Resting Membrane Potential, Extracellular Potassium Activity, and Intracellular Sodium Activity during Acute Global Ischemia in Isolated Perfused Guinea Pig Hearts

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SUMMARY. Transmembrane potentials, extracellular potassium activity, and intracellular sodium activity were determined during acute global ischemia in Langendorff perfused guinea pig ventricles by microelectrode techniques. Resting membrane potential decreased with a sigmoidal time course from $-82 \text{ mV}$ to $-49.5 \pm 2.7 \text{ mV}$ (SD, $n = 6$) and extracellular potassium activity increased from 4 to 5 mM to $14.7 \pm 1.3 \text{ mM}$ ($n = 8$) during 15 minutes of ischemia. The estimated potassium equilibrium potential was 7 mV more negative than resting membrane potential prior to occlusion, but approached resting membrane potential during ischemia. An increase in extracellular potassium accumulation occurred when heart rate was increased abruptly from 60 to 170 beats/min. After rapid stimulation, a transient decrease of extracellular potassium activity occurred which was abolished in the presence of $10^{-6} \text{ M}$ strophanthidin. If the preparations were paced before and after aortic occlusion at a constant rate, potassium accumulation was independent of heart rate within a range of 50-170 beats/min. Intracellular sodium activity was $8.8 \pm 2.8 \text{ mM}$ ($n = 8$) prior to occlusion and decreased slightly to values between 4.7 and 7.6 mM after 10-15 minutes of ischemia. The results suggest that relative potassium permeability largely predominates over relative sodium permeability during the decrease of resting membrane potential after interruption of aortic flow. Furthermore, active sodium-potassium exchange compensates for the rate-dependent fraction of potassium efflux and maintains a low intracellular sodium activity. For reasons of electroneutrality, the potassium efflux underlying extracellular potassium accumulation must be balanced by an equivalent charge movement which is not carried by sodium. The most probable hypothesis regarding the charge carriers is that net potassium efflux occurs secondary to efflux of phosphate and lactate generated during ischemia. (Circ Res 52: 442–450, 1983)
early acute ischemia. Furthermore, the results show that $a_{ka}$ remains low and $Na^+\div K^+$ pump activity persists during early ischemia.

Methods

Perfused Heart Preparation

Guinea pigs (weight 900 g) were anesthetized with ether and stunned by a blow to the head. The heart was removed rapidly and transferred to a tissue chamber. The aorta was cannulated and the heart perfused with cold Tyrode's solution within 150 seconds after removal. Draining cannulas were inserted in both ventricles, and the heart was connected to the final perfusion apparatus and placed horizontally in a recording chamber (Fig. 1). The Langendorff perfusion apparatus incorporated a roller pump to collect the returning venous blood and propel it through an oxygenator and a thermostat back to the heart in a closed loop. The priming volume of the perfusion system was 400 ml. The hearts were perfused at constant pressure (45-55 mm Hg); myocardial flow rates varied between 100 and 150 ml/min per 100 g. The heart was superfused concurrently with the same solution, except for a small epicardial area (diameter approximately 7 mm) which was kept in open air. Temperature varied between 31°C and 33°C, but remained constant during individual experiments. The oxygenator was gassed with a mixture of oxygen and CO$_2$; the flow rate of CO$_2$ was adjusted to yield a pH between 7.34 and 7.37. A conventional glass electrode was used to measure pH of the perfusate close to the aortic inlet (see Fig. 1). Arterial oxygen content of the perfusate varied between 13 and 15 ml O$_2$ per 100 ml. A filter (pore size 40 μm) was introduced into the perfusion tubing to prevent embolism by corpuscular fibrin aggregates. Normal perfusion fluid was composed of a mixture of washed bovine erythrocytes (hemoglobin concentration, 8 g/100 ml), dextran (mol wt, 70,000; 4 g/100 ml), insulin (1 U/liter), heparin (400 U/liter) and Tyrode's solution of the following composition (mm): Na$^+$, 149; K$^+$, 4.3; Mg$^{2+}$, 0.49; Ca$^{2+}$, 1.8; Cl$^-$, 145.8; HCO$_3^-$, 1.19; H$_2$PO$_4^-$, 0.4; and glucose, 20. Final [K$^+$] in the perfusion fluid varied within a ±0.5 mm range among different experiments, due to potassium uptake by erythrocytes during storage and/or hemolysis. Therefore, in each experiment, [K$^+$] was determined by flame photometry or by an ion-selective probe.

Preparation and Calibration of Electrodes

Floating electrodes for recording conventional and ion-sensitive signals were constructed by means of different techniques. Intracellular floating electrodes for the measurement of transmembrane potentials were pulled from borosilicate glass. DC tip resistances were 15-20 MΩ when filled with 3 m KCl. The tips of similar borosilicate glass microelectrodes were broken to an outer diameter of 30 μm to prepare floating electrodes for measurements of extracellular reference electrograms. The broken tips were fire-polished to produce a smooth surface with an opening of 3-4 μm. This procedure prevented injury to the subepicardial cells of the contracting preparation. Extracellular microelectrodes were filled with a mixture of agar and 0.5 m KCl, except those which served as a reference for extracellular $K^+$-sensitive electrodes which contained agar and 0.5 m Na$_2$SO$_4$.

Potassium-sensitive electrodes were prepared by two different methods. Floating extracellular $K^+$-sensitive electrodes for some of the measurements (shown in Figs. 2 and 3) were made from fire-polished micropipettes silanized in an oven (200°C for 30 minutes) with trimethylsilyldimethylamine (TMPSDA; Fluka, Switzerland) and backfilled with potassium sensor (Corning 477317). Calibration curves were obtained from measurements of the potential difference between the $K^+$-sensitive electrode and a reference electrode in perfusion fluid and in Tyrode's solution containing varying [K$^+$] but constant total [Na$^+$] + [K$^+$]. In other measurements, $K^+$-sensitive electrodes were made from polyethylene tubing pulled to an inner tip diameter of 70-100 μm. These tubes were filled with 0.5 m KCl and sealed at the tip by a Valinomycin-PVC matrix membrane (valinomycin 4%). The fabrication and calibration of these electrodes were the same as described by Hill and Gettes (1978). The Valinomycin electrodes proved to be superior because they exhibited better DC stability and could be stored up to 2 weeks with minimal loss of sensitivity (<10%). An activity coefficient of 0.748 was assumed to evaluate voltages reflecting extracellular $K^+$ activity (Bailin et al., 1979).

Floating Na$^+$-sensitive microelectrodes were pulled from borosilicate glass and beveled to a tip diameter of 1 μm. The electrodes were silanized in an oven (200°C for 30 minutes) using TMPSDA and stored in a desiccator for several hours to several days. Subsequently, the electrodes

![Figure 1. Experimental arrangement. The perfused heart was placed horizontally in a perspex chamber and also superfused except at the measuring site (area of 7 × 7 mm) which was kept in open air.](image-url)
were backfilled with sodium sensor [10% neutral ligand ETH 227 + 0.5% sodium tetraphenylborate dissolved in o-nitrophenyl-octylether, kindly provided by Dr. Ammann (Steiner et al., 1979) and calibrated with a set of solutions containing varying [Na+] but constant total [Na+] + [K+]. The ionic composition of the calibration solutions was made similar to that of the sarcoplasm (in mM): Na+ + K+, 142; MgCl2, 2; Tris, 10; pH 7.2. The DC shift of the Na+-sensitive electrodes was less than 3 mV/hour and the selectivity for Na+ vs. K+ was 50:1 (for details see Cohen et al., 1982). An activity coefficient for Na+ of 0.764 was used (Bates et al., 1970) to evaluate the calibration records in terms of Na+ activity. Both ion-selective and conventional microelectrodes were mounted on a fine AgCl-coated silver wire (diameter 20 μm) to provide more stable records from both extra- and intracellular locations.

**Recording Procedure**

Measurements of extra- and intracellular potentials were made on the air-exposed part of the anterior left ventricular surface. Extracellular electrodes touched the epicardial surface, whereas intracellular electrodes penetrated the epicardium to an estimated depth of 125-200 μm (Janse et al., 1978; Tranum-Jensen et al., 1982). Recording electrodes were connected to high-input impedance preamplifiers (Burr-Brown 3225 for conventional extra- and intracellular electrodes; Analog Devices 515 for ion-sensitive electrodes) and the signals amplified by a differential instrumentation amplifier. The recorded potentials were stored on an analog tape recorder (Ampex PR 2200) and displayed either on a UV fiberglass recording system (Electronics for Medicine VR 12) or on a pen recorder. K+-Sensitive recordings were filtered for display at low speed (low pass, corner frequency 1 Hz). A bipolar electrode was apposed to the surface of the ventricle for delivery of electrical stimuli that controlled the ventricular rate. In some experiments, the effect of stimulation frequency on extracellular K+ activity was investigated by superfusing the sinoatrial node with cold solution to lower the spontaneous heart rate.

Transmembrane potentials (Vint) were measured as the potential difference between an intracellular microelectrode and an extracellular reference microelectrode placed as close as possible to the impalement site. Extracellular K+ activity (aK) was measured from the potential difference (Vint) between the extracellular K+-sensitive electrode (VKE) and an extracellular reference electrode (Vref). Recordings of Vdiff showed a small bipolar extracellular electrogram due to the finite distance (<200 μm) between the K+-sensitive electrode and the intracellular reference. The measurements of Vdiff were taken during the T-Q segment of the extracellular electrogram. Intracellular Na+ activity (aNa) was measured from the potential difference (VNaK - Vint) between a Na+-sensitive intracellular electrode (VNaK) and a conventional 3 M KCl intracellular electrode (Vint). A single extracellular floating micropipette served as extracellular reference for both intracellular measurements (VNaK and Vref). Both intracellular electrodes were impaled within a distance of 200 μm. In preliminary experiments, an attempt was made to employ double-barreled floating electrodes in the hope of obtaining measurements from single cells. Unfortunately, the inertia of the large double-barreled tips did not allow stable intracellular measurements in the contracting preparation due to cell damage.

**Figure 2.** Panel A: simultaneous recording of membrane potential and aK impalement maintained between 2 and 6 minutes after aortic occlusion. Resting membrane potential declined and action potential amplitude decreased. Arrow indicates brief period of electrical alternans prior to unresponsiveness occurred at a resting membrane potential of ~60 mV. Panel B: time course of resting membrane potential (filled squares) and aK (filled circles) during and after a 15-minute period of ischemia; same experiment as panel 2A. Smooth curve was fitted by eye to aK values. Dotted line represents potassium equilibrium potential Ek, calculated from aK, as described in Methods, using an assumed value of 100 mV for initial intracellular potassium activity.

**Figure 3.** Time course of resting membrane potential (filled squares) and aK (filled circles) during the first 15 minutes after aortic occlusion. Mean values from nine experiments with bars indicating standard deviation. Number of measurements given near each point. Smooth curve was fitted by eye to the aK values. Dotted line corresponds to time course of calculated Ek.
Several possible problems with the measurement techniques were addressed. The decline of PO2 from the air-surface interface into the subepicardial cell layers was calculated because oxygen diffusion from the air to the site of recording theoretically could affect the results during ischemia. PO2 declines as a parabolic function of distance depending upon oxygen consumption and the permeation coefficient for oxygen (see Tsacopoulos et al., 1981). Partial pressure of oxygen is expected to fall from a level of 147 mm Hg at the surface to below 5 mm Hg at a depth of 90 μm. Since the estimated depth of electrode penetration is assumed to be 0.33 m (Page, 1962).

Calculation of Potassium Equilibrium Potential

The potassium equilibrium potential (EK) was calculated from the measured values of extracellular potassium activity as follows:

$$E_K = 60.3 \text{ mV} \times \log \frac{a_{k}}{a_{k} - f \times \Delta a_{k}}$$

where 60.3 mV = Nernst slope for a temperature of 31°C; aK represents an assumed value of 100 mEq/L for initial intracellular potassium activity (see discussion); ΔaK is the difference between the actual aK and the extracellular K+ activity prior to occlusion (i.e., the extra potassium accumulated); and f is the extra- to intracellular volume ratio assumed to be 0.33 (Page, 1962).

Results

Relationship between Changes in Resting Membrane Potential and Extracellular Potassium Activity

In nine experiments, aK was measured simultaneously with resting membrane potential (RMP) during a 15-minute period of ischemia. The ventricular rate was 150 to 180 per minute in all experiments. Figure 2A shows the result of an experiment in which transmembrane potential and aK were recorded continuously from an epicardial site between 2 and 6 minutes after coronary occlusion. The gradual increase of aK was accompanied by a decrease in RMP and action potential amplitude. Electrical alternans, which has been described by several investigators (see Janse and Kleber, 1981), occurred between 4.5 and 5.5 minutes after occlusion, just prior to unresponsiveness (RMP —60 mV). The results of the entire experiment (combining the data in Figure 2A with other membrane potential records obtained within a 300 μm radius of the K+-sensitive electrode) are shown in Figure 2B. Prior to occlusion, the resting potential was —82 mV. In the first 8 minutes after aortic occlusion, RMP declined rapidly to —54 mV, followed by slower depolarization to —46 mV after 15 minutes of ischemia. Successive impalements within the area of study gave no indication of more than one level of resting membrane potential. Changes in extracellular K+ activity showed a similar time course to the changes in RMP. After an initially steep increase, aK rose more slowly to a value of 17.7 mEq/L after 15 minutes of occlusion. The dotted line in Figure 2B represents the potassium equilibrium potential calculated from the measured values of aK (see Methods section). Before occlusion, EK was 4 mV more negative than the resting membrane potential; during the subsequent depolarization, EK approached RMP as aK increased. The relationship between EK and RMP during reperfusion was less clear, probably reflecting the technical difficulty of maintaining stable impalements during early reperfusion due to the increased strength of contractions. Furthermore, heart rate often was uncontrolled during early reperfusion because of ventricular tachyarrhythmias. This was a significant problem because sudden increases in heart rate (i.e., during the ventricular tachyarrhythmia) resulted in a transient increase in aK. This effect could be mimicked by a sudden increase in stimulation rate during reperfusion (see Fig. 4).

The time course and magnitude of changes in RMP and aK during ischemia were similar in all nine experiments (see Fig. 3). Resting membrane potential was —81.7 ± 2.0 mV (SD) prior to occlusion. After 8 minutes, RMP was —55.3 ± 3.0 mV and by 15 minutes, —49.5 ± 2.7 mV. Extracellular K+ began to rise within the first minute of occlusion and reached average values of 11.0 ± 2.0 mEq/L and 14.7 ± 1.3 mEq/L after
8 and 15 minutes, respectively. Prior to occlusion, the average potassium equilibrium potential was calculated to be —89.2 mV, 7.5 mV more negative than RMP. EK approached RMP after 5 minutes of ischemia at an ak of 9 mm. Fifteen minutes after the onset of ischemia, EK averaged —49.4 mV, virtually identical to the average RMP. However, this apparently accurate relationship should be interpreted with caution since the calculated EK depended on the assumed initial value of 100 mm for ak (see Discussion).

Effects of Heart Rate on Extracellular Potassium Accumulation

Abrupt changes in heart rate lead to fluctuations of extracellular potassium activity in different isolated cardiac tissues, caused by the delay between the rate-dependent change of K+ efflux and active, pumped K+ influx. Therefore, changes in heart rate provide a means to study activation and inactivation of the Na+/K+ pump (Kunze, 1977; Kline and Morad, 1978). In three experiments, spontaneous heart rate was lowered to 60/min by local superfusion of the right atrium with cold perfusate. As shown in Figure 4, a sudden increase in heart rate to 170/min during normal perfusion resulted in a transient increase of ak followed by a decrease toward the former steady state level. A transient undershoot of the steady level of ak was observed after the train of rapid stimuli, consistent with delayed inactivation of active K+ influx. Both the time course and magnitude of changes in ak were similar to those reported from isolated cardiac tissue (Kunze, 1977). After aortic occlusion, rapid stimulation led to a pronounced K+ accumulation. The rate of accumulation was fastest immediately after the onset of stimulation followed by a gradual slowing. A transient decline of ak was again present after rapid stimulation. Since extracellular washout was prevented during the period of coronary occlusion, this transient depletion (1.2 mm) is assumed to reflect a net potassium movement from the extracellular space.

In two experiments, strophanthidin (10^-6 M) was added to the perfusion fluid in order to assess the contribution of changes in active K+ influx to the variation of ak before and after coronary occlusion (Fig. 5). Measurements were performed 30 minutes after the administration of the cardiac steroid. The experimental procedure was the same as described for Figure 4. The left part of Figure 5 shows that the initial increase of ak after the onset of stimulation (170/min) was not followed by a delayed decrease. Instead, ak remained at a level 1 mm higher than ak of the perfusion fluid. After rapid stimulation, ak declined to the former baseline level without transient undershoot. During ischemia (Fig. 5, right), rapid stimulation (170/min) caused an immediate increase in the rate of K+ accumulation and there was no distinct decline in the rate of K+ accumulation during rapid stimulation, in contrast to experiments without strophanthidin (e.g., Fig. 4). Furthermore, there was no decline in ak following cessation of rapid stimu-
rate was increased abruptly to 170/min, 5 minutes prior to occlusion. In the latter case, extracellular K⁺ activity initially rose but then declined to approach the former steady state level before occlusion (cf. Fig. 4). During ischemia, the time course of aK was almost identical at both rates. This result, confirmed in two other experiments, suggests that potassium accumulation during early ischemia is largely independent of heart rate (within a 50 to 170/min range), providing active K⁺ influx is allowed to reach a steady state prior to occlusion, and heart rate during occlusion is constant.

Intracellular Sodium Activity during Acute Ischemia

Intracellular sodium activity (aNa) was measured before and after aortic occlusion in eight experiments. These experiments tested the hypothesis that the net movement of potassium ions from the intracellular space to the extracellular space is compensated by an inward movement of sodium ions. Intracellular Na⁺ activity was determined by means of two separate microelectrodes impaled within a distance of 200 μm. With this technique, measurements were obtained before and at different times after interruption of aortic flow. Figure 7 shows original recordings of transmembrane potential (Vm) and potential measured by the Na⁺-sensitive electrode (VNa). Two simultaneous records before aortic occlusion are given in panel A. Resting membrane potential (RMP) was −81 mV; 35 sec after the impalement VNHE was −136 mV. The potential difference (Vdiff) between VNHE and RMP was −55 mV, corresponding to an aNa of 9.9 mM. In panel B, recordings from the standard intracellular microelectrode (upper trace) and the Na⁺ electrode (lower trace) are displayed at a rapid paper speed. The action potential recorded by the Na⁺ electrode was distorted by its low frequency response. The potential reached a steady resting level only 400 msec after the upstroke. This poor electrical response time limited the range of heart rates over which aNa could be measured. In panel C, simultaneous recordings of Vm and VNa are depicted, from the same experiment, after 15 minutes of ischemia. Vm was −52 mV and VNa −112 mV; Vdiff of −60 mV corresponded to an aNa of 7.6 mM, i.e., 2.3 mM less than that prior to aortic occlusion. The combined results of eight experiments (in seven preparations) are summarized in Figure 8. Heart rate varied between 70 and 120/min in the different experiments. Resting membrane potentials and aNa are given for each experiment; up to four successful simultaneous impalements were obtained in a single experiment. The time course of RMP was comparable to the data presented in Figure 3. RMP decreased from a value of −79 ± 3.6 mV to values ranging from −47 to −54 mV between 10 and 15 minutes after aortic occlusion. During normal perfusion, the mean aNa was 8.8 ± 2.8 mM (so, n = 8). During ischemia, no increase or a slight decrease in aNa was recorded. Between 10 and 15 minutes after aortic occlusion, when resting membrane potential was approximately −50 mV, eight measurements were obtained, ranging from 4.7 to 7.6 mM. Mean aNa before occlusion from these five experiments was 7.9 mM.

From the resting membrane potentials shown in Figure 8 and the relationship between RMP and aK (Fig. 3), a theoretical estimate was made for the in-
crease of $\Delta K_\text{m}$ which should occur if extracellular $K^+$ accumulation was fully compensated by intracellular $Na^+$ accumulation. Thus, depolarization to $-50$ mV (see Fig. 3) was accompanied by an increase in $aK$ of 11 mm. Therefore, assuming an extra- to intracellular space ratio of 0.33, a 3.6 mm increase of $aK$ should have occurred after 10 to 15 minutes of ischemia. For the type of $Na^+$ electrodes employed, an increase of $aK$ of this magnitude (i.e., from 8 to 11 mm) would be expected to change $V_{\text{tir}}$ by approximately 8 mV. A potential difference of that size certainly should have been detectable with these methods but was not observed.

**Discussion**

Intracellular potentials and extracellular $K^+$ activity were measured simultaneously in guinea pig hearts to evaluate the relationship between resting potential and the potassium equilibrium potential after cessation of myocardial perfusion. A model of global ischemia was used to reduce spatial differences that occur with regional ischemia. The results demonstrate a magnitude and time course for changes in $aK$ during ischemia similar to those reported for intramural $aK$ during ischemia in vivo (Hill and Gettes, 1980). This close agreement for $aK$ suggests that local variations in ischemic metabolism, evaporation from the epicardial surface, and $O_2$ diffusion into the air-exposed ventricle were unlikely to have affected the results significantly. In addition, the decrease in resting potential described qualitatively in the perfused pig heart (Downar et al., 1977) and in isolated measurements during regional ischemia (Kléber et al., 1978) has been verified and more precisely defined by the present results. Moreover, the results reveal that changes in resting potential and $aK$ both follow a similar sigmoidal time course, suggesting (not surprisingly) a close relationship between the transsarcolemmal $K^+$ distribution and the resting potential.

This relationship can be evaluated by comparing RMP with estimates of $E_K$. The results demonstrate a closer approximation of RMP to $E_K$ as ischemia progressed (the two values concuring around $-50$ mV). The close correspondence between $E_K$ and RMP arises partly because the initial $aK$ was assumed to be 100 mm. This was not an unreasonable assumption, since measured values for guinea pig papillary muscle (99 mm, Wier, 1978; 106 mm, Baumgarten et al., 1981) and the mean of other reported values for $aK$ (86 mm, Lee and Fozzard, 1975; 116 mm, Cohen et al., 1982) are close to this value. Deviations of initial $aK$ ($\pm 10$ mm) would have shifted $E_K$ by $\pm 2$ to 3 mV but would not have affected the conclusion that $E_K$ is closer to RMP during ischemia than during normal perfusion. In addition, since total tissue $K^+$ is constant in the absence of extracellular washout, changes in $aK$ during ischemia were estimated (3–4 mm after 15 minutes of occlusion) and allowed for in the calculation of $E_K$. A similar relation between RMP and $E_K$ at elevated $[K^+]$, has been described in normoxic myocardium (Lee and Fozzard, 1975).

The implication of a close relationship between $E_K$ and RMP during ischemia is that relative $K^+$ permeability ($P_K$) predominates over relative $Na^+$ permeability ($P_{Na}$). The $P_K/P_{Na}$ ratio may be even higher in ischemic than normal myocardium at elevated $aK$. Comparison of upstroke velocities and action potential amplitudes during ischemia and during perfusion with increased $[K^+]_o$ suggests that potassium conductance is increased and/or fast inward sodium current is decreased in myocardial ischemia (see Janse and Kléber, 1981). Additionally, Vleugels et al. (1980) have measured an increase in slope conductance at $E_K$ and time-independent $K^+$ outward current during hypoxic perfusion.

A major emphasis of the present study was to investigate the mechanism underlying the reversible increase in $aK$ that occurs during the first 15 minutes of ischemia. The current findings, together with those of Tranum-Jensen et al. (1981), would suggest that the increase in $aK$ can be attributed largely to a net efflux of $K^+$ from the myocardial cells. Certainly, a shift of water from the extra- to the intracellular space must be discussed as a possible factor contributing to the increase in $aK$. Such a shift is expected because new osmotically active particles (e.g., lactate, phosphate) are formed in the intracellular compartment during ischemic metabolism. On the other hand, quantitative considerations argue that transsarcolemmal water movements influence $aK$ to a rather small extent. Thus, Tranum-Jensen et al. (1981) measured a 20 mOsm increase in extracellular osmolality after 15 minutes of ischemia in Langendorff perfused pig hearts. In the worst case (i.e., no new osmotically active particles added to the extracellular space), the water shift required to account for that increase in extracellular osmolality would amount to a 6% loss of extracellular fiber water and a concomitant 2% gain of intracellular fiber water. This calculation certainly argues against a significant effect of extra- to intracellular water movement, since an 80% loss of extracellular volume would be required to explain a rise in $aK$ from 3 to 14.7 mm. Thus, the rise in $aK$ during ischemia must have resulted from a net loss of $K^+$ from the cells.

The relative contributions of changes in passive $K^+$ efflux and in active $K^+$ influx to the potassium accumulation were studied by measuring the effect of heart rate on $aK$ under two conditions: (1) during and after rapid stimulation and (2) during constant stimulation at different rates. The first setting allowed discrimination between instantaneous changes of $K^+$ efflux and delayed variations in active $K^+$ influx (Kunze, 1977; Kline and Morad, 1978). Rapid stimulation during ischemia resulted in an immediate increase in the rate of change of $aK$, reflecting an increase of efflux at the high rate of stimulation. The slowing in the rate of rise of $aK$ that developed during stimulation and the subsequent $K^+$ depletion after stimulation strongly suggest that the mechanism for active $K^+$ inward transport, i.e., the $Na^+/K^+$ pump, remains at least partially functional during ischemia. This interpretation is supported by the blocking effect.
of $10^{-6}$ M strophanthidin on these changes. Similar effects of rapid stimulation on $a'_K$ have been reported recently by Weiss and Shine (1982).

In a second series of experiments, $K^+$ accumulation was measured at constant stimulation rates of 50 and 170 beats/min. If $K^+$ influx (at 170 beats/min) was allowed to reach a steady state prior to occlusion, $a'_K$ was found to be independent of heart rate during ischemia. This result suggests that, even during ischemia, active $K^+$ inward transport is still capable of fully compensating for the frequency-dependent increase in $K^+$ efflux between rates of 50–170 beats/min, and it is in accordance with measurements reported from in situ pig and dog hearts (Wiegand et al., 1979; Hill and Gettes, 1980). However, the findings differ from the results of Weiss and Shine (1982), who found an increase in extracellular $K^+$ accumulation if heart rate was changed from 60–120 beats/min prior to circulatory arrest and kept constant during the ischemic period. Any explanations for this discrepancy are necessarily speculative, but it seems possible that the relatively low $O_2$ content of their perfusate (Tyrode’s solution, no oxygen carrier) could have limited the maintenance of oxygen delivery during the increased oxygen consumption expected at higher rates. Such a situation might lead to changes in intracellular metabolism prior to interruption of the circulation (e.g., decrease in levels of energy-rich phosphates, intracellular acidosis) which could then influence extracellular $K^+$ accumulation during the subsequent ischemic period.

In the final series of experiments, intracellular $Na^+$ activity determined prior to occlusion (8.8 ± 2.8 mm) agreed with values obtained in sheep and guinea pig ventricular strands measured with the same type of $Na^+$-sensitive ligand (7.9 mm, pacing at 0.5 Hz; Cohen et al., 1982). The observation that $a'_K$ remained low (4.7–7.6 mm, after 10 to 15 minutes of ischemia) suggests that the normal regulation of active $Na^+/K^+$ exchange by extracellular $K^+$ and intracellular $Na^+$ is little affected in early ischemia. In normally perfused tissue, changes in the activity of the $Na^+/K^+$ pump are due mainly to variations in $a'_K$ because pump activation by $[K^+]_o$ becomes saturated at $[K^+]_o$ above 4–5 mm (Glitsch et al., 1976; Gadsby, 1980; Glitsch et al., 1981). Therefore, when $a'_K$ is elevated, only those changes in $K^+$ efflux linked to concomitant changes in $Na^+$ influx involve a change in the activity of the $Na^+/K^+$ pump (e.g., rate-dependent fraction of $K^+$ efflux, see Fig. 6). Depolarization of the cells possibly may contribute to a low $a'_K$ during ischemia. A change of $RMP$ by +30 mV after 15 minutes of ischemia reduces the electrochemical gradient for $Na^+$ ($E_{Na} - E_m$, assumed $E_{Na} = +60$ mV). This, in turn, diminishes the energy requirement by 22% for maintenance of $a'_K$ in the static situation, i.e., when changes in $Na^+$ influx are neglected. Measurements of energy-rich phosphate compounds indicate that ATP levels decrease relatively slowly during the initial phase of ischemia. Furthermore, ADP is largely converted to ATP and AMP, the thermodynamic buffering systems and glycolysis tending to maintain a high ATP potential (Jennings et al., 1981). In addition, the effect of a potential-dependent change of $Na^+$ influx on $a'_K$ should be considered. This has been studied in sheep Purkinje fibers where depolarization induced a decrease in $Na^+$ influx and, hence, in $a'_K$ (Eisner et al., 1981).

For reasons of electroneutrality, the net efflux of potassium ions must be balanced either by an equivalent influx of cations or by an equivalent efflux of anions. The present results exclude the possibility of a net influx of sodium, but they do not provide direct information concerning the identity of the charges which do maintain electroneutrality. For instance, an increase in intracellular $Ca^{2+}$ cannot be excluded. However, even inward movement of all $Ca^{2+}$ ions available in the extracellular space would not be sufficient to compensate for the millimoles of extracellular $K^+$ accumulated. Moreover, a significant shift of $Ca^{2+}$ ions into the intracellular compartment would be expected to increase resting tension, an effect not observed by Weiss and Shine (1982). Therefore, the most probable hypothesis is that net $K^+$ efflux occurs concomitantly with efflux of anions. In fact, such a mechanism is suggested from experiments in which anaerobic metabolism was induced by severe restriction of coronary flow. Analysis of venous effluent in this situation demonstrated that the time course of the increase in potassium, phosphate, and lactate was identical. The quantity of lactate and phosphate even exceeded that of potassium, probably by the amount of protons released (Mathur and Case, 1973). Loss of potassium associated with efflux of anions also could have its counterpart in skeletal muscle brought into a state of fatigue at low extracellular pH. Under such conditions, the resulting loss of intracellular lactate ions is greater than the efflux of H$^+$ (Mainwood and Worsley-Brown, 1975), and an increase in net $K^+$ efflux also occurs (Mainwood and Lucier, 1972). Mainwood and Lucier (1972) provided a hypothesis which might explain the relationship between intracellular metabolic acidosis and net potassium efflux during ischemia. Generation of weak acids inside the cells by breakdown of energy-rich phosphates and glycolysis will result in binding of the protons to negative charges of intracellular proteins which may have a buffer capacity as high as 60 mm per unit pH and per kg sarcoplasmic fluid (Heisler and Piper, 1971). A loss of permeant anions so formed, associated with an efflux of cations, is then to be expected as a result of the decrease in fixed negative charges and the rise in freely movable anions (Boyle and Conway, 1941). Decrease of myocardial intracellular pH during ischemia, determined indirectly by nuclear magnetic resonance (Garlick et al., 1979), showed the same time course as the rise in $a'_K$, further supporting the above hypothesis of anion loss.

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References


Boyle PJ, Conway EJ (1941) Potassium accumulation in muscle and associated changes. J Physiol (Lond) 100: 1-63


Garlick PB, Radda GK, Seeley PJ (1979) Studies of acidosis in the ischemic heart by phosphorous magnetic resonance. Biochem J 184: 547-554


Lee CO, Fozzard HA (1975) Activities of potassium and sodium ions in rabbit heart muscle. J Gen Physiol 65: 695-708


Mathur PP, Case RB (1973) Phosphate loss during reversible myocardial ischemia. J Mol Cell Cardiol 5: 375-393


Schwartz A, Wood JM, Allen JC, Bornet EP, Entmann ML, Goldstein MA, Sordahl LA, Suzuki M, Lewis RM (1973) Biochemical and morphologic correlates of cardiac ischemia. I. Membrane systems. Am J Cardiol 32: 46-61


Wier WG (1978) Ionic currents and intracellular potassium in hypoxic myocardial cells (abstr). Biophys J 21: 1664

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