**K\textsubscript{ATP} Channels and Cardiovascular Disease**

**Suddenly a Syndrome**

Colin G. Nichols, Gautam K. Singh, Dorothy K. Grange

**Abstract:** ATP-sensitive potassium (K\textsubscript{ATP}) channels were first discovered in the heart 30 years ago. Reconstitution of KATP channel activity by coexpression of members of the pore-forming inward rectifier gene family (Kir6.1, KCNJ8, and Kir6.2 KCNJ11) with sulfonylurea receptors (SUR1, ABCC8, and SUR2, ABCC9) of the ABCC protein subfamily has led to the elucidation of many details of channel gating and pore properties. In addition, the essential roles of Kir6.x and SURx subunits in generating cardiac and vascular KATP and the detrimental consequences of genetic deletions or mutations in mice have been recognized. However, despite this extensive body of knowledge, there has been a paucity of defined roles of KATP subunits in human cardiovascular diseases, although there are reports of association of a single Kir6.1 variant with the J-wave syndrome in the ECG, and 2 isolated studies have reported association of loss of function mutations in SUR2 with atrial fibrillation and heart failure. Two new studies convincingly demonstrate that mutations in the SUR2 gene are associated with Cantu syndrome, a complex multi-organ disorder characterized by hypertrichosis, craniofacial dysmorphology, osteochondrodysplasia, patent ductus arteriosus, cardiomegaly, pericardial effusion, and lymphoedema. This realization of previously unconsidered consequences provides significant insight into the roles of the KATP channel in the cardiovascular system and suggests novel therapeutic possibilities. (Circ Res. 2013;112:1059-1072.)

**Key Words:** arrhythmias, cardiac Cantu syndrome edema Kir6.1 protein, human Kir6.2 channel SUR2 receptor, human vasodilation

**K\textsubscript{ATP} Channel Structure and Molecular Regulation**

Canonical ATP-sensitive potassium (K\textsubscript{ATP}) channels are heterooctameric complexes of pore-forming Kir6 channel-forming subunits associated with regulatory SUR subunits, members of the ATP binding cassette (ABC) family of membrane proteins (Figure). Two Kir6-encoding genes, KCNJ8 (Kir6.1) and KCNJ11 (Kir6.2), and 2 SUR genes, ABCC8 (SUR1) and ABCC9 (SUR2), encode mammalian K\textsubscript{ATP} subunits, but alternative RNA splicing can give rise to multiple SUR protein variants (eg, SUR2A and SUR2B) that confer distinct physiological and pharmacological properties on the channel complex. Interestingly (Figure C), the genes for Kir6.2 and SUR1 are located next to each other on human chromosome 11p15.1, suggesting an as yet unconsidered coregulation at the gene level. In addition, the genes for Kir6.1 and SUR2 are also adjacent to one another on chromosome 12p12.1, implicating an evolutionary duplication. In heterologous expression systems, both Kir6.2 and SUR1 subunits coassemble in a 4:4 stoichiometry to generate functional K\textsubscript{ATP} channels. Similarly, biochemical studies demonstrate that the SUR2 protein variants, SUR2A and SUR2B, can also coassemble with Kir6 subunits, presumably in a similar octameric arrangement.

Crystallographic studies of bacterial and eukaryotic Kir channels demonstrate a conserved architecture of Kir channels with 2 transmembrane helices (M1, M2) bridged by an extracellular loop that generates the narrow portion of the pore and controls ion selectivity (Figure A). As with other ABCC family members, SURs contain 2 6-helix transmembrane domains, TMD1 and TMD2, but SURs also have an additional N-terminal TMD0 domain consisting of 5 transmembrane helices (Figure A), critical for Kir6.x trafficking and gating. SURs also contain one nucleotide binding fold (NBF1) between TMD1 and TMD2, and a second NBF (NBF2) after TMD2 in the cytoplasmic loops (Figure A). NBFs from bacterial ABC proteins crystallize as head-to-tail dimers, and this is likely the functional arrangement between NBF1 and NBF2 in SUR (Figure B). How the Kir6 and SUR subunits are physically connected remains unknown, but electron micrography and intersubunit fluorescence resonance energy transfer studies of complete K\textsubscript{ATP} complexes suggest an intimate packing of 4 SUR and 4 Kir6.x subunits (Figure A).

The key regulatory features of K\textsubscript{ATP} channels are rapid and reversible closure by cytoplasmic ATP and activation by...
channels in these cell types do respond to the relatively SUR2-specific openers cromakalim and pinacidil, suggesting a major role for SUR2 in nodal K\textsubscript{ATP} channels.\textsuperscript{36–38}

**Smooth Muscle Myocytes**

K\textsubscript{ATP} channel density is relatively low in vascular smooth muscle (VSM) compared with cardiac myocytes\textsuperscript{40,41} and the biophysical and the pharmacological properties are quite variable, reflecting variable expression of K\textsubscript{ATP} subtypes in vascular beds.\textsuperscript{42–49} There is considerable variation in reported single channel conductances,\textsuperscript{45,46,50–54} although low-conductance channels (unitary conductances from 20–50 pS) may represent the predominant K\textsubscript{ATP} channel subtype, with a more limited distribution of medium-conductance and high-conductance K\textsubscript{ATP} channels (50–70 pS and >200 pS, respectively).\textsuperscript{55} Importantly, and unlike classic K\textsubscript{ATP} channels of the heart,\textsuperscript{56} or pancreas,\textsuperscript{57} the predominant VSM K\textsubscript{ATP} conductances are inactive in isolated membrane patches and require nucleotide diphosphates (ADP, UDP, GDP) in the presence of Mg\textsuperscript{2+} to open, leading to their functional designation as nucleotide-dependent K\textsuperscript{+}-channels, or K\textsubscript{NDP} channels.\textsuperscript{47,48,53}

Heterologously expressed Kir6.1/SUR2B channels recapitulate many of these biophysical properties of native VSM K\textsubscript{ATP}/K\textsubscript{NDP}.\textsuperscript{14,56–62} A subpopulation of VSM K\textsubscript{ATP} in portal vein exhibits spontaneous activity in excised membrane patches and displays high sensitivity to inhibitory ATP (K\textsubscript{1/2 ATP} = \approx 20 \mu M), and higher unitary conductance, reminiscent of Kir6.2/SUR2A-dependent K\textsubscript{ATP} channels.\textsuperscript{3,47,34,63} Thus, the Kir6.1/SUR2B channel may represent the predominant VSM K\textsubscript{ATP} but other subtypes are also likely to be expressed in specific vascular beds, separately or in combination with Kir6.1/ SUR2B subunits\textsuperscript{53} (Figure D).

**Vascular Endothelium**

K\textsubscript{ATP} channels are also present in vascular endothelium\textsuperscript{64} and, by regulating endothelial electric activity, they may affect release of vasoactive agents that, in turn, modulate smooth muscle function. Activation by potassium channel openers (KCOs) and inhibition by glibenclamide have been demonstrated in coronary endothelium\textsuperscript{65} and in aortic endothelial cells.\textsuperscript{66,67} The molecular composition of endothelial K\textsubscript{ATP} channels remains largely unknown, but the presence of Kir6.1, Kir6.2, and SUR2B mRNA in guinea pig\textsuperscript{68} and in human coronary artery endothelial cells\textsuperscript{69} suggests that all 3 subunits may be involved in channel generation in these cells.

**Mitochondrial K\textsubscript{ATP}**

A K\textsuperscript{+}-selective, small conductance channel was first identified in rat liver mitochondria\textsuperscript{70} and was reported to be reversibly inhibited by application of ATP, glibenclamide, and 4-aminopyridine (4-AP). These mitoK\textsubscript{ATP} channels were inhibited by acyl-CoA and activated by GTP, GDP, and diazoxide.\textsuperscript{70,71} The pharmacology of heterologously expressed SUR1/Kir6.1 complexes appears to most closely resemble such properties,\textsuperscript{71,73} yet mitoK\textsubscript{ATP} function is apparently unaffected in both Kir6.1\textsuperscript{1+} and Kir6.2\textsuperscript{2+} animals\textsuperscript{36,37} and efforts to determine whether specific SUR or Kir6 subunits are normally present in mitochondria have yielded inconsistent results.\textsuperscript{73,75–79}

Chutkow et al\textsuperscript{80} generated a SUR2 knockout mouse in which the (NBF1) of SUR2 was disrupted by deletion of exons

<table>
<thead>
<tr>
<th>Nonstandard Abbreviations and Acronyms</th>
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<td>ABC</td>
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<td>K\textsubscript{ATP}</td>
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<td>mitoKATP</td>
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<td>TMD1, TMD2</td>
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Experiments using these SUR2−/− mice revealed novel glibenclamide-insensitive channels in isolated sarcolemmal membrane patches, and antibodies raised against specific regions of the SUR2 protein suggested that the novel channels are formed of short SUR2 constructs that lack NBF1.81,82 Subsequent studies from the same group indicate that these proteins may be expressed in mitochondria,83 and that SUR2−/− mice are protected against myocardial infarction resulting from global ischemia (as we also reported for SUR1−/− mice),84 inconsistent with the generally accepted notion that opening of (SUR-dependent) sarcolemmal KATP channels is a protective mechanism in ischemia. A later study from the group indicated that re-expression of full-length SUR2A improved recovery from ischemia,85 leading to the slightly convoluted argument that the improvement in the SUR2−/− animals over wild-type is somehow the result of the short-form SUR2 constructs. The possibility that these are increased in mitochondria might then explain improved mitochondrial energetics in these animals.86 Lack of confirmed presence of canonical SUR or Kir6 subunits in mitochondria has led to alternative hypotheses regarding mitoKATP structure. In addition to opening KATP channels, diazoxide may inhibit succinate dehydrogenase87 and, consistent

Figure. Cardiovascular KATP channels. A, Kir6 subunits generate the channel pore and SUR subunits serve the regulatory role, with each channel being a functional octamer of 4 Kir6 subunits and 4 SUR subunits. B, The metabolically controlled gate of the channel is located at the cytoplasmic end of the inner cavity. ATP binds to Kir6 subunits, and this provides the energetic push to channel closure. MgATP binds to the ATP-binding sites (ABSs) formed at the NBF1–NBF2 interface on SUR subunits. ATP hydrolysis results in a conformational activated state that is transduced to override ATP inhibition. The activated state persists through ADP dissociation and can be maintained by ADP rebinding. In addition, PIP2 interaction at a site near the ATP inhibitory site also provides an energetic pull to open channels, and sulfonlureas (SU) or K channel openers (KCO), interacting with the SUR subunit within the membrane, respectively, cause channel closure or opening. C, Human KATP gene structure. ABCC8 (SUR1) and KCNJ11 (Kir6.2) are immediately adjacent on chromosome 11p, whereas ABCC9 (SUR2) and KCNJ8 (Kir6.1) are immediately adjacent on chromosome 12. D, KATP channel subunit distribution in the cardiovascular system.
with the idea, that this key enzyme of both the Krebs cycle and electron transport chain might be a component of the mitoK\textsubscript{ATP} channel. Ardekhi et al identified a macromolecular complex that recapitulated mitoK\textsubscript{ATP} activity, including diazoxide activation and 5-hydroxydecanoate inhibition.\cite{98,99} The complex included succinate dehydrogenase, mitochondrial ATP-binding cassette protein-1 (mABC-1), ATP synthase, adenine nucleotide translocase, and phosphate carrier proteins, and it is not clear which component should be forming the channel pore. The reported records show only single channel activity over brief periods, and follow-up studies have not yet emerged.

Most recently, proteomic analysis of purified bovine mitochondrial inner membranes identified a short-form (ROMK2) product of the KCNJ1 gene as containing an N-terminal mitochondrial targeting signal and colocalization of a full-length epitope-tagged ROMK2 with mitochondrial ATP synthase \( \beta \).\cite{100} Additional experiments showed that tertapain Q, a relatively specific ROMK blocker, inhibited functional assays of mitoK\textsubscript{ATP} activity in isolated mitochondria and inhibited the diazoxide-activated component of mitochondrial thallium uptake. Although these studies await independent confirmation, they imply a role for ROMK2 (Kir1) subunits in generating the mitoK\textsubscript{ATP} channel (Figure D).

K\textsubscript{ATP} and Cardiovacular Disease: The Potential Compared With the Genetic Evidence

It has long been recognized that K\textsubscript{ATP} channels provide a large potential ionic conductance in the surface membranes of cardiac myocytes as well as VSM and endothelium, and perhaps in the mitochondrial inner membrane of many cells. Under normal metabolic conditions, cardiac sarcolemmal K\textsubscript{ATP} channels are predominantly closed, and they do not significantly contribute to cell excitability. However, these channels can open when exposed to a severe metabolic stress such as anaerobiosis, metabolic inhibition, or ischemia. In muscle cells, shortening the action potential reduces calcium entry and inhibits contractility,\cite{101} thereby reducing energy consumption, potentially protecting the cell. Such a preservation strategy is of course self-limiting because if too many myocytes stop contracting, the heart will stop pumping and the animal will die, but it has always been a reasonable, if unproven, notion that temporary protection of a small number of cells, or region of the heart, against the damage of Ca overload during ischemia, is likely to be operable.

In the vasculature, inhibition of K\textsuperscript{+} channel activity will tend to cause depolarization of the membrane potential, activation of L-type voltage-sensitive Ca\textsuperscript{2+} channels, Ca\textsuperscript{2+} entry, and vasoconstriction.\cite{102} Conversely, activation of K\textsuperscript{+} channels will lead to membrane hyperpolarization, decrease in voltage-dependent Ca\textsuperscript{2+} entry, and vasodilation.\cite{103} The relationship between membrane potential and Ca\textsuperscript{2+} influx is especially steep in smooth muscle, with membrane depolarization or hyperpolarization of only a few millivolts causing several-fold increases or decreases in [Ca\textsuperscript{2+}], respectively.\cite{104,105} Endothelial cells lack voltage-dependent Ca channels, and Ca entry through nonelective channels is enhanced at hyperpolarized voltages, in contrast to excitable cells.\cite{106} Activation of K\textsubscript{ATP} channels will tend to hyperpolarize cells, leading to elevated [Ca\textsuperscript{2+}], and elevated release of vasoactive agents, including endothelium-derived hyperpolarizing factor and endothelin. Thus, gain of or loss of K\textsuperscript{+} channel activity in either smooth muscle or endothelium could have profound prorelaxant or proconstrictive effects, respectively, on smooth muscle tone.

Kir6 Genes and Disease

As discussed in detail, genetic manipulation of K\textsubscript{ATP} genes in mice can result in dramatic cardiovascular pathologies, yet until recently there has been little evidence for human cardiovascular disease resulting from K\textsubscript{ATP} gene mutations (Table 1). KCNJ11 encodes the predominant K\textsubscript{ATP} channel pore-forming subunit (Kir6.2) in the pancreatic \( \beta \) cell and in cardiac myocytes.\cite{107} Gain-of-function and loss-of-function mutations in this gene are now well-understood to underlie neonatal diabetes mellitus and congenital hyperinsulinism, respectively,\cite{108} but there is no published evidence for any cardiac problems in these patients.

KCNJ8 encodes Kir6.1, which is the main channel-forming subunit expressed in smooth muscle and also may be expressed in some cardiac myocytes,\cite{109,110} (Figure D). Several recent studies have reported a single mutation, S422L, in the Kir6.1 protein to be associated with the J-wave phenomenon, characterized by abnormalities in the J-point of the ECG and including Brugada syndrome and early repolarization syndrome. First reported by Haissaguerre et al,\cite{111} J-point elevation in 1 patient with the S422L variant showed multiple (>100) recurrences of unresponsive ventricular fibrillation associated with accentuated early repolarization. Additional studies include that of Delaney et al,\cite{112} who reported 2 (of 325) atrial fibrillation probands with early repolarization, that of Medeiros-Domingo et al,\cite{113} who reported 1 Brugada syndrome patient and 1 early repolarization syndrome patient carrying the same S422L variant of 101 analyzed patients, and that of Barajas-Martinez et al, who reported 3 additional Brugada syndrome and 1 early repolarization syndrome probands carrying the same variant.\cite{114} The variant has not been identified in any control alleles. The latter 2 studies both reported enhanced channel activity for the S422L variant, arguing that gain-of-function in Kir6.1 channel activity is underlying the early repolarization syndrome and, hence, atrial fibrillation. Conversely, sequence analysis of DNA from necropsy tissue on 292 unrelated sudden infant death syndrome cases identified novel KCNJ8 variants in 2 individuals, an in-frame deletion (E332del) and a missense mutation (V346I), both in the distal C terminus of Kir6.1. In this case, reduced channel activity was reported from recombinantly expressed mutant channels, leading the authors to conclude that loss-of-function mutations in Kir6.1 may be a cause of sudden infant death syndrome through as yet unexplained mechanisms.

SUR Genes and Disease

ABCC8 encodes SUR1, which is the predominant regulatory sulfonylurea receptor (SUR1) in the pancreatic \( \beta \) cell and is also present in the heart, predominantly in atria in rodents,\cite{115} but potentially more widespread in humans.\cite{116} Because of its involvement in the pancreatic K\textsubscript{ATP} channel, gain-of-function and loss-of-function mutations in this gene also underlie neonatal diabetes mellitus and congenital hyperinsulinism,
respectively, but again there is no report of cardiac problems in these patients.\textsuperscript{105–107} \textit{ABCC9} encodes the second \textit{SUR2} subunit, and this is likely to be the major \textit{SUR} isoform in both cardiac and vascular muscle. There have been 2 reports of \textit{SUR2} loss-of-function mutations leading to cardiac disease, both from Terzie et al.\textsuperscript{108,109} (Table 1). In each case, the mutations are present in the C-terminal exons and will lead to a disruption of the NBF2 of \textit{SUR2A} and, hence, reduce nucleotide dissociations, all associated with Cantu syndrome,\textsuperscript{111} and \textit{hypertrichosis-osteochondrodysplasia-cardiomegaly syndrome}, was first described in 1982.\textsuperscript{111} Subsequent reports\textsuperscript{112,114–121} have confirmed a constellation of features in \textit{≈} 30 patients (Table 2). Congenital hypertrichosis is a constant feature, with thick scalp hair and excessive hair growth on the forehead, face, back, and extremities. Generalized macrosomia is present in most cases, with large birth weights and lengths, although ultimate adult height is usually within the normal range. Macrocephaly is typically present at birth and usually persists. Multiple dysmorphic features (Table 2), including coarse facial appearance, skeletal abnormalities, and generalized osteopenia, as well as multiple additional clinical features also have been described. The cardiac features include cardiac enlargement, concentric hypertrophy of the ventricles, pulmonary hypertension, and pericardial effusion. Yet, despite the enlargement of the heart with increased muscle mass, cardiac function is typically normal, with normal ventricular contractility on imaging studies.\textsuperscript{112} Cardiac muscle biopsy in 1 patient showed mild myofibrillar disorganization but normal myofibers and mitochondria on electron microscopy, and in 2 other patients cardiac biopsy result was reported as normal.\textsuperscript{112,122} Pulmonary hypertension secondary to partial pulmonary venous obstruction has been

<table>
<thead>
<tr>
<th>Gene</th>
<th>Clinical Condition</th>
<th>Features</th>
<th>No. of Affected Individuals</th>
<th>References</th>
</tr>
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<tbody>
<tr>
<td>KCNJ8 (Kir6.1)</td>
<td>J-wave syndrome</td>
<td>S422L mutation; reportedly GOF abnormalities in the J-point of the ECG, including Brugada syndrome (BrS) and ERS, including ventricular fibrillation and atrial fibrillation</td>
<td>9</td>
<td>100–102</td>
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<td></td>
<td>Sudden infant death syndrome</td>
<td>In-frame deletion (E332del) and loss-of-function mutation (V346I) through as yet unexplained mechanisms</td>
<td>2</td>
<td>104</td>
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<tr>
<td>KCNJ11 (Kir6.2)</td>
<td>Neonatal diabetes mellitus</td>
<td>Multiple GOF mutations cause inhibition of insulin secretion; no cardiovascular phenotype</td>
<td>&gt;100</td>
<td>182</td>
</tr>
<tr>
<td>Type 2 diabetes mellitus</td>
<td>E23K variant, mild GOF, associated with T2DM, and potentially associated with HF</td>
<td>30% Caucasians</td>
<td>183–188</td>
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<tr>
<td>ABCC8 (SUR1)</td>
<td>Neonatal diabetes mellitus</td>
<td>Multiple GOF mutations cause inhibition of insulin secretion; no cardiovascular phenotype</td>
<td>&gt;100</td>
<td>182</td>
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<tr>
<td>ABCC9 (SUR2)</td>
<td>Congenital hyperinsulinism</td>
<td>LOF mutations cause hypersecretion of insulin; no cardiovascular phenotype</td>
<td>&gt;100</td>
<td>98,182</td>
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<td></td>
<td>Congenital hyperinsulinism</td>
<td>Multiple LOF mutations cause hypersecretion of insulin; no cardiovascular phenotype</td>
<td>&gt;100</td>
<td>98,182</td>
</tr>
<tr>
<td>ABCC9 (SUR2)</td>
<td>Atrial fibrillation</td>
<td>Isolated case of LOF mutation associated with atrial fibrillation originating in the vein of Marshall</td>
<td>1</td>
<td>109</td>
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<tr>
<td>Idiopathic dilated cardiomyopathy</td>
<td>Two cases with distinct LOF mutations associated with heart failure attributable to idiopathic dilated cardiomyopathy</td>
<td>2</td>
<td>108</td>
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<tr>
<td>Cantu syndrome</td>
<td>GOF mutations associated with complex multi-organ disease (see Table 2)</td>
<td>25</td>
<td>110,113</td>
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ERS indicates early repolarization syndrome; GOF, gain of function; and LOF, loss of function.

**Table 1. Reported Association of Disease With KATP Channel Mutations**

Cantu Syndrome: Multiple Tissue Symptoms

Cantu syndrome (MIM 239850), or hypertrichosis-osteochondrodysplasia-cardiomegaly syndrome, was first described in 1982.\textsuperscript{111} Subsequent reports\textsuperscript{112,114–121} have confirmed a constellation of features in \textit{≈} 30 patients (Table 2). Congenital hypertrichosis is a constant feature, with thick scalp hair and excessive hair growth on the forehead, face, back, and extremities. Generalized macrosomia is present in most cases, with large birth weights and lengths, although ultimate adult height is usually within the normal range. Macrocephaly is typically present at birth and usually persists. Multiple dysmorphic features (Table 2), including coarse facial appearance, skeletal abnormalities, and generalized osteopenia, as well as multiple additional clinical features also have been described. The cardiac features include cardiac enlargement, concentric hypertrophy of the ventricles, pulmonary hypertension, and pericardial effusion. Yet, despite the enlargement of the heart with increased muscle mass, cardiac function is typically normal, with normal ventricular contractility on imaging studies.\textsuperscript{112} Cardiac muscle biopsy in 1 patient showed mild myofibrillar disorganization but normal myofibers and mitochondria on electron microscopy, and in 2 other patients cardiac biopsy result was reported as normal.\textsuperscript{112,122} Pulmonary hypertension secondary to partial pulmonary venous obstruction has been
reported in 1 case and was associated with severe mitral valve regurgitation that spontaneously resolved. Some patients have required pericardio centesis and ultimately needed pericardial stripping to prevent reaccumulation of the pericardial effusion. A significant number of patients have had patent ductus arteriosus requiring surgical closure, as well as bicuspid aortic valves with and without stenosis. Lymphedema involving the lower extremities may develop over time and, in 1 patient, lymphangiogram demonstrated dilated lymphatic vessels in the legs with delayed lymphatic drainage.

Diazoxide, minoxidil, and other related drugs have been used since the 1960s to treat severe refractory hypertension. Multiple reports of side effects of these drugs also include pronounced hypertrichosis, pericardial effusions, and edema in treated patients. One report even noted coarsening of the facial features, reminiscent of Cantu syndrome, after 8 months treatment with minoxidil. It was subsequently recognized that 1 major action of minoxidil is opening of KATP channels

<table>
<thead>
<tr>
<th>Table 2. Major Clinical Features of Cantu Syndrome</th>
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<tr>
<td><strong>Neonatal Features</strong></td>
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<tr>
<td>Neonatal macrosomia</td>
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<tr>
<td>History of maternal polyhydramnios</td>
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<tr>
<td>Macrocephaly</td>
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<tr>
<td>Occasional slow postnatal growth and short stature later in life</td>
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<td>Craniofacial dysmorphism</td>
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<td>Coarse facial appearance (can be confused with a storage disorder)</td>
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<td>Epicanthal folds</td>
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<td>Broad nasal bridge</td>
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<td>Anteverted nostrils</td>
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<td>Long philtrum</td>
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<td>Wide mouth with full lips</td>
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<td>Macroglossia</td>
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<td>High or narrow palate</td>
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<td>Gingival hyperplasia</td>
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<tr>
<td>Anterior open bite</td>
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<tr>
<td><strong>Hair</strong></td>
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<tr>
<td>Congenital generalized hirsutism</td>
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<tr>
<td>Thick scalp hair</td>
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<tr>
<td>Thick and/or curly eyelashes</td>
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<tr>
<td>Excessive hair growth on forehead, face, back, and limbs</td>
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<tr>
<td><strong>Cardiovascular</strong></td>
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<tr>
<td>Cardiomegaly</td>
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<tr>
<td>Concentric hypertrophy of the ventricles</td>
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<td>Normal ventricular contractility</td>
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<td>Pericardial effusion</td>
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<td>Pulmonary hypertension</td>
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<td>Partial pulmonary venous obstruction</td>
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<td>Mitral valve regurgitation</td>
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<td>Congenital anomalies</td>
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<tr>
<td>Patent ductus arteriosus</td>
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<td>Bicuspid and/or stenotic aortic valve</td>
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<td><strong>Skeletal abnormalities</strong></td>
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<tr>
<td>Thickened calvarium</td>
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<td>Narrow shoulders and thorax</td>
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<td>Broad ribs</td>
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<tr>
<td>Platyspondyly and ovoid vertebral bodies</td>
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<tr>
<td>Hypoplastic ischium and pubic bones</td>
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<tr>
<td>Erlenmeyer flask-like long bones with metaphyseal flaring</td>
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<td>Narrow obturator foramen</td>
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<td>Coxa vara</td>
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<td>Osteopenia</td>
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<td>Delayed bone age</td>
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(Continued)
the various features, and even now the realization of SUR2 mutations as causal does not immediately provide explanations for all features. There is strong evidence, for a physiologically important role of SUR2 in vascular relaxation, such that persistence of the patent ductus arteriosus in Cantu syndrome patients may be readily explained as a consequence of maintained vessel dilation after birth. Patency of the ductus arteriosus is controlled by many factors, the most important of which are relatively low fetal oxygen tension, prostaglandin 2, and prostacyclin 2 in the fetus. After birth, the abrupt increase in oxygen tension and decreasing prostaglandin 2 and prostacyclin 2 levels lead to inhibition of voltage-gated K channels and contraction of the smooth muscle fibers in the ductus, resulting in wall thickening and lumen obliteration. Mechanisms of persistent patent ductus arteriosus are not clear, but the enhancement of a K current in smooth muscle presents an obvious potential explanation in Cantu syndrome patients. Altered vascular tone also may underlie the edema and pericardial effusion, but the reason for cardiomegaly is not obvious. Cardiomegaly reported in most cases of Cantu syndrome is attributable to increased myocardial mass (hypertrophy) with larger cardiac chambers but with normal systolic function, and this does not fit the diagnostic criteria of dilated or hypertrophic cardiomyopathy. As we reported, cardiomegaly in 2 related Cantu syndrome cases has been associated with high output failure and may well be a second-cardiomegaly in 2 related Cantu syndrome cases has been associated with high output failure and may well be a second.

Cardiovascular Disease and K_{ATP} Mutations: Insights From Genetically Modified Animals

KATP Channels and Cardiovascular Disease

Nichols et al

Kir6.2 and SUR1 Knockout Animals Exhibit Complex Cardiac Phenotypes

Murine knockout models of each of the 4 K_{ATP} channel genes have been generated and extensively analyzed. Knockout of Kir6.2 results in a loss of glucose-dependent insulin secretion, modeling features of hyperinsulinism in humans. Knockout of SUR1 reiterates essentially the same phenotype as Kir6.2−/−, and again the major effects are in the pancreas. Conversely, knockout of Kir6.1 or SUR2 leads to a vascular phenotype, presumably attributable to loss of K_{ATP} channel activity in either VSM or endothelium.

Cardiac sarcolemmal K_{ATP} channels are predominantly closed and do not contribute significantly to the process of excitation-contraction coupling in physiological conditions (except perhaps under adrenergic stimulation), because application of sulfonylureas generally has little or no effect on the cardiac action potential. Accordingly, although Kir6.2 is the major cardiac Kir6 isoform, baseline ventricular action potential duration and contractile function are unaffected in isolated ventricular myocytes from Kir6.2−/− animals. When metabolism is inhibited, the action potential can shorten markedly and contraction can be inhibited as a result of K_{ATP} activation. K_{ATP} activation during ischemia is likely to be cardioprotective, because reduction of action potential duration and contraction may preserve ATP stores that otherwise would be consumed during the contractile cycle. In support of this idea, treatment with the K_{ATP} opener pinacidil during ischemia increases cellular ATP and energy stored as creatine phosphate. AP shortening is absent in Kir6.2−/− hearts, and the time to contracture failure is prolonged but the time to onset of rigor contracture is reduced. Diastolic Ca^{2+} overload, myocardial damage, and increased mortality also are observed in isoproterenol challenged Kir6.2−/− myocytes. In addition to highlighting the acute protective effect of K_{ATP} activation, Kir6.2−/− animals show increased mortality and exaggerated hypertrophy in response to pressure overload and to mineralocorticoid/salt challenge. Together, these studies suggest that loss of K_{ATP} by stopping the protective unloading that K_{ATP} activation leads to, should cause Ca overload and perhaps hasten the transition to heart failure under stressed conditions. However, 2 further studies seem to contradict a cardioprotective role. In these studies, from independent groups, both SUR2-knockout (SUR2−/−) and SUR1-knockout (SUR1−/−) mice were found to be more tolerant of global ischemia-reperfusion than control mice, with reduced infarct sizes. Because the SUR2−/− mice have a marked reduction of ventricular sarcolemmal K_{ATP} channels, the enhanced cardioprotection is opposite the expected phenotype (ie, impaired protection). Cardioprotection in SUR2−/− mice conceivably might be attributable to the concomitant loss of the SUR2B component of vascular K_{ATP} channels, but similar cardioprotection in SUR1−/− mice could not be explained by such a mechanism.

As noted, no cardiac problems have been reported for individuals with loss-of-function or gain-of-function mutations in Kir6.2 or SUR1 with profound pancreatic problems (hyperinsulinism or neonatal diabetes mellitus, respectively). In this regard, the lack of dramatic effects in both Kir6.2−/− and K_{ATP} overactive hearts is consistent and, although it still does not answer the question of why this large potential conductance is present in the heart, it really does seem to tell us that change of sarcolemmal K_{ATP} channels may not be so critical.

Kir6.1/SUR2 Knockouts Highlight Vascular Roles

Mouse models in which the Kir6.1 and SUR2 genes have been knocked-out highlight the critical role of these subunits in the cardiovascular system, particularly in the coronary circulation. The cardiovascular phenotypes of Kir6.1−/− and SUR2−/− mice are similar and include baseline hypertension, coronary artery vasospasm, and sudden cardiac death. Electrocardiograms from both animals show ST segment elevation and atroventricular block, which may account for the sudden death. Importantly, SUR2−/− mice treated with the Ca channel blocker nifedipine exhibit a reduction in coronary artery vasospasm, implicating abnormally elevated [Ca^{2+}]{_i} attributable to loss of hyperpolarizing K_{ATP} current as...
causal in the hypercontractility. Collectively, these $K_{ATP}$-null mice recapitulate clinical features of the human disorder of Prinzmetal (or variant) angina, but several studies have failed to demonstrate any association of human coronary vasospasm or hypertension with loss-of-function mutations in Kir6.1 or SUR2, even though linkage analysis indicates that there are associated genes within the same locus as Kir6.1 and SUR2.

Kir6.1 transcripts are detected in heart, lung, brain, pancreas, and endothelium, and SUR2 transcripts are found in multiple tissues, including cardiac and skeletal muscle (SUR2A), brain (SUR2A), and endothelium (SUR2B). Thus, the possibility exists that the cardiovascular phenotypes of Kir6.1<sup>−/−</sup> and SUR2<sup>−/−</sup> mice (or of Cantu syndrome patients) reflect loss (or gain) of $K_{ATP}$ in smooth muscle or other tissues. A role for nonsmooth muscle $K_{ATP}$ in cardiovascular homeostasis is supported by the finding that targeted suppression of endothelial $K_{ATP}$ (Kir6.1/SUR2B) by transgenesis results in an increase in coronary perfusion pressure and a decrease in coronary blood flow, a similar phenotype to that observed in Kir6.1<sup>−/−</sup> mice. Interestingly, release of the vasoconstrictor endothelin-1 is increased by transgenic suppression of endothelial $K_{ATP}$, potentially implicating an elevated level of circulating endothelin-1 as causal in the vasocostriction. These studies raise the possibility of $K_{ATP}$-dependent paracrine signaling between endothelial cells and overlying vascular smooth myocytes, with the endothelial $K_{ATP}$ regulating the release of endothelin-1. Transgenic restoration of VSM $K_{ATP}$ currents by specific expression of the SUR2B isoform in VSM of SUR2<sup>−/−</sup> mice does not resolve the coronary artery vasospasm, atrioventricular heart block, or sudden cardiac death exhibited by SUR2<sup>−/−</sup> animals, providing further support for a potential role of non-VSM $K_{ATP}$ in regulation of vascular tone.

**Transgenic $K_{ATP}$ Gain-of-Function Models**

Given that sarcenolemmal $K_{ATP}$ channels are normally predominantly closed, we have long argued that gain-of-function mutations are as likely, if not more likely, to be key drivers of human disease as loss-of-function mutations. To that end, we have generated multiple gain-of-function mouse models. The first, modeling Kir6.2 gain-of-function clearly revealed the potential for such gain-of-function mutations to cause neonatal diabetes mellitus and led to the subsequent demonstration that such mutations are causal in human neonatal diabetes. In parallel studies, we have explored the potential for Kir6.2 gain-of-function action in the heart, with considerably less emergent clarity. Although we introduce channels that are very ATP-insensitive, they still remain closed under all but extreme circumstances and cause no overt malfunction, mirroring the human Kir6.2 gain-of-function condition—neonatal diabetes mellitus with no cardiac phenotype. Curiously, we found that in ventricular myocytes from these animals there is a dramatically enhanced Ca current, which may be some compensatory response to an initial or local action potential shortening, and conceivably might be related to high-output heart failure that was seen in Cantu syndrome. These studies also reveal that overexpressing the SUR1 isoform, the myocardium has an effect to prolong the PR interval, and that when Kir6.2 gain-of-function is expressed together with SUR1, second-degree and third-degree atrioventricular block, progressing to ventricular and supraventricular arrhythmias, and sudden death follows. This is accompanied in some cases by cardiac hypertrophy and, in the most extreme cases, causes cardiac malformation at the very earliest stages of embryonic cardiac development. In recombinant channels, SUR1-dependent channels are more sensitive to metabolic activation than SUR2A-dependent channels, and we conclude that these pathologies are reflecting channel overactivity in some critical, but as yet unidentified, time window or region of the heart. These results highlight that $K_{ATP}$ overactivity in heart muscle certainly can be structurally and functionally detrimental and may be modeling some of the cardiac consequences of SUR2 overactivity in Cantu syndrome, although cardiac hypertrophy and failure in Cantu syndrome patients are not obviously accompanied by arrhythmias or other cellular defects.

Following the same rationale of exploring gain-of-function models, we have embarked on generation of a series of Kir6.1 and SUR2 GOF transgenic animals. Expression of Kir6.1 GOF mutants in smooth muscle leads to a reduction of systolic and diastolic blood pressures (A. Li, J.C. Koster, R. Knutsen, and C.G. Nichols, unpublished), paralleling the effects of KCOs in human hypertensive patients. Conceivably, further study of these animals, as well as of SUR2 gain-of-function transgenic animals, will reveal additional features that model Cantu syndrome effects and permit testing of novel therapeutic approaches.

**Potential for Therapeutic Modulation of Cardiovascular $K_{ATP}$ Activity**

There is tremendous potential for modulation of $K_{ATP}$ channel activity in general and, more importantly, perhaps, in a tissue-specific manner, because there is already a rich pharmacology, not only of channel inhibitors but also of KCOs. KCOs have been used in 2 major clinical settings: as insulin secretion blockers in conditions of hyperinsulinema and as antihypertensives. So far, clinical use of sulfonylureas has been limited to treatment of type 2 diabetes mellitus, and there has been debate about negative cardiovascular effects.

Minoxidil is reportedly the most active KCO at causing human hair growth, hence its commercial use in topical hair restoration products, and it appears that most, if not all, of the effects of Cantu syndrome are replicated by high-dose minoxidil, including hypertrichosis, facial dysmorphology, and pericardial effusion. Such features have been reported for other KCOs; there is 1 report of pericardial effusion as a result of diazoxide therapy and, although not attributed to the drug by the authors, another reported case of a patient using diazoxide who experienced pericardial effusion. Interestingly, a clinical trial for the use of nicorandil, as a SUR2A-specific activator, in the setting of acute myocardial infarction actually reported lower rates of pericardial effusion than in untreated patients.

Although there are certain dogmas in the literature regarding specificity of KCOs or inhibitors, careful binding analyses performed on cloned SURs have revealed complexities of binding and dependence on nucleotides, which makes it difficult to predict in vivo efficacies at different SUR targets. In
addition, it is clear from intact cell and excised patch-clamp recordings that the ability of KCOs to activate K\textsubscript{ATP} channel currents depends critically on the metabolic state of the intracellular milieu, making direct comparison between different studies difficult.\textsuperscript{169} The ability of diverse KCOs to lower blood pressure is well-recognized, leading to their clinical use in acute and refractory hypertensive settings. Sulfonylureas inhibit K\textsubscript{ATP} channels and have been seen widespread use as glucose-lowering agents in the type 2 diabetes. There is a wide therapeutic range and the main recognized side effect is hypoglycemia, but there is a long-standing debate regarding potential cardiovascular side effects. K\textsubscript{ATP} channel inhibitory drugs have not reached clinical acceptance in the cardiovascular arena, with the expectation being that blockade of cardiac K\textsubscript{ATP} channels may be detrimental in conditions of myocardial ischemia, during which these channels can open and are presumed protective. This debate is still not resolved.\textsuperscript{170,171}

Given the new realization of the SUR2-dependent basis of Cantu syndrome, the opportunity immediately presents itself for the use of K\textsubscript{ATP} channel inhibitors as a potential magic bullet therapy, because they have proven in the treatment of Kir6.2-dependent or SUR1-dependent neonatal diabetes mellitus.\textsuperscript{172} It is generally accepted that most sulfonylureas are physiologically more potent inhibitors of SUR1-dependent K\textsubscript{ATP} than SUR2A-dependent channels, although there has been no careful comparison of effect on SUR1-dependent vs SUR2B-dependent channels. There has been a long-standing dogma that the drug HMR1098 is a cardiac-specific K\textsubscript{ATP} blocker,\textsuperscript{173–176} although several studies including our recent direct head-to-head comparison confirm that it is also a more effective blocker of SUR1-dependent than SUR2A-dependent K\textsubscript{ATP} channels.\textsuperscript{34,177,178} Relative efficacies of HMR1098 vs sulfonylureas in specific physiological conditions may be important to understand, because it is conceivable that specific K\textsubscript{ATP} inhibitors may counteract the symptoms of Cantu syndrome without significantly affecting blood glucose control, a key issue if K\textsubscript{ATP} channel inhibition is to be a viable treatment for the disease.

Further Implications and Future Prospects

Despite almost 30 years of research, we have remained “largely in the dark regarding the true physiological determinants and relevance of sarcolemmal K\textsubscript{ATP} activity”\textsuperscript{179} until very recently. We now realize that the subunit makeup of sarcolemmal K\textsubscript{ATP} channels can be far more complex and labile than originally thought\textsuperscript{179} and, together with the existence of mitoK\textsubscript{ATP} it may be reasonable to consider K\textsubscript{ATP} channels as a family of channels.\textsuperscript{180} The details of the involvement of sarcolemmal vs mitochondrial K\textsubscript{ATP} channels in cardiovascular physiology and pathology remain unclear, but the growing association of Kir6.1 and SUR2 variants with specific electric and contractile derangements and the new clear association with a complex syndrome firmly establish the importance of appropriate activity in normal function of the heart and vasculature. In addition to consideration of potential therapeutic implications of these new findings, we can also consider the broader mechanistic implications. As discussed, key features of Cantu syndrome are consistent with activation of SUR2B-dependent K\textsubscript{ATP} channels in the vasculature, leading to vasorelaxation. In this case, the likely associated Kir channel subunit

is Kir6.1 (Figure D), and we might reasonably suggest that GOF mutations in Kir6.1 also should be associated with these, if not all, symptoms of Cantu syndrome, paralleling the similar neonatal diabetic phenotypes of Kir6.2 and SUR1 GOF mutations. A purported GOF Kir6.1 mutation is already associated with the J-wave syndrome,\textsuperscript{109–113} and this leads to a clear inconsistency: neither J-wave abnormalities nor other arrhythmias have been reported in Cantu syndrome patients, and none of the Cantu syndrome features has been reported for early repolarization syndrome patients. It remains conceivable that Cantu syndrome features are not attributable to enhanced cell membrane K\textsubscript{ATP} activity, but instead they are the result of Kir6-independent (ie, mitochondrial) SUR2 activity. Also unexplained thus far is how opposing effects of loss-of-function mutations\textsuperscript{108,109} vs gain-of-function mutations\textsuperscript{110,113} in SUR2 could give rise to myocardial electric derangements in the first case, but vascular derangements in the second case.

Finally, we should recognize that the monogenic disease-associated K\textsubscript{ATP} mutations, which cause relatively severe changes in channel function, are likely to represent only the tip of the iceberg when it come to the disease-promoting effects of change in protein activity. Further studies of patients with some or all symptoms of Cantu syndrome will be facilitated by efforts to bring such patients together (www.cantu-syndrome.org) and will no doubt reveal new mutations in the K\textsubscript{ATP} subunits and perhaps in proteins that regulate K\textsubscript{ATP} synthesis, trafficking, or location. We do not yet know which of the Cantu syndrome features are the most penetrant and, hence, which of these features might appear in isolation, because the severity of the effect of a specific mutation is reduced. If one or another of the affected cardiovascular functions is the most sensitive to SUR2 gain of function, then we may find far more cases of individuals with gain-of-function variants linked to specific features such as patent ductus arteriosus, pericardial effusion, and cardiomegaly with or without high-output cardiac failure. It may require the detection of these patients with newer cardiac imaging modalities, such as strain imaging to study the heterogeneity of myocardial fiber mass and orientation, or to detect abnormal electric activation sequences at subclinical levels that may exist with SUR2 gain-of-function mutations. We are only just beginning to recognize the cellular control mechanisms that regulate K\textsubscript{ATP} channel subunit synthesis, trafficking, and degradation.\textsuperscript{181} Any alterations in such mechanisms, whether genetic or environmentally based, also may give rise to disease phenotypes similar to those resulting from the mutations discussed, and ultimately may benefit therapeutically from the unique pharmacology of the sulfonylurea receptors.

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Disclosures

None.

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KATP Channels and Cardiovascular Disease


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