Recovery of trout myocardial function following anoxia: preconditioning in a non-mammalian model

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Gamperl, A. K., A. E. Todgham, W. S. Parkhouse, R. Dill, and A. P. Farrell. Recovery of trout myocardial function following anoxia: preconditioning in a non-mammalian model. Am J Physiol Regulatory Integrative Comp Physiol 281: R1755–R1763, 2001.—Studies with mammals and birds clearly demonstrate that brief preexposure to oxygen deprivation can protect the myocardium from damage normally associated with a subsequent prolonged hypoxic/ischemic episode. However, it is not known whether this potent mechanism of myocardial protection, termed preconditioning, exists in other vertebrates including fishes. In this study, we used an in situ trout (Oncorhynchus mykiss) working heart preparation at 10°C to examine whether prior exposure to 5 min of anoxia (P<sub>2</sub>O<sub>2</sub> ≤ 5 mmHg) could reduce or eliminate the myocardial dysfunction that normally follows 15 min of anoxic exposure. Hearts were exposed either to a control treatment (oxygenated perfusion) or to one of three anoxic treatments: 1) anoxia with low P<sub>out</sub> (15 min of anoxia at an output pressure (P<sub>out</sub>) of 10 cm H<sub>2</sub>O; 2) anoxia with high P<sub>out</sub> (10 min of anoxia at a P<sub>out</sub> of 10 cm H<sub>2</sub>O, followed by 5 min of anoxia at P<sub>out</sub> = 50 cm H<sub>2</sub>O); and 3) preconditioning (5 min of anoxia at P<sub>out</sub> = 10 cm H<sub>2</sub>O, followed after 20 min of oxygenated perfusion by the protocol described for the anoxia with high P<sub>out</sub> group). Changes in maximum cardiac function, measured before and after anoxic exposure, were used to assess myocardial damage. Maximum cardiac performance of the control group was unaffected by the experimental protocol, whereas 15 min of anoxia at low P<sub>out</sub> decreased maximum stroke volume (V<sub>max</sub>) by 15% and maximum cardiac output (Q<sub>max</sub>) by 23%. When the anoxic workload was increased by raising P<sub>out</sub> to 50 cm H<sub>2</sub>O, these parameters were decreased further (by 23 and 38%, respectively). Preconditioning with anoxia completely prevented the reductions in V<sub>max</sub> and Q<sub>max</sub> that were observed in the anoxia with high P<sub>out</sub> group and any anoxia-related increases in the input pressure (P<sub>in</sub>) required to maintain resting Q (16 ml·min<sup>-1</sup>·kg<sup>-1</sup>). Myocardial levels of glycogen and lactate were not affected by any of the experimental treatments; however, lactate efflux was sevenfold higher in the preconditioned hearts. These data strongly suggest that 1) a preconditioning-like mechanism exists in the rainbow trout heart, 2) increased anaerobic glycolysis, fueled by exogenous glucose, was associated with anoxic preconditioning, and 3) preconditioning represents a fundamental mechanism of cardioprotection that appeared early in the evolution of vertebrates.

IN 1986, MURRY ET AL. (33) reported that prior exposure of the dog heart to short periods of ischemia greatly diminished the degree of myocardial necrosis that resulted from exposure to 30 min of ischemia and reperfusion. This phenomenon, termed preconditioning, has been the focus of intense research over the past 15 years. Ischemic preconditioning has been demonstrated in nearly every mammalian species studied, including humans, and most recently in birds (39). It appears that a wide variety of stimuli have the ability to trigger preconditioning-like effects in the mammalian heart, and researchers have made significant progress in understanding which signaling pathways and end-effectors are central to the infarct-limiting ability of preconditioning (9, 34, 35).

In contrast to the extensive work that has been conducted on preconditioning and myocardial protection against acute hypoxia/ischemia in mammals, scant research has been conducted on lower vertebrates. In the fishes, a vertebrate group containing over 20,000 species, there exists a wide range of myocardial sensitivity to oxygen-limiting conditions. For example, although the tuna heart is extremely sensitive to even modest decreases in environmental oxygen (6) and the in situ trout heart fails rapidly when required to maintain routine cardiac work under severely hypoxic conditions (1), the hearts of eel (23) and hagfish (2, 22) are able to maintain cardiac function during prolonged periods of hypoxia and/or anoxia. Given the scope of hypoxia sensitivity in fishes, it could be concluded that mechanisms that mediate anoxia/hypoxia tolerance are absent in fishes in which myocardial performance and viability are compromised by acute exposure to conditions of limited oxygen availability. However, it is also possible that the hearts of hypoxia-intolerant fishes, like those of mammals, only require biochemical or other signals to trigger the protective mechanisms that are inherent in hypoxia/anoxia-tolerant fishes. To our knowledge, there is no

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experimental evidence to suggest that mechanisms of myocardial protection can be triggered in hypoxia-intolerant lower vertebrates or that a mechanism similar to preconditioning exists in fishes. If preconditioning can be confirmed in the fish heart, this would strongly suggest that this phenomenon developed early in vertebrate evolution and would be a very important discovery in the context of cardiovascular/integrative biology.

The present study examined whether a prior 5-min anoxic exposure could reduce the degree of myocardial dysfunction that results when the in situ rainbow trout (Oncorhynchus mykiss) heart is exposed to 15 min of anoxia. In addition, lactate efflux and myocardial levels of glycogen and lactate were measured to investigate whether any improvements in myocardial function were associated with changes in carbohydrate metabolism. We selected the in situ rainbow trout heart as a model for studying myocardial preconditioning in fishes for several reasons. Foremost, the largest knowledge base on cardiac anatomy, biochemistry, and physiology exists for this species. Second, the in situ trout heart can perform at workloads equivalent to maximum in vivo levels (29, 47). This makes it an extremely tractable preparation for examining anoxic preconditioning. Third, previous experiments (1, 19) demonstrated that the hearts of this species are normally extremely hypoxia intolerant. Last, the time course and magnitude of the loss of myocardial function during acute anoxia are similar in the trout and rabbit at 20°C (19, 29). These data suggest that the hypoxia/anoxia sensitivity of the trout and mammalian heart is comparable.

METHODS

Experimental animals. Rainbow trout (O. mykiss), 498 ± 28 g, were obtained from a local supplier (West Creek Trout Farms, Aldergrove, BC, Canada) and maintained in 2,000-liter fiberglass tanks supplied with dechlorinated Vancouver tap water. These fish were held under natural photoperiod at a temperature of 10 ± 1°C, and fed commercial trout pellets ad libitum daily.

Surgical procedures. Fish were anesthetized in an oxygenated and buffered solution of tricaine methane sulfonate (0.1 g/l MS-222; 0.1 g/l sodium bicarbonate) and transferred to an operating table where their gills were irrigated with oxygenated and buffered anesthetic (0.05 g/l MS-222; 0.05 g/l sodium bicarbonate) at 4–6°C. Fish were injected with 1.0 ml of heparinized (10 IU/ml) saline via the sinus venosus, through a hepatic vein and provided an initial assessment of cardiac viability. The heart was maintained at this initial control level of performance for a period of 10 min to allow it to recover from surgery and for equilibration of the saline bath. Thereafter, P\text{in} was gradually increased until Q reached 25 ml\text{min}^{-1}\text{kg}^{-1}. This brief cardiac stretch cleared any air bubbles from within the heart and provided an initial assessment of cardiac viability. Hearts that required more than a 2-cmH\text{2}O increase in P\text{in} to reach a Q of 25 ml\text{min}^{-1}\text{kg}^{-1} were discarded and assumed to have poor cannula placement, cannula obstruction, or myocardial damage.

After the cardiac stretch, Q was reset to 16 ml\text{kg}^{-1}\text{min}^{-1} for 25 min, and the hearts were randomly assigned to one of the four experimental protocols (n = 7 or 8). These protocols (schematically illustrated in Fig. 1) were identical in duration (~1.5 h) and were designed to examine the effect of anoxic workload and anoxic preexposure (preconditioning) on the recovery of resting and maximum cardiac function. The groups were I control: these hearts were exposed to oxygen-
ated saline, and changes in P_out were identical to those for the anoxia with high P_out group; 2) anoxia with low P_out; 15 min of anoxia (saline PO_2 ≤ 5 mmHg) at a P_out of 10 cmH_2O; 3) anoxia with high P_out; 10 min of anoxia at a P_out of 10 cmH_2O followed by 5 min of anoxia at P_out = 50 cmH_2O; and 4) preconditioning: 5 min of anoxia at P_out = 10 cmH_2O followed after 20 min of oxygenated perfusion by the protocol described for the anoxia with high P_out group. For all hearts, maximum Q (Q_{max}) was measured before and 30 min after anoxic exposure, and resting cardiac function was recorded before Q_{max} \_1, before the 15-min anoxic period and before Q_{max} \_2. In this way, each heart acted as its own control. Q_{max} was measured by increasing P_in to 3.0 cmH_2O, then to 4.0 cmH_2O, and finally to 4.5 cmH_2O (Fig. 1). These levels of P_in were reached by gradually increasing P_in over ~1 min, and P_in was maintained at 3.0, 4.0, and 4.5 cmH_2O for ~20 s to ensure that cardiac function had stabilized.

Several preliminary experiments showed that hearts failed to regain contractile function when P_in was increased in an effort to maintain resting Q during the anoxic challenge. Therefore, P_in was not adjusted and Q was allowed to fall during periods of anoxia (or during identical periods for the control group). Although Q was quickly returned to 16 ml·min\(^{-1}\)·kg\(^{-1}\) following all anoxic periods, P_out was maintained at 10 cmH_2O following anoxic exposure for 5 or 10 min. (see Fig. 1). Reducing P_out following anoxia facilitated the functional recovery of the hearts by 1) reducing the amount of pressure development required by the heart to produce positive flow and 2) reducing the time before oxygenated perfusion was restored to the myocardium.

Following Q_{max} \_2, the heart was stabilized at a resting Q of 16 ml·min\(^{-1}\)·kg\(^{-1}\) for 2 min. Thereafter, the fish was quickly moved to the surgical table, and isolation of the heart from the experimental bath was verified by connecting a 3-ml syringe to the input cannula and ensuring that a negative pressure was created when the plunger was retracted. The beating heart was then quickly removed from the pericardiun, weighed, and freeze-clamped with aluminum tongs.

Perfusate samples were collected 15 and 30 min after the main anoxic period to determine the rate of myocardial lactate efflux (Fig. 1). Perfusate samples were collected for 1 min with Q set at 16 ml·min\(^{-1}\)·kg\(^{-1}\). Heart tissue and perfusate samples were stored at ~80°C before biochemical analyses were performed.

Instrumentation and data analysis. An in-line electromagnetic flow probe (Zepeda Instruments, Seattle, WA) was used to record Q, and pressure transducers (Narco Life Sciences, Houston, TX) were used to measure P_in and P_out through saline-filled sidearms. Before experimentation, pressure changes due to cannula resistance were calculated at known flow rates. These values were then used to adjust P_in and P_out to those in the sinus venosus and bulbus arteriosus, respectively. Pressure transducers were calibrated daily against a static water column and were referenced to the saline level in the experimental bath. Pressure and flow signals were amplified and displayed on a four-channel chart recorder (Gould, Cleveland, OH), which was coupled to a microcomputer running Labtech Notebook (Laboratory Technologies, Wilmington, MA). Data were continuously collected at 5 Hz, and block averages were calculated every 5 s. Heart rate (f_H) was measured by counting the number of systolic peaks recorded during a 10-s period.

Stroke volume was calculated as: \( V_s = (Q/f_H)/M_b \)

where Q is measured in milliliters per minute and M\(_b\) is body mass in kilograms.

Biochemical measurements. Whole hearts were powdered under liquid N\(_2\) using a precooled mortar and pestle and added to ice-cold 0.6 N perchloric acid (PCA). The PCA extracts were homogenized on ice for 2 × 15 s at maximum speed with a tissue homogenizer (Ultragene). An aliquot was immediately frozen for determination of glycogen. The remaining PCA extract was then centrifuged at 13,000 rpm at 4°C in a microcentrifuge. A known volume of the supernatant was removed and immediately transferred to another Eppendorf tube and neutralized with saturated Tris. The neutralized extracts were stored at ~80°C until analysis.

Glycogen was digested with amyloglucosidase, and glucose levels were determined as described by Parkhouse et al. (37). Muscle lactate was also determined as described by Parkhouse et al. (37). Perfusate lactate concentration was determined on 100-μl aliquots, and lactate efflux rate was calculated as

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\text{Lactate efflux rate (nmol·ventricle g}^{-1} \cdot \text{min}^{-1}) = \frac{\text{perfusate lactate conc (nmol/ml) \times cardiac output (ml/min)}}{\text{ventricular mass (g)}}
\]

Statistics. All statistical analyses were performed using StatView Software (SAS Institute, Cary, NC). One-way
ANOVARs were used to compare parameters between the treatment groups, including 1) body and ventricular mass, 2) the percent change in maximum cardiac performance (before anoxia vs. after), and 3) differences in lactate efflux rate and heart biochemical levels. Repeated-measures ANOVAs were performed for comparison of 1) maximum cardiac performance (before anoxia vs. after) within a specific treatment group and 2) resting $P_{\text{in}}$ (before $Q_{\text{max}1}$, anoxia, and $Q_{\text{max}2}$) within and between treatment groups. A repeated-measures ANOVA could not be used to examine treatment differences in $Q$ during the 15-min anoxic challenge because of a significant interaction ($P < 0.001$) between treatment and within-treatment (time) effects. Therefore, separate repeated-measures ANOVAs were performed for the first 10 min of anoxia (all groups at $P_{\text{out}} = 10$ cmH$_2$O) and for the last 5 min of anoxia when anoxia with high $P_{\text{out}}$ and preconditioned hearts were exposed to a $P_{\text{out}} = 50$ cmH$_2$O. Between-group differences were identified using Fisher’s least-significant difference post hoc test, and within-treatment effects were examined using Dunnett’s post hoc tests or multiple contrasts. All percentage data were arc-sine transformed before any statistical tests were run. $P < 0.05$ was used as the level of statistical significance in all analyses.

RESULTS

Fish mass (498 ± 28 g) and ventricular mass (0.516 ± 0.02 g) were not significantly different ($P > 0.05$) among the treatment groups. In addition, there were no significant differences in resting cardiovascular parameters between the groups at the start of the experiment. A mean $P_{\text{in}}$ of $-0.39 ± 0.02$ cmH$_2$O was required to maintain the resting $Q$ of 16 ml.min$^{-1}$.kg$^{-1}$ and, at this $Q$, $V_s$ and $f_h$ were 0.33 ± 0.02 ml/kg and 56.6 ± 4.3 beats/min, respectively. There were also no differences in $Q$ (45.4 ± 2.2 ml.min$^{-1}$.kg$^{-1}$), $V_s$ (0.93 ± 0.07 ml/kg), or $f_h$ (50.0 ± 3.3 beats/min) between groups at $Q_{\text{max}}$. $f_h$ varied considerably among the 30 preparations at $Q_{\text{max}}$. However, this had no apparent effect on $Q_{\text{max}1}$, because $V_{s \text{max}}$ and $f_h$ were negatively correlated. $V_{s \text{max}}$ decreased by ~0.14 ml/kg with every 10 beat/min increase in $f_h$ (Fig. 2).

$Q$ fell gradually in the anoxia with low $P_{\text{out}}$ group, reaching $10.1 ± 1.2$ ml.min$^{-1}$.kg$^{-1}$ by the 15th min of anoxia (Fig. 3). The rate of decline in $Q$ during the first 10 min was comparable to that measured in the other two groups exposed to anoxia (anoxia with high $P_{\text{out}}$ and preconditioning). However, $Q$ immediately fell by 50% when $P_{\text{out}}$ was raised to 50 cmH$_2$O and remained at ~5–7 ml.min$^{-1}$.kg$^{-1}$ until the heart was reoxygenated. Preconditioning had no significant effect on the decreases in $Q$ that were associated with the duration of anoxia or an increase in cardiac workload ($P_{\text{out}}$). These results indicate that anoxic duration and workload, but not preconditioning, significantly influenced cardiac function during anoxia.

$Q_{\text{max}}$, $V_{s \text{max}}$, and $f_h$ were not affected by the control protocol. In contrast, 15 min of anoxia with low $P_{\text{out}}$ significantly ($P < 0.05$) decreased $V_{s \text{max}}$ (by 0.14 ml.min$^{-1}$.kg$^{-1}$, 15%) and $Q$ (by 9.8 ml.min$^{-1}$.kg$^{-1}$, 23%; Fig. 4). Again, it was clear that myocardial workload during anoxia significantly influenced cardiac function. Increasing $P_{\text{out}}$ to 50 cmH$_2$O for 5 min during the anoxic period caused a further reduction in both $V_{s \text{max}}$ (by 23%) and $Q_{\text{max}}$ (by 38%). Preconditioning completely eliminated the reductions in $V_{s \text{max}}$ and $Q_{\text{max}}$ that were associated with anoxic exposure. When the $P_{\text{in}}$ required to maintain resting $Q$ was used as an index of cardiac function, similar effects of anoxic cardiac workload and preconditioning were observed (Fig. 5). $P_{\text{in}}$ increased by ~0.4 cmH$_2$O in the control and anoxia with low $P_{\text{out}}$ groups, and by 0.8 cmH$_2$O in the anoxia with high $P_{\text{out}}$ group, during the last half of the experiment. However, $P_{\text{in}}$ was unchanged in preconditioned hearts over this time period.
In the control group, the rate of lactate efflux rate was 24.5 and 13.7 nmol·min⁻¹·g ventricle⁻¹ at time points equivalent to 15 and 30 min postanoxia (Table 1). The rate of lactate efflux was highly variable in the three anoxic groups at 15 min postanoxia. Thus, although lactate efflux values for these groups were 1.5- to 3-fold greater compared with the control group, these differences were not significant (P = 0.32). Lactate efflux was significantly elevated (~7-fold) in the preconditioned hearts at 30 min postanoxia compared with the other three groups (Table 1). Myocardial concentrations of lactate and glycogen at the end of the experiment were not significantly different between groups (Table 1).

**DISCUSSION**

In our experiments, we showed that 5 min of anoxic preexposure completely eliminated the loss of maximum and resting cardiac function that normally followed 15 min of anoxia (P<sub>0.2</sub><sub>2</sub>=5 mmHg). These data strongly suggest that a preconditioning-like mechanism exists in the trout heart. This is a novel finding, the implications of which are discussed below.

**In situ trout hearts: performance and anoxia tolerance.** In our experiments at 10°C, physiological levels of resting Q (27) were achieved at slightly negative filling pressures (P<sub>in</sub>; approximately −0.4 cmH₂O), and maximum values of Q and V<sub>o</sub> were 45.4 ± 2.2 ml·min⁻¹·kg⁻¹ and 0.93 ± 0.07 ml/kg, respectively. These values compare very well with those measured in other in situ experiments (15, 16, 27) and with direct measurements of cardiac performance in trout during intense exercise (47). Collectively, these favorable comparisons indicate that the trout hearts were not damaged during surgery and that our findings with regard to myocardial hypoxia tolerance and preconditioning
are relevant to the whole animal. Despite the good health of the preparations used in these experiments, an increase in $P_{\text{out}}$ (~0.8 cm H2O) was needed during the 2-h experiment to maintain resting $Q$ (Fig. 5). This small change in perfusion conditions likely reflects a diminished myocardial sensitivity to the tonic levels of epinephrine in the perfusate (15 nM). Epinephrine has positive chronotropic and inotropic effects on the trout heart (12, 17, 21), and the slight fall in $f_H$ during the experiments (~8%) would necessitate an increase in resting $P_{\text{in}}$ to elevate $V_s$ and restore $Q$.

Previous studies with working in situ heart preparations strongly suggest that the trout heart is intolerant of anoxia or severe hypoxia. Farrell et al. (18) showed that the threshold $P_{\text{out}}$ for maintaining maximum power output is between 46 and 67 mmHg. Arthur et al. (1) demonstrated that the severely hypoxic ($P_{\text{O}_2} < 5$ mmHg) perfused trout heart failed rapidly when cardiac workload was raised to in vivo levels. A similar conclusion was reached using isolated trout myocardial strips where only 40% of initial force development is recovered after 30 min of anoxia (19). We made several observations that confirm the anoxia/hypoxia sensitivity of the in situ trout heart: 1) in preliminary experiments, hearts made to perform at resting in vivo physiological pressure (50 cmH2O) for 10 min during anoxia could not be recovered (not shown), 2) $Q$ fell immediately by ~50% when $P_{\text{out}}$ was raised to 50 cmH2O during anoxia (Fig. 3), and 3) increasing workload during anoxia resulted in greater decreases in $V_s$ and $Q_{\text{max}}$ (Fig. 4). In view of this hypoxia intolerance, we consider the rainbow trout heart to be a suitable non-mammalian model for preconditioning studies.

Significant levels of lactate were detected in the perfusate leaving control hearts, and the rate of lactate efflux was greater at 15 min than at 30 min after these hearts were exposed to a $P_{\text{out}}$ of 10 cmH2O (Table 1). These results suggest that some anaerobic metabolism had occurred in the myocardium despite continuous perfusion of the heart lumen with oxygenated saline ($P_{\text{O}_2} > 600$ mmHg). We suspect that lowering $P_{\text{out}}$ to 10 cmH2O altered cardiac anatomy sufficiently to negatively impact $O_2$ delivery to the myocardium and that the lactate that accumulated during this period was still washing out of the heart 15 min after $P_{\text{out}}$ had been restored to 50 cmH2O. It is unlikely, however, that the level of hypoxia experienced by control hearts was severe. The rate of lactate efflux (24.5 nmol-min$^{-1}$-g ventricle$^{-1}$) was <1% of that reported for severely hypoxic ($P_{\text{O}_2} < 5$ mmHg) in situ trout hearts performing at basal workloads (3.21 nmol-min$^{-1}$-g ventricle$^{-1}$; Ref. 1).

At $Q_{\text{max}}$, there was a significant negative relationship between $f_H$ and $V_s$, but not between $f_H$ and $Q$ (Fig. 2). These data are consistent with previous studies on cardiac function in hearts acclimated to and tested at different temperatures (13, 21, 27) and point to a strong interdependence between $f_H$ and $V_s$ in the in situ trout heart that is not temperature dependent. Whether this effect is due to inadequate time for ventricular filling (decreased end-diastolic volume) or the inability of the ventricle to empty completely (increased end-systolic volume) awaits direct studies of heart chamber volumes during maximum cardiac function. Nonetheless, the results indicate that changes in $f_H$ must be considered when interpreting the effect of experimental perturbations on $V_s$.

**Preconditioning in the trout heart.** The phenomenon of preconditioning, originally described by Murry et al. (33), has been shown to exist in almost all homeothermic vertebrates examined to date (for an exception, see Ref. 31). Preconditioning has been demonstrated in mice, dogs, pigs, rats, and rabbits, and evidence is now accumulating that preconditioning exists in the human heart (8, 20, 25, 50). In addition, Rischard and McKeon (39) showed that the buffer-perfused pigeon heart could be preconditioned. In our study, we demonstrated that prior exposure to 5 min of anoxia was sufficient to eliminate the myocardial dysfunction that normally follows 15 min of anoxic exposure (Figs. 4 and 5). These data strongly suggest that preconditioning exists in the hypoxia-intolerant rainbow trout heart and that the phenomenon of preconditioning appeared early in the evolution of vertebrates.

We caution, however, that these results should not be interpreted as evidence that the entire trout heart was preconditioned by anoxic preexposure. The rainbow trout ventricle has two types of myocardia: an outer compact myocardium, which is normally perfused with highly oxygenated arterial blood supplied by the coronary artery, and an inner spongious myocardium, which is continuously exposed to a hypoxic microenvironment because it is perfused by the venous blood that percolates through its trabecular sinusoids. In rainbow trout of the size used in this study, we would expect 35–45% of the ventricle to be composed of compact myocardium (14). Thus it is feasible that the 38% reduction in $Q_{\text{max}}$ following the high workload anoxic protocol was primarily or solely the result of damage to the compact myocardium and that this is the only myocardium that was salvaged by the preconditioning protocol. The mammalian literature contains evidence that both supports and refutes the idea that the trout’s compact myocardium, but not its continuously hypoxic spongious myocardium, was precondi-

### Table 1. Myocardial biochemistry and lactate efflux in trout hearts exposed to anoxic or oxygenated saline

<table>
<thead>
<tr>
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<th>Lactate Efflux, nmol·g$^{-1}$·min$^{-1}$</th>
<th>Myocardial Concentrations, μM/g</th>
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<td></td>
<td>15 min</td>
<td>30 min</td>
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<td></td>
<td>Lactate</td>
<td>Glycogen</td>
</tr>
<tr>
<td>Control</td>
<td>24.5 ± 5.0</td>
<td>13.7 ± 2.7</td>
</tr>
<tr>
<td>Anoxia low $P_{\text{out}}$</td>
<td>37.4 ± 21.9</td>
<td>14.3 ± 2.0</td>
</tr>
<tr>
<td>Anoxia high $P_{\text{out}}$</td>
<td>42.2 ± 10.5</td>
<td>12.8 ± 3.6</td>
</tr>
<tr>
<td>Preconditioned</td>
<td>72.9 ± 24.7</td>
<td>80.0 ± 31.9</td>
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Values are means ± SE; $n = 7$ or 8 hearts. Hearts were sampled for biochemical analysis 2 min after the second maximal cardiac output ($Q_{\text{max}}$) test. Dissimilar symbols indicate group values that were significantly different from each other ($P < 0.05$) as determined by ANOVA and Fisher's least-significant difference tests. $P_{\text{out}}$, output pressure.
tioned. Hearts from newborn rabbits that were raised for 7–10 days in a hypoxic environment (12% O2) could not be preconditioned (4). Furthermore, a decreasing tolerance of the rat heart to ischemia during postnatal life was counteracted by the ability to be preconditioned (36). In contrast, Tajima et al. (46) demonstrated that the protective effects of chronic hypoxia (3 wk, 10% O2) and preconditioning on posts ischemic functional recovery of the adult rat heart were additive. Whether preconditioning in the fish heart is limited to compact myocardium that is supplied with oxygen-rich coronary arterial blood in vivo awaits further study. However, it is conceivable that preconditioning mechanisms are absent in the two-thirds of teleost fish species in which hearts are without a coronary circulation (42).

This is the first study of preconditioning in fish. Therefore, it is not known whether the pathways and end-effectors responsible for myocardial preconditioning in fish are similar to those proposed for mammals (34, 35, 50). The substantial increase in lactate efflux in preconditioned hearts following 30 min of anoxia (Table 1) suggests that increased anaerobic glycolysis is associated with anoxic preconditioning of the trout heart. This finding agrees with previous studies on rabbit hearts where preconditioning increased myocardial lactate production and reduced myocardial necrosis during low-flow ischemia (26). However, it contrasts with studies in the dog or rat that show that lactate efflux is decreased or unchanged in preconditioned hearts (7, 10, 33). The increased lactate production by preconditioned hearts could have been fueled by myocardial glycogen stores or by exogenous glucose. However, we believe that exogenous glucose was the predominant fuel source used by preconditioned trout hearts to enhance anaerobic glycolysis during the 15 min of anoxia. This conclusion is supported by recent experiments on the hypoxia-tolerant American eel (An
guilla rostrata L.) heart showing a requirement for extracellular glucose for anaerobic performance (3) and an upregulation of facilitated glucose transport during anoxia (40). Furthermore, studies on mammalian hearts indicate that 1) preconditioning-induced increases in lactate production during ischemia are paralleled by changes in exogenous glucose uptake (26), 2) ischemic preconditioning is associated with increased glucose uptake and increased glycolysis from glucose (10, 48), and 3) increased glycolytic rate and use of exogenous glucose during ischemia increase functional recovery (49). The use of exogenous glucose during ischemia may have additional benefits for the ischemic/hypoxic mammalian myocardium that are independent of increases in total glycolytic flux (41). Although there is no direct evidence that similar mechanisms of myocardial protection are exhibited by the fish heart, Driedzic et al. (11) demonstrated that tension development in myocardial strips from hypoxia-adapted Zo
arces viviparous could be restored to preanoxic levels if glucose, but not pyruvate, was provided in combination with 3 mM Ca2+.

While the glycolytic metabolism of extracellular glucose appears to be important in the preconditioning response of trout hearts, it is unlikely that alterations in cardiac function can explain the ability of our preconditioning protocol to improve functional recovery of the trout heart. Q and cardiac work during the 15 min of anoxia were not significantly different between hearts exposed to preconditioning or anoxia with high Pout protocols (Fig. 3).

Limitations of the current study. In our study, we showed that the negative effects of 15 min of anoxia on performance of the in situ trout heart could be alleviated by prior exposure to a 5-min period of anoxia. Although this indicates that our protocol improved functional recovery of the trout myocardium following anoxia, the interpretation of whether this effect represents preconditioning is dependent on the definition used. In its strictest sense (termed “classical preconditioning”), preconditioning refers to the ability of short periods of ischemia and reperfusion (or other stimuli) to reduce or delay myocardial necrosis/infarction following a subsequent period of prolonged ischemia. Although we attempted to measure the release of creatine kinase (CK) as an index of myocardial necrosis (26) in these experiments, CK levels in the perfusate were below the detection limit of our spectrophotometric assay (<10 units). Therefore, we are unable to conclude whether the enhanced recovery of myocardial function in hearts preexposed to 5 min of anoxia was associated with a reduction in necrosis, the prevention of contractile dysfunction in viable myocardium (“stunning”), or both. Nevertheless, recent studies suggest that both a reduction in infarct size and the prevention of stunning are characteristic of myocardial preconditioning. First, Mosca et al. (32) showed that preconditioning with 5 min of ischemia prevented stunning but that the degree of necrosis was slight (~10%) and similar between preconditioned and control hearts. Second, Perez et al. (38) convincingly demonstrated that ischemic preconditioning prevents abnormalities in myofilament function that were previously shown to be associated with reversible postischemic contractile dysfunction. Consequently, we feel confident that our results provide direct evidence that preconditioning exists in the trout heart.

Hearts in these experiments were sampled 35 min after the end of anoxia and frozen ~20–30 s after perfusate flow to the heart was stopped. Although we report no differences in myocardial metabolite levels between groups at the end of the experiment, we do not know whether differences existed shortly after anoxia.

In these experiments, preconditioning prevented the small time-dependent decrease in resting cardiac function that was seen in control hearts (Fig. 5). We do not have an explanation for this observation at this time. However, we feel it is unlikely that the “preconditioning effect” we report is related to the prevention of hyperoxia-mediated myocardial injury, rather than protection against anoxia-mediated damage. First, if hyperoxic perfusion (free radical generation) was mediating the time-dependent loss of resting cardiac func-
tion and preconditioning diminished/prevented this effect, we would have expected $P_in$ to increase less in the preconditioned group between “before $Q_{max}$ 1” and “before anoxia.” This was not the case; the increase in $P_in$ was the same in both groups. Second, although free radical generation is a major contributor to reperfusion-mediated myocardial damage in the mammalian heart, it is not clear whether hyperoxia increases this myocardial damage. Schnier et al. (43), using an opened-chest rabbit model, showed that hyperoxic reperfusion (arterial $P_{O_2}$ 550 mmHg) did not result in more myocardial necrosis following 45 min of ischemia compared with normoxic (arterial $P_{O_2}$ 96 mmHg) reperfusion. Sterling et al. (44) showed that hyperbaric oxygen (100% $O_2$, 2.5 atm) reduced infarct size in the perfused rabbit heart compared with normobaric hyperoxia. In contrast, Hearse et al. (24) showed that reperfusion damage in crystalloid-perfused rat hearts increased with $P_O_2$.

**Perspectives**

The present study demonstrated that brief (5 min) anoxic preexposure completely eliminated the loss of cardiac function that normally follows a 15-min anoxic period and that this protection was associated with an increased rate of anaerobic glycolysis. These data provide the first evidence that myocardial preconditioning exists in fishes and suggest that preconditioning is a mechanism of myocardial protection that preceded the evolution of homeotherms. At present, it is not known whether preconditioning in the fish heart is restricted to myocardium that normally receives highly oxygenated arterial blood or whether the cellular mechanisms that mediate preconditioning (e.g., protein kinase C, ATP-sensitive $K^+$ channels, adenosine, etc.) in mammals are similar to those that mediate preconditioning and inherent myocardial hypoxia tolerance in the fish heart. These are intriguing questions, the answers to which have the potential to yield novel information about hypoxia tolerance of the fish myocardium and to provide further evidence that myocardial protection against ischemia/hypoxia-related damage in mammals and fishes is fundamentally similar. However, quantitative techniques for the measurement of myocardial necrosis in the perfused fish heart should be developed before these important experiments are conducted.

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