Cardioprotection of ischemic preconditioning in rats involves upregulating adiponectin

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Abstract

It has been reported that ischemic preconditioning (IPC) and adiponectin (APN) are cardioprotective in many cardiovascular disorders. However, whether APN mediates the effect of IPC on myocardial injury has not been elucidated. This study was conducted to investigate whether IPC affects myocardial ischemic injury by increasing APN expression. Male adult rats with cardiac knockdowns of APN and its receptors via intramyocardial small-interfering RNA injection were subjected to IPC and then myocardial infarction (MI) at 24 h after IPC. Globular APN (gAd) was injected at 10 min before MI. APN mRNA and protein levels in myocardium as well as the plasma APN concentration were markedly high at 6 and 12 h after IPC. IPC ameliorated myocardial injury as evidenced by improved cardiac functions and a reduced infarct size. Compared with the control MI group, rats in the IPC + MI group had elevated levels of left ventricular ejection fraction and fractional shortening and a smaller MI size ($P < 0.05$). However, the aforementioned protective effects were ameliorated in the absence of APN and APN receptors, followed by the inhibition of AMP-activated protein kinase (AMPK) phosphorylation, but reversed by gAd treatment in wild-type rats, and AMPK phosphorylation increased ($P < 0.05$). Overall, our results suggest that the cardioprotective effects of IPC are partially due to upregulation of APN and provide a further insight into IPC-mediated signaling effects.

Introduction

Ischemic preconditioning (IPC) is a well-known phenomenon in which brief intermittent periods of ischemia-reperfusion protect the myocardium against subsequent long and lethal ischemia. It is also known that the prognosis after myocardial infarction (MI) is better for patients with unstable angina than those suffering an unpredicted MI. These fundamental observations suggest that endogenous mechanisms of IPC exist in the heart to protect against future ischemic events. Many studies have attempted to define the signaling mechanisms induced by IPC with the goal of developing pharmacological mimics to provide protection. Such studies have found that one or more factors released in response to brief episodes of ischemia during IPC interact with receptors, locally or at a
Adiponectin (APN) is an adipocyte-derived cytokine normally present in human plasma at concentrations of 0.5–30 µg/mL, comprising about 0.01% of all plasma proteins (Hotta et al. 2000). In addition to its well-defined insulin sensitization and metabolic regulatory effects, APN increases the phosphorylation of AMP-activated protein kinase (AMPK) that has vascular protective, anti-inflammatory and anti-ischemic effects (Ling et al. 2007). Numerous epidemiological studies have shown that reduced APN levels correlate with an increased risk of cardiovascular disease (Goldstein et al. 2009), whereas high plasma APN concentrations are associated with a lower risk of MI in men (Pischon et al. 2004). In vivo experiments have also demonstrated that increasing plasma APN protects the myocardium against ischemic injury (Shibata et al. 2005, Ling et al. 2007). A proteolytic cleavage product of APN, which includes the globular domain, also exists in plasma biologically. Globular APN (gAd) administration protects the myocardium against ischemia-reperfusion injury, involving a reduction of oxidative/nitrative stress and inhibition of endoplasmic reticulum stress (Jia et al. 2013, Song et al. 2014). Therefore, enhancing APN production has been accepted as a potential therapeutic modality for amelioration of cardiovascular injury. Although APN has been regarded to be of exclusive adipocyte origin, interestingly, cardiomyocytes also synthesize and secrete biologically active APN (Pineiro et al. 2005), and such cardiac-derived APN protects against myocardial ischemia/reperfusion injury and has a peroxisome proliferator-activated receptor-γ-mediated anti-hypertrophic effect (Amin et al. 2010, Wang et al. 2010b). These findings indicate that endogenous cardiac-derived APN may exert its cardioprotective effect through paracrine/autocrine activation.

Some studies have also implicated APN in angiogenesis (Ouchi et al. 2004, Shibata et al. 2004). A recent study reported that gAd induces endothelial cell proliferation as well as in vitro migration and stimulates the release of endothelial angiogenic factors (Raghu et al. 2012). As a kind of angiogenic factor, whether APN is a mediator of IPC in cardioprotective effects remains unknown. Data from our previous study have demonstrated that IPC upregulates myocardial expression of APN at mRNA and protein levels and increases the plasma APN concentration (Wang et al. 2010a). Here, we hypothesized that the increase in myocardium and plasma APN levels induced by IPC results in protection against ischemia. Therefore, the aims of the current study are (1) to delineate the potential causative relationship between IPC-induced APN upregulation and the resultant cardioprotective effects and (2) to investigate the underlying mechanisms using myocardial delivery of small-interfering RNA (siRNA) and administration of human recombinant gAd.

### Materials and methods

#### Experimental protocols

All experiments were performed with adherence to the National Institute of Health’s Guide for the Use and Care of Laboratory Animals and were approved by the Committee on Animal Care and Use of the China-Japan Friendship Hospital (Beijing, China). Male Sprague-Dawley rats (8 weeks of age, weighing 300±50 g) were obtained from Vital River Laboratory Animal Technology Co. Ltd. (Beijing, China). Rats were randomized to receive IPC or a sham procedure. At 24 h after IPC, some rats in both groups were subjected to MI for cardiac function and infarct size determinations. To investigate the potential causative relationship between APN- and IPC-induced cardioprotective effects and the further signaling activation of APN, rats were injected with APN or APN receptor (AdipoR) 1 and 2 siRNAs (Sugano et al. 2005) in their myocardium at 10 min before IPC or administered with 4 µg/g gAd (Sigma) at 10 min before MI (Ling et al. 2007). All surgical procedures as well as blood and cardiac tissue collections were performed under anesthesia to avoid stress.

#### IPC and MI model in rats

Animals were divided into IPC and sham groups, which were randomized to receive IPC or a sham procedure according to our previously published protocol (Zheng et al. 2006), with slight modifications. In brief, after anesthesia with 1% pentobarbital sodium, a tracheotomy...
was performed, and then the animal was intubated and ventilated with air. A left intercostal thoracotomy was performed at the fourth and fifth intercostal space. Upon identification of the left anterior descending artery (LAD), a 7–0 suture was secured at 2 mm below the level of the tip of the normally positioned left auricle, and four rounds of 6-min ischemia and reperfusion were induced to achieve minimal mortality, which differed from our previous ischemia protocol with high mortality (Zheng et al. 2006). The success of ischemic induction was verified by a color change in the cardiac surface from reddish to pale and continuous electrocardiographic monitoring. The recovered reddish color and the appearance of ventricular arrhythmia indicated successful reperfusion. After the conclusion of the fourth ischemia-reperfusion cycle, the suture was removed, the chest wall was closed and the animal was removed from the ventilator and placed under a heat lamp to recover. Sham-operated control rats underwent the same surgical procedures except the LAD was subjected to transient occlusion.

Additional sets of rats, which underwent repeated operations after sham or IPC procedures, had a permanently ligated LAD. Briefly, at 24 h after IPC or sham operation, the rats were re-anesthetized and their LAD was permanently ligated with 8–0 nylon sutures, which are indicated as IPC+MI or MI, respectively. The chest wall was closed, and the rats were returned to their cages and fed routinely for 2 weeks.

All rats were killed under anesthesia. Rats in IPC and sham groups were killed at 0, 6, 12 or 24 h after the procedure (n=14 for each time point). Blood samples (3 mL) were collected in BD EDTA anticoagulant tubes from the abdominal aorta. The tubes were centrifuged at 3000 g for 10 min at room temperature, and plasma samples for 10 min at room temperature, and plasma samples were frozen as quickly as possible at −80°C for storage. APN, AdipoR1 and AdipoR2 in the rat heart. Specific siRNAs were designed using Block-iT RNAi Designer and chemically modified by the manufacturer (Invitrogen). A scramble Stealth RNAi duplex (Cat. No. 45-2001, Invitrogen) served as a negative control. Briefly, rats were anesthetized with 1% pentobarbital sodium, and their heart was exposed via a left thoracotomy at the fifth intercostal space. According to a previously described method (Sugano et al. 2005), 200 µL of siRNA solution (20 µmol/L) at a final dosage of 0.5 µg/g and in vivo jetPEI (Polyplus-transfection, Bioparc, France) (ratio: 8 µL/50 µg siRNA) were delivered via intramyocardial injections at three symmetrical points following two sides of the anterior descending branch to avoid injecting heart chambers or the artery lumen as described previously (Zheng et al. 2006). Successful injection was confirmed by a local swollen and pale myocardium. Rats were processed for further sham operation, IPC or IPC+MI protocols after the exposure period (n=8 in each group).

gAd injection

Ten minutes before MI, human recombinant gAd (4 µg/g; Sigma) was administered intraperitoneally to anesthetized IPC rats, and saline was administrated to rats as the control group (n=8 in each group). It has been previously reported that no human APN is detected before gAd administration, intraperitoneally administered gAd (2 µg/g) is partially absorbed and human APN is detected at 10, 60 and 120 min after injection (Ling et al. 2007).

Determination of cardiac functions and the MI size

After inducing anesthesia by intraperitoneal injection of 1% pentobarbital sodium, the heart rate of the rat was kept at 350–400 beats/min, and cardiac functions were determined via echocardiography (Vivid E9, GE Healthcare) by evaluating the left ventricular ejection fraction (LVEF%) and fractional shortening (FS%) at 14 days after MI. FS% and LVEF% were acquired by measuring the average left ventricular end-diastolic diameter (LVDd) and left ventricular end-systolic diameter (LVEd) for three cardiac cycles by the formula FS(%)=((LVDd−LVEd)/LVDd)×100%, and LVEF (%)=((LVEd−LVDs)/LVDd)×100%.

After completing the functional determinations, the hearts were harvested and stained. Briefly, the left ventricle was sectioned into six equal transverse slices starting from the apex to base. Sections at the level of the midpapillary muscle were prepared at 6 µm thicknesses and stained with hematoxylin and eosin and aldehyde fuchsin Gomori’s trichrome. The myocardial infarction size was scored using the Universal Image-1 video.
image analyzer system and expressed as a percentage of the total left ventricular myocardial area as described previously (Zheng et al. 2006). After staining, the infarcted myocardium is blue because of replacement by collagen fibers, whereas normal myocardium is reddish.

Quantitative real-time PCR analysis
Total RNA was extracted from rat hearts using TRIzol (Life Technologies) according to the manufacturer’s instructions. The RNA concentration was determined by the absorbance at 260 and 280 nm. Total RNA was reverse transcribed into cDNA using a PrimeScript RT-PCR Kit (Takara Bio). Primers were designed as follows: 5'-AATCCCTGGCCAGTCTGAAGG-3' and 5'-CTCAGGAGTGCCTATCTCT-3' for rat APN; 5'-CCCTCACCCAGGAAATC-3' and 5'-GCTCTGGCTGCTAAGCCTGAG-3' for rat glyceraldehyde-3-phosphate dehydrogenase (GAPDH). Real-time PCR amplification was performed using SYBR Premix Ex Taq (Perfect Real Time) (Takara Bio). The reactions were carried out at 94°C for 3 min, followed by 35 cycles at 94°C for 30 s, 54–62°C for 30 s and 72°C for 30 s, and finally 72°C for 10 min (PRISM 7300, Applied Biosystems). Expression of APN was normalized to GAPDH expression. Relative expression was determined using the 2^−ΔΔCt method.

Western blot analysis
Frozen tissues (100 mg) from each sample were homogenized for 10 min with tissue protein lysis buffer (Beyotime Institute of Biotechnology, Haimen, China) using a homogenizer, chilled on ice for 30 min, and then centrifuged at 10,000 g for 5 min at 4°C. The protein concentration was determined using the BIO-RAD protein assay (Bio-Rad, Hercules, CA, USA). Protein samples were diluted each sample 1000-fold in the diluent provided by the manufacturer. The APN concentration was then measured at 450 nm. The lowest detectable limit of the APN concentration was 0.004 ng/mL according to the manufacturer, and the coefficient of variation was <10%. To measure circulating APN in plasma, we diluted each sample 1000-fold in the diluent provided by the manufacturer. The APN concentration was then determined according to the manufacturer’s instructions.

Immunohistochemistry
Consecutive frozen sections of heart were immunostained with an anti-APN antibody (Abcam plc) to examine APN expression at 24 h after IPC. Six rat heart sections 3–4 µm in thickness were analyzed in each group. Sections were examined by blinded analysis (Edelberg et al. 2002). The mean density of APN expression in the ischemic myocardium was analyzed by IPP 6.0 software (Zheng et al. 2006).

Quantification of the plasma APN concentration
Plasma APN levels were measured using an enzyme-linked immunosorbent assay (ELISA) for total rat APN (Rat Total Adiponectin ELISA kit; R&D Systems). Optical density was measured at 450 nm. The lowest detectable limit of the APN concentration was 0.004 ng/mL according to the manufacturer, and the coefficient of variation was <10%. To measure circulating APN in plasma, we diluted each sample 1000-fold in the diluent provided by the manufacturer. The APN concentration was then determined according to the manufacturer’s instructions.

Statistical analysis
All continuous data are presented as the mean ± standard error of the mean (S.E.M.). The protein band density was normalized to the corresponding loading control and then to the mean of the corresponding control group. One-way analysis of variance was used to compare more than two groups. The Student’s t-test was used to analyze differences between two groups. Statistical analysis was performed using GraphPad Prism 5.0 (GraphPad Software). P <0.05 was considered as statistically significant.

Results
IPC ameliorates myocardial ischemic injury and increases cardiac-derived APN and plasma APN levels
Similar to our previous study (Wang et al. 2010a), we again verified the cardioprotective effects of IPC and the increased level of APN in myocardium and plasma regulated by IPC. To determine the cardioprotective effects,
we evaluated cardiac functions by echocardiography (LVEF% and FS%) and determined the myocardial infarct size at 14 days after permanent ligation of the LAD. IPC significantly enhanced the survival of MI rats by 60%. IPC-treated hearts had better cardiac functions than the control MI group (increases in LVEF% and FS%) and a reduced infarct size (data shown in Supplementary material, see section on supplementary data given at the end of this article). Next, we detected the mRNA and protein levels of cardiac APN and the plasma APN concentration. Similar to our previous results, the expression of APN induced by IPC in the ischemic tissue was greatly upregulated at 6 h, peaked at 12 h and decreased at 24 h. Plasma APN levels increased at 6 h after IPC and reached their peak at 24 h after IPC (data shown in Supplementary material). Therefore, we confirmed the findings that cardiac-derived APN was induced and plasma APN levels had increased after IPC.

Cardioprotective effects of IPC are partially mediated by increasing APN expression

IPC exerted cardioprotective effects along with increased APN levels. Therefore, we delineated the potential causative relationship between IPC-induced APN upregulation and the resultant cardioprotective effects. To this end, we first knocked down APN levels in the heart in vivo by cardiac microinjection of siRNA. The APN protein level was downregulated to 60% at 24 h compared with scramble siRNA and the control IPC group (Fig. 1A and B), indicating the feasibility of the method.

After decreasing the expression of APN by intramyocardial siRNA delivery, we analyzed the protective effect of IPC on MI. Compared with the control group, the delivery of APN siRNA greatly abolished the protective effect of IPC against MI. The myocardial infarct size was larger with APN siRNA after IPC than that with scramble siRNA (Fig. 1C and D, 30.17 ± 1.29% vs 22.35 ± 2.44%, P < 0.05). In agreement with histological observations, the elevated LVEF% and FS% by preconditioning were ameliorated by cardiac APN silencing to a level comparable to wild-type hearts (LVEF%, 45.11 ± 3.14% vs 56.89 ± 2.74, P < 0.05; FS%, 18.64 ± 1.60 vs 24.40 ± 1.76, P < 0.05) (Fig. 1E, F and G), with significant changes in other cardiac structural parameters (Table 1). Unsurprisingly, infusing exogenous human recombinant gAd significantly improved cardiac functions and reduced the infarct size compared with the vehicle (Fig. 2A, B, C, D and E). These data showed that the cardioprotective effects of IPC are weakened by cardiac APN silencing and strengthened by exogenous gAd administration, indicating that its effects are partially mediated by APN.
### Table 1: Cardiac functional and structural parameters using echocardiography.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Sham</th>
<th>MI</th>
<th>MI + IPC</th>
<th>APN KD + IPC + MI</th>
<th>NC</th>
<th>APN KD</th>
<th>gAd + IPC + MI</th>
<th>gAd</th>
<th>AdipoRs KD + IPC + MI</th>
<th>NC</th>
<th>AdipoRs KD</th>
<th>KD + gAd</th>
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<tr>
<td>LVESD (mm)</td>
<td>3.98 ± 0.22</td>
<td>6.73 ± 0.22*</td>
<td>5.69 ± 0.23**</td>
<td>5.38 ± 0.21</td>
<td>6.75 ± 0.32*</td>
<td>0.89 ± 0.10</td>
<td>1.16 ± 0.12*</td>
<td>1.25 ± 0.18</td>
<td>1.38 ± 0.09*</td>
<td>1.25 ± 0.09</td>
<td>0.94 ± 0.10*</td>
<td>1.08 ± 0.05*</td>
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<tr>
<td>IVSTd (mm)</td>
<td>0.28 ± 0.10</td>
<td>0.38 ± 0.10*</td>
<td>0.34 ± 0.10**</td>
<td>0.29 ± 0.10</td>
<td>0.41 ± 0.10**</td>
<td>0.29 ± 0.10</td>
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<tr>
<td>LVPWTd (mm)</td>
<td>2.29 ± 0.09</td>
<td>2.53 ± 0.13</td>
<td>2.44 ± 0.07</td>
<td>2.61 ± 0.13</td>
<td>2.43 ± 0.09</td>
<td>2.38 ± 0.18</td>
<td>2.55 ± 0.17</td>
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<td>LVFS (%)</td>
<td>73.50 ± 1.62</td>
<td>45.36 ± 2.46*</td>
<td>56.22 ± 2.57**</td>
<td>56.89 ± 2.74</td>
<td>45.11 ± 3.14*</td>
<td>49.12 ± 4.19</td>
<td>52.42 ± 4.64*</td>
<td>49.12 ± 4.19</td>
<td>52.42 ± 4.64*</td>
<td>49.12 ± 4.19</td>
<td>52.42 ± 4.64*</td>
<td>49.12 ± 4.19</td>
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<tr>
<td>LVFS (%)</td>
<td>32.97 ± 1.28</td>
<td>18.46 ± 1.28*</td>
<td>24.40 ± 1.51**</td>
<td>24.89 ± 1.76</td>
<td>18.46 ± 1.60*</td>
<td>20.83 ± 2.20</td>
<td>29.36 ± 3.18*</td>
<td>20.83 ± 2.20</td>
<td>29.36 ± 3.18*</td>
<td>20.83 ± 2.20</td>
<td>29.36 ± 3.18*</td>
<td>20.83 ± 2.20</td>
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All the measurements were taken 2 weeks after MI. Data are shown as mean ± standard deviation (s.d.). n = 6–12 in each group.

*P < 0.001 vs shamp; **P < 0.05 vs APN KD; #P < 0.05 vs respective NC; *P < 0.05 vs AdipoRs KD.

Adiponectin receptors; APN: adiponectin; gAd: global adiponectin; IPC: ischemic preconditioning; IVSTd: end-diastolic interventricular septal thickness; LVESD: left ventricular end-diastolic diameter; IVFS: left ventricular short-axis fractional shortening; LVEF: left ventricular ejection fraction; LVFS: left ventricular end-systolic fractional shortening; MI, myocardial infarction; NC, negative control.

AdipoR1 and AdipoR2 knockdowns in rats attenuate the cardio-protective effects of IPC

To further investigate the relationship between AdipoR1 and AdipoR2 and IPC delivery, we used a knockdown strategy to ablate the AdipoR1 and AdipoR2 genes in the myocardium in vivo. Intramyocardial AdipoR1 and AdipoR2 knockdown rats showed no significant improvement in infarct size, functional parameters, and contractile function compared with wild-type animals (Figs 3D and 4H). These data suggest that loss of AdipoR1 and AdipoR2 reduces the cardioprotective effect of IPC, reflecting a loss of cardioprotection and reduced LV function.

AdipoR1 and AdipoR2 knockdowns in rats attenuate the cardio-protective effects of IPC

AdipoR1 and AdipoR2 knockdowns in rats attenuate the cardio-protective effects of IPC...
**Figure 2**
The cardioprotective effect of IPC was strengthened by exogenous gAd administration. (A) Representative echocardiography images from gAd administered rats 14 days after MI showed gAd administration improved systolic function of left anterior wall (as arrow indicated). (B) and (C) quantification of echocardiography from gAd administered rats by echocardiography 14 days after MI. (D) Exogenous gAd administration decreased infarct size as demonstrated by representative Masson's trichrome staining of rat hearts with gAd or saline administration. (E) Measurement of cardiac injury (% left ventricular area) in gAd administrated rats. n=6–8 animals/group. *P<0.05 vs saline injected rats.

**Figure 3**
Protective effect of IPC was attenuated in AdipoR1 and AdipoR2 knockdown rats. (A) siRNA targeting AdipoR1 and AdipoR2 were delivered by intramyocardial injection 10min before IPC, the expression of myocardial AdipoR1 and R2 were tested by Western blot. Quantitative analysis of Western blot showed AdipoR1 expression (B) and AdipoR2 expression (C) (*P<0.05 vs WT rats, #P<0.05 vs scramble siRNA). (D) Representative echocardiography images in AdipoRs knock down rats showed the attenuated systolic function of left anterior wall (as arrow indicated), without improvement by gAd administration. (E) and (F) quantification of LVEF and FS from AdipoR knockdown or AdipoR knockdown with gAd administration rats by echocardiography 14 days after MI. (G) and (F) Myocardial infarct size in AdipoRs knockdown rats was showed by Masson's trichrome staining in AdipoR knockdown rats with or without gAd treatment and by quantitative analysis (% left ventricular area). n=6–8 animals/group. *P<0.05 vs scramble siRNA, #P<0.05 vs IPC without siRNA.
Discussion

The beneficial effect of IPC on ischemic injury of cardiomyocytes has long been recognized, although the underlying mechanisms are not fully understood. In the present study, we obtained evidence to support the efficacy of IPC against myocardial ischemic injury and upregulated APN expression induced by IPC, thereby conferring the cardioprotective effects against MI injury. To our knowledge, we have demonstrated for the first time the causative relationship between IPC-induced APN upregulation and consequent cardioprotective effects. These results are consistent with our previous study concerning the induced expression of APN in ischemic myocardium and plasma by IPC and the relationship between APN and cardioprotective effects of IPC (Wang et al. 2010a).

Since 1986 when Murry and coworkers first described the phenomenon of IPC, researchers have paid close attention to its protection against myocardial ischemic injury induced by acute MI or myocardial ischemia/reperfusion injury (Murry et al. 1986). Similar to the results of previous studies (Zheng et al. 2006, Eckle et al. 2008) that evaluated the effects of IPC on heart protection in animal models of MI, we found that the MI size was significantly smaller in IPC rats at 14 days after permanent ligation of the descending coronary artery compared with sham-operated rats. During the past 20 years, many studies have focused on IPC and its mechanisms. Several studies have suggested that the release of endogenous substances during preconditioning episodes plays an essential role in the protective effect of IPC. Adenosine, bradykinin, catecholamine and opioids are some of the substances released locally during IPC, which are of primary importance in mediating cardioprotection (Downey et al. 2005, 2007). Signaling pathways are activated by these factors combining with certain receptors through divergent pathways and activate the downstream signaling pathways of protein kinase C (Saurin et al. 2002, Simkhovich et al. 2013), p38 mitogen-activated protein kinase and AMPK (Lochner et al. 2009). The results of the present study support that APN may be one of the primary substances involved in protection by IPC via activation of the downstream signaling pathways of AMPK through its receptors.

Furthermore, we determined that IPC is responsible for the increased APN levels, thereby exerting cardioprotective effects against MI injury. There are many disputed clinical trials about the relationship between plasma APN levels and myocardial ischemic injury. De Roeck and coworkers found no significant relationship between circulating APN levels and ischemic reperfusion injury (De Roeck et al. 2016). However, most clinical trials show that low plasma APN levels are observed in patients with acute myocardial infarction (AMI), and those with the complication of hypoadiponectinemia are considered as a high-risk population for AMI events (Nakamura et al. 2004, Takashi et al. 2010). In addition, a prospective study has shown that high plasma APN levels are associated with a lower risk of MI (Pischon et al. 2004). In animal studies, APN possesses anti-inflammatory and anti-ischemic properties (Lau et al. 2011) that are significantly downregulated after myocardial ischemia/reperfusion injury (Wang et al. 2010b). APN-knockout mice manifest significantly enlarged infarct sizes and increased apoptosis during myocardial ischemia/reperfusion injury, which can be reversed by exogenous APN administration (Shibata et al. 2005). Although promising as a therapeutic agent for ischemic injury, APN only comprises about 0.01% of all plasma proteins. It would be clinically difficult to increase the concentration of APN by injecting purified protein. Thus far, few studies have reported on the effect of restoring the APN imbalance in animals.
Adiponectin and IPC protection

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dependent change and reached its apogee at 12 h after and its plasma concentration, which exhibited a time-
elevation, upregulated cardiac-derived APN expression 
point upstream of the pathology responsible for APN 
elevation, upregulated cardiac-derived APN expression 
and its plasma concentration, which exhibited a time-
dependent change and reached its apogee at 12 h after 
IPC. Therefore, we present direct evidence that both 
systemically and locally derived APN levels vary after IPC, 
which may protect the heart from ischemic injury.

Previous studies have shown that insulin upregulates APN expression in visceral adipose tissue (Halleux et al. 2001), and the increased APN, once released into plasma, is capable of protecting ischemic hearts (Ouchi et al. 2006). In addition to abdominal fat, studies have suggested that epicardial fat may secrete a high amount of adipokines, mediating their physiological functions partly through a paracrine/autocrine manner. However, Fei and coworkers found that the expression of APN in epicardial fat increases with age, and histology cannot be performed because of the very low availability of epicardial fat tissue (Fei et al. 2010). Similar to their study, the 8-week-old male rats had almost no epicardial fat in our study. Therefore, we did not investigate the physiological effects of APN from epicardial fat. The increased plasma APN after IPC in our study may also partly arise from adipose tissue, which is biologically active to protect the myocardium from ischemic injury. However, the specific role of cardiac-derived APN in mediating ischemic injury after IPC is unknown. To demonstrate that IPC upregulates cardiac-derived APN levels, which subsequently confer cardioprotective effects against MI injury, we performed in vivo siRNA-mediated knockdown of APN and AdipoRs via intramyocardial delivery to knockdown local APN, AdipoR1 and AdipoR2. AdipoR1 is abundantly expressed in skeletal muscle and cardiomyocytes, which has high affinity for globular APN. AdipoR2 is predominantly expressed in the liver and has high affinity for full-length APN. In addition to these receptors, T-cadherin is a putative cell-surface-binding protein for full-length and oligomeric APN. It has been reported that both APN and its receptors are expressed in cardiomyocytes. Because APN-, AdipoR1- or AdipoR2-knockout rats were not commercially available, we used the siRNA-mediated gene silencing technique to knockdown APN and AdipoR expression in the rat heart. The results showed that the cardioprotective effects of IPC were abolished by siRNA-mediated repression of APN and AdipoR expression. Although increased APN levels by gAd treatment directly improved the protective effects in APN-knockdown rats, there were no significant changes in AdipoR-repressed rats, followed by inhibition of AMPK phosphorylation. Therefore, our study has revealed a central role of APN in myocardial IPC to increase myocardial resistance against subsequent ischemic tissue injury and suggests pharmacological strategies for APN activation in the treatment of AMI.

However, there is a major limitation using the siRNA-mediated gene-silencing technique in our study. The siRNA delivery only suppressed APN and AdipoR expression to 60% and 64%, respectively, in knockdown animals, leading to incomplete blockade of APN signaling activation.

In summary, our study provides evidence for a novel mechanism of IPC that may improve the outcomes of ischemic patients. Thus, investigation of APN may provide unique insights into the cardioprotective effects of IPC and might lead to more therapeutic options for ischemic cardiovascular diseases. IPC results in changes in the levels of several circulating factors. Therefore, it will be important to perform further studies in large animals or clinical trials to elucidate the roles and interactions of these various factors in cardiovascular responses to IPC.

Supplementary data
This is linked to the online version of the paper at http://dx.doi.org/10.1530/JME-16-0163.

Declaration of interest
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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