Monocyte Chemoattractant Protein-1 Is an Essential Inflammatory Mediator in Angiotensin II-Induced Progression of Established Atherosclerosis in Hypercholesterolemic Mice

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Objective—Chronic inflammatory processes might be involved in the progression and destabilization of atherosclerotic plaques. Therefore, identification of the mechanism underlying arterial inflammatory function might lead to the development of novel therapeutic strategies. Angiotensin II (AngII) is implicated in atherogenesis by activating the vascular inflammation system, mainly through monocyte chemotaxis. Therefore, we hypothesized that AngII increases plaque size and promotes destabilization of established atheromas by activating the monocyte chemoattractant protein-1 (MCP-1) pathway.

Methods and Results—We report here that 4-week infusion of AngII not only increased plaque size but also induced a destabilization phenotype (ie, increased macrophages and lipids and decreased collagen and smooth muscle cells) of pre-existing atherosclerotic lesions of hypercholesterolemic mice. AngII also enhanced the gene expression of inflammatory cytokines (TNFα, IL-6, etc.) and chemokines (MCP-1, CCR2, etc). Blockade of MCP-1, by transfecting the deletion mutant of the human MCP-1 gene into the skeletal muscles, limited AngII-induced progression and destabilization of established atherosclerotic lesions and suppressed the induction of proinflammatory genes.

Conclusions—These data suggest that MCP-1 functions as a central inflammatory mediator in the AngII-induced progression and changes in plaque composition of established atheroma. (Arterioscler Thromb Vasc Biol. 2004; 24:534-539.)

Key Words: atherosclerosis ■ hypercholesterolemia ■ cell adhesion molecules ■ inflammation ■ gene therapy
which are produced mainly from lesional macrophages, are believed to greatly contribute to destabilization of human atherosclerotic lesions.1 Recently, our group and others have also reported that MCP-1 has a vital role in the initiation and progression of atherosclerotic or arteriosclerotic lesions in experimental animals.17–24 Essential roles of MCP-1 and its interactions with its receptor (CCR2) in AngII-induced arteriosclerosis are shown in CCR2-deficient mice.25 Therefore, we hypothesized that AngII increases plaque size and promotes destabilization of established atherosclerotic lesions by activating MCP-1. To block the MCP-1/CCR2 signal pathway, an N-terminal deletion mutant of the MCP-1 gene (7ND), which lacks the N-terminal amino acids 2 to 8, was transfected into the skeletal muscle.17,18 This mutant MCP-1 binds to its receptor CCR2 and blocks MCP-1–mediated monocyte chemotaxis. In previous studies, we demonstrated that 7ND protein was secreted from the transfected skeletal muscle cells into the circulating blood and subsequently blocked MCP-1–induced chemotaxis in remote organs. Here, we report that AngII infusion into hypercholesterolemic apolipoprotein-E knockout (apoE-KO) mice not only increased plaque size but also promoted atherosclerotic plaque transformation to a more destabilized phenotype, which had more lipid and macrophages and less collagen and fewer smooth muscle cells.1 In addition to the morphological changes, AngII markedly induced gene expression of several important cytokines and chemokines. Blockade of the MCP-1 pathway limited AngII-induced lesion progression and destabilization and suppressed gene expression of proinflammatory factors.

Methods

Experimental Animals
C57BL/6j apoE-KO and wild-type mice, purchased from Jackson Laboratory (Bar Harbor, Me), were bred and maintained in the Laboratory of Animal Experiments at Kyushu University. The study protocol was reviewed and approved by the Committee on the Ethics of Animal Experiments at Kyushu University Graduate School of Medical Sciences. A part of this study was performed at the Kyushu University Station for Collaborative Research and the Morphology Core at Kyushu University School of Medical Sciences.

Expression Vector
7ND was constructed by recombinant polymerase chain reaction using a wild-type human MCP-1 cDNA as the template and cloned into BanHI (5′) and NotI (3′) sites of the pcDNA3 expression vector (Invitrogen).18

Treatment
Male apoE-KO mice were fed a normal chow diet (Oriental Yeast) during the experiment. At age 30 weeks, mice were randomly assigned to 1 of 5 groups. The first group (sham group, n=10) received physiological saline via a subcutaneously implanted osmotic minipump (model 2004; Alzet). The second group (AngII+plasmid group, n=10) received AngII dissolved in saline through the minipump for 4 weeks and intramuscular injections of pcDNA3 plasmid DNA (100 μg) at biweekly intervals. The third group (AngII+7ND group, n=10) received AngII dissolved in saline through the minipump for 4 weeks and AngII receptor blocker (ARB) (olmesartan 7.5 μg/g) in chow. This dose of olmesartan has no effect on AngII-induced increase in arterial pressure.26 The fifth group (sham+7ND group, n=10) received physiological saline and intramuscular injections of pcDNA3–7ND plasmid DNA (100 μg).

In the sham+7ND, AngII+plasmid, and AngII+7ND groups, transgene expression was enhanced by local intramuscular electroporation at the injection site immediately after the injection. Six 100-V, 50-ms electronic pulses were applied to each injection site using an Electroporator CUY21 (BTX).27 The dose of AngII (0.75 mgkg−1d−1) provides a serum level of AngII similar to that reported in patients with renovascular hypertension.28 After 4 weeks of saline or AngII infusion, mice were euthanized after collection of blood from the vena cava.

Tissue Preparation
Tissue preparation was performed essentially as previously described.18 Briefly, after the mice were euthanized, the heart and total aortic segments were rapidly removed after perfusion with phosphate-buffered saline. The total aortic segments (ascending thoracic aorta, arch, descending thoracic aorta, and abdominal aorta) were rapidly frozen in liquid nitrogen for later extraction of RNA. The heart, including the aortic root, was snap-frozen in OCT compound (Tissue-Tek) for histology and immunohistochemistry.

Histology and Immunohistochemistry
Serial cryostat sections (6 μm) of the aortic root were prepared as described.18 In brief, atherosclerotic lesions in the aortic root were examined at 5 locations, each separated by 120 μm, and 5 to 6 serial sections were prepared from each location. Some of these sections were conventionally stained with orcein (for elastic fiber staining) and oil red O (for lipid staining). Intersitial collagens were stained by Picrosirus red (Sigma Chemical, St. Louis, Mo) and photographed under polarization microscopy as described previously.29 The remaining sections were used for immunohistochemical analysis. Air-dried cryostat sections were fixed in acetone and stained with the respective antibody; anti-mouse monocyte/macrophage mononuclear antibodies (MOMA-2; Serotec), anti-alpha-SM actin monoclonal antibodies (alkaline phosphatase conjugated; Sigma Chemical), and anti-human MCP-1, CCR2, MMP-13 polyclonal antibodies (Santa Cruz Biotechnology, Santa Cruz, CA), anti-mouse MMP-9 polyclonal antibodies (Santa Cruz Biotechnology), and anti-rabbit tissue factor monoclonal antibody (American Diagnostica), as described previously.30 Respective nonimmune IgGs (Dako) were used as negative controls. After incubation with the appropriate biotinylated affinity-purified secondary antibodies (Nichirei, Tokyo), the sections were incubated with alkaline phosphatase-labeled streptavidin solution (Nichirei) and visualized using a fast red substrate kit (Nichirei). The sections were then counterstained with Mayer hematoxylin.

A single observer blinded to the experiment protocol performed quantitative analysis of atherosclerotic lesions. All images were captured with a Nikon microscope equipped with a video camera and analyzed using Adobe Photoshop 6.0 and National Institute of Health Image Software. Orcein staining was used to delineate the internal elastic lamina for determination of the intimal area. The lipid composition of the lesion was evaluated by calculating the percent of the oil red O positive area versus the total cross-sectional vessel wall area. Similarly, the percent area of macrophage accumulation (MOMA-2–positive area), alpha-SM actin–positive area, and collagen deposition were estimated. In each case, the average value for 4 or 5 locations for each animal was used for analysis.

RNA Extraction and RNase Protection Assay
Total RNA was extracted from the aorta using the acid guanidinium thiocyanate-phenol-chloroform method (Isogen, Nippon Gene). RNase protection assays were performed with 20 μg of total RNA using a RiboQuant kit with a custom template set according to the manufacturer’s protocol (PharMingen; San Diego, Calif). After RNase digestion, protected probes were resolved on denaturing polyacrylamide gels and quantified using a BASS-3000 system (Fuji Medical Sciences). A part of this study was performed at the Kyushu University Graduate School of Medical Sciences.
The value of each hybridized probe was normalized to that of glyceraldehyde-3-phosphate dehydrogenase (GAPDH) included in each template set as an internal control.

Serum Analysis and Systolic Blood Pressure Determination

Serum total and high-density lipoprotein cholesterol and triacylglycerol concentrations were determined using commercially available kits (Wako). Systolic blood pressure was measured weekly using a tail-cuff system with the mice in a conscious state.

Commercially available ELISA kits (Biosource) were used to measure human MCP-1 and mouse MCP-1 according to manufacturer’s instructions. Plasma 7ND concentrations were measured by the use of this human ELISA kit.

Statistical Analysis

Data were expressed as mean±SEM. Differences between groups were determined using 2-way analysis of variance and a multiple comparison test; P<0.05 was considered to be statistically significant.

Results

7ND Gene Transfer Limits AngII-Induced Progression and Destabilization of Atherosclerotic Lesions

After a 4-week treatment, cross-sections of the aortic sinus region were examined. The sham group had established lesions characteristic of early fibrous plaques containing necrotic cores and a few foam cells covered by a well-formed fibrous cap (Figure 1A), as previously reported.17,30,31 There was a marked increase in the intimal area in the AngII+plasmid group, compared with that observed in the sham and sham+7ND group (Figures 1A and 2). 7ND gene transfer prevented the AngII-induced increase in the intimal area. Treatment with ARB also prevented the AngII-induced enhancement of the intimal area.

We next examined the effects of 7ND gene transfer on AngII-induced changes in plaque composition using immunohistochemical analysis. In particular, lipid deposition, macrophages, smooth muscle cells, and interstitial collagen content were evaluated (Figures 1A and 2). AngII infusion enhanced lipid staining and macrophage staining and attenuated α-SM–positive and collagen–positive areas (Figures 1A and 2). 7ND gene transfer reduced the AngII-induced increases in lipid deposition and macrophage infiltration, and AngII-induced decrease in α-SM actin and collagen (Figures 1A and 2). Treatment with ARB also prevented the AngII-induced changes in lesion composition.

7ND Gene Transfer Attenuates AngII-Induced Upregulation of Cytokine and Chemokine Expression

To explore the mechanisms by which 7ND gene transfer limited progression and destabilization of pre-existing atheromas, we examined gene expression of a number of chemokines, chemokine receptors, and cytokines (Figure 3). RNase protection assay revealed AngII-induced increases in proinflammatory genes. 7ND gene transfer significantly attenuated the increased gene expression of inflammatory cytokines and chemokines (Figure 3).

Because 7ND gene transfer reduced MCP-1 gene expression, immunohistochemical staining for MCP-1 and its receptor (CCR2) was performed (Figure 1B). As expected, AngII infusion increased immunoreactive MCP-1 and CCR2 in the intimal lesions. Incomplete colocalization of MCP-1 and CCR2 suggests that CCR2 expression might increase not only in lesional monocytes but also in activated cells such as vascular smooth muscle cells. 7ND gene transfer reduced the...
AngII-induced increase in immunostaining for MCP-1 and CCR2.

Immunohistochemical staining for MMP and tissue factor were also performed (Figure 1B). AngII infusion increased immunoreactive MMP-9, MMP-13, and tissue factor. 7ND gene transfer reduced the AngII-induced increase in MMP and tissue factor.

**Beneficial Effects of 7ND Gene Transfection Had No Relation With Serum Lipid Levels or Systolic Blood Pressure**

There were no statistically significant differences in serum total cholesterol levels among the groups (sham group, 480±21; AngII+plasmid group, 503±18; AngII+7ND, 488±19; ARB group, 478±22 mg/dL). 7ND gene transfer did not affect AngII-induced increases in systolic blood pressure (sham group, 102±3; AngII+plasmid group, 153±8; AngII+7ND, 157±6; ARB group, 110±8 mm Hg at 4 weeks of treatment).

**7ND Gene Transfer Increases Plasma Concentrations of 7ND**

Concentrations of 7ND and MCP-1 in plasma and transfected muscle were measured. In wild-type mice transfected with 7ND without AngII infusion, 7ND was detected in transfected muscle and plasma 3, 7, and 14 days after transfection (Table). Plasma MCP-1 concentrations did not change during the course of experiments.

**Discussion**

We demonstrated that blockade of MCP-1×7ND gene transfer limited AngII-induced progression of pre-existing advanced atherosclerotic lesions in hypercholesterolemic mice. Because 7ND gene transfer did not affect serum lipid or blood pressure levels, AngII-induced enhancement of atherogenesis must be a direct effect of AngII on cells in the atherosclerotic vascular wall. These data suggest that the essential role of MCP-1 in AngII increases plaque size of the pre-existing atheroma.

A clinically significant finding of the present study is that AngII increased markers of plaque instability. Qualitative changes in plaque are more likely than a decrease in plaque size or the degree of stenosis to contribute greatly to a reduction in cardiovascular events caused by atherothrombotic complications. Lesional macrophages might be a major source of cytokines, MMP, and tissue factor. Increased degradation of interstitial collagen by MMP and decreased cytokine synthesis have been demonstrated in human atherosclerotic lesions prone to rupture.1 Resultant decreases in interstitial collagen might weaken the plaque’s biomechanical strength, which in turn increases the likelihood of plaque rupture.1 Tissue factor regulates plaque’s thrombogenicity.32 MCP-1 increases tissue factor expression and activity in human vascular smooth muscle cells.8 We recently reported that 7ND gene transfer inhibited progression and destabilization of advanced atheroma by reducing inflammation in apoE-KO mice that were not received AngII.24 We demonstrate the preservation of interstitial collagen in the atherosclerotic plaque associated with decreased expression of MMP and tissue factor by 7ND gene transfer. Therefore, MCP-1-induced inflammation appears to be an essential step not only in AngII-induced progression but also in AngII-induced changes in composition of established atheroma.
AngII causes endothelial dysfunction by decreasing nitric oxide synthase activity, mainly through oxidative stress, which in turn results in inflammation in the arterial wall.\textsuperscript{1, 2} We previously demonstrated an increase in tissue Ang-II activity after blockade of nitric oxide synthesis.\textsuperscript{34} In the present study, 7ND gene transfer suppressed AngII-induced increase in MCP-1, CCR2, and other cytokine expression. Because recent data\textsuperscript{1} suggest that lesional inflammatory cells release enzymes such as angiotensin-converting enzyme that generate AngII,\textsuperscript{2, 35, 36} local AngII levels increase as macrophages becomes activated by oxidized LDL.\textsuperscript{35} Our data strongly support the notion that an increased concentration and/or activity of AngII creates a positive-feedback mechanism for further increases in AngII generation, atherogenesis, and atherothrombotic events.

In conclusion, the present data demonstrate the essential role of MCP-1–mediated inflammation in AngII- induced progression of established atheroma in hypercholesterolemic mice. Because the activity and formation of AngII is enhanced at the inflamed human atherosclerotic sites that are prone to rupture, it is reasonable to propose that increased local action of AngII contributes greatly to the process of plaque rupture and subsequent cardiovascular ischemic complications by acting as an inflammatory mediator. Thus, AngII might augment inflammatory functions of atherosclerotic lesions in the presence of risk factors such as hypercholesterolemia. The clinical benefit of angiotensin-converting enzyme inhibitors or AngII receptor blockers might be caused by anti-inflammatory activity.

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