**K<sub>ATP</sub> Channels and Cardiovascular Disease**

**Suddenly a Syndrome**

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

**Abstract:** ATP-sensitive potassium (K<sub>ATP</sub>) channels were first discovered in the heart 30 years ago. Reconstitution of K<sub>ATP</sub> 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 K<sub>ATP</sub> 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 K<sub>ATP</sub> 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 K<sub>ATP</sub> 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

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**K<sub>ATP</sub> Channel Structure and Molecular Regulation**

Canonical ATP-sensitive potassium (K<sub>ATP</sub>) channels are hetero-octameric complexes of pore-forming Kir<sub>6</sub>.x channel-forming subunits associated with regulatory SUR subunits, members of the ATP binding cassette (ABC) family of membrane proteins (Figure). Two Kir<sub>6</sub>-encoding genes, KCNJ8 (Kir6.1) and KCNJ11 (Kir6.2), and 2 SUR genes, ABCC8 (SUR1) and ABCC9 (SUR2), encode mammalian K<sub>ATP</sub> 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<sub>ATP</sub> 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 ABC 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 Kir<sub>x</sub> 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<sub>ATP</sub> complexes suggest an intimate packing of 4 SUR and 4 Kir6.x subunits (Figure A).

The key regulatory features of K<sub>ATP</sub> channels are rapid and reversible closure by cytoplasmic ATP and activation by...
Nonstandard Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABC</td>
<td>ATP-binding cassette family of proteins</td>
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<tr>
<td>GOF</td>
<td>gain of function</td>
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<tr>
<td>( K_{ATP} )</td>
<td>ATP-sensitive potassium channel</td>
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<tr>
<td>KCNJ</td>
<td>inward rectifier K channel gene family</td>
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<tr>
<td>KCO</td>
<td>potassium channel opener</td>
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<tr>
<td>Kir1, Kir6</td>
<td>pore-forming subunits of KATP channels</td>
</tr>
<tr>
<td>LOF</td>
<td>loss of function</td>
</tr>
<tr>
<td>M1, M2</td>
<td>transmembrane helices of Kir6 subunits</td>
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<td>mitoKATP</td>
<td>mitochondrial KATP channel</td>
</tr>
<tr>
<td>NBF1, NBF2</td>
<td>nucleotide binding folds of SUR subunits</td>
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<tr>
<td>ROMK</td>
<td>protein product of the KCNJ1 gene</td>
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<tr>
<td>TMD1, TMD2</td>
<td>transmembrane domains of SUR subunits</td>
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<td>VSM</td>
<td>vascular smooth muscle</td>
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nucleotide triphosphates and diphosphates\(^{20}\) (Figure, B). In the absence of other nucleotides, the free ATP concentration that causes half-maximal channel inhibition is in the micromolar range. Because cellular levels of cytosolic ATP concentration are in the millimolar range (1–5 mmol/L) and change little with metabolism, ATP is probably always sufficient to almost fully inhibit channel activity. Channel activation then arises from the activating effects of Mg nucleotides, particularly MgADP, on the SUR subunits.\(^{23}\) Nucleotide regulation is probably the key molecular regulator of \( K_{ATP} \) channel activities, although other second messenger systems and regulators\(^{24}\) may be involved in control of channel activity and in causing channel-dependent pathologies.

### Cardiovascular Tissue Distribution of \( K_{ATP} \) Channel Subunits

#### Cardiac Myocytes

Kir6.1 and Kir6.2, as well as SUR2A, SUR2B, and SUR1, and additional potential splice variants of SUR1 and SUR2 are all expressed in the heart.\(^{4,25,26}\) Given that any pair of SURx:Kir6.x tetramers can coassemble when heterologously expressed,\(^{4,5}\) and given that even within a single channel \( >1 \) SUR isoform or Kir6 isoform can coexist,\(^{27–32}\) determining the molecular make-up of the channel in specific cell types is a challenge. There is now good evidence that in mouse hearts, the Kir6.2−/− sino-atrial node cells,\(^{39}\) indicating a necessary requirement for Kir6.2. The identity of the SUR component of \( K_{ATP} \) in these tissues is unknown, although \( K_{ATP} \) channels in cell types do respond to the relatively SUR2-specific openers cromakalim and pinacidil, suggesting a major role for SUR2 in nodal \( K_{ATP} \) channels.\(^{36–38}\)

#### Smooth Muscle Myocytes

\( K_{ATP} \) channel density is relatively low in vascular smooth muscle (VSM) compared with cardiac myocytes\(^{40,41}\) and the biophysical and the pharmacological properties are quite variable, reflecting variable expression of \( K_{ATP} \) subtypes in vascular beds.\(^{42–49}\) There is considerable variation in reported single channel conductances,\(^{45,46,50–54}\) although low-conductance channels (unitary conductances from 20–50 pS) may represent the predominant \( K_{ATP} \) channel subtype, with a more limited distribution of medium-conductance and high-conductance \( K_{ATP} \) channels (50–70 pS and >200 pS, respectively).\(^{55}\) Importantly, and unlike classic \( K_{ATP} \) channels of the heart\(^{56}\) or pancreas,\(^{57}\) the predominant VSM \( K_{ATP} \) conductances are insensitive to isolated membrane patches and require nucleotide diphosphates (ADP, UDP, GDP) in the presence of Mg\(^{2+}\) to open, leading to their functional designation as nucleotide-dependent \( K^{+} \)-channels, or \( K_{NDP} \) channels.\(^{47,48,53}\) Heterologously expressed Kir6.1/SUR2B channels recapitulate many of these biophysical properties of native VSM \( K_{ATP} \) channels.\(^{47,48,53}\) A subset of Kir6.2/SUR2A-dependent \( K_{NDP} \) channels,\(^{53,54,63}\) Thus, the Kir6.1/SUR2B channel may represent the predominant VSM \( K_{ATP} \) but other subtypes are also likely to be expressed in specific vascular beds, separately or in combination with Kir6.1/ SUR2B subunits\(^{53}\) (Figure D).

#### Vascular Endothelium

\( K_{ATP} \) channels are also present in vascular endothelium 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\(^{65}\) and in aortic endothelial cells.\(^{66,67}\) The molecular composition of endothelial \( K_{ATP} \) channels remains largely unknown, but the presence of Kir6.1, Kir6.2, and SUR2B mRNA in guinea pig and in human coronary artery endothelial cells\(^{68}\) suggests that all 3 subunits may be involved in channel generation in these cells.

#### Mitochondrial \( K_{ATP} \)

A \( K^{+} \)-selective, small conductance channel was first identified in rat liver mitochondria\(^{69}\) and was reported to be reversibly inhibited by application of ATP, glibenclamide, and 4-aminopyridine (4-AP). These mito\( K_{ATP} \) channels were inhibited by acyl-coA and activated by GTP, GDP, and diazoxide.\(^{70,71}\) The pharmacology of heterologously expressed SUR1/Kir6.1 complexes appears to most closely resemble such properties.\(^{72,73}\) Yet mito\( K_{ATP} \) function is apparently unaffected in both Kir6.1−/− and Kir6.2−/− animals\(^{26,27}\) and efforts to determine whether specific SUR or Kir6 subunits are normally present in mitochondria have yielded inconsistent results.\(^{73,75–79}\)

Chutkow et al\(^{80}\) generated a SUR2 knockout mouse in which the (NBF1) of SUR2 was disrupted by deletion of exons...
12–16. 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

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 sulfonylureas (SU) or K channel openers (KCO), interacting with the SUR subunit within the membrane, respectively, cause channel closure or opening. C, Human Kir6 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 mitoKATP channel, Ardehali et al identified a macromolecular complex that recapitulated mitoKATP activity, including diazoxide activation and 5-hydroxydecanoate inhibition.88,89 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 β. Additional experiments showed that tertiapin Q, a relatively specific ROMK blocker, inhibited functional assays of mitoK( 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 mitoKATP channel (Figure D).

KATP and Cardiovascular Disease: The Potential Compared With the Genetic Evidence

It has long been recognized that KATP 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 KATP 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 anoxia, metabolic inhibition, or ischemia. In muscle cells, shortening the action potential reduces calcium entry and inhibits contractility, 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 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+ channel activity will tend to cause depolarization of the membrane potential, activation of L-type voltage-sensitive Ca channels, Ca entry, and vasoconstriction. Conversely, activation of K+ channels will lead to membrane hyperpolarization, decrease in voltage-dependent Ca entry, and vasodilation. The relationship between membrane potential and Ca influx is especially steep in smooth muscle, with membrane depolarization or hyperpolarization of only a few millivolts causing several-fold increases or decreases in [Ca2+], respectively. Endothelial cells lack voltage-dependent Ca channels, and Ca entry through nonselective channels is enhanced at hyperpolarized voltages, in contrast to excitable cells. Activation of KATP channels will tend to hyperpolarize cells, leading to elevated [Ca2+] and elevated release of vasoactive agents, including endothelium-derived hyperpolarizing factor and endothelin. Thus, gain of or loss of K+ 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 KATP genes in mice can result in dramatic cardiovascular pathologies, yet until recently there has been little evidence for human cardiovascular disease resulting from KATP gene mutations (Table 1). KCNJ11 encodes the predominant KATP channel pore-forming subunit (Kir6.2) in the pancreatic β cell and in cardiac myocytes. Gain-of-function and loss-of-function mutations in this gene are now well-understood to underlie neonatal diabetes mellitus and congenital hyperinsulinism, 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 (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, 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, who reported 2 (of 325) atrial fibrillation probands with early repolarization, that of Medeiros-Domingo et al, 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. 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 β cell and is also present in the heart, predominantly in atria in rodents but potentially more widespread in humans. Because of its involvement in the pancreatic KATP 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} ABCC9 encodes the second SUR2 subunit, and this is likely to be the major SUR isoform in both cardiac and vascular muscle. There have been 2 reports of SUR2 loss-of-function mutations leading to cardiac disease, both from Terzic 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 SUR2A and, hence, reduce nucleotide binding and function, ultimately leading to enhanced KATP channel activity.

The first report, the single patient with the mutation presented in the first study, but the conclusion that these mutations all lead to a gain-of-channel function\textsuperscript{112} is cemented by the second study,\textsuperscript{113} which identified ABCC9 coding mutations in an additional 14 of 16 identified patients. In that study, recombinant expression of mutant channel proteins clearly demonstrated a reduced sensitivity to ATP inhibition in 3 example mutants that, as discussed, will lead to enhanced K\textsubscript{ATP} channel activity wherever the channels are located.

**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 ≈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{112,113} Pulmonary hypertension secondary to partial pulmonary venous obstruction has been reported in 5.

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

<table>
<thead>
<tr>
<th>Gene</th>
<th>Clinical Condition</th>
<th>Features</th>
<th>No. of Affected Individuals</th>
<th>References</th>
</tr>
</thead>
<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>
</tr>
<tr>
<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>
</tr>
<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></td>
<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>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<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></td>
<td>Atrial fibrillation</td>
<td>Isolated case of LOF mutation associated with atrial fibrillation originating in the vein of Marshal</td>
<td>1</td>
<td>109</td>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td></td>
<td>Cantu syndrome</td>
<td>GOF mutations associated with complex multi-organ disease (see Table 2)</td>
<td>25</td>
<td>110,113</td>
</tr>
</tbody>
</table>

ERS indicates early repolarization syndrome; GOF, gain of function; and LOF, loss of function.
reported in 1 case and was associated with severe mitral valve regurgitation that spontaneously resolved. Some patients have required pericardiocentesis 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, and this led us to note the parallels between the symptoms of minoxidil exposure and the features of Cantu syndrome, and to suggest the possibility that Cantu syndrome might be the result of K channel hyperactivity. Teratogenic effects of minoxidil, including marked hypertrichosis, dysmorphic facial features, and low blood pressure, have been reported in the offspring of a minoxidil-treated mother. In additional reported cases of minoxidil teratogenicity, 1 infant had transposition of the great vessels and pulmonary bicuspid valvular stenosis leading to neonatal death, and another infant had hypertrichosis that resolved over the first 3 months of life.

The 2 recent studies that describe specific mutations in the ABCC9 gene in a total of 25 of 31 Cantu syndrome patients definitively link the gene defect to the syndrome. All reported patients had the typical Cantu syndrome phenotype (Table 2), but 6 of 31 patients had no identifiable ABCC9 mutation, suggesting that additional gene defects may be involved. Previous studies of Cantu syndrome patients have provided no definitive explanation of the underlying cause of

<table>
<thead>
<tr>
<th>Major Clinical Features of Cantu Syndrome</th>
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<tbody>
<tr>
<td><strong>Neonatal Features</strong></td>
</tr>
<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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<tr>
<td><strong>Craniofacial dysmorphology</strong></td>
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<tr>
<td>Coarse facial appearance (can be confused with a storage disorder)</td>
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<tr>
<td>Epicanthal folds</td>
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<tr>
<td>Broad nasal bridge</td>
</tr>
<tr>
<td>Anteverted nostrils</td>
</tr>
<tr>
<td>Long philtrum</td>
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<tr>
<td>Wide mouth with full lips</td>
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<tr>
<td>Macroglossia</td>
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<tr>
<td>High or narrow palate</td>
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<tr>
<td>Gingival hyperplasia</td>
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<tr>
<td>Anterior open bite</td>
</tr>
<tr>
<td><strong>Hair</strong></td>
</tr>
<tr>
<td>Congenital generalized hirsutism</td>
</tr>
<tr>
<td>Thick scalp hair</td>
</tr>
<tr>
<td>Thick and/or curly eyelashes</td>
</tr>
<tr>
<td>Excess hair growth on forehead, face, back, and limbs</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
</tr>
<tr>
<td>Cardiomegaly</td>
</tr>
<tr>
<td>Concentric hypertrophy of the ventricles</td>
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<tr>
<td>Normal ventricular contractility</td>
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<tr>
<td>Pericardial effusion</td>
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<tr>
<td>Pulmonary hypertension</td>
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<tr>
<td>Partial pulmonary venous obstruction</td>
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<tr>
<td>Mitral valve regurgitation</td>
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<tr>
<td>Congenital anomalies</td>
</tr>
<tr>
<td>Patent ductus arteriosus</td>
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<tr>
<td>Bicuspid and/or stenotic aortic valve</td>
</tr>
<tr>
<td><strong>Skeletal abnormalities</strong></td>
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<tr>
<td>Thickened calvarium</td>
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<tr>
<td>Narrow shoulders and thorax</td>
</tr>
<tr>
<td>Broad ribs</td>
</tr>
<tr>
<td>Platyspondyly and ovoid vertebral bodies</td>
</tr>
<tr>
<td>Hypoplastic ischium and pubic bones</td>
</tr>
<tr>
<td>Erlenmeyer flask-like long bones with metaphyseal flaring</td>
</tr>
<tr>
<td>Narrow obturator foramen</td>
</tr>
<tr>
<td>Coxa vara</td>
</tr>
<tr>
<td>Scoliosis</td>
</tr>
<tr>
<td>Osteopenia</td>
</tr>
<tr>
<td>Delayed bone age</td>
</tr>
<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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<tr>
<td>Scoliosis</td>
</tr>
<tr>
<td>Osteopenia</td>
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<tr>
<td>Delayed bone age</td>
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</tbody>
</table>

**Skin and joints**
- Loose and/or wrinkled skin, especially in neonates
- Deep palmar and plantar creases
- Persistent fingertip pads
- Hyperextensibility of joints

**Lymphatic system**
- Lymphedema, onset usually in adolescence or adulthood

**Gastrointestinal**
- Pyloric stenosis
- Increased risk for upper gastrointestinal bleeding

**Other reported features**
- Immune dysfunction or recurrent infections
- Umbilical hernia
- Renal anomalies
- Genital anomalies
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 secondary response to reduced vascular tone. Similarly, the reason for osteochondrodysplasia and facial dysmorphology is not obvious, and the mechanism by which minoxidil causes hair growth has remained controversial. It has been speculated that by opening vascular K channels and dilation of blood vessels, the supplies of oxygen, blood, and nutrients to the hair follicle are increased, causing follicles in the telogen phase to shed and to be replaced by new thicker hairs in a new anagen phase. However, there is also evidence that SUR2 isoforms are present in follicular dermal papillae, and although the new realization definitively ties the hair growth to an action on KATP channels, it does not immediately prove where the action is.

**Cardiovascular Disease and K\(_{\text{ATP}}\) Mutations: Insights From Genetically Modified Animals**

**Kir6.2 and SUR1 Knockout Animals Exhibit Complex Cardiac Phenotypes**

Murine knockout models of each of the 4 K\(_{\text{ATP}}\) 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\(_{\text{ATP}}\) channel activity in either VSM or endothelium.

Cardiac sarcolemmal K\(_{\text{ATP}}\) 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 conduction can be inhibited as a result of K\(_{\text{ATP}}\) activation. K\(_{\text{ATP}}\) activation during ischemia is likely to be cardioprotective, because reduction of action potential duration and conduction may preserve ATP stores that otherwise would be consumed during the contractile cycle. In support of this idea, treatment with the K\(_{\text{ATP}}\) 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 contractile 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\(_{\text{ATP}}\) 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\(_{\text{ATP}}\) by stopping the protective unloading that K\(_{\text{ATP}}\) 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\(_{\text{ATP}}\) 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\(_{\text{ATP}}\) 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\(_{\text{ATP}}\) 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 SARCOLEMMAAL K\(_{\text{ATP}}\) 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 atrioventricular 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\(^{2+}\)]\(_{\text{i}}\) attributable to loss of hyperpolarizing K\(_{\text{ATP}}\) current as...
curiously, we found that in ventricular myocytes from the neonatal diabetes mellitus with no cardiac phenotype—neonatal diabetes mellitus156 and led to the subsequent demonstration of a causal role for Kir6.2 gain-of-function action in the heart, with considerable less emergent clarity.158–160 Although we introduce these features that model Cantu syndrome effects and permit testing of novel therapeutic approaches.

Potential for Therapeutic Modulation of Cardiovascular \( \text{K}_{\text{ATP}} \) Activity

There is tremendous potential for modulation of \( \text{K}_{\text{ATP}} \) 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 hyperinsulinemia 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 hair growth, hence its commercial use in topical hair restoration products,164,165 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.128 Such features have been reported for other KCOs; there is 1 report of pericardial effusion as a result of diazoxide therapy166 and, although not attributed to the drug by the authors, another reported case of a patient using diazoxide who experienced pericardial effusion.167 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.168 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_{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_{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_{ATP} channel inhibitory drugs have not reached clinical acceptance in the cardiovascular arena, with the expectation being that blockade of cardiac K_{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_{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_{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_{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_{ATP} channels.\textsuperscript{177,178} Relative efficacies of HMR1098 vs sulfonylureas in specific physiological conditions may be important to understand, because it is conceivable that specific K_{ATP} inhibitors may counteract the symptoms of Cantu syndrome without significantly affecting blood glucose control, a key issue if K_{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_{ATP} activity”\textsuperscript{179} until very recently. We now realize that the subunit makeup of sarcolemmal K_{ATP} channels can be far more complex and labile than originally thought\textsuperscript{180} and, together with the existence of mitochondrial K_{ATP} it may be reasonable to consider K_{ATP} channels as a family of channels.\textsuperscript{181} The details of the involvement of sarcolemmal vs mitochondrial K_{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_{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{109–110} 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_{ATP} activity, but instead they are the result ofKir6-independent (ie, mitochondrial) SUR2 activity. Also unexplained thus far is how opposing effects of loss-of-function mutations\textsuperscript{101,113} vs gain-of-function mutations\textsuperscript{108,109} 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_{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_{ATP} sub-units and perhaps in proteins that regulate K_{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_{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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None.

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Domain organization of the ATP-sensitive potassium channel complex


KATP Channels and Cardiovascular Disease


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