MCIP1 Overexpression Suppresses Left Ventricular Remodeling and Sustains Cardiac Function After Myocardial Infarction

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Abstract—Pathological remodeling of the left ventricle (LV) after myocardial infarction (MI) is a major cause of heart failure. Although cardiac hypertrophy after increased loading conditions has been recognized as a clinical risk factor for human heart failure, it is unknown whether post-MI hypertrophic remodeling of the myocardium is beneficial for cardiac function over time, nor which regulatory pathways play a crucial role in this process. To address these questions, transgenic (TG) mice engineered to overexpress modulatory calcineurin-interacting protein-1 (MCIP1) in the myocardium were used to achieve cardiac-specific inhibition of calcineurin activation. MCIP1-TG mice and their wild-type (WT) littermates, were subjected to MI and analyzed 4 weeks later. At 4 weeks after MI, calcineurin was activated in the LV of WT mice, which was significantly reduced in MCIP1-TG mice. WT mice displayed a 78% increase in LV mass after MI, which was reduced by 38% in MCIP1-TG mice. Echocardiography indicated marked LV dilation and loss of systolic function in WT-MI mice, whereas TG-MI mice displayed a remarkable preservation of LV geometry and contractility, a pronounced reduction in myofiber hypertrophy, collagen deposition, and α-MHC expression compared with WT-MI mice. Together, these results reveal a protective role for MCIP1 in the post-MI heart and suggest that calcineurin is a crucial regulator of postinfarction-induced pathological LV remodeling. The improvement in functional, structural, and molecular abnormalities in MCIP1-TG mice challenges the adaptive value of post-MI hypertrophy of the remote myocardium. The full text of this article is available online at http://circres.ahajournals.org. (Circ Res. 2004;94:e18-e26.)

Key Words: myocardial infarction • heart failure • calcineurin • signaling • hypertrophy

Despite significant progress in the prevention and treatment of cardiovascular disease in the United States in the past two decades, statistics indicate that the incidence and prevalence of heart failure have been increasing steadily, especially in the elderly. Chronic heart failure affects 4.8 million Americans and is the leading cause of hospitalization for people aged 65 years and over. Despite improved medical treatment and intense investigation, heart failure is a leading cause of morbidity and mortality in industrial countries.1,2

A fundamental shift in the underlying etiology of heart failure is becoming evident, in which the most common cause of chronic heart failure is no longer hypertension or valvular disease, but rather coronary artery disease (CAD) and long-term survival after myocardial infarction (MI).1 Unfortunately, the prognosis of patients with heart failure and CAD is considerably worse compared with heart failure without CAD.1 MI induces scar formation and global changes in surviving myocardium, designated post-MI ventricular remodeling. This process consists of an initial wall thinning of the infarcted area, ventricular chamber dilation, side-to-side slippage, and eccentric myocyte hypertrophy of the individual myofibers in the noninfarcted (remote) portion of the myocardium.3 In spite of clinical evidence that the postinfarcted heart often progressively dilates and displays accelerated deterioration of left ventricular function, the early hypertrophic remodeling of the viable portion of the left ventricle (LV) after ischemic damage is considered an adaptive response to compensate for the acute loss of functional myocardium and preserve cardiac performance.4
Sustained cardiac hypertrophy has been recognized as the single most important risk factor for heart failure development, at least in conditions with increased load such as chronic hypertension or valvular disease, and a powerful predictor for cardiovascular morbidity and mortality.\textsuperscript{5} One signaling pathway that links extracellular stimuli to a hypertrophic transcriptional response of the myocyte uses the Ca\textsuperscript{2+}–calmodulin–dependent phosphatase calcineurin and its downstream transcriptional effector nuclear factor of activated T cells (NFAT).\textsuperscript{6,7} Pressure overload hypertrophy studies using genetic mouse models that prevent calcineurin–NFAT activation have confirmed its crucial role in this form of hypertrophic remodeling.\textsuperscript{8–11} Whether calcineurin is involved in myocyte hypertrophy post-MI, or whether inhibition of this type of hypertrophic remodeling may have therapeutic potential, remains uncertain. To address these questions, we pursued a genetic approach to evaluate the functional significance of calcineurin in post-MI cardiac remodeling, using a genetic mouse model with mild myocyte-restricted overexpression of MCIP1, which was previously shown to efficiently antagonize cardiac hypertrophy in response to an activated calcineurin transgene, after pressure overload or \(\beta\)-adrenergic stimulation.\textsuperscript{10,12} Accordingly, MCIP1-TG mice and their wild-type littermates were randomized to receive either a large transmural LV infarct or sham operation. We confirmed increased calcineurin activation and substantial hypertrophy in the LV 4 weeks after MI in WT mice, whereas TG mice were protected against both characteristics. Remarkably, MCIP1-TG mice also demonstrated preservation of LV geometry and contractility, improved survival, a diminution of \(\beta\)-MHC expression, and a pronounced reduction in interstitial collagen deposition in the remote myocardium. These findings suggest that calcineurin activation is crucial for maladaptive post-MI remodeling.

**Materials and Methods**

**Animals and Surgical Procedures**

All protocols were approved by institutional guidelines. All surgeries and subsequent analyses were performed in a blinded fashion for genotype. Eight-week-old mice from both sexes carrying the human MCIP1 transgene under the control of the \(\alpha\)MHC promoter (an order of magnitude overexpression of MCIP1 at the mRNA level) in a C57BL/6 background (TG)\textsuperscript{10} and their nontransgenic littermates (WT) were anesthetized with 2.4% isoflurane and placed in a supine ventilator (Hugo Sachs Elektronik, Germany; stroke volume 250 \textsuperscript{\circ} C). Animals were intubated with a 19G needle and their body temperature was maintained at \(37^\circ\) C. Echocardiography was performed using a Sonos 5500 ultrasound machine (Hewlett-Packard) with a 12-MHz transducer applied parasternally to the shaved chest wall. For optimal resolution, the transducer was covered with a surgical latex finger filled with ultrasound transmission gel to obtain a standoff of 0.5 to 0.7 cm and used at a depth setting of 2 cm. The transducer was maneuvered to obtain both live 2-dimensional (2-D) images in a parasternal long-axis and short axis view and 2-D guided M-mode tracings crossing the anterior wall, LV cavity, and posterior wall. Images were stored on an optical disk and analyzed offline using EnConcert Image Diagnosis Application (Philips, Netherlands). All parameters were measured on both live 2-D images and M-mode tracings and averaged from four cardiac cycles.

**Invasive Pressure Measurement**

After the animals were anesthetized with urethane, a 1.4F high-fidelity micromanometer catheter (Millar Instruments) was introduced into the right carotid artery, advanced into the left ventricle, and pressure measurements were performed as described previously.\textsuperscript{13}

**Northern Blot Analysis**

Northern blot analysis for MCIP1 was performed with 20 \(\mu\)g of total RNA in each lane and probed in Ultraspec (Ambion) with a \(32^P\)-labeled DNA fragment encompassing the 5\textsuperscript{\prime} exon 4 splice variant of murine MCIP1 (Radprime, Invitrogen). Northern blot analysis for ANF, \(\beta\)-MHC, and GAPDH was performed as previously described.\textsuperscript{14} Signals were detected using a phosphor imaging screen (Biorad), and quantified with Quantity 1 software (Biorad).

**Calcineurin Activity Assay**

Phosphatase activity was measured using the calcineurin (PP2B) Assay kit (cat No. 20700, Calbiochem) according to the manufacturer’s instructions. Calcineurin activity was measured as the dephosphorylation rate of a synthetic phosphopeptide substrate (RII peptide).

**Histological Analysis**

Four weeks after MI, all animals were anesthetized, and the hearts were arrested in diastole and perfused antegradely at physiological pressures with PBS containing 1 mg/mL sodium nitroprusside and 5% formalin. Heart tissue was fixed in 3.7% formaldehyde, cut either (1) longitudinally and perpendicular to the infarcted area and aortic root or (2) transversally, and embedded in paraffin. Sections (4 \(\mu\)m) were cut and stained with AZAN, laminin, hematoxylin and eosin (H&E), or Sirius red.\textsuperscript{15} Longitudinal AZAN-stained sections were used to determine infarct size. A computerized morphometric system (Quantimet 570, Leica) was utilized to calculate the percentage of LV tissue stained positive for Sirius red. Interstitial collagen was also monitored with Sirius red stained sections. The amount of collagen was determined as the percentage of left ventricular tissue stained positive for Sirius red. Because the presence of collagen was more intense toward the apex, measurements were presented for both the whole septum and the apical half of the septal wall.

**Statistical Analysis**

The results are presented as mean±SEM. Statistical analyses were performed by using INSTAT 3.0 software (GraphPad) and ANOVA followed by Tukey’s post hoc test when appropriate. Statistical significance was accepted at a value of \(P<0.05\).
Results

MCIP1 Overexpression Attenuates Postinfarction-Induced Calcineurin Activation

After MI, the heart undergoes an adaptive response that is accompanied by eccentric hypertrophy of the noninfarcted myocardium. Although calcineurin is activated and intimately involved in pressure overload-induced hypertrophy, it is uncertain whether calcineurin is also activated during postinfarction remodeling.

To explore this, calcineurin (PP2B) activity was first measured as the dephosphorylation rate of a synthetic phosphopeptide substrate. Calcineurin activity was elevated by 35% in the remote myocardium of WT-MI mice (P<0.05). In contrast, total calcineurin activity was decreased in TG-MI hearts by 26% compared with WT-MI (Figure 1A). LV Calcineurin Aβ abundance has previously been shown to correlate with LV PP2B activity. Calcineurin Aβ immuno-reactivity was increased by 19% in WT-MI compared with the corresponding sham group (P<0.05), whereas this increase amounted to only 6% TG-MI animals (NS; Figure 1B).

Because activated calcineurin dephosphorylates members of the NFAT family, which in turn drive expression of the MCIP1 exon 4 splice isoform via an upstream cluster of NFAT binding sites, the phosphorylation status of two cardiac NFAT members and expression level of the MCIP1 exon 4 splice isoforms was determined. As expected, endogenous NFATc1 and NFATc3 decreased by 51% and relatively higher endogenous PP2B activity. In contrast, the levels of both phosphorylated NFATc1 and NFATc3 decreased by 16% (P<0.05) in WT-MI compared with the corresponding sham group (P<0.05), whereas this increase amounted to only 6% TG-MI animals (NS; Figure 1C).

Expression of the MCIP1 exon 4 isoform provides an additional indication of myocardial calcineurin activity in vivo (see Discussion). The MCIP1 exon 4–specific probe was designed to the untranslated 5′ region of the endogenous mouse 2.2 kb mRNA and therefore does not detect transcripts from the MCIP1 transgene. Northern blot analysis indicated an approximate 9-fold induction of the 5′ exon 4 splice variant of MCIP1 expression after MI in WT hearts, whereas in TG-MI hearts, only a 2-fold induction was observed (Figure 1D and Discussion). Collectively, these results indicate that calcineurin is activated in the LV after MI, and that MCIP1 overexpression efficiently counteracts the activation characteristics of cardiac calcineurin.

MCIP1 Overexpression Attenuates LV Hypertrophy After MI

No significant difference in infarct size was observed between MCIP1-TG animals and their nontransgenic littermates (WT-MI 41±3% versus TG-MI 38±4%; Figure 2A).

A more prominent increase in the HW/BW ratio was observed in the WT-MI group (48%) compared with MCIP1-TG MI mice (24%; P<0.05). The hypertrophic remodeling was more pronounced in the LV and this was reflected in LVW/BW and LVW/TL ratios, which both showed a 77% and 78% increase in WT-MI mice, and only a 36% and 41% increase in the MCIP1-TG groups, respectively (Table 1). Measurement of septal wall thickness in histological sections further supported these findings (WT-MI 1.1±0.1 mm versus TG-MI 0.8±0.2 mm; P<0.05). Interestingly, in both genotypes, females exhibited less pronounced hypertrophy than their male littermates (data not shown). Atrial weight (AW) and right ventricular weight (RVW) increased to a similar extent in both WT-MI and MCIP1-TG animals (Table 1).

Laminin-staining demonstrated an 81±2% increase of the cross-sectional area of myocytes in the spared myocardium in...
the WT-MI group, whereas TG-MI mice only demonstrated a 29±7% increase relative to corresponding, noninfarcted, control groups (Figure 2C). Conclusively, these findings indicate that MCIP1 overexpression protects the myocardium against postinfarction hypertrophy.

**Preservation of Cardiac Geometry and Function in MCIP1 TG Mice After MI**

To examine the impact of MCIP1-mediated attenuation of postinfarction hypertrophy on hemodynamic behavior, all groups were subjected to 2-D and M-mode echocardiography.

**Figure 2.** Attenuated hypertrophy after MI in MCIP1 transgenic mice. A, Morphometric analyses of AZAN sections indicate no significant difference in infarct size between the wild-type and MCIP1 transgenic mice (n=6 in both groups). B, After MI, an increase in LVW in the wild-type mice is evident (n=10), which is significantly blunted in the MCIP1 transgenic mice (n=12). *P<0.05 vs sham-operated group; †P<0.05 vs WT-MI group. C, Laminin staining reveals a significant increase in cardiomyocyte size after MI compared with the sham-operated animals, which is more pronounced in wild-type animals compared with MCIP1 transgenic animals (n=4 in both sham groups, n=6 in both MI groups). Bar=0.1 mm. Quantification of cross-sectional area of myofibers from indicated groups shows significant attenuation of myocyte hypertrophy in MCIP1 transgenic mice. *P<0.05 vs sham-operated group; †P<0.05 vs WT-MI group.

**TABLE 1.** Morphological Characteristics in Wild-Type and MCIP1 TG Mice After Sham Operation and 4 Weeks After Myocardial Infarction

<table>
<thead>
<tr>
<th></th>
<th>Sham</th>
<th>Myocardial Infarction</th>
<th>Percent Change TG Versus WT 4 Weeks After MI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WT</td>
<td>TG</td>
<td>WT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>HW, mg</td>
<td>114±2</td>
<td>112±4</td>
<td>169.6±9*</td>
</tr>
<tr>
<td>LWM, mg</td>
<td>77±2</td>
<td>76±5</td>
<td>137±10*</td>
</tr>
<tr>
<td>RWM, mg</td>
<td>19.5±2</td>
<td>21.8±3</td>
<td>28.1±2*</td>
</tr>
<tr>
<td>Lung weight, mg</td>
<td>150±4</td>
<td>153±3</td>
<td>162±5</td>
</tr>
<tr>
<td>Liver weight, mg</td>
<td>909±33</td>
<td>880±34</td>
<td>1042±50</td>
</tr>
<tr>
<td>Atrial weight, mg</td>
<td>10.9±0.8</td>
<td>10.5±0.5</td>
<td>15.7±2.2</td>
</tr>
<tr>
<td>TL, mm</td>
<td>21.5±0.1</td>
<td>21.9±0.2</td>
<td>21.5±0.2</td>
</tr>
<tr>
<td>BW, g</td>
<td>23.8±0.7</td>
<td>22.9±0.4</td>
<td>23.9±1.0</td>
</tr>
<tr>
<td>HW/BW, mg/g</td>
<td>4.8±0.1</td>
<td>4.9±0.1</td>
<td>7.1±0.4*</td>
</tr>
<tr>
<td>HW/TL, mg/mm</td>
<td>5.3±0.1</td>
<td>5.1±0.1</td>
<td>7.9±0.5*</td>
</tr>
</tbody>
</table>

Data are expressed as mean±SEM. TG indicates transgenic; HW, heart weight; LWM, left ventricular weight; RWM, right ventricular weight; TL, tibial length; and BW, body weight.

*P<0.05 vs corresponding sham group; †P<0.05 vs WT postinfarction group.
3 days and 4 weeks after MI, because hypertrophic remodeling in mice starts 3 days after the ligation of the coronary artery. Representative images of M-mode recordings are shown in Figure 3A. Already 3 days after infarct, an increase in left ventricular internal diameter (LVID) and decrease in contractility was evident in both MI groups compared with sham-operated animals, with no functional or geometric differences between WT-MI and TG-MI (Table 2). In contrast, 4 weeks after MI, a thickening of the posterior wall in diastole (PWthd) and a further increase in LVID was visible in WT-MI mice, suggestive of progressive LV dilation (Table 2). These geometric changes were accompanied by a further functional deterioration in WT-MI mice as indicated by progressive decreases in fractional shortening (FS) and ejection fraction (EF) compared with the corresponding sham group (Figure 3B). The presence of the MCIP1 transgene resulted in a significant reduction of PWthd and LVID in response to MI, and a preservation of FS (Table 2) and EF (Table 2).

To further evaluate the hemodynamic profile of all experimental groups, invasive pressure measurements were performed. A relatively lower systolic baseline function was observed in sham-TG compared with sham-WT mice (Table 3). At present, we have no explanations for this difference. More importantly, the response of both genotypes to MI was clearly different. In the WT-MI group, a dramatic decrease in LV dP/dtmax, LV dP/dtmin, LVEF, and LVDP was observed (P < 0.05). In contrast, TG-MI mice showed a marked preservation of these parameters, and this level of preservation correlates well with the echocardiographic observations (Table 3 and Figure 3).

Taken together, these results indicate that MCIP1 overexpression specifically alters the late phase of post-MI remodeling rather than the acute response to the infarct itself and efficiently counteracts the geometric and functional deterioration after MI.

**Overexpression of MCIP1 Improves Survival After Myocardial Infarction**

The survival rates of WT and MCIP1-TG mice were evaluated up to 4 weeks after MI. The survival of WT-MI mice was 89% and 61% at 1 and 4 weeks after surgery, whereas
MCIP1-TG MI mice displayed a survival of 90% and 79%, respectively (Figure 3C). Differences in survival became evident in the last 3 weeks before euthanasia (Figure 3C) and was more pronounced in male littermates (data not shown). These observations correlate well with the fact that infarct acceptance. The use of genetically modified mice with hypertrophic signals in the heart has gradually gained more acceptance. The involvement of calcineurin as a transducer of prohypertrophic signals in the heart has been studied extensively. Previous studies have shown that inhibition of calcineurin activity reduces or enhances calcineurin activity in the heart has been effective in reducing infarct size and improving postinfarction survival.

Attenuated Intersitial Collagen Deposition After Calcineurin Inhibition in MI

H&E staining confirmed the presence of extensive myofiber hypertrophy and disarray in WT-MI mice (Figure 4A), accompanied by a patchy presence of cellular infiltrates in the interstitial compartment (indicated by arrowheads). These histological alterations in response to infarction were nearly absent in TG-MI hearts similar to both sham-operated groups (Figure 4A). In the noninfarcted area, reactive fibrosis, such as perivascular and interstitial fibrosis, was observed in a gradient with more pronounced presence of collagen deposition toward the infarct. WT-MI mice exhibited the most severe fibrotic alterations, both expressed as percentage of the complete septum (10%) as well as the lower apical half of the septal wall (16%), and this was substantially attenuated in MCIP1-TG MI mice (Figure 4B). These results indicate that the presence of the MCIP1 transgene led to a significant reduction of the major structural alterations of the remote myocardium in the postinfarcted heart.

Cardiac Gene Expression in Infarcted Hearts With Calcineurin Inhibition

We examined the gene expression profile of genes activated during postinfarction hypertrophy. At 4 weeks after MI, an induction of both ANF and β-MHC was observed in WT-MI hearts relative to corresponding sham-operated mice, indicating the activation of a fetal cardiac gene program. ANF expression was similar in both TG-MI and WT-MI hearts. In contrast, the induction of β-MHC expression was significantly blunted in TG-MI hearts compared with WT-MI hearts (Figure 5). These results indicate that the transcriptional response of the MCIP1 transgenic animals is different than that of wild-type animals during MI-induced LV remodeling.

Discussion

Suppression of Postinfarction Hypertrophic Remodeling by MCIP1

The involvement of calcineurin as a transducer of prohypertrophic signals in the heart has gradually gained more acceptance. The use of genetically modified mice with reduced or enhanced calcineurin activity in the heart has

### TABLE 2. Echocardiographic Characteristics in Wild-Type and MCIP1 TG Mice After Sham Operation and After Myocardial Infarction

<table>
<thead>
<tr>
<th></th>
<th>Sham</th>
<th>3 Days After MI</th>
<th>4 Weeks After MI</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WT</td>
<td>TG</td>
<td>WT</td>
<td>TG</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR</td>
<td>400±81</td>
<td>402±17</td>
<td>388±12</td>
<td>390±15</td>
</tr>
<tr>
<td>PWhd, mm</td>
<td>0.68±0.05</td>
<td>0.67±0.06</td>
<td>0.73±0.05</td>
<td>0.73±0.02</td>
</tr>
<tr>
<td>PWths, mm</td>
<td>1.39±0.07</td>
<td>1.29±0.06</td>
<td>1.31±0.03</td>
<td>1.28±0.07</td>
</tr>
<tr>
<td>LVIDd, mm</td>
<td>3.52±0.12</td>
<td>3.21±0.07</td>
<td>4.44±0.13</td>
<td>4.34±0.13*</td>
</tr>
<tr>
<td>LVIDs, mm</td>
<td>1.68±0.08</td>
<td>1.52±0.04</td>
<td>3.11±0.11*</td>
<td>3.10±0.10*</td>
</tr>
<tr>
<td>% FS</td>
<td>62.75±2.3</td>
<td>58.5±2.8</td>
<td>35.5±3.4*</td>
<td>32.5±1.5*</td>
</tr>
<tr>
<td>% FS</td>
<td>52.2±2.0</td>
<td>52.6±1.4</td>
<td>29.3±1.4*</td>
<td>29.7±1.3*</td>
</tr>
</tbody>
</table>

Data are expressed as mean±SEM. TG indicates transgenic; PWhd, posterior wall thickness in diastole; PWths, posterior wall thickness in systole; LVIDd, left ventricular internal diameter in diastole; LVIDs, left ventricular internal diameter in systole; FS, left ventricular fractional shortening calculated as (LVIDd−LVIDs)/LVIDd; and EF, left ventricular ejection fraction.

*P<0.05 vs corresponding sham group; †P<0.05 vs WT 4-week postinfarction group.

### TABLE 3. Hemodynamic Characteristics in Wild-Type and MCIP1 TG Mice After Sham Operation or Myocardial Infarction

<table>
<thead>
<tr>
<th></th>
<th>Wild-Type</th>
<th>Percent Change</th>
<th>MCIP1 Transgenic</th>
<th>Percent Change</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Sham</td>
<td>MI</td>
<td>Versus Corresponding Sham Group</td>
<td>Sham</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td></td>
<td></td>
<td>n</td>
</tr>
<tr>
<td>LV dP/dtmax, mm Hg · s⁻¹</td>
<td>9338±481</td>
<td>6202±903</td>
<td>−34</td>
<td>5522±886</td>
</tr>
<tr>
<td>LV dP/dtmin, mm Hg · s⁻¹</td>
<td>−6645±672</td>
<td>−4681±517</td>
<td>−30</td>
<td>−5128±651</td>
</tr>
<tr>
<td>LVIDd, mm</td>
<td>93.5±4.9</td>
<td>72.9±4.7</td>
<td>−22</td>
<td>66.4±6.2</td>
</tr>
<tr>
<td>LVIDs, mm</td>
<td>94.6±5.3</td>
<td>76.9±4.3</td>
<td>−19</td>
<td>67.1±6.1</td>
</tr>
<tr>
<td>LVEDP, mm</td>
<td>1.1±1.0</td>
<td>4.1±1.5</td>
<td>372</td>
<td>0.8±0.3</td>
</tr>
</tbody>
</table>

Data are expressed as mean±SEM. LV dP/dtmax indicates first maximal derivative of left ventricular pressure; LV dP/dtmin, first minimal derivative of left ventricular pressure; LVIDd, left ventricular end-diastolic pressure; LVIDs, left ventricular end-systolic pressure; and LVEDP, left ventricular end-diastolic pressure.
confirmed the pathological role of this enzyme in cardiac muscle cell biology.8–11,16,20 Most studies, however, have focused on the function of calcineurin in hypertrophy development after acute increases in loading conditions (e.g., aortic banding procedures) or agonist infusion protocols. The potential role of calcineurin in LV remodeling after ischemic loss of functional myocardium has remained ill defined. In view of the increasing proportion of heart failure patients with coronary artery disease as a primary etiology,1 elucidation of the regulatory pathways controlling postinfarction remodeling will have both fundamental and therapeutic avenues.

Preceding the present study, three groups have used rat models of myocardial infarction (MI) in combination with systemic delivery of the calcineurin inhibitor cyclosporin A (CsA) to address the role of calcineurin in post-MI remodeling. All three groups found a correlation between CsA administration and reduced postinfarct hypertrophy.21–23 CsA toxicity and potential calcineurin-independent effects of CsA can confound interpretation of these studies.20 Our findings from the present study using MCIP1 transgenic mice are in agreement with the rat studies insofar as the attenuation of hypertrophy is concerned. However, in contrast to some of the CsA studies, long-term prognosis of the MCIP1 transgenics is improved compared with wild-type rather than in the CsA-treated rats, which showed a more rapid progression toward heart failure. The MCIP1-TG mice allowed us to achieve cardiac-specific inhibition of calcineurin without the concern of secondary drug effects or systemic toxicity.20

Quantification of calcineurin phosphatase activity from tissue lysates using biochemical assays is problematic, due to the dynamic, calcium/calmodulin-dependent regulation of activity and the sensitivity of calcineurin to oxidation of the Fe-Zn active center, and does not reflect the proportion of the enzymatic calcineurin pool that is actually in an active state. We could detect both increased phosphatase activity and more abundant presence of the calcineurin A isoform after MI in wild-type mice. We also used the phosphorylation status of endogenous NFAT and expression levels of the NFAT-responsive exon 4 splice variant of MCIP1 as criteria to monitor calcineurin activity.10 These assays were in line with increased calcineurin activation in the postinfarcted heart. The present study confirms the earlier documented calcineurin activation profile in the postinfarcted LV, but our interpretation of its value in LV remodeling differs in several respects from other studies.

**Postinfarction Hypertrophy Is Maladaptive in Nature**

Myocardial hypertrophy is traditionally viewed as a long-term adaptive response of the cardiac muscle to either altered mechanical loading conditions (e.g., resulting from valvular disease or hypertension) or decreased performance due to loss of contractile units (e.g., after MI).4 After this interpretation, increased wall thickness serves as the means to restore wall stress in line with the law of Laplace.4 Recent insights into the particulars of the hypertrophic phenotype, however, have demanded a more nuanced interpretation of this phenomenon of “compensatory hypertrophy.” First, ventricular hypertrophy is demonstrably a risk factor for cardiovascular mortality.
of natriuretic peptides in the calcineurin-NFAT axis. Conclusively, Laplace’s law, although conceptually sound, does not take into account any qualitative alterations of the wall, and only incompletely explains the phenotypic particulars of heart enlargement.

Third, several studies using genetically engineered mice with markedly blunted growth responses to pressure overload appear to be protected from adverse effects of stress signaling and heart failure progression. In fact, Esposito et al subjected normal and hypertrophy-resistant mice to aortic constriction and observed that hemodynamic function and overall cardiac geometries were better preserved in hypertrophy-resistant mice than in wild-type mice, despite the inability of the transgenic mice to correct wall stress. Hence, the value of normalizing wall stress through hypertrophic myocardial growth is dispensable for the preservation of cardiac function in the face of a long-term hemodynamic burden.

The findings in the present study fortify the conclusions that postinfarction-, and load-induced reactive signaling and hypertrophic remodeling share fundamental similarities and may be equally deleterious in nature. One outspoken observation in postinfarcted MCIP1 overexpressing mice was their marked inhibition of interstitial collagen deposition. It is important to note, that the MCIP1 transgene is targeted exclusively to the cardiac muscle cell population, which suggests a crucial role and hierarchy for the cardiomyocyte expression that are reminiscent of fetal cardiac myocytes. In many of quantitative and qualitative changes in cardiac gene expression, most prominently to pressure overload and chronic adrenergic stimulation. We interpret the protective effects of MCIP1 on post-MI cardiac pathology to reflect the reduction in calcium load and observed that hemodynamic function and chronic adrenergic stimulation. We take into account any qualitative alterations of the wall, and only incompletely explains the phenotypic particulars of heart enlargement.

Dual Roles of MCIP1 in Calcineurin Signaling

Although we interpret the protective effects of MCIP1 on post-MI cardiac pathology to reflect the reduction in calcium load and observed that hemodynamic function and chronic adrenergic stimulation. We interpret the protective effects of MCIP1 on post-MI cardiac pathology to reflect the reduction in calcium load and observed that hemodynamic function and chronic adrenergic stimulation. We interpret the protective effects of MCIP1 on post-MI cardiac pathology to reflect the reduction in calcium load and observed that hemodynamic function and chronic adrenergic stimulation. We interpret the protective effects of MCIP1 on post-MI cardiac pathology to reflect the reduction in calcium load and observed that hemodynamic function and chronic adrenergic stimulation. We interpret the protective effects of MCIP1 on post-MI cardiac pathology to reflect the reduction in calcium load and observed that hemodynamic function and chronic adrenergic stimulation. 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MCIP1 Overexpression Suppresses Left Ventricular Remodeling and Sustains Cardiac Function After Myocardial Infarction

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