Inhaled nitric oxide (iNO) is approved by the Food and Drug Administration for the treatment of persistent pulmonary hypertension of the newborn, largely as a result of the pioneering research efforts of Warren Zapol. Inhaled nitric oxide (NO) dilates pulmonary resistance vessels to improve ventilation-perfusion matching before being inactivated by reactions with hemoglobin (Hb) in blood exiting the lung. Inhaled NO therefore is a selective pulmonary vasodilator.1 Notwithstanding the validity of this model, investigators including Claes Frostell2 and David Wessel3 noted early on that high therapeutic doses of iNO led to subtle decreases in blood pressure. It had recently been discovered that albumin could be S-nitrosylated by NO,4 endowing it with long-lived vasodilatory activity. So, when presented with the quandary of systemic effects, it was quickly demonstrated that iNO could S-nitrosylate plasma proteins,5 potentially providing systemic vasodilatory activity6 and thus acting in an endocrine-like manner. S-nitrosoalbumin since has been implicated in protection by iNO against reperfusion injury in systemic vessels,7,8 but also may form within airways of iNO-treated patients,5,9 potentially contributing to “pulmonary selectivity.” In subsequent studies, the family of circulating S-nitrosylated proteins (SNO-proteins) was expanded to include S-nitrosohemoglobin (SNO-Hb),10 which exhibits the remarkable ability to mediate hypoxic vasodilation,11 the selective vasodilation in proportion to degree of hypoxemia. A number of recent studies have provided evidence that iNO may utilize SNO-based pathways12 to confer protection against ischemic insults13–18—not more remarkable than the report by Terpolilli et al19 in this issue of Circulation Research, which illustrates beautifully in cerebral vessels the principles of endocrine NO bioactivity and hypoxia-coupled delivery of NO bioactivity. Their demonstration that iNO promotes dilation of cerebral resistance vessels selectively in hypoperfused tissue, without changes in systemic blood pressure, points to new strategies to ameliorate damage after ischemic insult.20

The opinions expressed in this article are not necessarily those of the editors or of the American Heart Association.

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Circulation Research is available at http://circres.ahajournals.org
DOI: 10.1161/CIRCRESAHA.111.263996
Also delivered to the brain29). One interpretation of these data is that SNOs in the lung may be viewed as part of an integrated system in which the relationship between SNOs in the lung (endogenously or from exogenously administered NO as in the present study) and in other tissues (eg, skeletal muscle). The delivery of vasoregulatory SNO-based bioactivity to peripheral sites, including the brain, may be described as a set of equilibria whereby SNO generation at a site of origin is coupled to the release of bioactivity in tissues. Release of SNO-based bioactivity may be regulated by a number of physiological stimuli, and the response to hypoxic stimulation is conveyed primarily by SNO-Hb.

Low yields of these reactions aside, there is still something notable about the fact that increasing SNO levels in the lungs results in increased SNO levels in the brain19 (this property is not unique to NO bioactivity generated in the NO molecule picked up in the lung is the same as that of S-nitrosylation–based signaling in transducing ambient O2 signals in both anemic and hypoxic conditions.38,39 Taken together, these observations emphasize that O2 delivery within the respiratory cycle is a function of both O2 content of blood (Hb O2 saturation) and blood flow (tissue perfusion, regulated by SNO-Hb). Current efforts in medicine to improve O2 delivery are focused on O2 content of blood without consideration of O2 delivery is required for physiological signaling on short time scales—in effect, a “bucket brigade” whereby an incoming NO group at one end displaces an NO group at the other end, by analogy to the flow of electrons in conducting wires or the movement of protons in water. Thus, there would be no requirement that the NO molecule picked up in the lung is the same as that delivered in the tissue.

Misconceptions surrounding the possible role and function of nitrite merit comment. Nitrite is relatively inert, being orders of magnitude less potent as a vasodilator than SNOs. Nitrite at concentrations observed in the circulation under normal physiological conditions—and in the amounts observed after administration of iNO in this study—does not appear to exert biological activity in its own right.25 Claims of nitrite-induced vasodilation under physiological (as opposed to pharmacological) conditions are not well-justified, and although the case for nitrite in NO-based signaling under ischemic conditions may be stronger on both empirical and mechanistic grounds, ischemic enhancement of the vasoactive potency of nitrite is inevitably commensurate with production of SNOs. Indeed, in cells and tissues, nitrite-forming reactions will almost always produce SNOs and the generation of NO bioactivity from nitrite will almost inevitably involve SNOs.15,23,30 Thus, the evidence for an alternative nitrite-based but SNO-independent mechanism of hypoxic vasoregulation in ischemia is, at best, circumstantial and the notion that nitrite may operate independently of SNOs is difficult to sustain.25 In addition, nitrite-based vasodilatory activity often is claimed to involve a nitrite reductase activity of Hb or xanthine oxidase, which reduces nitrite to NO.19 However, the available data would seem to rule out a role for a nitrite reductase activity of Hb in vasodilation,25,31 and xanthine oxidase evidently exerts a vasoconstrictive rather than vasodilatory influence in humans.2,23 With the exception of the SNO synthesis function of Hb,21 an enzymatic activity that may promote the vasodilatory activity of iNO remains to be identified.

Measurements of NO bioactivity in the blood of Tibetans show that levels of SNO-Hb are markedly increased compared with those of sea-level dwellers, commensurate with increases in peripheral blood flow.24 Additional potential benefits of SNO-Hb include roles in ventilation–perfusion matching in the lung and the centrally mediated hypoxic respiratory drive.21 Notably, SNO-Hb levels increase in normal subjects acclimatizing to high altitude, and levels of both Hb and SNO-Hb predict distance walked at 6 minutes.25 Human blood gas measurements show that O2 content (O2 saturation) of Hb is intimately linked to its SNO content,36,37 and recent studies highlight the centrality of S-nitrosylation–based signaling in transducing ambient O2 signals in both anemic and hypoxic conditions.38,39 Taken together, these observations emphasize that O2 delivery within the respiratory cycle is a function of both O2 content of blood (Hb O2 saturation) and blood flow (tissue perfusion, regulated by SNO-Hb). Current efforts in medicine to improve O2 delivery are focused on O2 content of blood without consideration of SNO bioactivity. In contrast, the findings of Terpolilli et al19 suggest therapeutic opportunities for iNO operating through SNO-based mechanisms, particularly in the setting of cerebral ischemia. As important, their findings point to the importance of developing new strategies that more effectively manipulate NO-based vasoactivity through SNO-based pathways.

Sources of Funding
Supported by National Institutes of Health grants R01HL059130, R01HL095463, R01HL091876, P01HL75443 and by DARPA N66001-10-C-2015.

Disclosures
J.S.S. has a financial interest in N30 Pharma, Adamas Pharma, Life Health, and Vindica Pharm. J.D.R. has a financial interest in N30 Pharma.
Acknowledgments
The authors acknowledge Dr Irwin Fridovich for thoughtful comments and discussion.

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Endocrine Nitric Oxide Bioactivity and Hypoxic Vasodilation by Inhaled Nitric Oxide
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doi: 10.1161/CIRCRESAHA.111.263996

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