Effect of Reoxygenation on the Electrical Stability of the Rat Heart In Vivo: A Chronobiological Study

P. ŠVORC¹,², A. MAROSSY¹, P. ŠVORC Jr², M. BUŽGA²

¹Department of Physiology, Medical Faculty, Safarik University, Košice, Slovak Republic, ²Department of Physiology, Medical Faculty, Ostrava University, Ostrava, Czech Republic

Received March 1, 2013  
Accepted May 26, 2013

Summary
Reoxygenation following hypoxic episodes can increase the risk for the development of ventricular arrhythmias, which, in addition to circadian aspects of reoxygenation arrhythmias has not been studied extensively. The aim of the present study was to evaluate circadian changes in the electrical stability of the heart during reoxygenation following a hypoventilatory episode. The electrical stability of the heart, defined in the present study as the ventricular arrhythmia threshold (VAT), was measured at 3 h intervals at clock times 09:00, 12:00, 15:00, 18:00, 21:00, 24:00, 03:00, 06:00 and 09:00 during 20 min hypoventilation (20 breaths/min, tidal volume = 0.5 ml/100 g body weight [n=17]) and subsequent 20 min reoxygenation (50 breaths/min, tidal volume = 1 ml/100 g body weight [n=4]) intervals. The experiments were performed using pentobarbital-anesthetized (40 mg/kg intraperitoneally) female Wistar rats that first underwent a four-week adaptation to a 12 h light:12 h dark regimen. Detailed analysis showed that circadian VATs changed to biphasic rhythms at 10 min of hypoventilation. The VAT circadian rhythms were observed immediately following the commencement of reoxygenation, with the highest values measured between 12:00 and 15:00, and the lowest values between 24:00 and 03:00. These results suggest that myocardial vulnerability is dependent on the light:dark cycle and characteristics of pulmonary ventilation.

Key words
Circadian rhythm • Electrical stability of the heart • Rat • Reoxygenation

Introduction
The onset and development of ventricular arrhythmias depend on many factors that are also associated with some disorders of pulmonary ventilation. However, not all previous studies have considered the effect of the resumption of oxygen delivery (i.e., reoxygenation) following hypoxic episodes on the onset or development of ventricular arrhythmias (Svorc and Podlubny 2002, Svorc et al. 2005). Reoxygenation following hypoxic episodes does not automatically normalize electrophysiological and mechanical myocardial properties, which can increase the risk for the onset of reoxygenation arrhythmias (Mubagwa et al. 1997, Shinmura et al. 1997, Guo et al. 2005).

The proarrhythmogenic effect of reoxygenation has been confirmed in previous studies using various agents. Tetrodotoxin (a Na+ channel blocker) and nicorandil (a K ATP channel opener that activates K ATP channels, causing K+ efflux) decreased the occurrence of arrhythmias, probably by decreasing Na+ current or by increasing the ATP-sensitive K+ current, respectively (Hayashi et al. 1996, Hayashida et al. 1996). Thus, nicorandil antagonizes the cellular mechanisms that underly reoxygenation arrhythmias and prevents reoxygenation-induced arrhythmias (Xu et al. 1993). Mitochondrial K ATP channel block is associated with protection from arrhythmogenesis during reoxygenation (Wakatsuki et al. 2009). The duration of reoxygenation arrhythmias was slightly reduced by increases in Mg2+ concentration and enhanced by decreases in Mg2+ concentration; however, this effect was not significantly different from controls. In contrast, low K+ levels led to significant prolongation, while high K+ levels led to

https://doi.org/10.33549/physiolres.932579
significant abbreviation of reoxygenation arrhythmias (Borchard et al. 1997). Ca^{2+} influx, via reverse-mode Na^{+}/Ca^{2+} exchange, has been demonstrated to play a key role in reoxygenation injury in guinea pig papillary muscles (Hayashi 2000, Mukai et al. 2000).

Hypoxia and reoxygenation expose the myocardium to extremes in redox stress, which can result in the initiation of a series of cellular pathways leading to tissue injury and death (Draper and Shah 1997, Kang et al. 2000). Hypoxia and reoxygenation are associated with additional damage to the myocardium through the oxidation of cellular components and activation of the inflammatory cascade (Cerniway et al. 2002). Dworschak et al. (2004) described the potentially harmful effects of accelerated oxygen radical production in association with diminished Ca^{2+} clearance or intracellular Ca^{2+} accumulation during ischemia/reperfusion. These effects may be fatal and result in the generation of reactive oxygen species and subsequent tissue damage (Danielsson et al. 2007). Attenuation of reactive oxygen species production during hypoxia and reoxygenation significantly decreased pulmonary vein arrhythmogenesis and induced various electrophysiological responses in the right and left atria, which may play a role in the pathophysiology of atrial fibrillation (Lin et al. 2012).

Adenosine A1-receptor stimulation facilitates ventricular fibrillation in hearts subjected to hypoxia and reoxygenation (Chi et al. 1994). Indirectly, the inhibition of inducible nitric oxide synthase increases peroxidative and apoptotic activity in the hypoxic heart, indicating that this isoform may have a protective effect against hypoxia/reoxygenation injuries and, furthermore, challenging the conventional wisdom that the production of inducible nitric oxide synthase is deleterious under these conditions (Milano et al. 2010, Rus et al. 2011).

Methods

Ethics approval

The present study was performed in accordance with the Guide for the Care and Use of Laboratory Animals, published by the United States National Institutes of Health (NIH publication number 85-23, revised 1996). The study protocol was also approved by the Ethics Committee of the Medical Faculty of Safarik University (Kosice, Slovak Republic) (permission number 2/05).

Adaptation and anesthesia of animals

Circadian fluctuations in the electrical stability of the heart, measured in the present study according to ventricular arrhythmia threshold (VAT), were examined in female, pentobarbital-anesthetized Wistar rats (40 mg/kg intraperitoneally) that had been adapted to a daily light-dark (LD) cycle of 12 h light:12 h dark (dark period from 18:00 to 06:00) for four weeks. The animals were housed two per cage at a temperature of 24 °C and humidity of 40 % to 60 %, with ad libitum access to food and water.

Anesthesia was maintained at a level at which painful stimuli and surgery did not evoke noticeable motor or cardiovascular responses. On completion of the experiments, the animals were euthanized by cardiac administration of an overdose of pentobarbital.

Experimental protocol

The animals were randomly divided into two groups. Group 1 (normoxic group) was ventilated using normal parameters of artificial ventilation (50 breaths/min, tidal volume = 1 ml/100 g body weight [n=17]) and group 2 (hypo-reoxy) underwent 20 min hypoventilation (20 breaths/min, tidal volume = 0.5 ml/100 g body weight [n=4]) followed by 20 min reoxygenation at parameters of artificial normal ventilation.

The electrical stability of the heart was defined by VAT, which was measured directly through the electrical stimulation of the right ventricle during open chest experiments. VAT measurements were performed...
at 3 h intervals at clock times of approximately 09:00, 12:00, 15:00, 18:00, 21:00, 24:00, 03:00, 06:00 and 09:00, while the rat was supine. The VAT measurements were performed at a temperature equivalent to the rectal temperature of the animal, which was measured before administration of the anesthetic agent. The body temperature of the animals was maintained using an infrared heat lamp.

Measurement of VAT

VAT was estimated as the minimal amount of electrical current (in mA) required to elicit a ventricular arrhythmia. The stimulating electrodes (1 mm in diameter; 5 mm interelectrode distance) were fixed at the base of the right ventricle while the animal was supine. Cardiac stimulation (using rectangular pulses with a frequency of 30 Hz, impulse length of 10 ms and duration of stimulation of 400 ms) was triggered by the initial pulse of the R wave. The current intensity was progressively increased in increments of 0.2 mA until ventricular arrhythmias were elicited. The parameters used for stimulation were chosen so that at least one impulse was applied during the vulnerable period, provided the duration of the stimulation covered a minimum of two to three heart cycles. The ventricular arrhythmias were of mixed type, with spontaneous mutual transitions among ventricular fibrillation, ventricular tachycardia and flutter, and were comparable between the two groups.

Statistical analyses

Results are expressed as mean ± SD. The basic circadian parameters were assessed using single and population mean cosinor tests. The data were obtained from experiments that were conducted over the seasons because circannual variation can also occur in the parameters that were examined.

Results

In the normoxic group, the acrophase of the significant VAT circadian rhythm was $-338^\circ$ (95% CI $-288^\circ$ to $-7^\circ$) at 22:53 (95% CI 19:20 to 00:28), with mesor 2.59±0.53 mA and amplitude 0.33±0.11 mA (Fig. 1).

In the hypo-reoxy group, more detailed analysis of changes in circadian VAT after 5 min, 10 min, 15 min and 20 min of hypoventilation showed that the acrophases from 10 min, 15 min and 20 min of hypoventilation were nonsignificantly shifted compared with 5 min of hypoventilation (Table 1). The characteristic biphasic course of the VAT circadian rhythms was apparent only after 10 min of hypoventilation (Fig. 2). An inverse course of VAT circadian rhythms were observed immediately following the commencement of reoxygenation with the highest values measured between 12:00 and 15:00, and the lowest values between 24:00 and 03:00 compared to normoxic group. Mesor was decreased (1.41 mA), amplitude was increased (0.57 mA) and acrophase was $-165\pm20^\circ$ (11:29±1:09) (Fig. 1).

Discussion

The aim of the present study was to analyze circadian rhythms of VAT under conditions of reoxygenation following a period of hypventilation. Hypoventilation and recovery of pulmonary ventilation produce different myocardial responses to electrical stimulation of the heart in individual animals.
Study limitations can be the absence of data regarding VAT parameters in nonanesthetized animals and the LD dependence of VAT parameters represented a limitation of the present study. These data, however, are also lacking in the literature. In addition, there was a relatively large dispersion of the values measured in the present study. VAT values revealed intra- and interindividual variability, which is an issue inherent to in vivo studies. The discrepancies can be explained by spontaneous, unpredictable alterations in the electrophysiological properties of the heart induced by anesthesia, or hormonal and homeostatic reflexes in the animals.

As mentioned above, changes in myocardial vulnerability depend primarily on changes in ion concentrations or on the activity of ion-exchange systems; LD differences in the electrical stability of the heart may also directly reflect LD differences in these systems. In hypoxia/reoxygenation or ischemia/reperfusion models, more studies have described myocardial Ca²⁺ accumulation. Ca²⁺ overload in myocytes is one of the many causes of reperfusion injury (Mubagwa et al. 1997, Shinmura et al. 1997, Sharikabad et al. 2000). It was hypothesized that the delay after depolarization, which produces the substrate for the genesis of serious ventricular dysrhythmias (i.e., Ca²⁺-mediated, non re-entry arrhythmias), is the result of such Ca²⁺ overload (Whalley et al. 1995). Sharikabad et al. (2000) described unchanged intracellular concentrations of Ca²⁺ ions during hypoxia; however, intracellular concentrations of Ca²⁺ ions were three to four times higher during reoxygenation in isolated rat hearts. During reoxygenation of hypoxic rat cardiomyocytes, a correlation exists between extracellular Ca²⁺ concentration and the levels of reactive oxygen species (the second factor involved in ischemia/reperfusion-induced cardiomyocyte damage), whereas the correlation between intracellular Ca²⁺

| Table 1. Parameters of ventricular arrhythmia threshold circadian rhythms in single intervals of measurement in a rat model of hypoventilation/reoxygenation. |
|---------------------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
| Initial hypoventilation         | 5 min | 10 min | 15 min | 20 min | Mesor  | 1.32±0.1  | 1.17±0.2  | 0.15±0.2  | 0.12±0.1  | 1.41±0.1  | 1.41±0.1  | 1.29±0.1  | 1.42±0.1  |
| Amplitude                        | 0.33±0.2  | 0.33±0.2  | 0.35±0.2  | 0.20±0.2  | 0.41±0.2  | 0.48±0.1  | 0.37±0.2  | 0.53±0.1  |
| Acrophase                        | Degrees | −356±25  | −11±37  | −36±30  | −30±58  | −166±24  | −165±17  | −172±29  | −156±10  |
| Acrophase                        | Hours  | 23:50±1.40  | 00:44±2.28  | 02:24±2.00  | 02:50±2.32  | 11:04±1.36  | 11:00±1.08  | 11:28±1.56  | 10:24±0.4  |

Data presented as mean ± SD

Fig. 2. Circadian rhythms of the VAT from the hypoventilation/reoxygenation model in order after 5 min, 10 min, 15 min and 20 min of the respective ventilation. A: Initial hypoventilation. B: Subsequent reoxygenation. The black bar on the x-axis indicates the dark period of the rat light-dark cycle.
concentration and the level of reactive oxygen species is less consistent. These results indicate that the levels of reactive oxygen species during oxidative stress are at least partly dependent on extracellular Ca\(^{2+}\) concentration; however, reactive oxygen species (e.g., H\(_2\)O\(_2\)) can increase or decrease cardiomyocyte Ca\(^{2+}\) accumulation during reoxygenation in a concentration-dependent manner (Sharikabad et al. 2004). Decreases in intracellular pH may also play a role in the mechanism of myocardial damage during reoxygenation. This decrease is mediated, at least in part, by anion exchange stimulation (Cl\(^{-}/\)HCO\(_3\)^{−} exchange) through protein kinase C activation. This exchange occurs in reoxygenation-induced Ca\(^{2+}\) overload as well as contractile dysfunction (Kawasaki et al. 2001). Decreases in the electrical stability of the heart can also be the result of cellular K\(^{+}\) loss during hypoxia (Shivkumar et al. 1997). Hypoxia significantly decreases the duration of action potentials, probably through the activation of K\(_{ATP}\) channels and increased K\(^{+}\) ion efflux (Perchenet and Kreher 1995). The inhibition of outward K\(^{+}\) currents demonstrated a cardioprotective effect during reperfusion (Liu et al. 1993, Tosaki et al. 1996). Increases in the intracellular concentration of Na\(^{+}\) ions in myocardial cells and Ca\(^{2+}\) overload can contribute to the onset of reoxygenation arrhythmias (Kamiyama et al. 1996, Shinmura et al. 1997).

Hypoxia likely increases vulnerability to reoxygenation damage by reducing antioxidant reserve capacity. Reoxygenation, either by ventilator or cardiopulmonary bypass, produces oxidative damage with resultant functional depression (Ihnken et al. 1995).

Two important and unanswered questions remain: Are the mechanisms responsible for the altered circadian rhythm of myocardial vulnerability mobilized primarily by hypoventilation-induced systemic asphyxia and reoxygenation, with an additive effect of the LD cycle, or are they mobilized by oscillating factors in circadian dependence, with an additive effect of hypoventilation/reoxygenation? The observed changes in the electrical stability of the heart at the change of pulmonary ventilation reflect circadian fluctuations and significant dependence on the LD cycle also in pentobarbital-anesthetized rats. It affirms that LD differences in myocardial vulnerability are not only transient events or events that are dependent on experimental methods. Rather, it is a systemic response regulated by different neurohumoral pathways in the dark (active) and in the light (nonactive) part of the day. From a clinical perspective, synchronization to local time may also be an important factor in the evaluation of cardiovascular risk in patients with various respiratory disorders.

**Conflict of Interest**

There is no conflict of interest.

**References**


