT-aldo  APNTG-aldo

*
Figure 5D

Phosphorylation of PLN at Thr17
(fold change vs. WT-saline)

WT-saline  APNTG-saline  WT-aldo  APNTG-aldo

P-PLN at Thr17

GAPDH
Figure 6

- PKA C-α
- GAPDH

Bar graph showing fold change in PKA C-α protein expression compared to WT-saline: WT-saline: 1.0, APNTG-saline: 1.0, WT-aldosterone: 0.5, APNTG-aldosterone: 0.5.
Figure 7A

CaMKII

WT-saline  APNTG-saline  WT-aldo  APNTG-aldo

GAPDH

Circulation
Heart Failure

CaMKII protein expression (fold change vs. WT-saline)
Figure 7B

WT-saline  APNTG-saline  WT-aldo  APNTG-aldo

P-CaMKII

GAPDH

Phosphorylation of CaMKII
(Fold change vs. WT-saline)

WT-saline  APNTG-saline  WT-aldo  APNTG-aldo
Figure 8
Effects of Adiponectin on Calcium Handling Proteins in Heart Failure with Preserved Ejection Fraction
Komei Tanaka, Richard M. Wilson, Eric E. Essick, Jennifer L. Duffen, Philipp E. Scherer, Noriyuki Ouchi and Flora Sam

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**SUPPLEMENTAL MATERIAL**

**Supplemental Methods**

**Experimental mice groups.** Mice were maintained on standard rodent chow and 1.0% sodium chloride drinking water for 4 weeks\(^1\).\(^2\). The 4 groups studied were: (a) WT mice infused with saline (WT-saline, n = 7); (b) APNTG mice infused with saline (APNTG-saline, n = 7); (c) WT mice infused with \(d\)-aldosterone (WT-aldosterone, n = 15); (d) APNTG mice infused with \(d\)-aldosterone (APNTG-aldosterone, n = 15).

Another group of WT mice underwent the same surgical procedures as outlined above; however 14 days after surgery, mice were treated with adenoviral vectors expressing either APN (Ad-APN) or \(\beta\)-galactosidase (Ad-\(\beta\)gal) as a control after aldosterone or saline infusion. \(2\times10^8\) plaque-forming units (pfu) of Ad-APN or Ad-\(\beta\)gal were injected into the jugular vein of WT mice. (a) WT-saline plus Ad-\(\beta\)gal, n=3; (b) WT-aldosterone plus Ad-\(\beta\)gal, n=4; (c) WT-saline plus Ad-APN, n=3; (d) WT-aldosterone plus Ad-APN, n=4.

**Physiological Measurements.** Heart rate and blood pressure were measured weekly using a noninvasive tail-cuff blood pressure analyzer, BP-2000 Blood Pressure Analysis System (Visitech Systems, Inc., Apex, NC)\(^1\),\(^2\).

**Echocardiography.**

*Diastolic function measurements:* To assess diastolic function, mice were anesthetized with isoflurane (0.5% for induction followed by 0.5 to 1.5% for maintenance) and maintained at a heart rate (HR) of \(~350\) beats per minute (bpm) since diastolic function is sensitive to HR and loading conditions. The maximum dose of isoflurane 1.5% has minimal effects on diastolic function\(^2\),\(^3\). Pulse wave and tissue Doppler measurements were recorded.

*LV structure and function:* Interventricular septum wall thickness (IVST), LV posterior wall thickness (LVPWT), LV end-diastolic diameter (LVEDD), LV end-systolic diameter (LVESD), and LV ejection fraction (LVEF) were obtained. Total wall thickness (TWT) was derived from an average of the IVST and LVPWT. LV mass was calculated using the formula \(LV\) mass= \(1.05[(LV\ EDD + IVST + PWT)^3 - (LV\ EDD)^3]\) as described by Kiatchoosakun S et al\(^4\).

**Biomarker, organ weight and tissue analysis.** After 4 weeks mice were sacrificed, and blood was obtained to determine serum adiponectin (B-Bridge International, Inc., Cupertino, CA) and aldosterone levels (Alpha Diagnostic Intl. Inc., San Antonio, TX). Body weights and heart weights were determined. Hearts were either arrested in diastole by KCl (30mmol/l), weighed, perfused with 10% buffered formalin and sliced horizontally for histology, or snap-frozen in liquid nitrogen. To measure fibrosis, Masson trichrome-stained sections (5\(\mu\)m) were visualized by using Olympus BX41 Clinical Microscope (Olympus America Inc., Center Valley, PA). The ratio of the fibrotic area to the entire heart area was calculated using ImageJ (National Institutes of Health, Bethesda, MD).
LV cardiomyocyte cross-sectional (C/S) area was assessed. For each section, 100 cardiomyocytes, showing a central nucleus, were randomly selected and C/S areas were measured \((\text{Area} = \pi r^2)\) using ImageJ (National Institutes of Health, Bethesda, MD). The wet-to-dry lung ratio, as an indicator of pulmonary congestion and HF was determined.\(^2\)\(^-\)\(^5\).

**Assessment of myocardial oxidative stress.** Myocardial specimens were stained with 3-nitrotyrosine staining as described previously.\(^6\) Briefly, sections were treated with 10 mmol/L citric acid (pH 6.0) and heated with a microwave (2 minutes, 3 times at 700W) to recover antigenicity. Nonspecific binding was blocked with 10% normal goat serum in phosphate-buffered saline (PBS) (pH 7.4) for 30 minutes before incubation with polyclonal anti-3-nitrotyrosine antibody (1 μg/mL) (Millipore, Billerica, MA) in PBS with 1% bovine serum albumin overnight at 4°C. Tissue sections were then incubated for 30 minutes at room temperature with a biotinylated anti-rabbit IgG (1:800) secondary antibody by using the Vectastain ABC kit (Vector Laboratories, Inc., Burlingame, CA). Vector Red alkaline phosphatase substrate (Vector Laboratories, Inc., Burlingame, CA) was used to visualize 3-nitrotyrosine. Semiquantitative analysis of tissue immunoreactivity for nitrotyrosine was done by estimating the degree of staining with the use of an arbitrary grading system from 1 to 4 as described previously.\(^7\)

**Western Blot Analysis.** Protein kinase A (PKA) C-α, Ca\(^{2+}\)/calmodulin-dependent protein kinase II (CaMKII), phospho-CaMKII at Thr286, sarco(endo)plasmic reticulum Ca\(^{2+}\)-ATPase (SERCA2a), phospholamban (PLN), phospho-PLN at Ser16, and phospho-PLN at Thr17 protein expression in the heart were determined by western blot analysis. Aliquots of cardiac tissue lysates (5-30 μg) were separated by sodium dodecyl sulfate-polyacrylamide gel electrophoresis (SDS-PAGE) and transferred onto polyvinylidene fluoride (PVDF) membranes (GE Healthcare UK Ltd., Little Chalfont, Buckinghamshire, England). The membranes were immunoblotted with the following primary antibodies: anti-PKA C-α (Cell Signaling Technology, Inc., Danvers, MA), anti-CaMKII (Cell Signaling Technology, Inc., Danvers, MA), anti-phospho-CaMKII at Thr286 (Cell Signaling Technology, Inc., Danvers, MA), anti-SERCA2a (Thermo Fisher Scientific Inc., Waltham, MA), anti-PLN (Thermo Fisher Scientific Inc., Waltham, MA), anti-phospho-PLN at Ser16 (Santa Cruz Biotechnology, Inc., Santa Cruz, CA), anti-phospho-PLN at Thr17 (Santa Cruz Biotechnology, Inc., Santa Cruz, CA), and anit-glyceraldehyde-3-phosphate dehydrogenase (GAPDH) (Abcam plc., Cambridge, MA), followed by the horseradish peroxidase (HRP)-conjugated secondary antibody (Santa Cruz Biotechnology, Inc., Santa Cruz, CA). Immunoblots were detected by ECL or ECL plus Western Blotting Detection Reagents (GE Healthcare UK Ltd., Little Chalfont, Buckinghamshire, England). The chemiluminescence intensities were quantified by ImageJ (National Institutes of Health, Bethesda, MD) and normalized to those of GAPDH or Coomassie Brilliant Blue (Sigma-Aldrich Co., St. Louis, MO) staining of the PVDF membranes.

**Quantitative real-time polymerase chain reaction (qRT-PCR).** Atrial natriuretic peptide (ANP) mRNA expression was determined by qRT-PCR. Total RNA was extracted by using RNeasy Fibrous Tissue Mini Kit (QIAGEN Inc., Valencia, CA) according to the manufacturer’s protocol. Complementary DNA (cDNA) from 1000 ng of
total RNA was synthesized by using a ThermoScript™ Reverse Transcriptase (RT)-PCR System (Life Technologies Corporation, Carlsbad, CA) according to the manufacturer’s protocol. qRT-PCR was performed on the StepOne™ Real-Time PCR System (Life Technologies Corporation, Carlsbad, CA) using SYBR Green PCR Master Mix (Life Technologies Corporation, Carlsbad, CA). The primer sequences were as follows: 5’-ATCTGCCCTCTTGAAGCA-3’ and 5’-AAGCTGTTCAGCCTAGTCC-3’ for mouse ANP; 5’-CCAAGGTCAATCCATGACAAGT-3’ and 5’-GGGACATCCAGTCTTCT-3’ for mouse GAPDH. The expression levels of examined transcripts were compared to those of GAPDH and normalized to the mean value of controls.
Supplemental Figure 1

![Graph showing systolic blood pressure (mm Hg) over weeks for different groups: WT-aldosterone (black circles), APNTG-aldosterone (black squares), WT-saline (white circles), and APNTG-saline (white squares). The graph illustrates the increase in systolic blood pressure over time, with significant differences marked by † and ††. N.S. indicates no significant difference.](image-url)
Supplemental

Figure 2

A

WT-saline
APNTG-saline
WT-aldosterone
APNTG-aldosterone

TNF-α mRNA expression (Fold change rel. to WT-saline)

B

WT-saline
APNTG-saline
WT-aldosterone
APNTG-aldosterone

MCP-1 mRNA expression (Fold change rel. to WT-saline)
Supplemental Figure Legends

Supplemental Figure 1. Tail cuff systolic blood pressure in WT and APNTG mice. There was a significant and progressive rise in tail-cuff blood pressure in APNTG-aldosterone. †P<0.01 vs. WT-saline, ††P<0.01 vs. WT-saline, ‡P<0.05 vs. APNTG-saline, ‡‡P<0.01 vs. APNTG-saline

Supplemental Figure 2. (A) Aldosterone infusion significantly TNF-α mRNA expression in the hearts of WT-aldosterone vs. WT-saline mice (¶ P<0.05) but not in APNTG-aldosterone (P=NS vs. APNTG-saline mice and WT-aldosterone mice). (B) There was no significant difference in myocardial MCP-1 mRNA expression between saline and aldosterone-infused WT and APNTG mice.
Supplemental References


