Cardiac fibrosis and down regulation of GLUT4 in experimental diabetic cardiomyopathy are ameliorated by chronic exposures to intermittent altitude

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Abstract

Introduction: Chronic intermittent hypoxia is considered as a preconditioning status in cardiovascular health to inducing resistance to the low oxygen supply. Diabetic cardiomyopathy leads to inability of the heart to effective circulation of blood preventing of consequent tissue damages so; the aim of this study was elucidation of effect of chronic exposure to hypoxia on Cardiac fibrosis and expression of GLUT4 in experimental diabetic cardiomyopathy.

Methods: A total number of 30 rats were randomly divided into three groups; 1: Normoxia control group (NN, n = 10). 2: Normoxia diabetic group (ND, n = 10) that took fat diet for 2 weeks then were injected by streptozotocin (37 mg/kg) and 3: Hypoxia diabetic group (HD, n = 10): that were exposed to chronic intermittent hypoxia (CIH) (altitude ≈3400 m, 14% oxygen for 8 weeks). After hypoxia challenge, plasma metabolic parameters including: fasting blood glucose (FBS), triglyceride (TG) and total cholesterol (TC) were measured by colorimetric assay. Cardiac expression of GLUT4 protein and cardiac collagen accumulation were determined in the excised left ventricle by western blotting, and Masson trichrome staining respectively.

Results: Based on resultant data, FBS, TG and TC were significantly ($P$ < 0.05) decreased in HD vs. ND. Homeostasis Model Assessment (HOMA) were also significantly attenuated after exposed to CIH in HD group compared to ND group ($P$ < 0.05). Significant increase in packed cell volume and hemoglobin concentration was observed in HD group compared to ND group ($P$ < 0.05). Comparison of heart wet weight between three groups showed a significant difference ($P$ < 0.05) with lower amount in HD and ND versus NN. Myocardial fibrosis was significantly more pronounced in ND when compared to NN. Eight weeks exposure to hypoxia ameliorated this increase in HD group. Intermittent hypoxia significantly increased GLUT4 protein expression in HD compared to ND group ($P$ < 0.05).

Conclusion: Data suggested that CIH might potentiate to improve glucose homeostasis and cardiac tissue structural damages created in type 2 diabetes (T2D).

by decreasing in the glucose trafficking across plasma membrane of myocardium cells by glucose transporters (GLUTs). GLUT4 is the most important transferring isoform of glucose, which is extensively expressed in insulin sensitive cells such as adipose tissues, skeletal muscles, and cardiomyocytes. Any kind of down regulation or conformational change in it cause to its malfunction, which is commonly happens in diabetes, leads to irregularity in glucose homeostasis. The capacity of GLUT4 synthesis also fall down inside the cells6,7 in T2D.

On the other hand, unknown hypertrophy in diabetic patients is without noticeable symptoms, which, according to the recent findings, is experienced by 56% of the diabetic patients. Myocyte hypertrophy is common in the biopsy of the diabetic heart.7 In some diabetic model rats, increased cardiac mass has been reported in 9 and 12 weeks. Moreover, an increase in the left ventricular (LV) mass and its septum thickness in streptozotocin-induced diabetic has been also reported.9 T2D is identified by the utilization decrease of glucose, the consumption increase of fatty acid, calcium-handling disorder, compromised mitochondrial energies, and the increase of cardiac connective tissues which are leading to induction of apoptosis by triggering of Fas receptors.9 Altitude is a potential condition for the reductions of morbidity and mortality rates for 400 million people who live around 1500 m above the sea level.1 The findings from the population of Andes indicate that the incidence of heart diseases low among people who live in high altitudes.12 In a research done in altitude of around 4260 m, no instances of cardiac infarction or coronary heart disease are found.13 It seems that the symptoms of moderate altitude appear quickly as a moderate altitude like stress may result in the reconstruction of cardiorespiratory reflections.12 Voors and Johnson have found a negative relationship between altitude and mortality in several big cities with more than 1650 m above sea level in the United States.14 This finding has also been confirmed with other recent studies.12,15 In Switzerland, the age mortality rate caused by cardiovascular diseases among 100 thousand people living in an altitude of above 1500 m has been shown to have a meaningful decrease among both men and women.16 High altitude may also have a protective role against cardiovascular and chronic respiratory diseases.17 Residence in a condition of hypoxia especially its intermittent type mimics a conditions like live in altitude creates. Chronic intermittent hypoxia (CIH) is considered as a useful experimental condition in cardiovascular health. From biological point of view, it is supposed that HIF-1 (Hypoxia Inducible Factor-1) may play a central role in pathophysiology of hypoxia.18 Moreover, it has already been shown that if rats be placed in hypoxic condition, their cardiac structure will changed. It is also reported that glucose consumption by heart is increased (by 70%) in simulated altitude hypoxia (14%-15% of oxygen saturation). Regular and chronic exercise in hypoxic condition can increase glycogen supply and glucose tolerance as well as raised expression of GLUT4.19 Similar finding was shown in Dill et al study on prolonged hypoxia which could induce GLUT4 expression and improve glucose metabolism in the cardiomyocytes and the whole body cells.20

Despite clear evidence in effect of altitude, only a few studies are available on the mechanism of effect of altitude on mortality rate caused by common diseases. Also, the effect of altitude on type 2 diabetic patients, especially on their heart, has been considered even much less. Therefore, further research in this field can shed light on mechanism of effect of altitude or CIH. Therefore, our hypothesis is that CIH may affect cardiac structure and metabolism that subsequently, may lead to improve diabetic cardiomyopathy. So, in this study, we aimed to know whether cardiac fibrosis, hypertrophy and down regulation of GLUT4 are ameliorated by chronic exposures to intermittent altitude in experimental diabetic cardiomyopathy.

Materials and methods

Animals

30 Male Wistar rats weighed 200-220 g at the start of experiment. Rats were bought from Pasteur Institute (Tehran, Iran) and were acclimatized to our lab for a period of one week before starting the intervention. Each rat was housed alone in one regular cage and was maintained less than 12 hours light/dark cycles in a quiet environment with 50% humidity and 22 ± 1°C temperature. The animals were fed standard lab rat chow dieting water ad libitum. Animals were equally divided into three groups: Normal normoxia group (NN, n = 10): healthy control rats living in normoxic conditions. Normoxia diabetic group (ND, n = 10): Diabetic control rats receiving fat rich diet for 2 weeks before intra-peritonealy receiving streptozotocin (Sigma Aldrich, USA) also living in normoxic conditions. Hypoxia diabetes group (HD, n = 10): rats treated in similar conditions with ND group but were exposed to CIH.

Induction of diabetes

Before injection, rats were fed with high-fat diet including carbohydrates (35%), proteins containing all essential amino acids (15%), lipids (50%), vitamins (0.5%) and minerals for 2 weeks. Then rats were assigned to the diabetic groups and injected intra-peritoneal (i.p.) with 37 mg/kg streptozotocin citrate buffer (0.1M, pH 4.5) 21 3-4 days after the injection of STZ, to confirm the induction of diabetes fasting blood glucose (FBG) measured in one-drop blood sample obtained from vein tail. FBG levels were rapidly measured by a digital blood glucose meter (Accu-Check Sensor, Roche, Mannheim, Germany). FBG more than 300 mg/dL were confirmed as diabetic rats and were included into the study.

Simulation altitude

Chronic exposure to intermittent hypoxia (CIH) was per-
formed by an environmental hypoxic chamber while rats were kept on it for 8-12 h/day and accessed to food and water and libitum. Hypoxia was made by placing animals (HD group) in a one large room chamber (length = 80 cm; width = 50 cm; high = 150 cm) with a partial pressure of 14% for oxygen. A balanced flow of the partial pressure of oxygen of 14% (PIO2 ≈ 106 mm Hg, altitude ≈ 3400 m) was created inside the chamber all over the 12-hour period, and an alarm oxygen sensor was used to check the oxygen concentration. (GO2Altitude, Biomed tech, Australia Pty. Ltd, Melbourne). Normoxia groups including normal and diabetic groups were maintained for 8 weeks at baseline (Tabriz, Iran) (PIO2 = 159 mm Hg, altitude ≈ 1100 m).

Sample collection
In the end of experiment, after 12 hours fasting, rats were deeply anesthetized with ketamine HCl (100 mg/kg) and xylazine (10 mg/kg) i.p. By using a syringe, Blood samples were totally withdrawn from the heart and divided into two tubes, one containing ethylenediaminetetraacetic acid (EDTA) and another one as separator tube without any anticoagulant to prepare plasma and serum, respectively. In serum tube, supernatant was collected by centrifuge at 3000 x g for 15 minutes after clot formation at RT. All serum samples were aliquoted and kept at −20°C to avoid repeated freeze–thaw. Whole blood was subjected to measurement of hematologic parameters by cell counter (Exigo-vet, Sweden). The heart of each animal was cutout from the chest and after removing of atria and large vessels was weighed. A mid LV section was vertically cut and fixed in 10% formaldehyde. Some ventricles tissues were quickly frozen in liquid nitrogen and were kept at -80°C for following immunobloting assay.

Biochemical measurements
Glycemic parameters including FBG and fasting blood insulin (FBI) were measured by enzymatic end procedure and enzyme linked immunosorbsort assay respectively. FBG, total cholesterol (TC) and triglyceride (TG) determined in serum using Pars Azmoon kits (Tehran, Iran). Homeostasis model of insulin resistance (HOMA-IR) was calculated as described:

\[
\text{HOMA-IR} = (\text{FBG} \text{ (mmol/l)} \times \text{fasting insulin (mIU/ml)} \times \text{fasting glucose (mg/dl)} / 405
\]

Statistical analysis
The results were expressed as mean ± SEM and analyzed using SPSS (version 18). To compare of means we used ANOVA followed by Tukey test as post hoc test. P<0.05 was considered as statistical significance.

Results

Mortality and survival
There was no mortality in control group throughout ex-
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Metabolic indexes
FBI was significantly decreased in STZ-diabetics groups compared to normoxia normal group (P<0.05). Table 1 shows CIH caused a diminish in FBG concentration after 8 weeks (243.250 ± 24.5229; P = 0.02) compared to ND group. HOMA-IR was significantly improved after exposure to hypoxia in HD group (2.14 ± 0.18) compared to ND group (3.4400 ± 0.2441) (P<0.05). In addition, total serum cholesterol and TG levels were significantly decreased in HD compared to ND group (P<0.05; Table 1).

Hematological parameters
The hematologic data were showed in Table 2. Significant decrease in red blood cell (RBC), hemoglobin (Hb) and hematocrit percentage (HCT%) were observed in ND group compared to NN group. Whereas significant increase in HCT%, Hb concentration and mean corpuscular hemoglobin (MCH) were observed in HD group compared to ND group (P<0.05). However, the total white blood cell (WBC) and lymphocyte counts were increased in the ND group but hypoxia return them to normal levels. WBC count was not significantly changed in the diabetic groups (Table 2).

Body weight and hypertrophic parameters
The initial mean body weights of the rats in the three groups before treatment did not differ. At the end of the 8-week CIH, the body weight of the ND group was significantly lower than that of the NN group (P<0.05) (Table 3). At the end of the study period, the means of heart wet weight among the three groups showed a significant difference (P<0.05; Table 3) with a lower weight in diabetic groups (ND and HD). Eight weeks treatment in hypoxic condition, could not improve weight loss in heart. There was no significant difference in the heart to body weight ratio between diabetic animals compared to normoxia normal control rats (3.5792 ± 0.13633 vs. 3.8457 ± 0.14081) as well as HD did not showed any change in this ratio. The ventricular weight was significantly decreased in ND group (0.4438 ± 0.01861) but there was no significant difference in the means of LV weight between NN group (0.5763 ± 0.02834) and HD group (0.5117 ± 0.03380). The hypoxia treatment significantly increased the LV to heart weight ratio, compared to normoxia diabetic group and backed to the normal state in NN group without altering the heart to body weight ratio (Table 3).

Histopathological examination
The ventricular myocardium under normoxia showed normal architecture (Figure 1B and C). The characteristics of diabetic cardiomyopathy including disarray and myocardial degeneration were found in LV sections of the diabetic groups with hematoxylin-eosin staining (Figure 1A). The ventricular myocardium under normobaric hypoxia showed less disarrangement and abnormality in architecture vs. normoxia diabetic group. Myocardial fibrotic remodeling, as reflected by trichrome staining of myo-

Table 1. Effect of hypoxia on serum levels of metabolic parameters and biomarkers of diabetic’s rat

<table>
<thead>
<tr>
<th>Normoxia control (n=10)</th>
<th>Normoxia diabetes (n=8)</th>
<th>Hypoxia diabetes (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting blood glucose (mg/dl)</td>
<td>104.68 ± 5.01</td>
<td>356.53 ± 40.15&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Fasting blood insulin (µU/L)</td>
<td>5.10 ± 0.14</td>
<td>3.44 ± 0.24&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>QUICKI</td>
<td>1.18 ± 0.01</td>
<td>0.92 ± 0.03&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>HOMA-IR</td>
<td>1.31 ± 0.08</td>
<td>3.52 ± 0.38&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Total serum cholesterol (mg/dl)</td>
<td>67.12 ± 1.31</td>
<td>76.00 ± 1.79&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>TG (mg/dl)</td>
<td>50.87 ± 1.97</td>
<td>57.37 ± 2.66&lt;sup&gt;a&lt;/sup&gt;</td>
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</tbody>
</table>

Abbreviation: FBG, fasting blood glucose; FBI, fasting blood insulin; TG, triglyceride; HOMA-IR, homeostasis model assessment (HOMA) of insulin resistance; QUICKI, Quantitative insulin sensitivity check index.
<sup>a</sup> P < 0.05 compared with control group.

Table 2. Effect of hypoxia on serum levels of hematologic parameters of diabetic rats

<table>
<thead>
<tr>
<th>Normoxia control (n = 10)</th>
<th>Normoxia diabetes (n = 8)</th>
<th>Hypoxia diabetes (n = 8)</th>
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<tbody>
<tr>
<td>WBC (10&lt;sup&gt;9&lt;/sup&gt;/L)</td>
<td>3.25 ± 0.20</td>
<td>6.12 ± 0.82&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>LYM (10&lt;sup&gt;9&lt;/sup&gt;/L)</td>
<td>1.80 ± 0.13</td>
<td>3.75 ± 0.59&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>MON (10&lt;sup&gt;9&lt;/sup&gt;/L)</td>
<td>0.21 ± 0.04</td>
<td>0.31 ± 0.04</td>
</tr>
<tr>
<td>Gran (10&lt;sup&gt;9&lt;/sup&gt;/L)</td>
<td>1.24 ± 0.07</td>
<td>2.06 ± 0.33</td>
</tr>
<tr>
<td>HCT (%)</td>
<td>38.34 ± 0.77</td>
<td>33.51 ± 0.61&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hb (g/dl)</td>
<td>12.78 ± 0.25</td>
<td>11.17 ± 0.20&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>MCH (pg)</td>
<td>18.31 ± 0.73</td>
<td>18.54 ± 1.03</td>
</tr>
<tr>
<td>RBC (10&lt;sup&gt;12&lt;/sup&gt;/L)</td>
<td>7.03 ± 0.24</td>
<td>6.11 ± 0.25&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Abbreviation: WBC, white blood cell; LYM, lymphocyte; MON, monocyte; Gran, granulocyte; HCT, hematocrit; Hb, hemoglobin; RBC, red blood cell; MCH, mean corpuscular hemoglobin. <sup>a</sup> P < 0.05 compared with control group. <sup>b</sup> P < 0.05 compared with Diabetes group. Data are represented as mean ± SEM.
cardial sections, was significantly more pronounced in the ND, when compared to NN and HD groups ($P < 0.05$). This increase in HD group was lower than ND group (Figure 1B). Semi-quantitative scoring of the staining showed a significant difference in LV fibrosis between the three groups (Figure 1C).

**GLUT4 expression**

The Heart GLUT4 protein expression was measured 24 hours after exposure to hypoxia. The resultant data from immunoblotting assay of GLUT4 protein in ND and HD were presented as the relative density of NN group. STZ induced diabetes significantly decreased GLUT4 Protein expression compared to NN group (Figure 2), but hypoxia significantly increased GLUT4 protein expression in heart compared with ND group ($P < 0.05$).

**Discussion**

To the best of our knowledge, this is the first time that a study evaluates effect of CIH on diabetic cardiomyopathy. In the current study, the most striking findings are that increased expression of GLUT4 protein decreased collagen accumulation in cardiac tissue and improved glucose homeostasis in CIH diabetic rats vs. diabetic rats. Increased GLUT4 immunoreactivity was in compliance to Chou et al findings; They observed a significant increase in GLUT4 protein under 4 weeks hypoxia in rats cardiac muscle. Increased expression of GLUT4 protein in the heart may suggest elevated expression of GLUT4 in all muscles of the body. Another important finding of this study is that CIH as a simulation of altitude suppressed diabetes-induced hyperglycemia and elevated HOMA-IR that partially resulted from increased GLUT4 protein expression in the heart tissue cells. Furthermore, chronic and intermittent hypoxia treatment could rearrange lipidic parameters such as plasma levels of TC and TG. Similar to our work, Mackenzie et al showed that intermittent hypoxia caused to increased acute glucose clearance in T2D.7

Energy deprivation associated with hypoxia and pressure overload leads to the activation of AMP-activated protein kinase (AMPK) in the myocytes. AMPK, a serine/threonine protein kinase, acts as a fuel sensor responsible for mediating the cellular adaptation to nutritional and environmental stress. AMPK has important metabolic roles in cardiac muscle. Activation of AMPK by 5-aminoimidazole-4-carboxamide-1-β-D-ribofuranoside (AICAR) increases muscle glucose uptake in vivo and in vitro by a phosphatidylinositol 3-kinase independent mechanism. AMPK has also been implicated to have a key role in the stimulation of glucose transport in the ischemic heart. Activation of AMPK leads to translocation of GLUT4 glucose transporters to the cell surface. However, the events downstream from AMPK that modulate GLUT4 translocation are largely unknown. Modified regulation of cardiac metabolism in T2D has been well established. In di-

**Table 3. Heart weights and body weights parameters. Data are represented as mean ± SEM**

<table>
<thead>
<tr>
<th></th>
<th>Normoxia control (n = 10)</th>
<th>Normoxia diabetes (n = 8)</th>
<th>Hypoxia diabetes (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial BW (g)</td>
<td>245.75 ± 6.04</td>
<td>246.00 ± 6.84</td>
<td>237.16 ± 5.75</td>
</tr>
<tr>
<td>Final BW (g)</td>
<td>298.12 ± 3.49</td>
<td>274.37 ± 10.07*</td>
<td>269.83 ± 9.50</td>
</tr>
<tr>
<td>Heart wet wt (g)</td>
<td>1.14 ± 0.04</td>
<td>0.97 ± 0.03†</td>
<td>0.97 ± 0.04</td>
</tr>
<tr>
<td>LV wet wt (g)</td>
<td>0.57 ± 0.02</td>
<td>0.44 ± 0.01†</td>
<td>0.51 ± 0.033</td>
</tr>
<tr>
<td>Heart wt/body wt x 1000</td>
<td>3.84 ± 0.14</td>
<td>3.57 ± 0.13</td>
<td>3.63 ± 0.14</td>
</tr>
<tr>
<td>LV wt/heart wt x 10</td>
<td>5.02 ± 0.14</td>
<td>4.54 ± 0.08</td>
<td>5.23 ± 0.26*</td>
</tr>
</tbody>
</table>

Abbreviations: wt; weight, LV; left ventricular.

* $P < 0.05$ compared with control group.

† $P < 0.05$ compared with diabetes group.

**Figure 1.** Histopathological analysis of left ventricular (LV) tissue sections stained with (A) Hematoxylin and Eosin (B) Masson trichrome and (C) Quantification of interstitial fibrosis with Masson trichrome stain were measured after 8 week from normoxia normal control group (NN), normoxia diabetes (ND), and chronic intermittent hypoxia diabetes (HD). Where blue = fibrous collagen, and red = cardiomyocytes 400X magnification. *$P < 0.05$. 

[Image of Table 3 and Figure 1]
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Based on the presented results, CIH improves glucose homeostasis, regulates metabolic parameters, ameliorates the heart tissue fibrosis and finally switches the diabetic hypertrophy to physiological hypertrophy in heart. Thus, we can suggest that chronic exposure to intermittent hypoxia (mimics of altitude) as a noninvasive intervention, may be a good choice to control of glucose and prevention of diabetic cardiomyopathy.

**Conclusion**

Based on the presented results, CIH improves glucose homeostasis, regulates metabolic parameters, ameliorates the heart tissue fibrosis and finally switches the diabetic hypertrophy to physiological hypertrophy in heart. Thus, we can suggest that chronic exposure to intermittent hypoxia (mimics of altitude) as a noninvasive intervention, may be a good choice to control of glucose and prevention of diabetic cardiomyopathy.

**Acknowledgments**

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**Competing Interests**

Authors declare no conflict of interest in this study.

**Ethical issues**

The compliance of all steps of this experiment with the National Institutes of Health publication (revised in 1996)
were approved by the Animal Care and Use Committee of Tabriz University of Medical Sciences (Tabriz, Iran).

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